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SHORTER ARTICLES/COMMENTS

THE RIGHT TO CHOOSE

Re C (Adult: Refusal of Medical Treatment)[1]

Introduction

DURING the past few years, starting with the decision of the House of Lords in *F* v *West Berkshire Health Authority,*[2] there have been several cases concerning the circumstances in which, in the absence of his consent, a patient may be ordered to receive medical treatment. In addition, in the landmark decision in *Airedale NHS Trust* v *Bland,*[3] the House of Lords considered the circumstances in which the medical treatment of a person might legitimately be terminated, even where the patient is unable to consent, and where the inevitable consequence of such termination will be his death. In the recent case of *Re C,*[4] the High Court in England has given further thought to the question of when a patient is, or is not, competent to control his own medical destiny.

The specific question which the court had to answer in *Re C* was whether or not a mentally ill patient was competent to withhold his consent to medical treatment, even though his failure to receive such treatment might endanger his life. It is necessary to look in some detail at the facts of the case and the medical evidence facing the judge, Thorpe J, in order to examine the legal significance of the decision.[5]

1 [1994] 1 All ER 819.

2 [1989] 2 All ER 545, *sub nom Re F (mental patient: sterilisation)* [1990] 2 AC 1 [1989] 2 WLR 1025.

3 [1993] 1 All ER 821, [1993] AC 789, [1993] 2 WLR 316 (*Bland's* case).

4 *Supra*, note 1.

5 In Singapore, the Mental Disorders and Treatment Act (Cap 178, 1985 Rev Ed) prescribes the law and procedure for managing the affairs of mentally incompetent patients. However, the Act is concerned with the making of orders for treatment of the patient's mental condition, and makes no specific provision for ordering him to have other forms of medical treatment. There are references in the Act to committees being appointed for "managing [the] affairs" of mental patients (see, *eg*, s 9), but it was held in *F* v *West Berkshire Health Authority*,

The Facts of Re C

Re C concerned a 68-year old man (the plaintiff in the action) who had been in Broadmoor Mental Hospital for almost thirty years, suffering from chronic paranoid schizophrenia. He had been transferred there from Brixton Prison during the 1960s, when it had become apparent that he was mentally ill. At the time of his transfer, he had been serving a seven-year prison sentence for stabbing a woman with whom he had formerly lived. In Broadmoor, he had been treated with various drugs, and with ECT (electro-convulsive therapy), and had long since ceased to be violent. In recent years he had been in an open ward of the parole house, and had been showing signs of growing gradually more sociable.

In September 1993, the staff at Broadmoor noticed that he had a swollen leg. The surgeon at Broadmoor diagnosed gangrene in the foot, and he was transferred to a local hospital, where he was seen by the hospital's consultant vascular surgeon, who found the leg to be grossly infected, with a necrotic ulcer covering the back. He considered that, unless the leg was amputated below the knee, the plaintiff would die in the very near future. At that time, he was of the opinion that the chances of the plaintiff surviving if he had more conservative treatment (*ie,* short of amputation) were 15% at best. However, the plaintiff refused to consider amputation, saying that he would "rather die with two feet than live with one.[6]" The surgeon, nevertheless, booked the plaintiff in for an operation to amputate the leg in five days' time, in the hope that the plaintiff would change his mind.

For a short while, the authorities at Broadmoor apparently thought that it would be possible to perform the operation without the plaintiff's consent as long as two surgeons agreed that he was not capable of deciding the matter for himself. However, two days before the operation was due to take place, arrangements were made for a solicitor to see the plaintiff. The solicitor established that the plaintiff was not going to consent to the operation, and discussed with the hospital's solicitor the need for the hospital to obtain a court order before the operation could take place. Meanwhile, the plaintiff, who was being treated with antibiotics, made some improvement.

The plaintiff's resident medical officer, a consultant forensic psychiatrist, then tried to persuade the plaintiff that he should have the amputation. The

supra, note 2, that almost identical wording in s 93(1) of the English Mental Health Act 1983 (c 20) referred solely to the managing of a patient's business affairs and the like, and did not extend to making decisions with regard to medical treatment. Thus, assuming that the same interpretation is given to the relevant words in Singapore, questions of medical treatment will technically be governed by the common law rules relating to such matters. For this reason, given the general influence of English decisions in this area, developments in the UK are pertinent in Singapore.

6 *Supra*, note 1, at 821.

plaintiff persisted in his refusal. The surgeon who was due to carry out the operation had by then made it clear that under no circumstances would he operate without the plaintiff's unequivocal consent. Therefore, the operation to amputate the leg was abandoned. The plaintiff did, however, agree to have more limited surgery to remove the dead tissue from the leg. This operation was successful, and the risk of his imminent death receded.

While these events were taking place, the plaintiff's solicitor sought from the hospital's solicitor an undertaking that the hospital would not amputate in any future circumstances, given the plaintiff's continuing refusal to consent to such a procedure. That request was refused, and so the plaintiff's solicitor arranged for an originating summons to be issued on the plaintiff's behalf, seeking an injunction to restrain the hospital from amputating his leg in the present or the future without his express consent.

The Medical Evidence

The summons was heard at the hospital a few days later. An outside expert in forensic psychiatry was called to give evidence, and a consultant psychiatrist from the hospital who had not hitherto been intimately involved with the plaintiff's case was called on to report. In addition, the consultant psychiatrist and the consultant surgeon who had been treating the plaintiff gave their views. Thorpe J assessed the opinions of the various experts. Where the psychiatric assessment of the plaintiff was concerned, he preferred the views of the outside expert to those of the plaintiff's own psychiatrist.[7]

The opinion of the outside expert was that, even though the plaintiff's capacity to decide whether or not he should have the operation was reduced by his mental illness, he was still capable of reaching a decision. Although the plaintiff was suffering from an all-pervasive mental illness giving rise to persecutory delusions, there was no evidence that these delusions had led him to believe that his present condition had been caused by the authorities who were treating him. The plaintiff was able to take in and retain information about the proposed treatment, even if he did not really believe it and was not able to evaluate it. It was not clear whether his failure to believe that he could die in the near future if he refused the amputation was caused by his mental illness, or by ordinary convictions, or both. In these circumstances, the expert was of the opinion that the need to preserve life must be weighed against the need to allow patient autonomy. In the

[7] The plaintiff's own psychiatrist was firmly of the view that the plaintiff was incapable of deciding for himself whether or not he should have had the amputation. Her evidence was, however, rejected in part because she had not been informed of the reduced risk of immediate mortality following the alternative treatment which the plaintiff had received, and Thorpe J was of the view that her belief in the plaintiff's imminent death had influenced her assessment of his ability to decide whether or not to agree to the amputation.

absence of mental impairment, autonomy would be the paramount consideration. The greater the degree of impairment, the less weight autonomy could command. On the facts of this case, the degree of impairment was not, in his opinion, sufficient to outweigh the demand for autonomy.

The opinion thus expressed was entirely compatible with the evidence of the the surgeon, who had already refused to operate in the absence of the plaintiff's consent. The surgeon stressed his belief in the sanctity of the individual's choice, however wrong one might objectively judge that choice to be. He did not regard the plaintiff's mental state as deviating from the mean, having dealt with many patients who had refused to have limbs amputated, and he was prepared to respect the plaintiff's wishes and treat him with intravenous antibiotics. He was of the opinion that the plaintiff's leg might continue to heal, or that it might again become necrotic. If the gangrene were to return, it would be life-threatening if it returned in a wet form (though not if it took the form of dry gangrene). He also pointed out that an operation to amputate a limb would itself carry a 15% risk of death.

The Decision in Re C

In view of the evidence given by these experts, and the evidence of the plaintiff himself, Thorpe J held that the plaintiff was capable of refusing to give his consent to the amputation, and he granted the injunction sought by the plaintiff to prevent such an operation from being performed. Though recognising that it was very unlikely that any efforts would be made to amputate the limb while the present surgeon was at the hospital, Thorpe J felt that the plaintiff must be protected against the possibility of that surgeon moving, or of the plaintiff himself being treated elsewhere, and he thus extended the order to cover future circumstances.[8]

Thorpe J's Reasoning

In reaching his decision, Thorpe J referred to two recent cases – the decision of the Court of Appeal in *Re T (Adult: Refusal of Medical Treatment)*[9] and the decision of the House of Lords in *Bland's* case.[10] *Re T* concerned

[8] Some commentators have suggested that, in making this novel order, Thorpe J was confirming the position of 'advance directives' where medical treatment is concerned. Such directives may, it seems, apply even to situations arising after a patient has become incompetent. (See the House of Lords *Report of the Select Committee on Medical Ethics*, HL Paper 21-I, 1994, p 39).

[9] [1992] 4 All ER 649 [1993] Fam 95 (*Re T*).

[10] *Supra*, note 3.

a woman who had signed a form refusing to consent to a blood transfusion, under the influence of her mother (a Jehovah's Witness), and possibly without knowing that such a transfusion might be necessary to save her life. Her father sought a declaration that, her refusal to consent to a transfusion notwithstanding, the health authorities treating her could administer such treatment if they considered it to be in her best interests to do so. *Bland's* case concerned one of the victims of the Hillsborough Football Stadium disaster, who had been in a persistent vegetative state for several years. The health authorities treating him applied for a declaration that it was lawful, in his own best interests, to cease treating him and to allow him to die naturally. In each case the declarations sought were ultimately granted – in *T's* case retrospective confirmation of the legitimacy of administering the transfusion was given, and in *Bland's* case the treatment was terminated.

Of the two cases, *Re T*, dealing with the validity or otherwise of the refusal to consent to medical treatment, was clearly the more applicable on the facts. *Bland's* case was important not so much for its factual similarities, as for the unequivocal acceptance by the House of Lords of the reasoning in *Re T*.

In reaching his decision, Thorpe J referred to the summary given by Lord Donaldson MR in *Re T* of the applicable legal principles in the area:

> (1) *Prima facie* every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so, notwithstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable.
>
> (2) An adult patient may be deprived of his capacity to decide by long-term mental incapacity or retarded development or by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs.
>
> (3) If an adult patient did not have the capacity to decide at the time of the purported refusal and still does not have the capacity, it is the duty of the doctors to treat him in whatever way they consider, in the exercise of clinical judgment, to be in his best interests.

> (4) Doctors faced with a refusal of consent have to give very careful and detailed consideration to what was the patient's capacity to decide at the time when the decision was made. It may not be a case of capacity or no capacity. It may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or irreparable damage to health. Others may not.[11]

Based on the expert evidence before him, Thorpe J concluded that the plaintiff in this case, although suffering from a reduced capacity, was nonetheless competent to refuse the proposed amputation:

> I am completely satisfied that the presumption that C has the right to self-determination has not been displaced. Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice.[12]

The Significance of the Decision in Re C

At first blush, the case may appear to be of limited significance – merely applying to a novel set of circumstances well-established legal principles. However, as an indicator of a possible trend towards greater patient autonomy, it is not without importance.

As Thorpe J recognised, in all cases involving medical treatment, the starting point is the presumption that every adult patient is able, and entitled, to decide whether or not he wishes treatment which has been proposed for him to be administered.[13] The presumption thus leads to the general rule that no one can be forced, against his will, to undergo medical treatment. Medical treatment administered in the absence of consent will, therefore, normally amount to the tort of battery. The presumption, and thus the need for consent, can be rebutted only where the court is convinced that the patient is, in some way, mentally incapacitated; and, even then, there must

[11] *Supra*, note 9, at 664, cited by Thorpe J in *Re C*, *supra*, note 1, at 824.

[12] *Supra*, note 1, at 824.

[13] See the dictum of Lord Donaldson in *Re T*, *supra*, note 11, which was quoted by Thorpe J in giving his judgment in this case.

be sufficient evidence that the patient's mental incapacity makes it impossible for him to make this particular medical decision, and not just that he is, in general terms, less able to make rational decisions than are ordinary members of society.[14] Since it is not possible for anyone else to consent to medical treatment on behalf of an adult patient,[15] the court in "incompetence" cases must decide whether or not the treatment should be administered. To do this, it uses the test of whether it considers the proposed treatment to be in the "best interests" of the patient.[16]

As a general rule, then, the presumption of patient competence and patient autonomy should prevail, even where the patient's decision may be universally condemned, and where it may result in hastening his death. However, if one looks at the cases in this area, from *F* v *West Berkshire Health Authority*[17] onwards, all, with the sole exception of *Re C* itself, have resulted in decisions where the presumption of patient competence has been rebutted, and where the courts have therefore found themselves applying the "best interests" test.

It is true that, in order for medical consent cases to come before the courts at all, there must be some compelling reason for arguing that the patient does not have the capacity either to give or to withhold the relevant consent. It is not, therefore, necessarily surprising that, in virtually all of the cases to date, the courts have been convinced of the patients' inability to decide for themselves. It is also true that, in most of the key cases where the patient has been deemed incapable of giving or withholding consent (and the courts have thus had to use the "best interests" test) the mental incompetence of the patient has been clear, as has the benefit of the proposed medical procedure. *F* v *West Berkshire Health Authority,*[18] a typical example, involved a 36-year old woman who had a mental capacity of only a four or five-year old, and who was at risk of becoming pregnant if she was not sterilised. She was clearly incapable of deciding whether or not to undergo the relevant surgical procedure, and she was equally clearly incapable of undergoing pregnancy and childbirth. In cases of this type, the fact that the presumption of competence is rebutted is hardly a matter to be commented upon.

14 *Ibid*.

15 This was conclusively established by the House of Lords in *F* v *West Berkshire Health Authority*, *supra*, note 2.

16 The test, which was originally adopted by the House of Lords in *F* v *West Berkshire Health Authority*, *supra*, note 2, has subsequently been applied in many cases, including *Re T*, *supra*, note 9, and *Bland's* case, *supra*, note 3.

17 *Supra*, note 2.

18 *Ibid*.

Cases in this area have not always, however, been so cut and dried. If one looks at *Re T,*[19] the case which set out the legal principles applied by Thorpe J in this case, it becomes more difficult to say with complete confidence that the patient could not possibly have had the mental capacity to make the relevant decision. In *Re T*, the plaintiff was not suffering from any form of mental illness, and was apparently of normal intelligence. The Court of Appeal nevertheless decided that, when she had signed a form refusing to consent to a blood transfusion, she had done so under the undue influence of her mother, a devout Jehovah's Witness. The undue influence thus made her refusal ineffective. One might well argue that the court's decision was a humane and, indeed, necessary one, given the imminent threat to the young woman's life in the absence of a transfusion. Furthermore, in that case, there was some question as to whether the patient was specifically informed before she signed the form that a transfusion might be necessary to save her life, and thus it was uncertain whether she fully understood the implications of what she was signing. However, the fact remains that the Court of Appeal in that case, applying the fourth of the principles outlined by Lord Donaldson,[20] decided to override the specific written instructions of a sane and mentally stable woman on the basis that her capacity was reduced below the level necessary to make a life and death decision of this kind. The decision was undoubtedly morally justifiable, but there is an argument that, legally, when faced with a borderline case, the court favoured paternalism over autonomy.

Thorpe J, in *Re C*, another borderline case, decided, on the evidence of experts, to favour autonomy. He was thus prepared to respect the wishes of a person who had, for many years, been suffering from an all-pervasive mental illness; this even in circumstances where that person was known to have a reduced mental capacity, and where the effect of honouring the person's wishes might be to precipitate his death.

Conclusion

The decision in *Re C* may thus indicate a growing willingness on the part of the English courts to respect patient autonomy, even in the most unusual of circumstances. It is unlikely that the decision will be appealed.[21] On one

[19] *Supra*, note 9.

[20] See *supra*, note 11.

[21] In this case, unusually, the patient was not only the plaintiff, but he also effectively initiated the action himself. Since his wishes have prevailed, there is little reason for the authorities to force the issue by taking the case further, as the Official Solicitor would normally do in cases where either the patient is nominally the defendant, and the action is initiated by the authorities seeking to impose or limit the relevant treatment (as in *Re T*), or where, even though the patient is nominally the plaintiff, the action is actually brought by a next friend

level, of course, the case merely offers confirmation of the views expressed in *Bland's* case[22] – that medical cases turn very much on their own facts, and that it is, for this reason, difficult to establish reliable precedents. On another level, however, the case is far more important. It recognises, and such recognition is not always fully apparent in decisions in this area, that the concept of patient autonomy is the rule, rather than the exception. Even in situations where the patient is mentally ill, and suffering from delusions, there can be no automatic assumption in favour of medical paternalism. A patient need not be rational; he need not even be sane. He need only understand the nature and effect of the proposed medical procedure for his consent, or lack thereof, to be valid. If such understanding can be shown, then the fact that his medical advisers may disagree with his decision is irrelevant.

Bland's case, though not a consent case (since the patient's persistent vegetative state made it quite impossible for him to decide whether or not his treatment should be discontinued) also lends some support to Thorpe J's decision. It shows that life itself is not always the only goal where medical treatment, or its cessation or limitation, is concerned. The quality of life is also a key consideration. In *Bland's* case, the House of Lords recognised that it could actually be in a patient's best interests to die, in circumstances where his continued existence was effectively valueless. Similarly, in *Re C*, the court was prepared to give considerable weight to the patient's view that he would rather die than lose a limb, since the quality of his life without it would, in his opinion, be so reduced as to make life no longer worth living.

There will be many observers who feel that, in reaching this decision, Thorpe J has gone too far. There is, after all, a strong argument that the most vulnerable members of society should be protected not only from dangers posed by others but also from dangers which they pose to themselves. However, there is an equally strong argument that even the most vulnerable have a right to self-determination, a right which should be overridden only in the most extreme circumstances. Such was the argument favoured by Thorpe J. We must await an opportunity for the higher courts to examine a case of this kind before determining whether or not the trend set in this case will be continued.

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(as in *F* v *West Berkshire Health Authority*). Moreover, without reopening questions of fact, there would be little to appeal in this decision.

22 *Supra*, note 3.

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