

CHAPTER 19

- Reading 19.1 **Kennedy, I. (1996). Patients, doctors and human rights. In *Treat Me Right: Essays in Medical Law and Ethics*. Oxford: Clarendon Press.**
- Reading 19.2 **McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, p. 335.**
- Reading 19.3 **McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, pp. 269–271.**
- Reading 19.4 **(1) Roth, L., Meisel, A., and Lidz, C. (1977). Tests of competency to consent to treatment. *American Journal of Psychiatry* 134: 279 (extracted in Kennedy, I. and Grubb, A. (2000). *Medical Law: text with materials*, (3rd edn). London: Butterworths, pp. 124–129), and (2) the case of *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819. pp. 819–825.**
- Reading 19.5 **McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, pp. 341–51**
- Reading 19.6a **Lord Chancellor's Department (1997). The key principles: capacity, best interests, and the general authority to act reasonably. In: *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*. Cmnd 3803. London: The Stationary Office Ltd, pp. 11–13 (Chapter 3).**
- Reading 19.6b **Szmukler, G. and Holloway, F. (1998). Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin*, 22: 663, 664.**
- Reading 19.6c **Fulford, K.W.M. (1998). Replacing the Mental Health Act 1983? How to change the game without losing the baby with the bath water or shooting ourselves in the foot. *Psychiatric Bulletin*, 22: 666, 667, 668.**
- Reading 19.6d **Sayce, L. (1998). Transcending mental health law. *Psychiatric Bulletin*, 22: 669**
- Reading 19.7 **Dickenson, D. and Fulford, K.W.M. (2000). In *Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press, (Extract page 91–92.)**

Readings 19.1**EXERCISE 1**

Read the three short extracts from: Kennedy, I. (1996). Patients, doctors and human rights. In *Treat Me Right: Essays in Medical Law and Ethics*. Oxford: Clarendon Press.

Extract 1: p 387

So, I will adopt here a frank assertion of rights inherent in the doctor-patient relationship. Apart from arguments of principle which elaborate the basis and nature of such rights, I assert them for a further contingent reason. As between the doctor and the patient there is an inevitable imbalance or disequilibrium of power. The doctor has information and skill which the patient, who lacks these, wishes to employ for his benefit. When it is remembered that among the powers possessed by the doctor is the privilege to touch and even invade the body of another and as a consequence exercise control to a greater or lesser extent over that person, it will be clear that, with the best will in the world, and conceding the good faith of the doctors, such powers must be subject to control and scrutiny, from an abundance of caution. This is the role of patients' rights, whereby the permissible limits are set by ethics and law to the exercise of the doctor's power.

Perhaps I should make it clear, before proceeding further, that as a matter of ethical analysis, when I talk of rights in the context of medical practice, I am talking of *prima facie* rights rather than absolute rights. This is not to deny that absolute rights may be urged by some. Instead, it is to suggest that in the everyday practice of medicine by civilised doctors in a civilised community, such absolute rights, if they exist, are not usually called into play. Thus, the rights we are concerned with are *prima facie* to be observed, by which I mean that they are to be observed in the absence of any powerful justifying argument which allows to be overridden. And, of course, any such justification must itself be derived from a morally sound principle.

Extract 2: pp 388–389**Consent**

All of these issues have attracted the attention of English law, whether by legislation or judicial decision; the response of English law has been to consider them as *ad hoc* factual problems to be dealt with by reference to traditional legal frameworks. As I have suggested, however, this may not be satisfactory. It may well cause certain themes and principles to be lost sight of. For example, it is clear that the single most important theme which runs through the examples I have given is the theme of *consent*. And

consent is, of course, the legal and ethical expression of the human right to respect for autonomy and self-determination. Lawyers who fail to recognize this and other such unifying themes may find themselves fighting the cause of patients on difficult ground, where everything turns on the meaning of a sub-clause of a statute, and in circumstances in which the court has been mesmerised once again by the spectre of doom which would follow any holding of liability against the doctor. Lawyers who do recognise the central role of human rights argue their cases against a wider background and take their cases further, out of the narrow confines of domestic law and into the more understanding environment of, for example, the European Convention on Human Rights.

Extract 2: pp 389–390

Seeing and understanding the legal concept of consent as the expression of the right to autonomy provides us with an ever-present example of, and alerts us to the need to recognise and explore, this unifying ethical theme or principle when considering apparently disparate areas of medical practice. First, respect for autonomy, in the form of a requirement of consent before a person may be touched, is contingent on the competence of the person to consent. Autonomy is not respected if reliance is placed on the expression of view of an incompetent person. The treatment of the mentally ill, the mentally handicapped, the senile or the child, while medically different, each have this in common and prompt a search at the level of abstract analysis for an appropriate meaning of competence and ways of establishing it. Secondly, respect for autonomy translated as the legal requirement of consent must also take account of whether the consent is given voluntarily. Out of this grows the notion of vulnerability. It becomes clear that it is not only a violation of respect for autonomy to *compel* someone to be treated, but also to take advantage of, or prey on, the vulnerability of patients to gain apparent consent. In this way, such different questions as whether it is right to treat compulsorily the mentally ill or the pregnant woman who refuses a caesarean section, to offer relief from prison on terms that the sex offender undergo castrating hormone therapy, or to take advantage of the prisoner, the impecunious the unemployed, or the patient-anxious-to-please by enrolling them as 'volunteers' in research, are seen as variations on a common theme. Finally, respect for autonomy in the legal form of consent requires an examination of whether the consent is appropriately informed. The whole range of interchanges between doctor and patient, from simple injection or prescription of medicine to life-saving operations, fall to be analysed by reference to this central principle as law and ethics seek to respond to the disequilibrium of power between doctor and patient.

Reading 19.2

EXERCISE 2

A typical consent form reproduced from: McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, p. 335.

CONSENT FORM

A(1)

For medical or dental investigation, treatment or operation

Health Authority Patient's Surname
 Hospital Other Names
 Unit Number Date of Birth
 Sex (*Please tick*) Male Female

DOCTORS OR DENTISTS (*This part is to be completed by doctor or dentist*)

See notes on reverse

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgment are suited to the understanding of the patient and/or to one of the parents or guardians of the patient

Signature Date
 Name of doctor or dentist

PATIENT/PARENT/GUARDIAN

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you don't understand about the explanation, or if you want more information, you should ask the doctor or dentist.
3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient/parent/guardian (*delete as necessary*)

I agree to what is proposed which has been explained to me by the doctor/dentist named on this form.

to the use of the type of anaesthetic that I have been told about.

I understand that the procedure may not be done by the doctor/dentist who has been treating me so far.

that the procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told the doctor or dentist about the procedures listed below I would *not* wish to be carried out straightaway without my having the opportunity to consider them first.

.....

Signature

Name

Address

(*if not the patient*)

Reading 19.3

EXERCISE 3

Extract From: McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, pp. 269–271.

Re T (Adult: Refusal of Treatment) [1992] 4 all E.R. 649, [1993] Fam 95, [1992] 3 W.L.R. 782, [1992] 2 F.L.R. 458, 9 BMLR 46, [1992] 3 Med. L.R. 306.

T was pregnant. She was involved in a car accident and went into premature labour which necessitated a Caesarean section operation. T's mother was a Jehovah's witness, although T herself was not. Shortly after a conversation with her mother, T told the hospital staff that she did not want a blood transfusion and signed a form refusing one. Prior to that point she had not indicated any concern about a transfusion. In the event the Caesarean section was carried out without the need for a blood transfusion, although the baby was still-born. However, T's condition subsequently deteriorated and she was admitted to an intensive care unit, where it was decided that without a blood transfusion she would die. The Court of Appeal had to decide whether her earlier refusal of a transfusion, in relation to the Caesarean section, precluded the court from authorising a transfusion in the new situation. The case raised a number of issues. First, it was necessary to consider whether her refusal was legally valid. This involved examining the test for capacity to decide whether or not to accept treatment. It was the first English case squarely to confront this issue in relation to adults. The Court of Appeal also considered whether T's purported refusal of consent was invalidated due to her mother's influence. This issue is addressed in Chapter 6 at pages 370–371. Finally, the Court of Appeal discussed the law governing a patient's right to refuse, in advance, treatments that they envisaged might be imposed upon them at some time in the future when they had lost their capacity to consent. That aspect of the case is examined in Chapter 14.

Lord Donaldson M.R.

“... The law requires that an adult patient who is mentally and physically capable of exercising a choice *must* consent if medical treatment of him is to be lawful, although the consent need not be in writing and may sometimes be inferred from the patient's conduct in the context of the surrounding circumstances. Treating him without his consent or despite a refusal of consent will constitute the civil wrong of trespass to the person and may constitute a crime. If, however, the patient has made no choice and, when the need for treatment arises, is in no position to make one, the classic emergency situation with an unconscious patient, *e.g.* the practitioner can lawfully treat the patient in accordance with his clinical judgment of what is in the patient's best interest.

There seems to be a view in the medical profession that in such emergency circumstances the next of kin should be asked to consent on behalf of the patient and that, if possible, treatment should be postponed until that consent has been obtained. This is a misconception because the next of kin has no legal

right either to consent or to refuse consent. This is not to say that it is an undesirable practice if the interests of the patient will not be adversely affected by any consequential delay. I say this because contact with the next of kin may reveal that the patient had made an anticipatory choice which, if clearly established and applicable in the circumstances—two major ‘ifs’—would bind the practitioner. Consultation with the next of kin has a further advantage in that it may reveal information as to the personal circumstances of the patient and as to the choice which the patient might have made, if he or she had been in a position to make it. Neither the personal circumstances of the patient nor a speculative answer to the question ‘What would the patient have chosen?’ can bind the practitioner in his choice of whether or not to treat or how to treat or justify him in acting contrary to a clearly established anticipatory refusal to accept treatment but they are factors to be taken into account by him in forming a clinical judgment as to what is in the best interests of the patient. For example, if he learnt that the patient was a Jehovah's Witness, but had no evidence of a refusal to accept blood transfusions, he would avoid or postpone any blood transfusion so long as possible . . .

The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned. However a small minority of the population lack the necessary mental capacity due to mental illness or retarded development (see, for example, *F v. West Berkshire Health Authority* [1989] 2 all E.R. 545). This is a permanent or at least a long-term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment.

Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. It may not be the simple case of the patient having no capacity because, for example, at that time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the patient had the requisite capacity, they are bound by his decision. If not, they are free to treat him in what they believe to be his best interests.

This problem is more likely to arise at a time when the patient is unconscious and cannot be consulted. If he can be consulted, this should be done, but again full account has to be taken of his then capacity to make up his own mind.

As I pointed out at the beginning of this judgment, the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent. That his choice is contrary to what is to be expected of the vast majority of adults is only relevant if there are other reasons for doubting his capacity to decide. The nature of his choice or the terms in which it is expressed may then tip the balance . . .”

Reading 19.4**EXERCISE 4**

Two readings, as extracts from: (1) Roth, L., Meisel, A., and Lidz, C. (1977). Tests of competency to consent to treatment. *American Journal of Psychiatry* 134: 279 (extracted in Kennedy, I. and Grubb, A. (2000). *Medical Law: text with materials*, (3rd edn). London: Butterworths, pp. 124–129), and (2) the case of *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819. pp. 819–825.

Extract 1**Tests for competency**

Several tests for competency have been proposed in the literature; others are readily inferable from judicial commentary. Although there is some overlap, they basically fall into five categories: 1) evidencing a choice, 2) 'reasonable' outcome of choice, 3) choice based on 'rational' reasons, 4) ability to understand, and 5) actual understanding.

Evidencing a choice

This test for competency is set at a very low level and is the most respectful of the autonomy of patient decision-making. Under this test the competent patient is one who evidences a preference for or against treatment. This test focuses not on the quality of the patient's decision but on the presence or absence of a decision. This preference may be a yes, a no, or even the desire that the physician make the decision for the patient. Only the patient who does not evidence a preference either verbally or through his or her behaviour is considered incompetent. This test of competency encompasses at a minimum the unconscious patient; in psychiatry it encompasses the mute patient who cannot or will not express opinion.

This test may be what one court had in mind when, with respect to sterilisation of residents of state schools, it rules that even legally incompetent and possibly noncomprehending residents may not be sterilized unless they have formed a genuine desire to undergo the procedure.

The guidelines proposed by the US Department of Health, Education and Welfare concerning experimentation with institutionalised mentally ill people also point in this direction by requiring even the legally incompetent person's 'assent to such participation . . . when . . . he has sufficient mental capacity to understand what is proposed and to express an opinion as to his or her participation.' Although this low test of competency does not fully assure patients' understanding of the nature of what they consent to or what they refuse, it is behavioural in orientation and therefore more reliable in application; it also guards against excessive paternalism.

'Reasonable' outcome of choice

This test of competency entails evaluating the patient's capacity to reach the 'reasonable', the 'right', or the 'responsible' decision. The emphasis in this test is on outcome rather than on the mere fact of a decision or how it has been reached. The patient who fails to make a decision that is roughly congruent with the decision that a 'reasonable' person in like circumstances would make is viewed as incompetent.

This test is probably used more often than might be admitted by both physicians and courts. Judicial decisions to override the desire of patients with certain religious beliefs not to receive blood transfusions may rest in part on the court's view that the patient's decision is not reasonable. When life is at stake and a court believes that the patient's decision is unreasonable, the court may focus on even the smallest ambiguity in the patient's thinking to cast doubt on the patient's competency so that it may issue an order that will preserve life or health. For example, one judge issued an order to allow amputation of the leg of an elderly moribund man even though the man had clearly told his daughter before his condition deteriorated not to permit an amputation.

Mental health laws that allow for involuntary treatment on the basis of 'need for care and treatment' without requiring a formal adjudication of incompetency in effect use an unstated reasonable outcome test in abridging the patient's common-law right not to be treated without giving his or her consent. These laws are premised on the following syllogism: the patient needs treatment; the patient has not obtained treatment on his or her own initiative; therefore, the patient's decision is incorrect, which means that he or she is incompetent, thus justifying the involuntary imposition of treatment.

The benefits and costs of this test are that social goals and individual health are promoted at considerable expense to personal autonomy. The reasonable outcome test is useful in alerting physicians and courts to the fact that the patient's decision-making process may be, but not necessarily is, awry. Ultimately, because the test rests on the congruence between the patient's decision and that of a reasonable person or that of the physician, it is biased in favour of decisions to accept treatment, even when such decisions are made by people who are incapable of weighing the risks and benefits of treatment. In other words, if patients do not decide the 'wrong' way, the issue of competency will probably not arise.

Choice based on 'rational' reasons

Another test is whether the reasons for the patient's decision are 'rational', that is, whether the patient's decision is due to or is a product of mental illness. As in the reasonable outcome test, if the patient decides in favour of treatment the issue of the patient's competency (in this case, whether the decision is the product of mental illness) seldom if ever arises because of the medical

profession's bias towards consent to treatment and against refusal of treatment.

The test of rational reasons, although it has clinical appeal and is probably much in clinical use, poses considerable conceptual problems; as a legal test it is probably defective. The problems include the difficulty of distinguishing rational from irrational reasons and drawing inferences of causation between any irrationality believed present and the valence (yes or no) of the patient's decision. Even if the patient's reasons seem irrational, it is not possible to prove that the patient's actual decisionmaking has been the product of such irrationality. The patient's decision might well be the same even if his or her cognitive processes were less impaired. For example, a delusional patient may refuse ECT not because he or she is delusional but because he or she is afraid of it, which is considered a normal reaction. The emphasis on rational reasons can too easily become a global indictment of the competency of mentally disordered individuals, justifying widespread substitute decision making for this group.

The ability to understand

This test—the ability of the patient to understand the risks, benefits and alternatives to treatment (including no treatment)—is probably the most consistent with the law of informed consent. Decision making need not be rational in either process or outcome; unwise choices are permitted. Nevertheless, at a minimum the patient must manifest sufficient ability to understand information about treatment, even if in fact he or she weights this information differently from the attending physician. What matters in this test is that the patient is able to comprehend the elements that are presumed by law to be a part of treatment decisionmaking. How the patient weights these elements, values them, or puts them together to reach a decision is not important.

Some of the questions raised by this test of competency are, What is to be done if the patient can understand the risks but not the benefits or vice versa? Alternatively, what if the patient views the risks as the benefits?

Furthermore, how potentially sophisticated must understanding be in order that the patient be viewed as competent? There are considerable barriers, conscious and unconscious and intellectual and emotional, to understanding proposed treatment. Presumably the potential understanding required is only that which would be manifested by a reasonable person provided with a similar amount of information. A few attempts to rank degrees of understanding have been made. However, this matter is highly complex and beyond the scope of the present inquiry. Certainly, at least with respect to nonexperimental treatment, the patient's potential understanding does not have to be perfect or near perfect for him or her to be considered competent, although one court seemed to imply this with respect to experimental psychosurgery. A final problem with this test is that its application depends on unobservable and inferential mental processes rather than on concrete and observable elements of behaviour.

Actual understanding

Rather than focusing on competency as a construct or intervening variable in the decisionmaking process, the test of actual understanding reduces competency to an epiphenomenon of this process. The competent patient is by definition one who has provided a knowledgeable consent to treatment. Under this test the physician has an obligation to educate the patient and directly ascertain whether he or she has in fact understood. If not, according to this test the patient may not have provided informed consent. Depending on how sophisticated a level of understanding is to be required, this test delineates a potentially high level of competency, one that may be difficult to achieve.

The provisional decision of DHEW to mandate the creation of consent committees to oversee the decisions of experimental subjects implicitly adopts this test, as does the California law requiring the review of patient consent to ECT. Controversial as these requirements may be, they require physicians to make reasonable efforts to ascertain that their patients understand what they are told and encourage active patient participation in treatment selection.

The practical and conceptual limitations of this test are similar to those of the ability-to-understand test. What constitutes adequate understanding is vague, and deficient understanding may be attributable in whole or in part to physician behaviour as well as to the patient's behaviour or character. An advantage that this test has over the ability-to-understand test, assuming the necessary level of understanding can be specified a priori, is its greater reliability. Unlike the ability-to-understand test, in which the patient's comprehension of material of a certain complexity is used as the basis for an assumption of comprehension of other material of equivalent complexity (even if this other material is not actually tested), the actual understanding test makes no such assumption. It tests the very issues central to patient decisionmaking about treatment.

Extract 2 (Re c Case) p. 819

C, a 68-year-old patient suffering from paranoid schizophrenia, developed gangrene in a foot during his confinement in a secure hospital while serving a seven-year term of imprisonment. He was removed to a general hospital, where the consultant surgeon diagnosed that he was likely to die imminently if the leg was not amputated below the knee. The prognosis was that he had a 15% chance of survival without amputation. C refused to consider amputation. The hospital authorities considered whether the operation could be performed without C's consent and made arrangements for a solicitor to see him concerning his competence to give a reasoned decision. In the meantime, treatment with antibiotics and conservative surgery averted the immediate threat of imminent death but the hospital refused to give an undertaking to the solicitor that in recognition of his repeated refusals it would not amputate in any future circumstances. There was a possibility that C would develop gangrene again. An application

was made on C's behalf to the court for an injunction restraining the hospital from carrying out an amputation without his express written consent. On behalf of the hospital it was contended that C's capacity to give a definitive decision had been impaired by his mental illness and that he had failed to appreciate the risk of death if the operation was not performed.

The plaintiff is 68 and of Jamaican origin. He came to England in 1956, his passage being paid by the woman with whom he had lived since 1949. In 1961 she left him, and in 1962 he accosted her at work and after an altercation stabbed her. He was sentenced at the Old Bailey to seven years' imprisonment. While serving that sentence he was diagnosed as mentally ill and transferred from Brixton to Broadmoor. On admission he was diagnosed as suffering from chronic paranoid schizophrenia. He was treated both with drugs and ECT. Over the years he has mellowed and has been accommodated for the past six years on an open ward of the parole house. He is described as neat and tidy, becoming more sociable with staff and other patients in the past two years.

On 6 August 1993 his annual medical revealed no physical problems. However, on 9 September the staff noticed that he had a swollen leg. The Broadmoor surgeon diagnosed gangrene in the foot and he was transferred to Heatherwood Hospital. On 10 September he was seen there by Dr Ghosh, a consultant forensic psychiatrist, and his resident medical officer at Broadmoor. He told her that he had knocked his foot in the shower about three weeks earlier. On the same day he was seen by Mr Rutter, the consultant vascular surgeon at Heatherwood. He found a grossly infected right leg with a necrotic ulcer covering the whole of the dorsum. Mr Rutter considered that he would die imminently if the leg were not amputated below the knee. He assessed the chances of survival with conservative treatment no better than 15%, but C refused to consider amputation. *He said that he would rather die with two feet than live with one.* Mr Rutter nevertheless booked him in for amputation on 16 September in the hope that consent would be forthcoming when C had had time to adjust to the prospective loss of the limb.

Dr Eastman saw C on 6 October and reported comprehensively in writing on 7 October. In his oral evidence he emphasised that

schizophrenia is an all-pervasive illness. Features present in C's case include *grandiose and persecutory delusions* as well as incongruity of affect, a technical term meaning mismatch between the words spoken and the accompanying emotional display. For the patient offered amputation to save life, there are three stages to the decision: (1) to take in and retain treatment information, (2) to believe it and (3) to weigh that information, balancing risks and needs. C had, in Dr Eastman's opinion, achieved the first stage but not the second. *Did his disbelief in the imminence of death arise out of his mental illness or other ordinary convictions, or a combination of both?* Of course, if to others he showed greater appreciation of the risk of death, that was evidence that he had proceeded further in the progressive stages. *It was significant that the persecutory delusions did not include the conviction that his present condition had been caused by agencies at Broadmoor or Heatherwood. For Dr Eastman, the ultimate conclusion should be reached by weighing in the scales the preservation of life against the autonomy of the patient. If the patient's capacity to decide is unimpaired, autonomy weighs heavier, but the further capacity is reduced, the lighter autonomy weighs. Plainly, C's capacity is reduced by his mental illness. But for him the decision as to whether it is sufficiently reduced remains marginal in the absence of any direct link between the persecutory delusions and his present condition.*

C's oral evidence did not add much to what had been reported by Dr Eastman and Dr Gall. He expressed the grandiose delusions of an international career in medicine during the course of which he had never lost a patient. He affirmed his complete faith in God and, subject to one reservation, in the Bible. He expressed complete confidence in his ability to survive his present trials aided by God, the good doctors and the good nurses. Although he recognised that he would die, death would not be caused by his foot. As he made clear in re-examination, that was his belief, although he could not say that that would not happen. Throughout he expressed his rooted objection to amputation. He did not ascribe the condition of his foot to persecution by authority. As in his interview with Dr Gall, he accepted the possibility of death as a consequence of retaining his limb.

Reading 19.5**EXERCISE 5**

Four extracts from: McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, pp. 341–51

NOTE: In this reading missing text within extracts is shown by “...”

Extract 1: The Case

Sidaway v. Bethlem RHG [1985] 1 All E.R. 643, [1985] 1 A.C. 871, [1985] 2 W.L.R. 480, 1 BMLR 132

Mrs Sidaway had undergone an operation on her spine to relieve pain. That operation involved two specific risks of injury over and above the more general risks of surgery. First, there was a possibility that a nerve root might be damaged in the area of the operation. Secondly, there was a risk that the spinal cord might be damaged. Neither risk was statistically large, estimated at between 1 per cent and 2 per cent by one expert witness. However, the consequences were very serious if either risk was to materialise. In the event, Mrs Sidaway was left severely disabled, with partial paralysis. She sued the doctor who had treated her, alleging that he had failed properly to warn her of the risks inherent in the operation, and that had she been so informed she would not have agreed to the operation. She did not suggest that the operation itself had been carried out negligently. The case was complicated by the fact that the doctor had died by the time it came to trial. He could not, therefore, give evidence about the precise nature of the warning that he had given Mrs Sidaway. Nevertheless, the judge felt able to infer that the doctor probably warned Mrs Sidaway about the risk of damage to the nerve root, but not that of damage to the spinal cord. Further, the judge found that the doctor did not explain to Mrs Sidaway that the operation was not absolutely necessary, but a matter of her choice. The case went to the House of Lords on appeal, on the basis that those were the true facts. The House of Lords had to decide whether the failure to advise Mrs Sidaway of the risk of injury to the spinal cord was negligent. In order to do so, they had to determine the standard of care that was applicable in this area of negligence.

Extract 2: Lord Scarman

...

But was the judge correct in treating the ‘standard of competent professional opinion’ as the criterion in determining whether a doctor is under a duty to warn his patient of the risk, or risks, inherent in the treatment which he recommends?

The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors. Responsible medical judgment may, indeed, provide the law with an acceptable standard in determining whether a doctor in

diagnosis or treatment has complied with his duty. But is it right that medical judgment should determine whether there exists a duty to warn of risk and its scope? It would be a strange conclusion if the courts should be led to conclude that our law, which undoubtedly recognizes a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes.

...

It is, I suggest, a sound and reasonable proposition that the doctor should be required to exercise care in respecting the patient’s right of decision. He must acknowledge that in very many cases factors other than the purely medical will play a significant part in his patient’s decision-making process. The doctor’s concern is with health and the relief of pain. These are the medical objectives. But a patient may well have in mind circumstances, objectives and values which he may reasonably not make known to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion. The doctor’s duty can be seen, therefore, to be one which requires him not only to advise as to medical treatment but also to provide his patient with the information needed to enable the patient to consider and balance the medical advantages and risks alongside other relevant matters, such as, for example, his family, business or social responsibilities of which the doctor may be only partially, if at all, informed.

I conclude, therefore, that there is room in our law for a legal duty to warn a patient of the risks inherent in the treatment proposed, and that, if such a duty be held to exist, its proper place is as an aspect of the duty of care owed by the doctor to his patient. I turn, therefore, to consider whether a duty to warn does exist in our law and, if it does, its proper formulation and the conditions and exceptions to which it must be subject.

Extract 3: Lord Diplock

...

The merit of the *Bolam* test is that the criterion of the duty of care owed by a doctor to his patient is whether he has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion. There may be a number of different practices which satisfy this criterion at any particular time. These practices are likely to alter with advances in medical knowledge. Experience shows that, to the great benefit of humankind, they have done so, particularly in the recent past. That is why fatal diseases such as smallpox and tuberculosis have within living memory become virtually extinct in countries where modern medical care is generally available.

...

My Lords, no convincing reason has in my view been advanced before your Lordships that would justify treating the *Bolam* test as doing anything less than laying down a principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient in the exercise

of his healing functions as respects that patient. What your Lordships have been asked to do, and it is within your power to do so, is to substitute a new and different rule for that part only of the well-established test as comprises a doctor's duty to advise and warn the patient of risks of something going wrong in the surgical or other treatment that he is recommending.

Extract 4: Lord Bridge

...
The important question which this appeal raises is whether the law imposes any, and if so what, different criterion as the measure of the medical man's duty of care to his patient when giving advice with respect to a proposed course of treatment. It is clearly right to recognize that a conscious adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of treatment proposed by the doctor, most significantly surgical treatment under general anaesthesia. This entitlement is the foundation of the doctrine of 'informed consent' which has led in certain American jurisdictions to decisions and, in the Supreme Court of Canada, to dicta on which the appellant relies, which would oust the *Bolam* test and substitute an 'objective' test of a doctor's duty to advise the patient of the advantages and disadvantages of undergoing the treatment proposed and more particularly to advise the patient of the risks involved.

...
A very wide variety of factors must enter into a doctor's clinical judgment not only as to what treatment is appropriate for a particular patient, but also as to how best to communicate to the patient the significant factors necessary to enable the patient to make an informed decision whether to undergo the treatment. The doctor cannot set out to educate the patient to his own standard of medical knowledge of all the relevant factors involved. He may take the view, certainly with some patients, that the very fact of his volunteering, without being asked, information of some remote risk involved in the treatment proposed, even though he describes it as remote, may lead to that risk assuming an undue significance in the patient's calculations.

...
It would seem to me quite unrealistic in any medical negligence action to confine the expert medical evidence to an explanation of the primary medical factors involved and to deny the court the benefit of evidence of medical opinion and practice on the particular issue of disclosure which is under consideration.

...
If it is to be left to individual judges to decide for themselves what a reasonable person in the patient's position would consider a risk of sufficient significance that he should be told about

it, the outcome of litigation in this field is likely to be quite unpredictable ...

...
In the instant case I can see no reasonable ground on which the judge could properly reject the conclusion to which the unchallenged medical evidence led in the application of the *Bolam* test. ... [T]he appellant's expert witness's agreement that the non-disclosure complained of accorded with a practice accepted as proper by a responsible body of neuro-surgical opinion afforded the respondents a complete defence to the appellant's claim ..."

Lord Templeman:

In my opinion, if a patient knows that a major operation may entail serious consequences, the patient cannot complain of lack of information unless the patient asks in vain for more information or unless there is some danger which by its nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment in deciding whether or not to submit to the operation.

There is no doubt that a doctor ought to draw the attention of a patient to a danger which may be special in kind or magnitude or special to the patient.

...
When a patient complains of lack of information, the court must decide whether the patient has suffered harm from a general danger inherent in the operation or from some special danger. In the case of a general danger the court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered. If the practice of the medical profession is to make express mention of a particular kind of danger, the court will have no difficulty in coming to the conclusion that the doctor ought to have referred expressly to this danger as a special danger unless the doctor can give reasons to justify the form or absence of warning adopted by him. Where the practice of the medical profession is divided or does not include express mention, it will be for the court to determine whether the harm suffered is an example of a general danger inherent in the nature of the operation and if so whether the explanation afforded to the patient was sufficient to alert the patient to the general dangers of which the harm suffered is an example. If a doctor conscientiously endeavours to explain the arguments for and against a major operation and the possibilities of benefiting and the dangers, the court will be slow to conclude that the doctor has been guilty of a breach of duty owed to the patient merely because the doctor omits some specific item of information. It is for the court to decide, after hearing the doctor's explanation, whether the doctor has in fact been guilty of a breach of duty with regard to information.

Reading 19.6a**EXERCISE 6**

Lord Chancellor's Department (1997). The key principles: capacity, best interests, and the general authority to act reasonably. In: *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*. Cmnd 3803. London: The Stationary Office Ltd, pp. 11–13 (Chapter 3).

Background

3.1. This chapter focuses on the concepts of capacity, best interests and the general authority to act reasonably, which underpin the Law Commission's proposals. The Law Commission's suggested definitions for these concepts received broad support on consultation.

3.2. The Government supports the principles behind the Law Commission's proposals in this area, but seeks views in this chapter, on whether the proposed definitions are practical and workable.

The test of capacity

3.3. The Law Commission's recommended a new statutory definition of incapacity(1).

Presumption against lack of capacity

3.4. The Law Commission recommended that there be a presumption against lack of capacity. This conforms with current principles of common law. It also supports the general principle that there should be minimal intervention in the affairs of individuals unless there is a demonstrable need to do so. This is a common sense approach, and the Government notes the wide support the Law Commission received for this on consultation.

3.5. The Government accepts this recommendation in principle.

Determining whether an individual lacks capacity

3.6. The Law Commission considered a number of possible approaches to the definition of capacity, but favoured the 'functional approach', which is currently the main method used in common law. This received overwhelming support on consultation.

3.7. This approach focuses on the decision itself and the capability of the person concerned to understand at the time it is made the nature of the decision required and its implications. This approach is thus very specific and avoids generalisations which may involve unnecessary intrusion into the affairs of the individual. For example, a person may be able to decide that they want to have contact with a particular relative, but may not be able to understand the nature of a particular financial contract on which a decision is needed. The functional approach would indicate that

the first decision is one for which the person had capacity, whereas the second decision is one for which s/he did not. The approach thus allows individuals to have the maximum decision-making powers possible. Restrictions would be dependent on the nature and complexity of the decision in hand and would not exclude the person from making decisions within their competence.

3.8. The Government accepts this recommendation.

A diagnostic threshold

3.9. The Law Commission consulted on the possibility of linking the test of capacity and the concept of "mental disorder" as defined in the Mental Health Act 1983. This possibility was rejected, the Law Commission considering that:

this was insufficiently broad to be able to deal with all possible scenarios; and there would be few, outside those specialising in mental health, who understood exactly what this meant.

3.10. The Law Commission thus recommended that the expression 'mental disability'(2) be used (except in cases where the person is unable to communicate) and should mean 'any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning'(3)

3.11. The Law Commission recommended that the test of incapacity should also apply to the communication of a decision as well as the ability to make the decision itself. This would cover cases where it is not possible to determine the person's response, even if they might be capable of making the decision concerned. They thus suggested that a person should be regarded as without capacity if at the material time (the time of the decision) he or she is:

'unable by reason of mental disability to make a decision on the matter in question; or—unable to communicate a decision on the matter because he or she is unconscious or for any other reason.'(4)

3.12. The Government accepts this recommendation in principle, but seeks views on whether these definitions are considered appropriate.

Further definition of inability to make a decision

3.13. The Law Commission suggested that the inability to make a decision could be split into two areas: the first question is whether the person concerned is able to understand and retain the relevant information, including the consequences, not only of deciding one way or another but also of making no decision at all. The second question is whether the disability means that the person concerned is able to use that information in order to arrive at a decision: some people may be unable to exert their will, whether because of delusions or compulsions, or because of susceptibility to influence, or any other reason connected with their disability. The schizophrenic who cannot believe what his doctors or financial

advisors tell him is one example; the manic depressive whose impulses override his understanding is another. This is supported by Thorpe J's judgement in *Re C* (5). The Law Commission thus recommended that a person should be regarded as unable to make a decision by reason of mental disability if the disability is such that, at the time when the decision needs to be made, the person is:

unable to understand or retain the information relevant to the decision or

unable to make a decision based on that information.

3.14. The recommendations made by the Law Commission in this area were generally well supported on consultation and they reflect that type of issues taken into account in common law at present.

3.15. The case of *Re MB*(6) has further clarified the common law in this area. In this case, the Court of Appeal set out the principles determining whether a person lacks capacity. The court also set out principles of procedure to be followed when it is thought necessary to seek declarations from the courts on such a matter. In the light of this, and a number of similar cases, the Department of Health has already issued a summary of legal rulings to the NHS, under cover of an Executive Letter (7), concerning the legal rulings in relation to caesarean sections and to the posthumous storage of gametes.

Maximising decision-making capacity

3.18. To maximise the person's potential to make their own decisions, the Law Commission recommended that a person should

not be regarded as unable to understand the information relevant to a decision if he or she is able to understand an explanation of that information in broad terms and simple language, including other languages if appropriate or other forms of communication such as audio tapes. They also recommended that a person should not be incapable of communicating their decisions unless 'all practicable steps to enable him or her to do so have been taken without success'(8).

1 Law Com 231, para. 3.23. The Key Principles

2 In reaching the conclusion that there should be a diagnostic threshold the Law Commission took into account that there may be a small number of cases where a finding of incapacity could lead to action which could amount to 'detention' within the meaning of Article 5 of the European Convention on Human Rights. The case law of the European Court of Human Rights requires that any such detention should be pursuant to a finding of unsoundness of mind based on "objective medical expertise" (see para 3.8 of the Commission's Report and Consultation Paper No 119, paras 3.10–3.14).

3 Law Com 231, para. 3.12.

4 *Ibid.*, para. 3.14.

5 *Re C* (Adult: Refusal of treatment) [1994] 1 WLR 290.

6 *Re MB* (Medical Treatment)[1997] 2FLR No3.

7 EL(97)32 Consent to Treatment—Summary of Legal Rulings.

8 Law Com 231, para. 3.21.

Reading 19.6b**EXERCISE 6**

Szmukler, G. and Holloway, F. (1998). Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin*, 22: 663, 664.

NOTE: missing text shown by 3 dots.

There is no logical reason to discriminate between mental incapacity occasioned by mental disorder and physical disorder. Many readers will by now have retorted that the Mental Health Act ensures that people treated for a mental disorder under compulsion are protected by an extensive set of regulations. These safeguards do not at present apply in this country to people without capacity suffering from physical disorders, and it was in part as a result of the recognition of the need for greater controls that the Law Commission embarked on its considerations of the implications of mental incapacity. Historically the discrepancy between protections for the treatment of mental disorder and physical disorder probably arises from treatments for the former having been seen as dubious and possibly resembling punishment more closely than treatment (e.g. electroconvulsive therapy, psychosurgery). But clearly if people with mental illness warrant protection against poor or inappropriate treatment. So indeed do those physically ill persons without the capacity to look after themselves. The surgeon's knife poses at least as great a threat as the psychiatrist's antipsychotic medication. (p. 663)

...

The Law Commission has provided workable definitions of 'incapacity' and 'best interests' (see Appendix). A range of methods for ensuring the proper treatment of patients with incapacity is presented. These include advance directives continuing powers

of attorney (as a method of substituted decision-making), second opinions for specified or controversial treatments court appointed managers for some procedures or situations and a judicial role for appeals and for treating objecting (rather than non-resisting) patients. In addition to needing to meet the test of 'best interests' each of these mechanisms has its associated protections. To this range of options may also be added advocacy, a useful means of representing the needs of patients who have difficulties in expressing their wishes. The Law Commission also recognises the value of a Code of Practice where provisions can be stipulated in greater detail and where they can evolve over time.

Judicial bodies for treating objecting patients need not be very 'court-like' or adversarial. They could for example function in a similar way to mental health review tribunals. Incapacity legislation of the type proposed by the Law Commission presents a framework for all paternalistic interventions for ill persons lacking mental capacity. These should include those suffering from mental disorders. Indeed the flexible range of provisions is very suitable for treatment in the community rather than hospital settings. It has been argued that advance directives for example present an autonomy-based solution to non-consensual treatment in the community (Halpern & Szmukler, 1997).

References

- Halpern, A. & Szmukler, G. (1997). Psychiatric advance directives; reconciling autonomy and non-consensual treatment, *Psychiatric Bulletin*. 21. 323–327.
- Law Commission (1995). *Mental Incapacity* (Law Commission Report No. 2311. London: HMSO).

Reading 19.6c**EXERCISE 6**

Fulford, K.W.M. (1998). Replacing the Mental Health Act 1983? How to change the game without losing the baby with the bath water or shooting ourselves in the foot. *Psychiatric Bulletin*, 22: 666, 667, 668.

NOTE: missing text shown by 3 dots.

The difficulty is this. Any proposal for equality of treatment of consent-incompetent adults between mental disorders and bodily disorders (whether under generic mental incapacity legislation or a revised mental health law) depends on equality of criteria for judging incompetence. For the game to be the same the 'diagnostic hurdle' (this is the Law Commission's own term, see e.g. para 3.8. of the 1995 report) must be the same. But there are grounds for believing that the diagnostic hurdle is considerably more complicated for mental disorders than for bodily disorders. (p. 666–667)

...

Mental disorder is no more of a mess (ethically or scientifically) than bodily disorder, it is just a lot more difficult to deal with (ethically and scientifically). A well-founded strategy must therefore be based on taking the difficulties seriously. In the case of judgments of incapacity this will include embarking on the range of empirical and legal research indicated by Eastman & Peay (1998). But it will also include coming to a better understanding of the nature of conceptual difficulties and how we should tackle them. I want to finish by looking briefly at one aspect of what this would involve.

Users of services and the use of concepts

Conceptual difficulties are, essentially, difficulties of meaning. Clinical work and research in psychiatry have benefited considerably from our attempts, through the work of Kraepelin, Jaspers and others right up to the DSM and ICD, to define our terms more carefully. But satisfactory explicit definitions as a way of resolving questions of meaning are the exception rather than the rule. In general, we are better at using concepts than defining them (try defining 'time' if you doubt this!). It follows, therefore, that a difficulty of definition is not in itself a barrier to the effective (reliable and valid) use of that concept.

As a general observation about concepts, the priority of use over definition goes back to the work of the Professor of Moral Philosophy in Oxford after the Second World War, J. L. Austin. His ideas are important to us in psychiatry in a number of respects (Fulford, 1990). His methodological message was that concept-use could be exploited as a guide to meaning: this offers rich returns in descriptive psychopathology, for example (Fulford, 1989). In respect of the diagnostic difficulty, the J. L. Austin message is that we should be concerned not just with the criteria adopted (i.e. with definitions of the concept of capacity) but with the processes by which these criteria are applied in practice (i.e. with the way the concept of capacity is actually used).

This takes us right back to the changes in mental health practice over the past 15 years which lie behind the 1983 Act rapidly becoming a square legal peg in a round clinical practice hole. The key change, you will recall, was the shift from paternalism to autonomy, or, with a convenient homonym, from patients to users. Nowadays, users (of mental health services) are as much users (in J. L. Austin's sense) of the concept of capacity as are professionals. Hence any changes in the legislation governing consent to psychiatric treatment must incorporate users in the processes by which judgments of capacity are made alongside professionals.

Again, there are deep difficulties here, not least the problem of insight. But as Szmukler & Holloway note in a different context, relevant mechanisms are already under active discussion—advance directives, continuing powers of attorney, advocacy, and so forth. We have a lot to learn. But the bottom line is clear. As Dr V. Y. Allison-Bolger has put it (personal communication), autonomy in psychiatry means people with mental disorders having a say not just in how their problems are treated but in how they are understood. (pp. 667–668)

References

- Eastman, N. & Peay, J. (1998). Bournewood: an indefensible gap in mental health law. *British Medical Journal*, 317: 94–95.
- Fulford, K. W. M. (1989). *Moral Theory and Medical practice*. Cambridge: Cambridge University Press.
- (1990). Philosophy and medicine: the Oxford connection. *British Journal of Psychiatry*, 157: 111–115.
- Szmukler, G. & Holloway, F. (1998). Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin*, 22: 662–665.

Reading 19.6d**EXERCISE 6**

Sayce, L. (1998). Transcending mental health law. *Psychiatric Bulletin*, 22: 669

First, who decides whether someone is incapacitated? This is no objective judgement, but relies on whether (in the view of whoever assesses it) a person understands information and can make a choice about it. So, where does that leave the person who is diagnosed with schizophrenia, disagrees, and believes they are rather in communication with God? If they can understand entirely what a neuroleptic drug is and refuse it, are they capable or incapable of making that decision? In whose frame of reference does the information have to be 'understood'? As Chamberlin argues, incapacity could be reduced in meaning to 'disagreeing with your psychiatrist'. This may suggest the need for a legal test, drawing on professional advice, rather than clinical decision-making alone.

Second, the need for safeguards for people deemed incapable is paramount. Research from the MacArthur study (1998) suggests

incapacity is often short-lived, sometimes limited to hours or days. This may indicate a need to overturn the notion of lengthy treatment sections, replacing them with the principle that no one should be treated without consent once capacity is regained.

Third, the proposal to introduce non-discriminatory provisions for prevention of violent crime is ethically deeply problematic, as the authors recognise: would we simply bring non-mentally ill people's rights to the same abysmal level as is currently experienced by those diagnosed mentally ill?

References

- Chamberlin, J. (1994). *Legal and Ethical Dilemma in Serving Persons with Mental Disabilities*, Boston, MA: National Empowerment Center.
- MacArthur Research Network (1998). *The MacArthur Treatment Competence Study. Executive Summary*. Charlottesville, VA: Virginia.

Reading 19.7**EXERCISE 7**

Extract from: Dickenson, D. and Fulford, K.W.M. (2000). *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press, (Extract page 91–92).

Martin McKendrick has a long history of involvement with psychiatric services, dating back to adolescence, when he made the first of many suicide attempts. His mother died when he was twelve, and he was largely brought up by an older sister; his father had abandoned the family when Martin was a little boy. Martin, now forty-two, lives alone and has lost contact with his sister. But he continually hears her voice, he says telling him that he is evil and that he ought to kill himself. He also believes that his sister is poisoning his food.

Martin has taken repeated overdoses, usually of paracetamol, requiring medical intervention in several cases. Twice he also slashed his wrists. He eats little but smokes and drinks heavily. His sister appears to have been anorexic, and his own weight is below eight stone.

Although Martin asks for help, he has always been poorly compliant with medication and follow-up. Often he has presented asking for admission, only to self-discharge after a few days, ignoring follow-up arrangements. He has been detained under the Mental Health Act several times, but finds compulsory admission very distressing. His eating patterns worsen, and his self-harm behaviour escalates. Therapeutic trials of several different medications, including antidepressants, were used while Martin was under section, with only minimal improvement: the hallucinations and suicidal thoughts remain. ECT has also been tried; his delusions become less fixed, but his desire to die does not alter.

Martin's experience of compulsory admission leads him to the despairing conclusion that psychiatrists can do nothing for his constant suffering. The only thing the doctors could do for him, he says, would be to help him end his life. When at home he has no daily contacts, apart from psychiatric services. He spends his days with the curtains drawn, afraid to venture outside or even look through the window. He has no activities despite repeated offers and suggestions. Martin gets no enjoyment from life, he says, and he sees no better prospects for the future.