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CHAPTER 19

It's the law! Rationality and consent as a case study in values and mental health law

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In this chapter we shall be examining the concepts of rationality and consent from a medico-legal viewpoint. These concepts have been central to the way the English courts have tried to reconcile the perception that the patient has a right to decide what happens to him with the perception that the doctor has a duty to try her best to heal her patient.

The tension between these two perceptions, as we have seen in Chapters 17 and 18, is central to the ethical issues raised specifically by involuntary psychiatric treatment. In common law the English courts, like most courts around the world, have repeatedly affirmed that an adult patient of 'sound' mind has an absolute right to accept or reject medical treatment. Correspondingly, therefore, the courts will sometimes override this right where the patient is of 'unsound' mind. The Mental Health Act, as we saw in Chapter 17, gives statutory authority to this autonomy override in respect of mental disorders, albeit not on the same incapacity basis applied by common law. Other legislation covers contexts, such as the patient being a child, or where the welfare of a viable foetus is at stake.

From the 'man of science' to legal value judgements

In all these cases, to anticipate a little, whether in common law or under the Mental Health Act, the model with which the courts work is essentially our, by now familiar, medical model. In considering a given case, it is assumed that the soundness or otherwise of a person's mind, or the 'appropriateness' of treatment, is a matter for 'expert evidence', the expert in question being, in the words of the well-worn legal aphorism, a 'man of science.' On closer inspection, however, we will find that, in some cases, the courts have been hesitant to inquire too closely into a patient's state of mind where it has felt compelled to intervene to protect the patient's *best interests*. Judgements of rationality in these cases have in practice turned on how 'sympathetic' the court is to the patient's point of view. These judgments do not reflect value-neutral concerns, therefore. Rather, they are value-laden judgements, judgements that is to say, in which the court's values are crucial to the medical and judicial determination of a patient's 'soundness' of mind.

It turns out, furthermore, that this 'value ladenness' is especially pertinent in the context of mental disorder, where, as we will see, evaluative issues enter into assessments of rationality and competence to a significant extent. We should *expect* this, given everything that has been said in earlier chapters about the inherent diversity of values in the areas of human experience and behaviour encompassed by mental disorders. And when we review these legal determinations with our now 'J.L. Austin-sharpened eye', it is clear that it is so.

Aims of the chapter

As in previous chapters our aim in exploring these legal cases, general medical and psychiatric, will not be to suggest that court procedures, to the extent that they involve value judgements, are somehow inherently flawed. Our aim, rather, will be to highlight, in the light of earlier chapters, the value judgements in question,

and to recognize their significance particularly in respect of mental disorders, as a step towards improving the validity of the procedures themselves.

Our focus, consistent with the case study approach of this book, will be mainly on a particular legislative framework (that of England and Wales) rather than attempting a general review. The issues, of course, are generic; but we shall be exploring them in, as it were, the particular. Similarly, even within the particular case (of the law in England and Wales), our aim will not be to provide a comprehensive review of mental health law, but to draw out the particular themes noted above, as themes of growing *practical* importance to which philosophy has a distinctive contribution to make.

The chapter also has the secondary aim of filling out an understanding of how value judgements come into the assessment of mental disorders generally. You will recall J.L. Austin's methodological point, in 'A plea for excuses' (1956/7), that legal cases make good (linguistic analytic) philosophy, because legal cases *have* to be resolved one way or another (Chapter 4). Examining the role of value judgements in legal cases involving mental disorders will thus help to pave the way for our more detailed examination of values in psychiatric diagnosis in Chapters 20 and 21.

Topics to be covered

These are the aims, then. We will start, though, by going back to basics. Hence in this chapter, we will:

- Look at the ethical basis of the doctrine of consent, placing it in the context of the concept of 'human rights.'
- Note the various ways a patient can give consent to medical treatment
- Identify the legal basis of the doctrine of consent.
- Distinguish the meanings of the terms 'rationality', 'capacity', and 'competence'.
- Define 'capacity'.
- Examine the meaning of 'informed consent' in English law.
- Consider the legal remedies available to patients who are treated against their wishes.
- Explain the '*Bolam*' test as it relates to standards in negligence in relation to assessing capacity and gaining consent.
- Uncover the hidden evaluative assessments behind recent so-called enforced Caesarean cases.
- Comment on recent proposals in England and Wales to introduce generic incapacity legislation, which will have the effect of further distinguishing the law relating to the treatment of mental disorders under statutory mental health legislation from the law relating to the treatment of bodily disorders.
- Apply the ethical and legal principles explored in this section to a hypothetical case of 'rational suicide'.

We introduce a number of key legal terms and concepts from English Law along the way. For ease of cross-reference, we list

these here in the order in which they are introduced: tort (p. 542), statute and common law (p. 542), estoppel (p. 543), status test (p. 544), cause of action (p. 549), civil and criminal law (p. 549), battery (p. 550), and negligence (p. 550).

Three sessions (and a focus on philosophy)

The chapter is divided into three sessions. *Session 1* sets out some of the key features of the law on consent (as it has been developed in England and Wales). *Session 2* takes a closer look at the legal concepts of capacity (including its links with rationality) and information. As we will see, what counts as sufficient information for valid consent in law draws out some of the hidden values driving legal determinations of capacity for consent. Finally, in *Session 3*, the importance of values becomes explicit in the legal concept of 'best interests' at the heart of legislation covering those who lack the capacity for consent.

Clearly, all of the topics covered in this chapter could occupy several legal tomes! We will thus not be attempting to provide a detailed legal commentary on them as they relate to mental health, still less to health care in general. Rather, our approach will be to tease out the underlying principles, as they are currently understood and illustrated by the law (mainly) of England and Wales. This will provide a basis for understanding the specifically philosophical contributions, i.e. by way of conceptual insights, to resolving the legal and practical problems in the area as they arise in mental health.

Session 1 The legal basis of consent

In this first session we lay the foundations for understanding the legal concept of consent by considering, briefly, its moral and cultural background, and then examining how the law (mainly in England and Wales) has developed. From this discussion, the rationale for the three key legal elements of consent will emerge. As noted above, we will be considering mainly the first of these, capacity, in this session, the second session will extend the discussion to information, and the third to voluntariness.

First, then, the background moral and cultural tradition.

The moral and cultural tradition

Difficulties with consent in health care normally (though not always) arise where a patient disagrees with the doctor's treatment proposal. The issue then arising is: should the doctor's or the patient's point-of-view prevail? This issue becomes especially serious where the patient's refusal puts that patient's life and health at risk. As we saw earlier in this part, a tension then arises between two ethical principles:

- ◆ The principle of *patient autonomy*.
- ◆ The principle of *medical beneficence*.

Both principles have deep roots, which it will be worth exploring briefly before coming to their instantiations in law. Thus the

principle of *autonomy* is an important concept in modern liberal political philosophy. According to this philosophy, part of what it is to be a free individual is to have the liberty to make choices affecting one's own person. This principle of individual liberty can be extended to the doctor–patient relationship in which the patient is normally in a vulnerable condition and potentially subject to procedures that affect him or her intimately. According to this way of looking at things, human dignity is closely associated with the patient's ability to make decisions about what happens to their own body. Correspondingly, a doctor does not have the right to compromise that dignity by treating that patient without that patient's consent, even if it is in that patient's therapeutic best interests.

The principle of medical *beneficence*, on the other hand, is associated with a venerable tradition within the history of the practice of medicine. This tradition enjoins a doctor, as a fundamental duty, to do all that he or she can to heal his or her patient, even if the patient does not agree with what the doctor has proposed. The underlying assumption of this tradition is that the patient is not in a position to decide what is best for him precisely because that patient is ill and vulnerable. This assumption has been criticized by modern academic commentators, perhaps rather pejoratively, as representing an attitude of medical *paternalism*.

Medical paternalism and the Hippocratic Oath

The seeds of this attitude of medical paternalism can perhaps be identified in the Hippocratic Oath (introduced in chapter 18), which stipulates that the doctor shall:

Perform these duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reproving sharply and emphatically, and sometimes comforting with solicitude and attention, revealing nothing of the patients' future condition.

The relevant point of note here is that the doctor–patient relationship is assumed to be an uneven power relationship, with the doctor holding most of the power. This model of the doctor–patient relationship assumes the reality of this power imbalance. The model of doctor–patient interaction envisaged in the Hippocratic Oath could be characterized as one of *entrustment*. The reality of this trust relationship gives rise to a corresponding 'trust duty' on the part of the doctor. Lawyers call this kind of duty a *fiduciary* duty. The word 'fiduciary' is related to the Latin word *fides* broadly meaning, faith, trust, or belief. Other examples of fiduciary relationships are the parent–child relationship, the teacher–pupil relationship, or the priest's relationship with one for whom he is providing pastoral care. So the question arises, should there be 'power equality' in the doctor–patient relationship? If so, why? If not, why not? And how can the law help?

Legal frameworks

These questions are explored in the first reading in this chapter, which is by the British lawyer, Ian Kennedy, in terms of rights. Kennedy sprang to fame in the 1980s, with a book provocatively entitled *The Unmasking of Medicine* (Kennedy, 1981). In this, he lifted the lid on what were increasingly seen as misuses of medical power, and he went on to set up the first major centre for medical ethics and law in England, at King's College in London. As a lawyer, Kennedy has wide experience of medical issues, and he has written many detailed and insightful legal commentaries on cases involving consent. The following reading provides a more general introduction to his views.

EXERCISE 1

(30 minutes)

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 pp. 385–390.)

Link with Reading 19.1

- ◆ What is Kennedy's line on medical paternalism here?
- ◆ What is his lawyer's answer to promoting patient self-determination?

Consent and human rights

Kennedy (1996) contends that trust between the doctor and patient cannot be taken for granted. Rather, the doctor has to earn the patient's trust in the context of a relationship that is already established on the ethical and legal foundations of 'human rights'. He (anticipating recent developments) argues that English medical law needs a much more highly developed concept of human rights in order to ensure that the courts respect the principle of self-determination. In his view, the English law of consent as it has hitherto developed, is more concerned with protecting doctors than patients. A human rights analysis would be advantageous in two respects:

1. It would force the courts to hold the patient's interests as being of primary importance and at the same time challenge medical paternalism.
2. It would provide the courts with a theoretical framework within which to develop the law more consistently and systematically.

The Human Rights Act

In this article, Kennedy (1996) was anticipating, by over 10 years, the incorporation of the European Convention on Human Rights into UK domestic law in the form of the Human Rights Act 1998. The result, as Kennedy anticipated, is that the courts have been forced to take on a new set of international

ethical and legal obligations. This is significant when we consider that the concept of human rights lies at the heart of the European Convention and that a number of Articles in the Convention have been used to assert the rights of patients. It is likely that the courts will be compelled to envisage the doctor–patient relationship as one involving fundamental issues of human freedom, which will need to be expounded in keeping with reasoned moral analysis. This may involve the need for a significant change in the way the courts approach the law of consent. This in turn brings us to a technical legal concept, referred to several times by Kennedy in this article, to the 'law of tort' or 'tort law'.

So, just what is tort law?

Tort law

Tort law is essentially the law of civil 'wrongs', the word 'tort' being derived from the French word for 'wrong'. The law of negligence is the largest part of the law of tort. The aim of tort law is to compensate a person for an injury wrongfully suffered at the hands of the other, e.g. because of a negligent act or omission. The aim, in terms of compensation, is to put the claimant back into the position he would have been in had he not been injured. Thus, if you suffer an injury through the act of a negligent driver, then that driver, or his insurers, will have to compensate you for all the damage that he could reasonably have foreseen would result from his negligent act, e.g. hospital bills (if any), loss of earnings, etc. From a legal point of view, it is to avoid an action in negligence that patients are nowadays normally required to give their consent to a medical procedure.

The difference between statute law and common law

A second terminology point that is worth noting at this stage is the difference between statute law and common law.

There are (apart from European Community Law) two main sources of jurisdiction in the English legal system:

1. Parliament.
2. The Courts/Judges.

Parliament-made law is known as statute law. A statute is 'enacted' by Parliament in an Act of Parliament. Before it is enacted it is known as a 'Bill'. For example, the Human Rights Bill became the Human Rights Act on 2 October 2000.

Judge-made law is also known as the 'common law'. However (and this can seem confusing), 'common law' has a number of meanings. It can refer to the existing body of 'case law' (a static meaning). It can also refer to the power judges have to interpret and develop the law (a dynamic meaning), including by interpreting statutes. Moreover, the term 'common law' is sometimes distinguished technically from the term 'equity', which relates to a jurisdiction that had a separate existence before the late nineteenth century, before merging with the common law.

Varieties of legal consent

Back, now, to consent.

EXERCISE 2

(10 minutes)

This reading is a typical NHS consent form reprinted in:

McHale, J. Fox, M., and Murphy, J. (1999). *Health Care Law: text and materials* London: Sweet and Maxwell, p. 335

Link with Reading 19.2

- ◆ What kind of consent is envisaged here?
- ◆ What is the role of the consent form in consent?
- ◆ In particular, do you think that such forms can be designed to cover everything that a patient in reality agrees to in the context of a particular medical procedure, e.g. heart surgery?

In practice, a patient can give consent in one of three ways. Consent can be:

- ◆ express
- ◆ implied, or by
- ◆ estoppel.

1. *Express consent.* A patient gives express consent when she states in clear, direct terms what she is agreeing to. Express consent can take one of two forms:

- ◆ *Written*—e.g. by signing a consent form like the one in Exercise 2 above produced by the NHS that stipulates what is being agreed to. It should be noted, however, that the signed form is not itself ‘the consent’, but rather evidence of what the patient has agreed to. A court will be concerned with ‘the reality’ of what has been consented to, including the way in which consent was ‘obtained’, which may or may not be adequately reflected in the contents of the form. Patients usually sign a consent form when they are about to undergo surgery in a hospital, perhaps not the best time for processing complete information! (We return to information in Session 2.)
- ◆ *Oral*—patients normally consent to most forms of medical treatment by word of mouth. A patient can either agree with what the doctor has proposed, or stipulate what he or she has agreed to.

2. *Implied consent.* If a patient has not signed a form or given oral consent, then that patient’s consent may be implied from the circumstances. For example, in one legal case, the court held that a patient who presented her arm to a nurse in a line of people who were receiving a vaccination prior to disembarking from an ocean liner had implicitly given consent to that procedure (*O’Brien v Cunard SS* (1891) 28 NE 266 (Mass Sup Jud Ct), see Kennedy and Grubb, 2000, p. 90).

3. *Estoppel.* This is not so much a way of giving consent, as of overcoming a patient’s denial that he has given consent. In some circumstances, the notion of an ‘implied’ consent can seem rather artificial. For example, you cannot impute consent to someone who is unable to give it because they are unconscious or otherwise without capacity (e.g. the patient is too young or suffering from a mental disorder). Instead, you can argue that implied consent is in fact a form of ‘estoppel’.

What this perhaps somewhat archaic legal word means in practice is that a patient cannot deny that he has given his consent if a reasonable person would conclude that the patient had given consent, looking at the situation in the light of all the circumstances. This may be relevant for example to decisions about whether a patient who has consented to routine blood tests in a hospital has also, by implication, consented to an HIV test undertaken without her knowledge. There is nothing in her conduct, unlike the ocean liner case, to indicate that she has agreed to that extra procedure. The doctrine of estoppel may help capture the reality of the situation better than the notion of implied consent. You can look at the situation and ask, what would the reasonable person have concluded in the circumstances in the light of all the facts?

The legal basis of consent

We have looked at the argument that the concept of human rights in the context of the doctor–patient relationship is underpinned by the ethical principle of self-determination. But how does this ethical principle translate into law?

Kennedy (1996, p 389) defines the doctrine of consent in human-rights terms as ‘the legal and ethical expression of the human right for autonomy and self-determination’. In the medical context, the ethical notion of self-determination has found classic expression in the widely cited statement of Justice Cardozo in the case of *Schloendorff v Society of New York Hospital* 211 NY 125 (1914): ‘Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon [or any doctor] who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.’

Although Justice Cardozo’s statement can be read as a ringing affirmation of the ethical and legal principle of self-determination, notice that there are two important conditions of eligibility:

- ◆ adult years
- ◆ sound mind.

Thus, according to Justice Cardozo, the principle of self-determination is not absolute. The principle is qualified by considerations of age and mental health. But what is the justification for qualifying the principle of patient autonomy on these grounds? To explain this question, we turn first to the meaning of legal *competence*.

Legal competence to consent

In the legal context, the term 'competence' has a technical meaning that aims to fix limits to those expressions of the patient's will that should be legally guaranteed. Legal competence, which relates to the patient's ability to make valid treatment choices, must be distinguished from the popular meaning of 'competence', which can be understood much more widely.

As in any other area of technical expertise, authorities vary as to precisely how the legal concept of consent should be defined. A widely respected authority on all aspects of medical law in the UK, and a valuable textbook, is Kennedy and Grubb (2000). Kennedy and Grubb reflect the prevailing approach of the courts in most administrations in regarding a patient as 'competent' to make a treatment choice, and effecting consent, if that patient has:

1. the *capacity* to make a decision that warrants a legal guarantee;
2. sufficient *information* about the treatment proposed to give a true consent; and
3. made a decision *voluntarily*.

For ease of recall, we could frame the ingredients of a legally valid consent in question form (let us assume that the questioner is the patient):

1. Is *this* (i.e. medical treatment) what I want?
2. Do I *know* enough to decide that this is what I want?
3. Is this what I want?

Here, then, we have the three key conditions of competency for legal consent, as widely understood. They seem straightforward enough! But the rest of this chapter will be taken up with spelling out some of the complications with them, starting, in the rest of this session, with capacity.

Competence, capacity, rationality, and status

First, we need to draw some tricky distinctions. In the legal literature, the words, 'competence', 'capacity', and 'rationality' are often used interchangeably, but in fact they bear subtle differences of meaning, and all three have to be distinguished from the legal 'status'. The terms competence and capacity, furthermore, are used with different meanings in different administrations. Current usage in England and Wales, however, makes the following distinctions:

- ◆ *Competence* is a composite term containing the three ingredients noted above: capacity, information, and voluntariness. All of these must be present to warrant the legal protection of the patient's right of self-determination.
- ◆ *Capacity* is one ingredient in the composite definition of competence. A patient must be *capable* of making a true treatment

choice. We will look at the legal test for capacity in greater detail below. Capacity must be distinguished from *actual* understanding, which may turn on how much information a doctor is prepared to disclose to a patient. There is thus a subtle conceptual distinction separating the first ingredient from the second ingredient of the composite legal test of competence.

- ◆ *Rationality* is perhaps most widely understood as referring to the patient's actual cognitive decision-making abilities, but could be understood in other ways. We will return to the legal concept of rationality later.
- ◆ *Status*. The legal test of capacity may take into account 'status' factors such as age and mental disorder. We will look at these 'status tests' next. They are particularly material to recent discussions (in the UK) about replacing the Mental Health Act, 1983 (which relies on the status test of mental disorder, albeit not as a trigger for applying an incapacity test) with a generic incapacity test as the legal basis of involuntary psychiatric treatment.

Status tests

A 'status' test of competence is one that attributes capacity to a patient on the basis of their status, e.g. a child or a mental health patient. A number of cases have rejected status tests regarding children, and patients suffering from a *mental* disorder who are treated for their *physical* disorders. However, the law in this area is very far from being clear and definite.

A patient suffering from a mental disorder who needs treatment for that mental disorder is liable to be compulsorily detained under the provisions of the Mental Health Act 1983 for the purposes of assessment and treatment. The Mental Health Act makes provision then for the compulsory treatment of 'detained' patients. However, the basis for this, as we saw in Chapter 18, is the status test of 'mental disorder' (plus 'appropriateness' of admission to hospital and 'risk', to self or others) rather than competence. Hence this constitutes an important exception to the common law principle that a competent patient has an absolute right to decide what happens to him, i.e. because a patient may satisfy the criteria of legal competence, and yet, if diagnosed with a mental disorder and if satisfying other 'secondary' criteria, be treated on an involuntary basis against his or her wishes. Hence, in turn, current discussion about abandoning the status test of mental disorder in favour of a generic incapacity test, both because of the 'inequity' of the distinction and because the distinction *per se* between 'treatment for mental disorder' and 'treatment for physical disorder' is not a robust one (Matthews, 1999).

The basic legal principles underlying consent

We will now take a closer look at the legal principles underlying consent, starting with an important case, *Re T*.

EXERCISE 3

(30 minutes)

Read the extract from the case of *Re T* [1992] 4 All ER 649 reprinted in:

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

Link with Reading 19.3

- ◆ Did T consent or refuse to consent to treatment?
- ◆ Can a doctor treat a competent patient without their consent? What might happen if the doctor does?
- ◆ What happens when a patient needing treatment can't make a treatment decision?
- ◆ What test of capacity does Lord Donaldson lay down?
- ◆ Does a patient's decision have to be rational?
- ◆ Does the judge say how informed the patient's choice must be?

This case, together with a second case, *Airedale NHS Trust v Bland* [1993] 1 All ER 821, has clarified the basic legal principles applying to the English law of consent. The principles defined in these cases are usefully supplemented by those set out in the case of *F v West Berkshire Authority* [1989] 2 All ER 545, which deals with the circumstances in which a patient can be treated without consent in her best interests. Taken together, these cases provide us with a useful analytical framework for tackling the law of consent. The basic legal position on consent can thus be summarized as follows.

1. The law will presume that all adult patients have the right and *capacity* to consent or refuse consent to medical treatment, even if it is life-saving and life-sustaining treatment. The doctor's fundamental duty to do all that she can to heal her patient must give way to a competent patient's right to decide what happens to him, whatever the cost to that patient. In other words, the competent patient's point of view prevails over that of the doctor.
2. However, there are exceptions, in particular the presumption of capacity (and therefore of competence) can be overridden if there is evidence to show that the patient in question does not have the capacity to make a legally valid consent. Establishing lack of capacity is, in practice, commonly arrived at as a *medical* judgement but subject to legally established capacity criteria (to which we will return shortly); although the ultimate arbiter of capacity is always potentially the court.
3. If the patient's doctor concludes that her patient is 'incompetent', then that doctor has a duty to treat that patient in his 'best interests'. The meaning of 'best interests' was perhaps initially restricted to refer to the patient's medical or 'therapeutic' interests. But the courts have recently broadened 'best interest' to refer to the patient's 'welfare' interests which includes both

medical factors—which doctors are clearly competent to determine—and non-medical factors—which they may not be competent to determine (see especially *R. (on the application of Oliver Leslie Burke) v. the GMC*-[2004] EWHC 1879).

The basic legal position, then, in English law (and in most other jurisdictions currently), is 'patient choice with exceptions'. So, what about these exceptions? In what circumstances can patients be treated without consent?

Exceptions (for adults)

An adult patient can be treated without consent in the following circumstances. In each case, the doctor is obliged to treat the patient in his or her 'best interests':

- ◆ *Incompetence*: where the patient lacks the capacity to make a true treatment choice, e.g. due to age or mental illness.
- ◆ *Emergency*: e.g. where a patient is unconscious following an accident needing emergency surgery. Though the doctor has a fundamental duty to act in his patient's best interests, he must do no more than is reasonably necessary in the circumstances.
- ◆ *Necessity*: the principle of necessity is especially applicable to states of affairs that are permanent or semi-permanent, e.g. in the case of mentally disordered or mentally handicapped persons. The sterilization of mentally handicapped women in order to prevent conception, under the doctrine of necessity, has stretched the definition of 'best interests' in a controversial direction. Are such sterilizations 'therapeutic'?

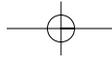
The scope of what is genuinely medical treatment is likely to be a matter of particular concern in coming years in new mental health legislation in the UK and elsewhere.

- ◆ *Mental Health Act 1983*: the Act allows otherwise competent patients to be treated without their consent in certain circumstances (see below).

Children

The legal position is more complicated where children (i.e. persons under 18 years of age) are concerned.

1. Under Section 8 of the Family Law Reform Act 1969, children under 18 years of age, but over 16, are treated as if they were adults for the purposes of surgical, medical, and dental diagnosis and treatment. However, the Act is unclear in three respects, namely whether it extends to:
 - ◆ clinical advice, over and above diagnosis and treatment;
 - ◆ 'therapeutic' treatment, over and above the cosmetic treatment (e.g. teeth-straightening);
 - ◆ a parental or judicial right to consent on the child's behalf.
2. Children under 16 are presumed to be incompetent unless they have a sufficiently full and mature understanding of the treatment proposed. In the House of Lords case of



Gillick v West Norfolk and Wisbech AHA [1985] 3 All ER 402. Lord Scarman held that:

... the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a valid consent in law.

Thus, children under 16 are not by definition unable to consent to medical treatment. The law will recognize the right and capacity of a child to decide what happens to them if they are so-called 'mature minors' or 'Gillick competent'.

3. A treatment refusal by a 'Gillick' competent child, whether under or over the age of 16, may currently be overridden by proxy consent in certain limited circumstances (*Re R (A Minor) (Wardship: Medical Treatment)* [1991] 4 All ER177; *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 4 All ER 627). However, it is questionable whether a parental or judicial veto of a mature minor's treatment decision is consistent with the ethics and law of consent. A capacity to consent to treatment must surely entail a right to *refuse* treatment (a position strongly implied in the *Gillick* case).
4. A limited class of people have the legal power to make treatment choices as proxies on behalf of children until (subject to 3 above) they are 'Gillick competent' (e.g. parents and the courts).

It should be noted that currently no similar power now exists (although it did at one time) to make proxy decisions on behalf of incompetent *adults*. This is an important respect in which mental health law in England and Wales differs from that in most other administrations. Australian courts, for example, have retained this jurisdiction and, in addition, have enacted specific laws that allow third parties other than doctors to make treatment choices on behalf of incompetent adults. Although doctors will usually take the views of close relatives and friends of incompetent adults into account, they are not obliged to do so, and such views are merely informative towards establishing best interest. In cases of adult incompetence, and in the absence of proxy consent for an immature minor, the 'best interests' test applies.

The Mental Health Act 1983

Under Section 63 of Part IV of the 1983 Act, a patient who is detained under the act may be treated without consent: 'The consent of a patient shall not be required for any medical treatment given to him for the mental disorder for which he is suffering, not being treatment falling within Section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.'

Sections 57 and 58 contain safeguards requiring the patient's consent and/or a second opinion before certain treatments can be given (currently electroconvulsive therapy, the administration of

medicines for more than 3 months, psychosurgery, and the surgical implantation of hormones for the reduction of the male sexual drive).

A number of conditions must be met before a patient can be treated without consent under the Act:

1. The patient must be detained under the Act. The patient can be detained for treatment under Section 3 if that patient is 'suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital.'
2. What is proposed must count as 'medical treatment'.
3. The treatment proposed must constitute treatment for the mental disorder, albeit this includes treatment for consequences of the mental disorder (*B v Croydon Health Authority* (1994) 22 BMLR 13).

Mental disorder is defined very widely in Section 1 of the Act. It means 'mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind'. A psychopathic disorder is defined as a persistent disorder or disability of the mind, which results in abnormally aggressive or seriously irresponsible conduct. Mental illness is not defined by the Act.

The courts, in a line of recent cases, have interpreted the meaning of 'treatment' for mental disorder within the terms of the Act expansively, such that it amounts essentially to any intervention carried out under the authority or auspices of the 'Responsible Medical Officer' (*Reid v Secretary of State for Scotland* [1999] 2 AC 513). The *Code of Practice* for the Mental Health Act, 1983, requires (though it is not as such a strict *legal* requirement) that staff should seek to secure the agreement of the patient first (Department Health and the Welsh Office, 1993).

Summary of the law of consent

Let us sum up the law of consent in the medical context:

1. According to English medical law, doctors have a fundamental duty to treat their patients in their 'best interests'. This is the legal expression of the ethical duty of beneficence.
2. This duty, however, gives way to the right of a legally competent adult patient to decide what happens to him or her. This is the legal expression of the ethical right of self-determination.
3. Where, in the case of a competent adult, the relevant provisions of the Mental Health Act apply, or where for some reason an adult is unable to consent to treatment, perhaps because of an emergency or because he is suffering from a serious mental disorder, the best interests test continues to apply.
4. Where children are too young (and/or immature) to decide for themselves, it falls to a legally authorised proxy, usually parents, to decide on the child's behalf. This authority may, in certain circumstances, include the right to override a 'Gillick-competent' child's treatment refusal. The law presumes parents to be the best arbiters of the child's best interests, although, in rare cases,

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the demands of public policy may override parental values (e.g. in certain cases involving blood transfusions and Jehovah's Witnesses).

5. Currently, there is no legal basis in England and Wales for proxy decision-making on behalf of adult patients.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What two principles lie behind the law on consent in health care? From what particular aspect of the moral and cultural traditions of medicine are they derived.
2. In what distinctively legal form are these two principles often cast?
3. What varieties of legal consent are commonly recognized? (We noted three.)
4. What are the three legal components of valid consent?
5. What is a 'status' test? Give two examples.

- ◆ Do you think that C was 'rational'? If so, in what sense?
- ◆ What were C's values? Did the court take them into account?
- ◆ What if C had been a cult member with extreme religious views?
- ◆ What does Re C add to the case of Re T (in the last session)?

Capacity and rationality

The concepts of capacity and rationality, although used with different meanings in different legislations, and in different areas of the Law within a given legislation, are closely connected in practice. We will look first at capacity and then come back to its links with rationality in relation to concept to treatment.

Capacity

The legal test for capacity in England and Wales was set out in the High Court case of *Re C*, subsequently endorsed by the Court of Appeal in *Re MB (Medical Treatment)* [1997] 3 Med. LR 217. In *Re MB*, Lady Justice Butler-Sloss (at 224) held that:

A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to, or to refuse treatment. The inability to make a decision will occur when: (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequence of having, or not having, the treatment in question; (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision.

The capacity criteria set out by *Re C* and *Re MB*, taken together, can be summarised thus:

1. *Understanding* and *retaining* information relevant to the treatment decision.
2. *Believing* it.
3. *Weighing up* the relative risks and benefits of treatment.
4. *Arriving* at a clear choice.

As the extract from Roth *et al.*, shows, there are many other definitions of capacity. But we will consider the case of *Re C* in detail by way of exploring the key legal concepts involved in all attempts to define capacity, and their links to values.

The case of Re C: the facts

'C' was a 68-year-old patient in Broadmoor Hospital with a diagnosis of paranoid schizophrenia. He developed gangrene in his left foot, which left him with an 85% likelihood of death unless he agreed to have his leg amputated immediately below the knee. He refused, arguing that 'he would rather die with two feet than survive with one' and 'because he had complete faith in God and, subject to one reservation, the Bible.' He trusted that with good medical care from his care team, he would survive. Moreover, he believed that his foot, if he did die, would not cause his death. C also expressed grandiose delusions of an international career in

Session 2 Capacity, information, and causes of action

Having set out the basic legal principles that apply to the issue of consent, it is now time to look more closely at the meaning of capacity, particularly its link with rationality, before going on to look at the other components of competence, information, and, in the next session, voluntariness.

In this session we will also be considering what, in legal terms, is called 'causes of action', essentially the routes to redress open to someone who believes they have been wrongly treated without consent. But we will start with a further look at capacity.

EXERCISE 4

(30 minutes)

Read the brief 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

Link with Reading 19.4

- ◆ What do you understand by the term 'rationality'?
- ◆ Which of the tests of competence noted by Roth *et al.*, best fits your understanding of rationality?

medicine during the course of which he had never lost a patient and a persecutory delusion that whatever treatment was offered was calculated to destroy his body. Notwithstanding, the hospital refused to give C's solicitor an undertaking that it would not amputate C's leg without his express written consent. As a result, C's solicitor applied to the High Court for an injunction restraining the hospital from carrying out an amputation without that consent. In the event, C survived with conservative surgery and antibiotics.

The judgment

Mr Justice Thorpe held that C was, despite his delusions, capable of understanding the 'nature, purpose and effects' of the treatment proposed. Although C's capacity was impaired by his mental disorder, he still had sufficient 'understanding' for the purposes of giving a legally valid consent. He could understand and retain the relevant information, believe it, weigh up the risks and benefits and arrive at a clear choice. The court was therefore affirming the principle that a person with a diagnosed *mental disorder* could still be competent to refuse treatment for a *physical disorder*. It thus represents, in the context of physical disorder, a rejection of a '*status*' test for individuals suffering from a mental disorder where what is proposed is treatment for an unrelated physical condition. As we shall see below, a UK Government 'Green Paper' has endorsed a Law Commission proposal to introduce statutory incapacity criteria within an Incapacity Act, which are essentially based on this case, reaffirmed by the Court of Appeal in *Re MB*, while still maintaining a separate *Mental Health Act* for treatments for *mental disorder administered under the latter Act*. Mr Justice Thorpe's decision also reaffirmed a principle laid down in an earlier case, *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 that linked capacity with 'understanding', albeit decisions in subsequent cases have adopted an approach that seems to go somewhat beyond simply the capacity rationally to 'weigh information in the balance' and to incorporate 'the content of the weighing' into those factors that can overturn capacity—see, for example, *Brady v Hopper* 751 F 2d 329 (1984)], thereby perhaps allowing the values of the person doing the weighing up into the court's assessment of their capacity. But what did Mr Justice Thorpe understand by 'understanding'?

Analysis

In his judgment, Mr Justice Thorpe worked within the framework of the basic legal principles applying to the law of consent. He needed to determine whether C had the capacity to decide what was to happen to him. In order to do that, he needed to satisfy himself that C *sufficiently* understood the broad nature, purpose and effects of the treatment proposed, i.e. the amputation. The word 'sufficiently' is significant. Mr Justice Thorpe did not suggest that C needed a complete and full understanding of the proposed surgery, but enough to demonstrate that he could make a true choice in the context of this particular medical procedure at the time that it was proposed.

Mr Justice Thorpe was not deciding anything new here. His decision was consistent with Lord Donaldson's 'sliding scale' approach, in *Re T*, i.e. a greater level of understanding is required for a more serious medical procedure. This suggests rather more than the 'evidencing a choice' test expounded in Roth *et al's* article. Though it is likely that, in non-serious cases, the courts will not feel the need to inquire too closely into the patient's state of mind. In C's case, a mere verbal or behavioural expression of will was not enough to demonstrate genuine understanding. The court needed some evidence that he grasped the reality of his predicament.

Understanding, 'rational reasoning' and values

Mr Justice Thorpe did not make his working concept of 'understanding' explicit in the judgment. It has to be inferred from the contents of his decision. Clearly, he rejected mental illness as a barrier to capacity (i.e. a status test). Rather, C's capacity for autonomy turns on a set of general capacity criteria, i.e. that he could understand the information he was given, believe it, weigh it up, and arrive at a clear choice. Must C be able to engage in *rational reasoning* to satisfy the test of capacity, i.e. the ability to reason to a conclusion from a set of premisses? This will depend on what is meant by an ability to reason.

English law does not require a patient's treatment refusal to be 'rational, sensible and well considered' (see *Re T*, per Lady Justice Butler-Sloss). However, the law probably does draw a distinction between somebody who is deluded about the world (e.g. the belief that blood is poison) and somebody who is able to reason to a conclusion from premisses that few people share, e.g. Jehovah's Witnesses who refuse blood transfusions on religious grounds.

The law does seem, then, in this case at least, implicitly to recognize that sometimes very diverse values can legitimately inform treatment decisions. On the one hand C's treatment refusal could be understood as a perfectly intelligible expression of his theological commitments and his faith in the competence of his care team. On the other hand, C's grandiose delusions may have suggested that he was losing touch with reality. Mr Justice Thorpe was prepared, perhaps, to find C competent because his delusions did not appear to be directly relevant to his treatment decision.

'Reasonable outcome': objective test or value judgement?

To what extent is Mr Justice Thorpe's decision explicable in terms of the '*reasonable outcome*' test, the second level of 'competence' or, as some would put it, 'rationality' described in Roth *et al's* article?

The capacity criteria appear to give a degree of objectivity to the way a doctor or a court determines capacity. But there may be a hidden evaluative dimension to the assessment. For example, might Mr Justice Thorpe have come to a different conclusion if C had been a member of an extreme sect with unpopular views

rather than a patient expressing a largely orthodox Christian position? While a judge may not doubt a patient's ability to use, process, and evaluate the information he is given, he may not like the way in which the patient does it. A judge could, without detection, and perhaps without even realizing it, penalize a patient for holding values he does not share.

As Roth *et al's* article puts it, 'if patients do not decide the "wrong way", the issue of competency will not arise'. And the notion of being able to 'weigh' information opens up the 'way' for this: what is involved in assessing 'weighing' may include consideration both of which factors are properly to be included in the weighing, and of the 'weights' to be attached to each.

Capable of understanding or actual understanding?

The 'capable of understanding' test, the fourth one described in Roth *et al's* article, perhaps best reflects the position in English law. This test seems to be consistent with the legal view that the patient is free not to make a sensible, rational or well-considered decision (although it must be rational in the sense of being based on rational manipulation of relevant information). As it happens, 'C's' decision was, arguably, perfectly sensible given his presuppositions and his reading of his situation.

The 'actual understanding' test (the fifth one described) probably goes too far and, if it did apply in English law, would, rather ironically, underscore medical paternalism. Doctors could, in theory at least, find a perfectly capable patient 'incompetent' by withholding from him the amount of information he would need to 'actually understand'. The test of patient competence would therefore turn on what the doctor would choose to tell the patient, rather than on the patient's decision-making capacity. The 'actual understanding' test, which should represent the highest view of patient autonomy, would, in practice, place in doctors' hands even greater power to determine competence.

Kennedy and Grubb (2000) have argued that:

Competence or incompetence is a state inherent in the individual patient which cannot depend on how much the doctor tells the patient. It must, therefore, be the law that competence is determined by reference to the unvarying conceptual standard of capacity or ability to understand. Whether, thereafter a patient who is judged competent because she has the capacity or ability to understand, in fact consented, is a distinct question turning on the reality of the consent based upon legally adequate information.

It is to this issue of the standard of legally adequate information that we now turn.

Information

We learned earlier in this chapter that the legal test of competence was a composite test with three ingredients: capacity, information, and voluntariness. We have already considered the issue of capacity. The legal test of capacity is set out in the case of *Re C* and requires a patient to be able to understand and retain the information he is given about his treatment proposal; be able to believe it;

and be capable of weighing up the information so as to arrive at a true choice. Thus, it is clear that the test of capacity itself implies that the patient's consent must be 'informed' to a certain degree. However, the requirement that consent be 'informed' begs the question, how informed is informed? The second ingredient of the composite test is associated with this question.

It should be noted that the requirement that consent be informed is not equivalent to the doctrine of 'informed consent' that many American jurisdictions have adopted. This doctrine relies on the language of individual rights and pays especial attention to the particular circumstances of the patient. Contrary to popular belief, the doctrine of 'informed consent' in that sense, is not a requirement of English law, and there is little evidence that the English courts will adopt that doctrine in the near future.

How much must a doctor tell the patient in order for that patient to give a legally valid consent? In English law, a doctor must tell the patient whatever is necessary to avoid civil actions in battery or negligence. Accordingly, the English law of consent is essentially *defensive*, i.e. it is designed to protect the doctor from civil litigation rather than to promote individual patient rights. For this reason, the English law of consent is criticized (Brazier, 1992, p. 92) for its continuing contribution to a culture of medical paternalism.

To explore this point, it will be helpful to consider, first, the ingredients of the law of battery and that of negligence. This will involve a brief excursion into a number of additional legal concepts before we return to the question of how much a patient needs to know in order to consent to medical treatment. First, we need to understand the legal concept of a 'cause of action'.

Causes of action

What happens when the doctor treats a patient without first having obtained that patient's consent? What redress is open to the patient? In legal terms, what are that patient's possible 'causes of action'?

In a nutshell, the doctor may be liable to criminal and/or civil proceedings:

- ◆ *criminal law* for the crime of battery (known as criminal battery), and/or
- ◆ *civil law* for:
 - trespass to the person (known as civil battery), and/or
 - negligence.

You should note that both civil battery and negligence are causes of action to fall under the legal 'head' of tort law (see above, Session 1 of this chapter)

Thus, there are three main contexts in which the issue of consent in the doctor-patient relationship arises:

1. in the *crime* of battery
2. in the *tort* of battery
3. in the *tort* of negligence.

These causes of action apply to doctors who *do* things to patients without consent; they do not apply to the failure to obtain

consent in itself, albeit a doctor can be negligent in the manner in which she purports to gain consent (for example, in the information that she gives to the patient during the process).

Criminal law

The word 'battery' refers both to the criminal offence or the civil action of trespass to the person.

However, a doctor will very rarely, if ever, be prosecuted for the crime of battery. A doctor who fails to obtain his patient's consent 'in the ordinary practice of medicine in good faith' will, in almost all cases, be liable to a civil action in battery or negligence. However, a criminal prosecution might follow a misrepresentation or fraud to secure consent to treatment, e.g. obtaining a patient's consent to sexual intercourse by presenting it as a legitimate medical examination.

For our purposes, therefore, when we refer to 'battery', it will be to the civil action rather than the criminal offence, unless otherwise stated. It should be noted that both criminal and civil battery actions share the same ingredients.

Civil law: the ingredients of battery

There are three ingredients to a civil battery action:

- ◆ touching
- ◆ damage
- ◆ proximity and foreseeability (non-remoteness) of damage.

We will deal with each of these in turn:

1. *Touching*. There must be physical contact between the doctor and the patient. A doctor may be liable if, for example, he injects a patient with a drug without his consent. But he will not be liable in battery if, without that patient's consent, he gives him a pill to take. In the latter case, there has been no physical contact and, therefore, no battery. The patient would be left to pursue any claim he had against the doctor in negligence.
2. *Damage*. It is *not* necessary for a patient to show that the damage occurred as a result of any touching. The patient need only prove that the doctor touched him without first obtaining his consent. Indeed, a patient could succeed even if the doctor's treatment actually benefited him. In a negligence action, by contrast, the patient must show that it was the doctor's negligent conduct that caused the damage.
3. *Remoteness of damage*. A doctor, if damage does occur, is responsible for all damage that results from the touching. Indeed, punitive damages may be awarded if the doctor's conduct was particularly disgraceful. In negligence, by contrast, the doctor is responsible only for damage that he could have reasonably foreseen might result from his negligent act or omission. Note that in negligence a doctor can be found negligent both for his positive acts and also for *failure to act* where he ought to have acted. Unforeseen damage will not be compensated. Note also that damages in negligence are awarded to compensate the plaintiff for his loss, not to punish the defendant.

Civil law: negligence

There are three ingredients to a negligence action. All three must be present if the patient is to succeed in his action against the doctor. These are:

- ◆ owing a duty of care
- ◆ breach of standard of care
- ◆ causation.

Again, we will consider each of these ingredients in turn:

1. *Duty of care*. The patient must establish that the doctor treating him/her owed him/her a duty of care. Normally, this will not be difficult to prove. However, complications can arise within the interdisciplinary context of an enlarged NHS community, e.g. in the context of a 'team' with collective responsibility for the patient's care. In order to establish the presence of a duty of care, the patient must demonstrate all of the following:
 - ◆ *Reasonable foreseeability*. The patient must establish that the doctor could have reasonably foreseen that his act or omission would harm the patient.
 - ◆ *Proximity*. There must be a sufficiently close relationship between the doctor and the patient to warrant legal redress. The doctor must have some role in the care of the patient. For example, it is not enough to show that the doctor was merely present in a busy hospital building when the patient was brought in for treatment.
 - ◆ *Public policy*. It must be just and reasonable to find the doctor liable in the circumstances. In some circumstances, the courts on public policy grounds will disallow a claim in negligence even though the injury in question was reasonably foreseeable and a relationship of proximity existed between the doctor and patient, for example so-called 'wrongful life' claims premised on the view that it would, for some, have been better never to have been born at all.
2. *Standard of care*. The patient must show that the doctor fell below the medical standard of care applicable to someone exercising his particular medical art. It is not enough to show that the doctor made an error of judgement. The medical standard of care is unique in that the medical profession itself under the so-called *Bolam* test, determines it. We shall look at this test in greater detail later.
3. *Causation*. The patient must prove that the doctor's negligent act or omission *caused* the damage the patient suffered. In other words, the patient must show that 'but for' the defendant's allegedly negligent conduct, no damage would have resulted (the so-called 'but for' test). This must be proved on the balance of probabilities (i.e. more than 50% chance). It can be, and often is, extremely difficult to prove causation, e.g. in 'lost chance' cases. For example, the House of Lords (the highest court in England and Wales) rejected a claim for damages, which reflected a percentage of a lost chance of recovery

resulting from an earlier misdiagnosis. A boy who fell out of a tree would have had a 25% chance of recovering from his injuries had his doctor's properly diagnosed and treated him the first time. The House of Lords held that the claimant had failed to prove on a 'balance of probabilities' that the defendants had 'caused' his injuries. He could not recover an amount corresponding to his 'lost chance', i.e. 25% of the amount of a full award. It was all (over 50% probability) or nothing (under 50% probability).

'Nature and purpose' (for battery)

A doctor who 'touches' his patient without that patient's consent will be liable to an action in battery, even if that touching benefited the patient. Therefore, it is of great importance for the doctor that he ensures that he has secured the patient's agreement to treatment. Of course, if there is no physical contact between the doctor and the patient, then no action in battery will arise and the patient will be left to pursue a claim against the doctor in negligence. In order to succeed, the patient will then have to show that the doctor owed the patient a duty of care, that the doctor fell below the medical standard of care and that the doctor caused damage to the patient.

But when will a patient be taken to have given a 'real' consent? The legal position is that a patient can be taken to have given a real consent when that patient understands in broad terms the nature and purpose of the treatment proposed (*Chatterton v Gerson* [1981] 3 WLR 1003). Thus, a doctor will be liable in battery where he misrepresents to the patient the nature of what is being done. An action in battery will clearly lie in cases of fraud where, as in the example above, a doctor 'dupes' a patient into agreeing to 'therapeutic' sexual intercourse. Actions in battery have also succeeded where a doctor has misrepresented to the patient the nature of what is being undertaken.

However, in some cases, the line between battery and no-battery may not be clear and distinct. Suppose you go into hospital and agree to a series of routine blood tests preparatory for surgery. Unknown to you, an extra HIV test is 'thrown in' that you would have refused if asked. You understood that several tests would be carried out on your blood, though not necessarily which ones. Yet, you might have wanted to avoid the risk altogether of the stigma, discrimination, and personal anxiety that a positive result would entail. It is suggested that you would not have given a real consent to the test because the HIV test is one for which, on policy grounds, your express consent should have been sought.

'Effects' (for negligence)

The courts have shied away from finding doctors liable in battery where the issue is not the nature and purpose of the treatment proposed, but the effects, i.e. where the risks of the procedure were not explained. For example, in the case of *Chatterton v Gerson*, a woman, Mrs Chatterton, failed in her action in battery for her doctor's alleged failure to inform her of the possible side-effects of her postoperative medication, i.e. pain and numbness.

The High Court rejected her claim arguing that the appropriate cause of action was in negligence, not in battery. Mr Justice Bristow stated:

In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause on which to base a claim for failure to go into the risks and implications is negligence, not trespass [i.e. *trespass* to the person or civil *battery*]. Of course, if information is withheld in bad faith, the consent will be vitiated by fraud.

The House of Lords has subsequently endorsed this view in the case of *Sidaway v Board of Governors of the Bethlem Royal and the Maudsley Hospital* [1894] 2 WLR 788 at 790. The Canadian courts have also adopted a similar position. Thus, apart from claims involving fraudulent misrepresentation of risks, the tort of battery probably now has a vestigial role in the law of consent.

Difficulties in winning negligence actions

By making negligence the appropriate cause of action for a doctor's failure to inform the patient of any risks inherent in an operation, the courts may arguably have compounded the pro-doctor character of the English law of consent. This is because it is more difficult to prove that a doctor is negligent than it is to prove that he 'touched' the patient without consent. Also, the test of negligence is itself based on essentially a medical standard, incorporating therefore medical and not patient values (see below).

As we outlined above, in order to succeed in negligence, a patient must prove that the doctor in question owed a duty of care, fell below the medical standard of care, and caused the damage that ensued. This is quite difficult to achieve. Medical negligence actions are notoriously slow moving, frequently lasting more than 10 years. Doctors and health authorities also have the advantage of powerful medical defence unions to handle their litigation. Patients often feel intimidated in the face of such institutional strength. Perhaps the greatest obstacle to patient success in negligence litigation lies in the nature of negligence action itself, namely the medical standard of care. This is unique in that, as noted above, the professional standard for doctors is largely set by the medical profession itself, rather than according to a judicially determined standard of 'reasonableness'.

In the last part of this session we will turn to an important legal test for negligence cases: the Bolam test, and its recent interpretation.

The 'Bolam' test

The *Bolam* test is so-called because it derives from a leading English case relating to the medical standard of care, i.e. *Bolam v Friern HMC* [1957] 2 All ER. In the *Bolam* case, a doctor will not be liable in negligence if he can establish that his conduct was '... in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area'.

There is continuing debate about what, precisely, the Bolam Test means: the judge in *Bolam* also used the term 'reasonable body' of opinion; in other judgements it becomes 'respectable body'.

Broadly, though, all agree that Bolam establishes that in English Law medical standards of care are subject to what has become known as a 'reputable minority' defence. This means that surgeons will be judged by the standards proper to surgeons, physicians to physicians, etc. Provided that a doctor can establish a reputable minority of relevant colleagues would have done what he or she did, the doctor will escape liability. His conduct will be deemed proper even if the majority of doctors practising in his area of medicine would have conducted themselves differently, provided that a 'responsible' minority of doctors would have endorsed his conduct. Whether such a reputable minority of doctors exists will be a matter of medical expert evidence. Despite more recent intimations to the contrary, the court has no discretion to substitute a judicially constructed 'reasonable doctor' test, although any 'accepted practice' must satisfy a basic test of being 'logically based' (see *Bolitho* below). As a result, many believe that *Bolam* is a charter for medical paternalism, reinforcing the assumption in the English courts that 'doctor knows best'. As we will see in the next reading, the Bolam test has found application particularly in relation to the information component of consent.

EXERCISE 5

(30 minutes)

Read *Sidaway v Bethlem RHG* [1985] 1 ALL ER 643, extracted in:

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

Link with Reading 19.5

Read each judgment carefully.

- ◆ How does each judge apply the Bolam test (if at all)?
- ◆ How much must a doctor disclose to his patient to avoid an action in negligence?

The 'Sidaway' case: the facts

The House of Lords case of *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 All ER 643 represents a major challenge to the view that the medical profession ultimately determines the scope of its obligation to the patient, at least in the context of information disclosure.

Mrs Sidaway underwent surgery to relieve severe pain in her neck, right shoulders and arms. As a result, she was left paralysed. She sued the surgeon and the hospital for the surgeon's failure to disclose the inherent risks of the operation, i.e. that there was a 1–2% risk of damage to the nerve roots and spinal cord. She argued that 'but for' this failure, she would not have consented to surgery and thus avoided paralysis. The surgeon's death prior to the trial complicated the issue of causation, which turned on what precisely he had told Mrs Sidaway. The Lord's decided the legal issue (i.e. how much should a doctor tell the patient) on the factual premiss that the surgeon (Mr Falconer) had not disclosed these risks.

The decision, the patient, and the patient's values

Mrs Sidaway lost her case. There was evidence to suggest that there was a reputable minority of neurosurgeons who would have chosen not to disclose the small risks inherent in the operation. All the judges agreed that Mrs Sidaway could not prove what was said in the consulting room. They unanimously agreed that a doctor was obliged to answer all the patient's specific inquiries. To this extent then, the patient's values should determine the extent of the information required in consent.

But the judges also agreed to reject a totally subjective test, i.e. what this particular patient wanted to know in this patient's particular circumstances, assuming that the patient has not made specific inquiries. The Bolam test was thus upheld against the patient's values, though the status of the *Bolam* test itself was left in doubt. Perhaps this is because the law still construes the doctrine of consent defensively, rather than as an expression of the patient's human rights. In other words, it is concerned with the question, what does it take to, as it were, get the doctor off the hook, legally speaking?, rather than 'what should we tell the patient in order to honour her dignity as a decision maker?' It is significant that the strongest critic of the Bolam test, Lord Scarman, was the Law Lord with the reputation of being most attentive to the concept of 'human rights'. In addition, the moment that a degree of judicial objectivity is allowed to qualify the medically determined standard of care relating to information, there is no reason in principle why a degree of judicial scrutiny should not also apply to questions of treatment and diagnosis. The range of views expressed by the judges in this case reflects the range of positions in English law at the present time on the balance to be struck between patients' values and those of professionals (usually taken by the courts to mean doctors). We will look at each of these in turn.

Lord Scarman: patients' values

Lord Scarman wanted to substitute the 'prudent patient' test, adopted in America, Canada, and Australia, for the *Bolam* test. This test, if adopted, would apply in the absence of a specific enquiry by the patient (which would otherwise need to be answered in full). The prudent patient test asks what the 'prudent' or 'reasonable' patient would want to know in the circumstances. This would include the obligation to disclose 'material' risks, which Lord Scarman defines as the risks the patient could reasonably expect to be informed of in the circumstances (a rather circular test, perhaps).

The prudent patient test is therefore distinguishable from a totally 'subjective' test, which is concerned with what a particular patient, who has not made a specific enquiry, actually wants to know. This, of course, assumes that there are ways of telling what a patient wants to know in the absence of putting specific questions to the doctor. However, Lord Scarman accepted that there were circumstances when it would be right for a doctor to withhold information from the patient on the basis of 'therapeutic privilege'. In other words, a doctor would be permitted to

withhold information from the patient if it could be shown that 'a reasonable assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient'. Again, then, we have an approach that amounts to 'patient choice with exceptions'.

Lord Diplock: doctors' values

Lord Diplock advocated the direct application of the *Bolam* test. He was therefore endorsing the *status quo*, i.e. an unabridged medical standard of care. Lord Diplock argued that to alter the *Bolam* test in the context of information disclosure would result in different standards of obligation across the clinical process. The *Bolam* standard would apply to diagnosis and treatment, but not to information disclosure. Lord Diplock thought that there was no warrant for varying the standard of care in this way.

The majority: doctors' values within limits

The majority (Lords Bridge, Keith (who concurred with the Lord Bridge) and Templeman) argued that the *Bolam* standard would apply in most cases. However, the courts remained the ultimate arbiters of the scope of the doctor's obligation. According to Lord Bridge, how much the doctor should tell a patient was not exclusively a matter of expert testimony, although great weight would always be given to the views of the experts.

Lord Templeman argued that doctors were obliged to act 'rightly' (Note the explicit value term here) and could be impugned for not doing so, even if a 'reputable minority' of doctors endorsed their conduct. According to both judges, doctors were obliged to disclose inherent risks in treatment in certain circumstances, even in the face of medical opinion. Lord Bridge argued that doctors should disclose 'substantial risk(s) of adverse consequence(s)', e.g. a 10% risk of a stroke. Lord Templeman argued that doctors should disclose 'special' as opposed to 'general' risks. Again, we can understand this is an attempt (implicit, no doubt) to give certainty in the face of potentially different evaluations of what, by this or that person's values, should count as a *substantial* risk of *adverse* consequences.

Post-Sidaway

As you can see, there was a broad spectrum of opinion in the *Sidaway* case. Lord Diplock delivered the most conservative judgment endorsing the traditional interpretation of the medical standard of care. In other words, it is up to the medical profession to determine how much information doctors should give their patients. Lord Scarman delivered the most radical judgment, endorsing the transatlantic 'prudent patient' test. In other words, doctors should tell their patients what the 'prudent' or 'reasonable' patient would want to know in the circumstances. The majority adopted a middle position in the form of a qualified version of the *Bolam* standard.

Subsequent 'information' cases have interpreted *Sidaway* both conservatively and liberally. For example, in a number of cases,

patients have taken doctors to court for failing to inform them of the inherent risks of sterilization procedures. In two Court of Appeal cases, the court applied the traditional *Bolam* standard to aspects of the doctor-patient relationship that *Sidaway* supposedly excluded. For example, in *Blyth v Bloomsbury Health Authority* [1993] Med LR 151, the court held that it was up to doctors to decide how much to tell their patients, even in response to specific enquiries. In *Gold v Haringay Health Authority* [1987] 2 All ER 888, the court perversely adopted Lord Diplock's judgment as the centre of the *Sidaway* decision (see the judgment of Lloyd LJ). Academic critics have impugned these two cases as overprotective of the medical profession. According to one, to read *Gold* 'is to imagine that *Sidaway* had not happened'. (Kennedy, 1996, p. 210).

Whose values?

However, a number of very recent information cases have reaffirmed the courts' role in setting limits to medical judgment. In the House of Lords case of *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771, the court argued that medical opinion must have a logical basis to it, even if it satisfies the 'reputable minority' standard. Medical opinion must be reasonable, responsible, and respectable. This is in keeping with the *Bolam* judgment itself, which refers to a *responsible* body of medical practitioners exercising a particular medical art. But the essential spirit of the test remains, that, at least within very wide limits, it is the values of the profession (as expressed in at least a minority of its members), rather than of the patient (or even a composite 'prudent patient') that determines the extent of the information required for consent.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What are the four key elements in the legal test of decision-making capacity defined by the case of *ReC* in the English courts?
2. Where (if at all) might values come into this test?
3. If a doctor treats someone without consent unlawfully, what 'causes of action' may a patient have under English law, in criminal law, and in civil law?
4. What are the elements of battery?
5. What are the elements of negligence?
6. What is the 'Bolam' test?
7. What is a prudent patient test?
8. Who 'sets the tests' and what are they really about?

Session 3 Consent, voluntariness, and best interests

The *third* ingredient of consent is voluntariness. In order to give valid consent, a patient must have the functional ability to understand the nature, purpose, and effects of the proposed treatment and arrive at a clear choice *without duress or undue influence*.

For example, in the case of *Re T*, the Court of Appeal upheld the lawfulness of an emergency Caesarean section on a supposedly non-compliant 34-year-old woman. The court held that the patient's mother—a Jehovah's Witness—had pressurized the patient into refusing potentially life-saving blood transfusion. The court also held that the mother's pressure had prevented the patient from making an independent decision and, therefore, a 'true choice'. As a result, the doctors were free in the ensuing emergency to act in the patient's best interests in the absence of a real refusal of consent.

The courts will perhaps be readier to find involuntariness where the patient has appeared to refuse than appeared to consent. For the doctor may be liable in battery where the patient appears to consent but later claims the consent was involuntary. Where the patient appears to refuse, doctors will be harder pushed to examine the state of the patient's mind, and to justify supposedly non-consensual treatment.

Medical paternalism, patient autonomy, and judicial values

While the courts have often affirmed the principle of patient self-determination, they have not always acted consistently with that affirmation. Kennedy (1996, p. 386) argues that the courts have traditionally analysed the doctor–patient relationship within the framework of doctor's duties rather than patient rights. It seems that the courts will hold back from too closely enquiring into the patient's state of mind in order to expand the scope of the doctor's clinical discretion. The principle of patient self-determination becomes a concession to the patient rather than a legitimate right.

The essentially defensive character of English consent law is evident in the longevity of the *Bolam* standard, the anomalous responses to treatment refusals by children and the expansive use of mental health legislation to overcome treatment refusals by clearly competent adults. Thus, the courts, arguably, have used the concepts of 'rationality', 'capacity', and 'competence' as levers to achieve what they think are reasonable outcomes. There can be few clearer examples of the operation of (implicit) judicial values!

Perhaps the most conspicuous examples of this kind of judicial leverage reflecting implicit judicial values are a number of controversial 'enforced Caesarean cases'.

Enforced Caesareans

The English courts have stated repeatedly that an adult patient who suffers from no mental incapacity has an absolute right to

make a treatment decision. The only possible exception to this principle cited in English law is where a treatment refusal might lead to the death of a viable foetus, i.e. a foetus that is sufficiently developed to survive outside the womb, albeit with medical help. This presumed exception to the legal capacity of a woman was perhaps always a dubious legal proposition, but the courts have taken advantage of the loophole on several occasions, especially in the mental health context.

Take two High Court cases, for example:

1. In *Tameside and Glossop Acute Services v CH (A Patient)* [1996] 1 FCR 753, the court declared that Caesarean section could constitute necessary treatment for a non-compliant woman's schizophrenia under Section 63 of the Mental Health Act 1983.
2. In *St George's Health Care National Health Service Trust v S (No. 2)*; *R v Collins, exp S (No. 2)* [1998] 3 All ER 673, a non-compliant woman suffering from pre-eclampsia was sectioned under Section 3 of the Mental Health Act. She knew that she was putting herself and her foetus at risk, but she wanted her child to be born naturally. Although she was treated for her mental disorder, nevertheless a declaration was sought authorizing a Caesarean section, premised presumably on the assumption that the woman in question was incompetent.

The Court of Appeal has castigated the use of mental health legislation as a lever for treating otherwise competent women against their will. In the case of *Re MB (a Caesarean section)* [1997] 8 Med LR 217, the court held that: 'The Act cannot be deployed to achieve the detention of an individual against her will merely because her thinking process is unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large.'

However, the court none the less allowed the Caesarian section on the perhaps even more unlikely ground that, in this case, fear (of needles) had 'paralysed the [woman's] will'.

There is other evidence of the judicial reluctance to examine closely the patient's state of mind before authorizing treatment on non-compliant women. The courts have acted on incoherent legal grounds (*Re S* [1992] 4 All ER 671), and on untested hearsay evidence (*Norfolk and Norwich (NHS) Trust v W* [1996] 2 FLR).

Clashes of values (and a role for Values-Based Practice?)

The enforced Caesarean section cases are significant because they show how the concepts of rationality, capacity, and competence, may operate in a 'gendered' fashion. In other words, most judges, being male, do not tend to identify with the values or beliefs of prospective mothers when they put themselves in danger of their lives and of the lives of their unborn children. Justice Cardozo might have added to his two conditions of eligibility (Adults and Sound Mind), a third (Not Very Pregnant).

These cases, however, illustrate a broader problem about the role of values and beliefs in assessments of rationality and capacity. We raised this issue above in the case of *Re C* and considered the possibility that the judge might have declared C competent because he identified with C's values. Similarly, it could be argued in the St George's Healthcare NHS Trust case (see above, previous page) that the woman was declared incompetent because the court did not identify with her reasons for refusing potentially life-saving treatment, i.e. because she wanted to bear her child naturally. The three-part competence test in *Re C* could easily be driven by unacknowledged medical and judicial value judgements. A woman might be capable of understanding and retaining the information, believing it, and arriving at a clear choice. But if she failed to weigh up the information in the way the judge thought right, then that judge could easily find her incompetent.

The problem, it seems, with the established competence test is its almost exclusive focus on the 'functional approach' to assessments of capacity. The medical profession and the courts have not, perhaps, adequately acknowledged that assessments of rationality and competence do not occur in an evaluative vacuum. This is not especially problematic in the context of most bodily disorders, where, as we saw in Part I, there is a greater likelihood of an identity of values between doctor, patient, and judge. However, differences of values become more problematic even in the context of bodily disorders, where the life of the patient or her viable foetus is put at risk.

You may think that the expansive use by the courts of mental health legislation to overturn a patient's 'wrong' treatment decision is a worrying development in that it could be a step towards abusive uses of psychiatry for coercive social purposes rather than for treating mental health problems. We return to the abusive uses of psychiatry later in this part. The essential point that will emerge is that the most serious abuses arise, not from deliberate ill will, but from a failure to recognize the operation of value judgements in assessments of rationality (and, correlatively, related concepts of competence, capacity, and so forth). Such failures, as we will see, are compounded by a naive medical model in which diagnostic assessments are assumed to be objective and, hence, value-free.

The English courts, then, in falling back on mental health legislation, in their (wholly understandable) attempt to hang on to an objective test of capacity, are at risk of just this form of abusive misuse of psychiatry. It is an open question whether, in legal as in health-care practice, values-based approaches may usefully complement court procedure in such cases. But as we argued in Chapter 18, the first and necessary step is to recognize the difficulty for what it is, a difficulty arising from (largely implicit) conflicts between (legitimately) different value perspectives, rather than a failure to find a 'golden bullet' in the form of a value-free, exclusively objective, test.

A generic incapacity act?

One response to the concerns about abusive uses of psychiatry is to put mental health on the same basis as bodily health when it comes to patient autonomy and consent to treatment.

The Mental Capacity Act, 2005, for England and Wales seeks to put on a statutory footing many of the common law principles that we have been discussing. We will not consider the Act in detail (it is not due to come into force until April, 2007) but will highlight some of the salient points. Section 2(1) of the Act provides: 'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment or disturbance in the functioning of the mind or brain.'

Section 1(2) transmutes into statutory form, with small modifications and elucidations, the presumption against lack of capacity in adults (i.e. people over 16 years of age) the incapacity criteria developed at common law and the 'best interests' test. Section 1(4) lays down a detailed checklist of things that must be done in order to determine 'best interests'. Nothing in the draft Bill will, if enacted, affect those provisions in existing mental health legislation, which allow compulsory treatment for mental disorder of otherwise (according to the draft Bill and common law) 'competent' people.

The provisions of the Bill represent a qualified transmutation of the contents of an earlier Government 'Green Paper', *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults* (Lord Chancellor's Department, 1997). Interestingly, the terms of reference of the original Law Commission work (on which the Green Paper proposals were based) excluded consideration of 'treatment for mental disorder', which was to remain under a separate Mental Health Act. This has been seen by many as reinforcing the stigma that has traditionally attached to a diagnosis of mental disorder, via continued 'discriminatory' legislation, which was based not on the (autonomy driven) principle of incapacity but on the (paternalistic) pragmatism of 'appropriateness' of medical treatment (Szmukler and Holloway, 1998, see reading linked with Exercise 6, below). However, others have argued that, even if incapacity had been extended to treatment for mental disorder, that might in reality have obscured yet further the value judgements that lie at the heart of all medical diagnoses, in the context of physical disorder, but with practical importance especially in the area of mental disorder (see readings linked with Exercise 6).

In the next set of readings we look at a section from the original discussion paper, *Who Decides*, together with three views on the role of generic incapacity legislation in mental health.

EXERCISE 6

(90 minutes)

Read the extracts from:

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

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

Link with Reading 19.6

- ◆ What are the advantages and disadvantages of applying a R C type competence test to treatment decisions relating to a patient's mental disorder?

This discussion speaks for itself! There are clear arguments, based on issues of equality and non-stigmatising treatment, for generic incapacity legislation to include mental disorder. But if the capacity test employed is insensitive to the greater conceptual and evaluative complications of mental disorder, this could prove abusive.

The point, as we have repeatedly emphasised in this book, is that diagnoses of mental disorder are complicated by particular conceptual difficulties not shared in the diagnosis of most bodily disorders. In the context of mental disorder, the principle of self-determination thus acquires a deeper dimension of conceptual difficulty. For patient autonomy is expressed not simply through the articulation of a treatment decision but by indicating to doctor and judge alike how the patient's condition is to be understood. This, again, requires a greater commitment by doctor and judge alike not only to examine the state of the patient's mind, but also to be guided in part by the patient to a proper understanding of his/her condition. Judicial past practice, e.g. in the enforced Caesarean cases, shows that this acknowledgement of the patient's role in determining their own diagnosis (rather than just their treatment), will require as significant a shift in legal as in medical thinking.

Rational suicide, psychiatric euthanasia, and best interests

The conceptual difficulties raised by consent in the context of mental health are brought to a particularly sharp focus by end of life issues.

The difficulties are illustrated by the following case, which raises important issues with respect to voluntariness in the context of mental health care.

EXERCISE 7

(10 minutes)

Read the extract from the case of Martin McKendrick, Case 4.1 in

Dickenson, D. and Fulford, K.W.M. (2000). *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press, p. 91–97 (Extract pp. 91–92.)

Link with Reading 19.7

Dickenson and Fulford discuss this case mainly from an ethical and philosophical point of view.

- ◆ What issues do you think it raises in mental health law?
- ◆ Is Martin's death wish rational? Is he of 'sound mind'?
- ◆ Could it ever be in his 'best interests' to die?
- ◆ who decides (and who should decide) what is truly in someone's 'best interests'?

'Rational suicide' and the Mental Health Act 1983

Martin had been detained under the Mental Health Act on several occasions. On the basis of the information we have, he was probably a candidate for admission under Section 3 (treatment) of the Act. Under Section 63 of the Act, Martin's doctors could lawfully have treated him without his consent, although as a matter of good practice, they should have sought to obtain his consent first. However, Martin's doctors must have obtained Martin's consent first before giving him electroconvulsive therapy (being a treatment falling under Section 58). All treatment proposed and carried out must constitute treatment for Martin's 'mental disorder'. The Act does not define 'mental illness' or 'mental disorder' (to the extent that this incorporates 'mental illness') but there is little doubt that Martin was suffering from depression with delusions.

However, whether Martin's desire to die was a symptom of mental illness is a moot point. Can we simply assume that Martin is mentally ill because he wants to die? If Martin's desire for death is a consequence, or aspect of mental illness, then he can be treated under the provisions of the 1983 Act for that mental illness. If it is not, then his request for suicide falls to be considered under the common law.

A few preliminary comments about the criminal law and suicide need to be made.

Criminal law

It is no longer unlawful in Britain to commit suicide (Suicide Act 1961). But it remains an imprisonable offence to assist the suicide or attempted suicide of another (Section 2). Under English criminal law, therefore, there is no scope for acceding to Martin's death wish. With one exception, no jurisdiction in the world has yet successfully legislated for a law of assisted suicide and/or euthanasia, except briefly in the Northern Territories of Australia. The one exception is the enactment in the United States of The Oregon Death With Dignity Act 1994. In the Netherlands, doctors who assist suicide or euthanize their patients enjoy immunity from prosecution provided they conform to legally prescribed guidelines and statutory reporting procedures. The criminal law aside, then, what would Martin's position be under common law in the UK?

Sound mind and Self-determination

Under common law Martin has a legally protected right of self-determination provided he is an adult, of sound mind (and of course not heavily pregnant), even if it means refusing life-sustaining treatment. However, the question arises, is Martin of 'sound mind'? Does his suicide request, by definition, reverse the presumption of capacity? This would depend on how related his death wish was to his other symptoms of mental disorder (delusion and depression), which, collectively, indicated that he had lost touch with reality. If we recall, the court, in the case of *Re C*, was prepared to disaggregate C's delusions, which suggested that 'C' had lost touch with reality, from his reasons for refusing the amputation. In other words, his irrationality was not all-pervasive.

In Martin's case, the court would have to decide whether Martin's symptoms indicated that he had lost his grip on reality or represented an intelligible existential commitment (i.e. life has no meaning therefore death is the only option). Moreover, the court would have to be satisfied that Martin's decision for death was unequivocal. Perhaps it was C's unequivocal decision for death that distinguishes the case of *Re C* from many of the enforced Caesarean cases (e.g. *Re T*), where the courts were not satisfied that there was a clear death wish.

The legal position in Martin's case is, however, distinguishable from the case of *Re C* in a significant respect. Martin is not refusing treatment but making a request for active 'treatment' in the form of assisted suicide or euthanasia. While doctors cannot treat competent patients against their wishes, they are not obliged to accede to treatment requests, especially if they involve the death of the patient. Such requests, if acceded to, would represent a fundamental abridgement of the Hippocratic tradition that lies at the basis of medicine in the West. Perhaps the best way of expressing the legal position is to say that the doctor has a fundamental duty to act in his patients' 'best interests' qualified only by the patient's right to self-determination. Thus, Martin's doctor is not obliged to *do* anything that is not in Martin's 'best interests'. As we have seen, in the United Kingdom treatment is lawful provided that a responsible body of professional opinion would regard it as in the patient's best interests (*F v West Berkshire Health Authority* [1989] 2 All ER 545.). This is basically the *Bolam* test as applied to the meaning of 'best interests'.

'Best interests'

But this begs perhaps the fundamental question. What are Martin's 'best interests'? And who is best qualified to determine those interests? Can it ever be in Martin's 'best interests' to die? All these questions, of course, central as they are to the legal issues, are questions of value. A relevant case, that brings out the clearly value-laden nature of judgments 'best interests', is that of Tony Bland.

The 'Tony Bland' case

The courts have decided, in the case of permanently insensate patients, that it may sometimes lie in the patient's best interests to die (*Airedale NHS Trust v Bland* [1993] 1 All ER 821). In the 'Tony Bland' case, a young man, Tony Bland, suffered hypoxic brain

damage when he was crushed during the Hillsborough disaster (a football match crowd disaster). His injuries caused the cessation of all his higher brain functions leading to an eventual diagnosis of 'persistent vegetative state', from which he would almost certainly never recover. Tony Bland was fed and hydrated through a tube in order to keep him alive. He was able to breathe unaided and digest his food. The hospital sought a court declaration allowing them to discontinue his 'treatment', i.e. his feeding and watering, which would lead to his almost inevitable death.

The case eventually reached the House of Lords. Here, the Law Lords were keen to detach the issue of 'best interests' from the eventuality of Tony Bland's inevitable death and relate it rather to the issue of his 'treatment'.

Thus three of the Law Lords (Lords Goff, Browne-Wilkinson, and Lowrie) argued (in what is clearly a process of balancing different values) that the burdens outweighed the benefits of continued treatment, thus rendering it 'futile' (another clearly evaluative judgment) and, therefore, not in Tony Bland's 'best interests'. Two others (Lords Mustill and Keith) argued that Tony Bland's injuries had deprived him of his interests entirely, thus there was nothing to weigh in the balance. Their Lordships were not clear about whether Tony Bland's doctors had a duty or discretion to discontinue 'futile' treatment. Their Lordships were clear, however, that the patient's interests were a matter of clinical judgment (following *F v West Berkshire*). Whether their Lordships were right to translate the *Bolam* test for the medical standard of care into the critical legal justification for the withdrawal of treatment remains a moot point.

Living wills (or advance directives)

Martin's case can be distinguished from Tony Bland's case in one obvious respect, namely that Tony Bland was not in a position to make his wishes known. Patients can give advance indications of treatment refusal, in the form of what now in the UK amounts to a legally binding 'living will' (in the case of refusal of specific interventions in clearly defined circumstances) or can indicate their wishes, either in favour or against types of treatment, through an 'advance statement' (in relation to less clearly defined circumstances and treatment). Both advance refusals and advance statements become applicable in the event of subsequent incompetence. The current draft Mental Health Bill, however, will continue the current exclusion of treatment for mental disorder under the Act from the terms of advance refusals, although looser and non-binding advance statements may have some role to play. The Mental Capacity Act, 2005 dealing with treatment for physical conditions, as well as mental conditions not treated under the Mental Health Act, puts advance decisions to refuse treatment in the event of incapacity on a statutory footing where the patient is suffering 'because of an impairment of or a disturbance in the functioning of the brain.' Where advance refusals are unambiguous and unequivocal (in writing, signed and witnessed), both doctors and the courts will be required to honour them, even if refusal of life-saving treatment is stipulated.

However, would it ever be possible to indicate a desire for assisted suicide or euthanasia in advance? This brings us back to

the crux of the issue of rational suicide, i.e. the inescapable role of values, and of balancing different values, in ethical and legal determinations of best interests.

True values?

If 'best interests' are constituted by the values of the patient, then it is difficult to see how the patient could not be best placed to determine them. Martin sincerely believes that there is no meaning or value in his life. Who are we to disagree? Martin's mental anguish might be so extreme that he no longer has a worthwhile life. In other words the burdens of his continued existence outweighs the benefits, thus rendering his continuing existence 'futile'. If Martin's death wish is unequivocal, then does the court not have a legal obligation to endorse his wish to be treated (as he is the best judge) in his 'best interests'?

We could argue, on the other hand, that the issues of a worthwhile life and worthwhile treatment need to be distinguished, as they were in the Tony Bland case. This line of reasoning is based on the doctrine of *double effect*, a principle that seeks to resolve tension between some kinds of conflicting values by stipulating that it is good to intend the good even though bad will inevitably result. In the Tony Bland context, it was right to discontinue futile treatment (good) even though his death would inevitably result (bad).

This is quite different, however, from being asked to endorse a patient's self-assessment as a mark of respect for patient self-determination. In other words, Martin can kill himself if he wants to, but don't make us a part of it. Because, by helping him, we will be endorsing implicitly the value proposition that some lives can be worthless. It could be argued that doctors are not required to identify with their patient's values, but merely to help him live or die in a manner that is consistent with those values. However, should things be that simple? Doctors have never been automatons responding mechanically to patient treatment requests. Doctors have to set criteria to distinguish hopeless cases from those for whom there is still hope. Yet this perhaps suggests, with a return to the desire for the 'golden bullet' of an objective test, some 'true values' standard against which the patient's values must be judged.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this Session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What do legal cases involving enforced Caesarian sections show in terms of judicial values?
2. Why might judicial values be problematic?
3. What does generic capacity legislation seek to achieve?
4. Does the concept of 'best interests', widely used as it is in legal contexts, make legal judgments objective?

Conclusions: diagnostic values in law and medicine

We have aimed in this chapter to examine the concepts of rationality and consent from a medico-legal viewpoint with particular reference to the (irreducible) role of (often conflicting) values and hence the (potential) importance of values-based approaches.

In relation to consent, we have argued that the law of consent reflects the ethical principle of self-determination. The law has sought to give a legal guarantee to those expressions of will that demonstrate that the patient has made a true choice. The theory is that a patient will be deemed competent if he can prove that he is capable of understanding the nature, purpose, and effects of the treatment proposed. The courts will regard a patient as competent if he can demonstrate to the court that he has the requisite cognitive decision-making powers to make a genuine treatment decision. This decision-making capacity, in adults, will be presumed, but, in children under 16, and perhaps between 16 and 18, will require evidence. The courts have strongly indicated that they are prepared to apply largely cognitive criteria in the cases of children (*Gillick*) and those adults suffering from mental disorders (*Re C* and the moves towards generic incapacity criteria).

Values visible!

However, the courts have been prepared to abridge the principle of self-determination in certain cases and this is where values start to become visible.

Thus, the courts have extended their protection where the life of the patient is in danger, or where non-intervention would have grave and adverse effects on the patient's health. With children, this has involved a dubiously defensive interpretation of the 'common law' of consent, and, with heavily pregnant women, rather an expansive use of mental health legislation. With both, the courts have revealed a reluctance to inquire too closely into the state of the patient's mind, perhaps for fear of finding the patient's cognitive decision-making powers intact. In these cases, arguably, hidden or acknowledged values are driving the courts to push the law of consent away from autonomy (self-determination) and towards beneficence (protective interventions).

Values invisible (and dangerous)

From the perspective of mental health, it is a particular concern that the unacknowledged legal values at work in these cases are *diagnostically related* values, i.e. values operating through such legal concepts as 'soundness of mind' and 'rationality'. To the extent that these concepts are assumed to be matters for expert testimony, hence matters of value-free medical evidence (from a 'man of science', you will recall, in the legal aphorism), the courts are working with the same incomplete conceptual model of medicine, the half-field view, that we explored in detail in Part I, and that, in Chapter 18, we identified as being at the root of the vulnerability of psychiatry to abusive misuses of its diagnostic categories (as in the former USSR).

Diagnostic determinations, legal and medical

This is not to say that such abuses are a feature of current legal determinations. But the risk is there so long as the courts operate, and as we have argued medicine itself continues to operate, with an incomplete—fact-only and values-free—model of its diagnostic concepts. The risk, furthermore, as we saw in Part III, is compounded so long as psychiatry, in particular, as the most ‘medical’ of the mental health professional disciplines, continues to work within an oversimplistic model of its own scientific infrastructure, a model embracing only one side (the ‘causal’ side) of the much richer, if conceptually more challenging, twin-stranded (causes + meanings) model, the origins of which, in Jaspers’ psychopathology, we traced in Part II to the *Methodenstreit* of nineteenth century philosophy and psychology, and that, in Part V we will find reflected in a major debate in modern philosophy of mind about the relationship between *reasons* and causes or, more precisely, reasons and (causal) laws.

A key item, then, on the agenda of mental health in the twenty-first century, will be to clarify the role of value judgements in the assessment of mental health problems in general, and in medical diagnostic assessments in particular. It is to the contribution particularly of linguistic analytic philosophy to this agenda that we turn in Chapters 20 and 21.

Reading guide**Introduction to medical law**

A lively and readable introduction to key issues in medical law is Margot Brazier’s (1992) *Medicine, Patients and the Law*. ‘Kennedy and Grubb’ (Kennedy, I. & Grubb, A., 2000) *Medical Law: text with materials*, (3rd edn) has become known as ‘the Bible of UK medical law’. It contains extracts from legal cases, legislation, and scholarly articles. Eastman and Peay’s (1999) *Law Without Enforcement*, analyses the interface between theories of justice and mental health.

Other useful sources include:

- ◆ Moore (1984) *Law and Psychiatry: rethinking the relationship*;
- ◆ Davies (1996) *Textbook on Medical Law*: chapters 6 (Ethical and legal basis of consent), and 7 (Informed consent to medical treatment);
- ◆ Mason and McCall Smith (1999) *Law and Medical Ethics*: chapters 10 (Consent to treatment), 21–22 (Psychiatry and the law);
- ◆ McHale, Fox, and Murphy (1999) *Health Care Law: text and materials*: chapters 5 (Capacity), 6 (Consent), 7 (Children), 9 (Mental health), and 12 (Reproductive choice II: abortion);
- ◆ Montgomery (1997) *Health Care Law*: chapters 10 (Consent to treatment), and 12 (Care for children).

If you are interested in following through some of the cases qualifying the traditional medical standard of care, have a look at:

- ◆ *Maynard v West Midlands RHA* [1984] 1 WL-1-R 643 (House of Lords) (pre-Sidaway) *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR (High Court), and *Joyce v Merton, Sutton and Wandsworth Health Authority* [1996] 7 Med LR 1 (Court of Appeal)

An important exemplar of the value of comparative empirical studies of decision-making by lawyers and others is Jill Peay’s (2003) *Decisions and Dilemmas*.

Rationality, responsibility and mental illness as an excuse in law

Detailed reading guides on rationality and responsibility in medical ethics and law are included in chapter 4 of Dickenson and Fulford’s *In Two Minds*.

Rationality, responsibility and psychopathology

Although there is a large philosophical literature on rationality and irrationality (to which we return later, especially in Part V), the rich variety of different forms of irrationality represented by psychopathology has been largely ignored. Among important exceptions are Bermudez (2001) on delusion, and Gardner’s (1993) *Irrationality and the Philosophy of Psychoanalysis*. As noted in chapter 18, Beauchamp and Childress’ (1989) *Principles of Biomedical Ethics* is one of the few bioethical accounts to take seriously the problem of judgements of rationality specifically in psychiatry. As also noted in Chapter 18, Fulford and Hope (1993) have argued that Beauchamp and Childress’ competencies approach works well for organic conditions such as dementia but fails to account for the kinds of irrationality exhibited by the functional disorders. A detailed treatment of the failure of traditional accounts of rationality to explain the ethical and legal status of delusion and other psychotic symptoms is given in chapter 10 of Fulford’s (1989) *Moral Theory and Medical Practice*; this is developed further in his *Value, Action, Mental Illness, and the Law* (1993). See also the classic, Fingarette’s (1972) *Insanity and Responsibility*, and among more recent accounts, Bermudez, 2001.

A feminist reconstruction of rationality, exploring the traditional philosophical links between agency and rationality, can be found in Donna Dickenson’s (1997) *Property, Women and Politics: Subjects or Objects?*, in the section ‘Rationality and its discontents’ (pp. 148–152). The significance of self-injurious behaviour is explored in Potter (2003a), with commentaries by Kruger (2003), Morris (2003), Sargent (2003), Woolfolk (2003), and a response by Potter (2003b).

Mental illness as a legal excuse

Mental illness as an excusing condition and, correspondingly, as a condition invalidating choice, is explored in *Philosophy*,

Psychiatry, & Psychology in Lavin's (1995) 'Who should be committable?' with a commentary by Brazier (1995). The issues of responsibility raised by dissociative states are discussed by Braude (1996) in his 'Multiple personality and moral responsibility' with commentaries by Clarke (1996) and Shuman (1996). Both Wilson's (1996) 'Sanity and responsibility', with commentaries by Fields (1996c) and Elliott (1996), and Robinson's (2000a) 'Madness, badness and fitness: law and psychiatry (again)', with a commentary by Broekman (2000) and a response (Robinson, 2000b), examine wider issues of mental disorder and responsibility.

A clear introduction to legal responsibility from the perspective of philosophy of law is H.L.A. Hart's (1968) *Punishment and Responsibility*. Anthony Flew's (1973) *Crime or Disease?* is a classic philosophical treatment of the issues. Lucas (1993) *Responsibility* is a clear analysis of the philosophical issues. McMillan (2003) provides an excellent recent update.

The role of mental illness as an excuse in law has been widely debated particularly in relation to the 'insanity defence' and related legal pleas. We noted in Part I, Daniel Robinson's (1996) scholarly historical *tour de force* on this topic, in his *Wild Beasts and Idle Humours*. Classic treatments include Nigel Walker's (1968) *Crime and Insanity in England* and the philosopher Anthony Flew's (1973) *Crime or Disease?*. The first chapter of R.A. Duff's (1986) *Trials and Punishments* offers a careful philosophical treatment. Lawrie Reznek's (1997) *Evil or Ill?* includes a valuable review of the issues. Henry Tam's (1996) *Punishment, Excuses and Moral Development* is a useful edited collection covering issues of responsibility from a number of perspectives, legal, bioethical, sociological, etc.

A clear introduction to the philosophical deep waters of determinism and responsibility is Mary Warnock's (1998a) 'Freedom, responsibility and determinism' (chapter 5 in her *An Intelligent Person's Guide to Ethics*). Jonathan Glover's (1970) *Responsibility* includes detailed analyses of the ways in which different forms of psychopathology may undermine responsibility.

Philosophy, Psychiatry, & Psychology has published a number of articles on responsibility and personality disorder: see, for example, Elliott's (1994) 'Puppetmasters and personality disorders: Wittgenstein, mechanism, and moral responsibility' with a commentary by Grant Gillett (1994); Fields' (1996a) 'Other-regarding moral beliefs, and responsibility' with commentaries by Adshead (1996), Duff (1996), Radden (1996), and a response by the author (Fields, 1996b); Benn's (1999a) 'Freedom, resentment, and the psychopath' with commentaries by Adshead (1999), Harold and Elliott (1999), Gillett (1999), and Slovenko (1999), and a response by Benn (1999b); and Ciochetti's (2003a) 'The responsibility of the psychopathic offender' with commentaries by Adshead (2003), Benn (2003), and Shuman (2003), and a response by Ciochetti (2003b). Woodbridge's (2003) *The Forgotten Self: training mental health and social care workers to work with service users*

shows the continuities between so-called borderline personality disorder and everyday responses to trauma, that can be explored in training.

Court-ordered Caesarian sections

The phenomenon of court-ordered Caesareans has caused much controversy and debate. See, for example Rhoden (1986) 'The Judge in the delivery room: the emergence of court ordered caesareans', and Stern (1993) 'Court-ordered Caesarian sections: in whose interests?.'

Psychiatric euthanasia

Jonathan Glover's (1977, second edition 1992) *Causing Death and Saving Lives* is a readable and thought-provoking pioneering work, written from a broadly utilitarian viewpoint. Many aspects of the rationality (or otherwise) of suicide are explored in a thematic issue of *Philosophy, Psychiatry & Psychology* on Suicide and Psychiatric Euthanasia (Volume 5 (2), 1998). This issue is based around a series of case studies by the Oxford psychiatrists, Sally Burgess and Keith Hawton (1998a), with commentaries by Warnock (1998b), Berghmans (a perspective from the Netherlands) (1998), Heginbotham (1998), Burnside (1998), Kelleher (1998), and the author's response (Burgess and Hawton, 1998b). Fairbairn explores the linguistic-analytic issues in his (1998a) 'Suicide, language, and clinical practice', with commentaries by Harré (1998) and Sadler (1998) and a response (Fairbairn, 1998b). Matthews' (1998) provides a philosophical overview, 'Choosing death: philosophical observations on suicide and euthanasia', and Montgomery (1998) a detailed legal 'footnote' in 'Suicide, euthanasia, and the psychiatrist'. Advance Directives in psychiatry and the importance of 'time frames' are explored in Savulescu and Dickenson's (1998a) 'The time frame of preferences, dispositions, and the validity of advance directives for the mentally ill', with commentaries by Dresser (1998), Brock (1998), Burgess (1998), and Eastman (1998), and a response (Savulescu and Dickenson, 1998b).

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