GUIDING PRINCIPLES IN MEDICAL LAW:
THE ABILITY TO TREAT

by

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ABSTRACT

The involvement of the medical profession in everyone's lives makes an understanding of the law governing the provision of medical treatment extremely important. This thesis argues that there is a logical and coherent structure to this area of the law. This is achieved through the application of key guiding principles to a range of important issues throughout a patient's life. The guiding principles considered herein are: self-determination, allowing treatment, best interests, and doctor protection. It is argued that the application of one or more of these guiding principles will determine whether or not treatment will be available in any scenario with which the courts may be confronted.

Whilst it is tempting to approach this topic by viewing each scenario involved as a distinct category of medical law it is submitted that this is both overly simplistic and unrealistic. It is more accurate to view the law as a scale, upon which each individual patient forms a distinctly unique point. This graduated concept accepts that the principles which apply will change in a continuing manner whilst still providing a workable method of determining which principles will be applied by the courts.

DEDICATION

This thesis is dedicated to my brother, Phillip Bunting,

who is my inspiration, my example and my guiding star.

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TABLE OF CONTENTS

PART I – INTRODUCTORY ISSUES

PART II – GENERAL TREATMENT ISSUES

PART III – SPECIFIC TREATMENT ISSUES

PART IV – DRAWING CONCLUSIONS

PART V – APPENDICES

TABLE OF CASES

UK CASES:

TABLE OF LEGISLATION

UK LEGISLATION:

TABLE OF FIGURES

PART I

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INTRODUCTORY ISSUES

CHAPTER 1:

BACKGROUND, CONCEPTS & GUIDING PRINCIPLES

1.1 – BACKGROUND:

It is a certainty that at some point in their lives everyone will be forced to rely upon the medical profession. Even if the need to use doctors, dentists and hospitals is avoided throughout the majority of life,[1] the activities of birth and death will inevitably involve recourse to medical treatment. As the average life expectancy increases, people will have to endure the pains of old age for longer and will once more be faced with having to rely upon the medical profession.[2] The almost certain involvement of the medical profession in achieving good health[3] makes the laws governing the availability of treatment vitally important. It is the aim of this thesis to ascertain whether or not this area of the law adheres to a coherent and logical structure. The principles and concepts that determine the outcome of court cases will be looked at in order to achieve this aim. This is important if the law is ever to be fully understood and the outcome of future cases reliably predicted.

The discipline of medical law[4] is a relatively new one necessitated by the advances in medical technology that have occurred in recent decades.[5] In essence the issues which arise in relation to medical treatment have not changed over those decades,[6] yet the scenarios in which these issues are encountered have altered considerably. The problem is that, whilst technology and

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[1] This eventuality, in itself, is practically impossible due to the encouragement of frequent check-ups.

[2] S.A.M. McLean, *A Patient's Right to Know* (Aldershot: Dartmouth, 1989), p.3

[3] It has been argued that for many people the achieving of good health is one of the most important concerns in life, see WHO, *Promotion of the Rights of Patients in Europe* (London: Kluwer Law International, 1995)

[4] To a certain extent it is misleading to talk about medical law as a legal discipline. Whilst it is now an accepted, and widespread, discipline of study it has certain characteristics which set it apart from other legal disciplines. Medical law is, in reality, an amalgamation of multiple areas of law. It borrows from both the public and civil law spheres, and elements of tort law, criminal law, public law and family law are evident.

[5] K. Paterson, 'Introduction' in K. Paterson (ed) *Law & Medicine* (Bundoora, Australia: La Trobe University Press, 1994), pp.1-2

[6] J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics* (London: Butterworths, 5th, 1999), p.vii

science have advanced at a startling rate, the law has lagged behind and this creates a level of uncertainty which is far from desirable.[7] As cases are brought, the courts are constantly faced with new, and previously unconsidered, problems. As the involvement of Parliament in this area of law is minimal, and is likely to remain so,[8] it is left to the courts to find coherent solutions to these problems. This discussion is, at least partly, concerned with the manner in which the courts deal with these new problems as they arise and are brought to their attention.

Many of the issues that arise in medical law debates are based on morality. Mason, McCall Smith and Laurie state that these moral debates touch upon people's most intimate interests, namely sex and death.[9] The problem is that there is no common morality and that the search for such is like the search for the end of a rainbow.[10] It is not unusual to find that strong moral convictions lie at the heart of the arguments encountered in medical law and that it is unlikely that those holding such convictions will be willing to compromise.[11] These moral debates raise questions as to the definition of a person, the value of human life and the role of the law in determining the future biology of the species.[12] The law, and specifically the courts, are faced with the task of having to answer these questions and provide guidance in a world of increasing moral uncertainty. It is, however, not for the courts to concern themselves with issues purely of morality. Court decisions must be based upon law; even if moral issues are concerned they must be approached through the application of legal principles. It is highly probable that decisions made from a legal viewpoint will vastly differ

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[7] J.D.J. Harvard, 'Legal Regulation of Medical Practice – Decisions of Life and Death: A Discussion Paper' (1982) J Roy Soc Med 351, p.354

[8] A. Kennedy & I. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.6. There are a number of areas where Parliament has intervened. Amongst these are abortion, assisted suicide, assisted conception and the treatment of the mentally incompetent. In general though Parliament refuses to intervene, possibly due to the way such issues cross the boundaries of party politics and involve complex issues of public morality.

[9] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), p.3

[10] J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics*, p.vii

[11] B. Markesinis, S. Deakin & A. Johnston, *Markesinis & Deakin's Tort Law*, pp.267-268

[12] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.3

from those of a moral basis.[13] It may be that the law adopts a more flexible approach to the problems in question, alternatively the law may take a more restrictive position. The law will define when it is acceptable to provide treatment and when it is not, yet there will always be an element of individual morality and choice to be exercised by the patient. An example of this is the law of abortion: whilst statute sets down what will be permitted, the individual can still decide whether or not they will ever approve of abortion. In essence the law places limits upon the freedom of doctors to treat their patients.

1.2 – RIGHTS:

1.2.1 – THE EXISTENCE OF RIGHTS:

Heavily linked to the moral debates central to many of the issues relevant to the availability of treatment are rights based arguments. The link between morality and rights is shown by Feldman when he states that a commitment to any right must be based upon a belief about the range of aspirations which it is proper or desirable for people to pursue.[14] In modern society the patient is more aware than ever before of the rights that they have and they are thus more likely to invoke rights based arguments.[15] Whilst the courts do not always give judgments in terms of rights, essentially it is rights that are being dealt with.[16] An example of this is *Re T (A Minor)(Wardship: Medical Treatment)*.[17] Whilst the judgment was phrased in terms of the child's interests and the practicalities of post-operative care, it could just as easily be seen as looking at the child's right to treatment when conflicting with the parent's right to determine what treatment the child should receive. Hence the importance of rights to this discussion

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[13] B. Markesinis, S. Deakin & A. Johnston, *Markesinis & Deakin's Tort Law*, p.268

[14] D. Feldman, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 2nd, 2002), p.6

[15] S.A.M. McLean, *A Patient's Right to Know*, p.4

[16] ibid, p.84

[17] [1997] 1 All ER 906

cannot be denied and any attempt to look at medical law without looking at the rights involved would be fundamentally flawed.

Whilst a person need not be autonomous in order to have rights worthy of protection by the law[18] it is certainly true to say, at least in relation to medical law, that the rights we have are intended to protect the dignity and autonomy of human beings. Yet autonomy and dignity are not clearly defined terms and can contradict each other.[19] Whilst dignity can exist on a number of levels,[20] different authors use autonomy to refer to different things.[21] The same is true of the notion of rights itself which Feldman divides into five categories: Liberty, Liberties, Civil Liberties, Fundamental Liberties and Human Rights.[22] This classification set is only one of many suggested ways of grouping the interests covered in relation to rights. A full discussion of the notions of autonomy, dignity and rights is far beyond the scope of this discussion, yet they cannot be totally ignored. For reasons of clarity and ease the term 'rights' shall be used in this thesis to refer to those interests recognised as such in English law, through both case law and statutes.

1.2.2 – ACCEPTED RIGHTS:

In 1997 it was stated that fundamental rights and liberties were not expressed in the English legal system.[23] Thanks to the Human Rights Act 1998 that statement is no longer true, yet even before that the common law was rich with human rights notions and ideals. To treat the

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[18] M. Minow, *Interpreting Rights* (1987) 96 Yale Law Journal 1860, p.1885

[19] This would be the case where a dignified death relied upon the use of pain control methods which the patient was opposed to. In such instances autonomy will probably be seen, by society at least, as more important than dignity.

[20] D. Feldman, *Civil Liberties and Human Rights in England and Wales*, p.125. The suggested levels are; the dignity of the species as a whole, the dignity of groups within the species, and the dignity of individuals.

[21] G. Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p.5. Whilst some authors see it as the ability to decide for-oneself without any constraints, others, including Dworkin, accept that this is unrealistic and argue that what is needed is freedom to rule oneself according to moral and social rules.

[22] D. Feldman, *Civil Liberties and Human Rights in England and Wales*, pp.3-5

[23] Lord Lester & D. Oliver, *Constitutional Law and Human Rights* (London: Butterworths, 1997), p102

Human Rights Act as encapsulating all the accepted rights protected by English law is to ignore the role played by the common law. Note should also be taken of the numerous other international treaties on human rights.[24] Whilst some treaties are binding only at the international level, and have no domestic impact, there is a tendency to cover the same issues and it is useful to look at even those treaties which do not apply domestically in order to understand what is meant when specific rights are debated. By combining these sources it can be seen that the important rights, so far as medical treatment is concerned are: the right to life, the right to privacy, the right to bodily integrity and the right to freedom of conscience.

Whilst not included in the above list, and not expressly identified in legislation, ideas such as self-determination, autonomy, dignity and consent are also of importance when discussing the ability to treat. It is possible to identify three distinct levels when looking at the issue of rights. Firstly there are concepts such as autonomy and dignity, which can be seen as constituting the foundations of rights. These concepts give rise to the second level, where the rights identified in legislative provisions, such as privacy, are found. Finally there are principles, such as consent, which are required to facilitate the exercising of the rights found at the second level.[25]

1.2.3 – DISPUTED RIGHTS:

Halpin states:

> "One can find 'right' being used to signify some position of benefit or advantage that has been determined as applying to a particular individual, but one can also find it employed

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[24] The important instruments are as follows: European Convention for the Protection of Human Rights and Fundamental Freedoms (1950); Universal Declaration of Human Rights (1948); International Covenant on Civil and Political Rights (1966); International Covenant of Economic, Social and Cultural Rights (1966); European Social Charter (1961), European Convention on Human Rights and Biomedicine (1997).

[25] Feldman states that it is pointless having rights without the ability to use them, see D. Feldman, *Civil Liberties and Human Rights in England and Wales*, pp.11-13

> to signify a claim to such a position that has yet to be determined, and even to signify a claim for such a position that has failed to be established.” [26]

Throughout this discussion such arguments in favour of disputed rights will be encountered. For example, does a woman have the right to have a baby and if so what treatment must the medical profession offer to assist in the fulfilment of that right? Perhaps the most hotly debated issue that will be encountered is the suggestion that there is a right to die entailed in the accepted right to life. This issue is at the heart of the euthanasia debate and the subject cannot be discussed without its acknowledgement. There are also the contentious issues of foetal and paternal rights in relation to pregnancy and abortion. One of the main tasks the law must undertake is the clarifying of such issues in order that people may be more fully aware of what rights they have.

1.3 – CONSENT:

1.3.1 – THE NEED FOR CONSENT:

The fundamental position in English law is that treatment of a competent adult will be unlawful unless the patient consents to it.[27] The need for consent is the legal expression of the principles of self-determination and autonomy.[28] Due to the centrality of consent to the ability to provide treatment, and its impact upon all areas of the law to be considered, it is important to be able to understand it from the outset. Without such understanding it would not be possible to fully comprehend the approach taken by the courts when confronted with new scenarios and problems.[29] It is also important due to the way consent is essential to the protection of the patient’s rights.

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[26] A. Halpin, *Rights & Law Analysis & Theory* (Oxford: Hart Publishing, 1997), p.3

[27] Re T (Adult: Refusal of Treatment) [1992] 4 All ER 649

[28] D. Feldman, ‘Human Dignity and Legal Values – Part II’ (2000) 116 LQR 61, p.67

[29] M. Davis, *Textbook on Medical Law*, (London: Butterworths, 2nd, 1998), p.126

Any treatment imposed without the consent of the patient will constitute the tort of battery.[30] It is exceedingly rare that, in the case of a competent adult patient, treatment will be allowed to proceed without their consent. One scenario where treatment without consent will be possible is that of a patient with a highly contagious and dangerous disease who refuses to be quarantined or treated.[31] In such a situation treatment would be allowed to proceed for the benefit of both the patient and society in general. More typically such paternalistic arguments are rightly rejected by the courts and the autonomy of the patient remains paramount.

In relation to children under the age of 16, the law is slightly different to that of adults: whilst it is not assumed that they are competent, they may be seen as such. This is known as *Gillick* competence and was first established in *Gillick v. West Norfolk and Wisbech Area Health Authority*.[32] In order to be competent, the child must not only understand the nature of the treatment proposed but also the consequences and side-effects and any possible consequences of refusal.[33] If the child possesses sufficient competency to understand these issues then they can consent to treatment. For the *Gillick* competent child, however, there is no ability to refuse to give consent to treatment.[34] The Court of Appeal has referred to consent as a flak jacket designed to protect the doctor from litigation; whilst the child may provide such protection, the parent or court may do the same and the child cannot prevent it.[35]

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[30] It has been suggested that informed consent is a prerequisite for the adequate respect of the legal requirement of consent, see S.A.M. McLean & G. Maher, *Medicine, Morals & The Law* (Aldershot: Gower, 1983), p.80. The suggestion is that, in order for consent to be real, the patient must be given information so that the decision can be made on a more adequate basis. Whilst English law has accepted that there is a duty of disclosure, it has rejected the notion that it is essential to the validity of consent. This is clearly shown by the way that treatment without consent will give rise to an action for trespass whereas failure to give information will give rise to an action for negligence and the patient will have to show that, had the information been given, they would not have consented.

[31] Public Health (Control of Diseases) Act 1984

[32] [1986] AC 112

[33] *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177

[34] ibid

[35] *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097

1.3.2 – PROCEEDING WITHOUT CONSENT:

There are certain situations in which the patient will not be able to give a valid consent to treatment. It should be noted that this does not cover the scenario where the patient refuses to give consent, rather it covers the patient who is incapable of either giving or withholding consent to treatment. These situations can be summarised as the unconscious patient, the non-*Gillick* competent child under 16, and the mentally incompetent patient over 16. Whilst there will be a detailed analysis of the law relating to the ability to treat without consent in these situations at a later point in the discussion, it is useful to give a brief outline of the issues to be considered at the outset as consent, and the ability to proceed without it, forms a background for all the issues relating to the provision of treatment.

Mason, McCall Smith and Laurie talk about how one approach that could be adopted in these situations would be to say that the patient would have consented had he been able to do so.[36] It could be argued that this provides a high level of respect for the patient's autonomy. This though, can only be true if it involves looking for evidence as to what the patient would have wanted. A blanket approach, which always presumes consent, is an unjustifiable violation of the patient's rights. Mason, McCall Smith and Laurie seem to miss this important distinction. Another issue is that it creates a complex legal problem if the patient, at some later time when he is competent, expresses that he would not have consented to the procedure. The law, however, does not accept this approach and prefers to find other, less artificial, ways of proceeding with treatment if the patient cannot voice consent.

In relation to children, the first option is that the parent or guardian may give consent on behalf of the patient. It is accepted law that proxy consent will be sufficient to authorise

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[36] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.311

treatment of a child. Even if the child is *Gillick* competent proxy consent will be enough to allow treatment to proceed as the child has no ability to withhold consent.[37] If proxy consent is withheld then the courts can intervene and authorise treatment. This is done on the basis of the best interests of the patient and, whilst the wishes of the parent may be important, they will not be decisive. For the adult patient proxy consent is not an option as there is no party who has the right to offer consent on behalf of another adult.[38] In relation to the normally competent patient who is in an unconscious state the doctrine of necessity[39] will apply. For the mentally incompetent patient we once more turn to the doctrine of best interests.[40] The effect of these doctrines will be looked at later as will the relationship and distinction between the two concepts.

1.4 – THE 'NORMAL' PATIENT:

It is possible to identify a theoretically 'normal' patient. This is the patient for whom consent to treatment is really the only issue in question. If consent is given then treatment may proceed without any problems. In the event that consent is not given, there will be no way in which doctors will be legally allowed to carry out the proposed treatment. In relation to the 'normal' patient the courts will rarely become involved as the issues are clear. Rather the courts, and this thesis, are concerned with the ability to treat 'non-normal' patients.

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[37] *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177

[38] The old parens patriae jurisdiction permitted the court to consent on behalf of an adult patient but this was abolished under the Mental Health Act 1959. Hornett makes it clear that a power of attorney could not be used to authorise proxy healthcare decisions, see S. Hornett, 'Advance Directives: A Legal and Ethical Analysis' in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998), p.303

[39] The doctrine of necessity permits non-consensual treatment, normally of the unconscious patient, which does not exceed the requirements of the patient's situation, see J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.312.

[40] This doctrine generally deals with patients who do not possess the competence necessary to be able to give effective consent. Lord Goff has stated that: "Where the state of affairs is permanent or semi-permanent, as may be so in the case of a mentally disordered person, there is no point in waiting to obtain the patient's consent. The need to care for him is obvious; and the doctor must then act in the best interests of his patient, just as if he had received his patient's consent so to do", see *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 567.

It might be assumed that the 'normal' patient is possibly the one most frequently encountered, yet, as has already been stated, this is not true when it comes to court cases. Whilst the 'normal' patient may be the most numerous in practice, it is unlikely that the treatment of such a patient will give rise to any controversial arguments which may need to be decided by way of a court hearing. The scarcity of the 'normal' patient in cases is partly due to the restrictive definition of a 'normal' patient. Firstly, the 'normal' patient must be a conscious adult who is free of both mental incompetence and any undue influence exerted by other people. Further to that the 'normal' patient will not be pregnant, nor subject to irrational fears or objectionable beliefs. Finally, and perhaps most importantly, the 'normal' patient will invariably favour life over death. A large proportion of patients will find themselves lacking in one or more of these characteristics when they are at their most vulnerable.

Hence it can be seen that whilst we talk of the 'normal' patient we are actually referring to the abnormal; the unusual. The 'normal' patient will be a rarity when it comes to important case law. It should not, however, be assumed that simply because the 'normal' patient is numerically insignificant that it is also theoretically insignificant. The concept of the 'normal' patient provides a useful 'control' against which to analyse the way the law approaches other, 'non-normal', patients. Hence the 'normal' patient remains of legitimate theoretical importance.

1.5 – GUIDING PRINCIPLES IN MEDICAL LAW:

Earlier in this chapter it was stated that this discussion was concerned with the way the law dealt with any new medical law problems it encountered. To be more precise, the aim is to search for an understanding of the legal rules relating to when it will be possible to provide treatment to any individual patient. It is suggested that this understanding may be achieved through an examination of the cases (and legislation) relating to medical law and, more specifically, the ability to provide treatment. What is being sought is a method of viewing the law, in this area, which allows it to be seen as a coherent whole, rather than as a collection of isolated topics.

Montgomery has stated that the current dominant approach to medical law sees it as unified around such concepts as respect for autonomy, respect for people, truth telling and justice.[41] He argues that this approach has:

> "Fostered a paradigm for the discipline of medical law that now makes it hard to understand and explain the rules of law and outcomes of cases involving the work of health professionals."[42]

As a result of this Montgomery argues that it is necessary to develop a new model for the discipline, one that more accurately represents the way issues are dealt with by the courts and the profession itself.[43] Montgomery suggests that the new model must take account of the role of the medical profession, both in creating guidelines and acting as a source for law and also in providing an alternative method of solving disputes.[44]

This thesis attempts to create a part of the new model which Montgomery suggests is needed. Whilst the increased role of the medical profession in determining the shape of the law is accepted, this thesis is concerned only with creating a framework for understanding how the courts deal with cases. In order to create this framework it is submitted that it will be necessary to reject a wholesale adoption of the notions and language typically used to discuss medical law. Instead, four guiding principles will be suggested as an alternative, more

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[41] J. Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition' (2000) 53 CLP 363, at p.363

[42] ibid, at p.364. Harvard has stated that it is hardly surprising that people are becoming confused by recent court decisions, see J.D.J. Harvard, 'Legal Regulation of Medical Practice – Decisions of Life and Death: A Discussion Paper', at p.354

[43] J. Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition', at p.365

[44] ibid, at pp.367, 369-371, 381 & 407

accurate, way of looking at the current law. In some instances these principles will represent the combination of existing notions, in others they will involve a breakdown of such notions into different parts. It is submitted that by applying these guiding principles a more appropriate model for the law can be arrived at.

It should not be thought that the principles, identified below, are mutually exclusive; the law could adopt a combination of principles. Different judges may favour different principles and hence a case could comprise of more than one principle. There is also the possibility that different principles could operate in different situations, thereby creating distinct areas of medical law. Finally it could be found that there is no unifying structure at all, and that in reality the law adopts an ad hoc approach to each case.

1.5.1 – SELF-DETERMINATION:

The importance of autonomy and consent in medical law has already been emphasised. It is submitted that these two factors can be combined to form the guiding principle of self-determination. The law, both in the medical context and in more general scenarios, can be seen as placing great importance upon the idea that adults who are of sound mind ought to be able to determine their own lives and that nothing ought to be done to, or for, that person without his express permission or approval. The guiding principle of self-determination would acknowledge, and protect, the individual’s right to control his own life and the right of that individual to be free from the undesired interference of others.

Whilst the law may place limits upon what a person can do, by attaching criminal or tortuous liability for example, this is not necessarily a denial of the importance of self-determination. Rather, it is an acknowledgement of the fact that one person’s right to choose to do something must be balanced against another person's right to choose not to have that thing done to him.[45] Melden argues that any person possessing a right must accept that it may have to yield to other considerations,[46] whilst Dworkin states that self-determination free from the constraints of external influences is impossible.[47] It could be argued, therefore, that the individual's right to choose not to have something done to him is stronger than the right to choose to do something. If this is the case then the guiding principle of self-determination will be of greatest importance when the desire of the patient is to refuse treatment.

1.5.2 – ALLOWING TREATMENT:

It could be argued that doctors have an ethical duty to provide treatment to those in need. The basis for such a duty could be found in the Hippocratic Oath itself, which states:

> "I swear… to keep according to my ability and my judgement the following oath… I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone."[48]

If such a duty does exist then the law could assume the role of furthering that duty. Such a role would be achieved through doing everything possible to make treatment lawful. It could be argued that this is simply abdicating, to the medical profession, the decision of when a particular treatment should be lawful. This would be incorrect though as the courts would be encouraging doctors to come to a decision in favour of treatment rather than unquestioningly accepting medical decisions. A guiding principle of allowing treatment could, therefore, offer assistance to the medical duty to treat without blindly accepting medical opinion.

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[45] D. Feldman, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 2nd, 2002), p.6

[46] A.I. Melden, *Rights and Persons* (Oxford: Basil Blackwell, 1977), p.21

[47] G. Dworkin, *The Theory and Practice of Autonomy*, p.12

[48] Similar statements can also be found in the Declaration of Geneva, the International Code of Medical Ethics and the Declaration of Tokyo which describes the doctor's fundamental role as alleviating the distress of fellow men regardless of any counteracting motive.

Further to that, the guiding principle of allowing treatment could also take account of the doctrine of sanctity of life. Whilst it could be argued that sanctity of life ought to constitute its own guiding principle this could be problematic as there is some dispute over the exact meaning of the doctrine. Keown, for example, argues that the courts are constantly being presented with a more overly vitalistic definition of the doctrine than is appropriate.[49] Also, it could be argued that the term 'sanctity' involves religious undertones. Yet the doctrine has also been used in non-religious contexts and is still seen to be of importance in an increasingly secular world. If, therefore, there is both a religious and a secular version of the doctrine, then which is to be adopted as the correct one?

By bringing the doctrine of sanctity of life within the guiding principle of allowing treatment, and combining it with a desire to protect any duty which the medical profession may have to provide treatment, these problems may be overcome. Any conflict between religious and secular notions is removed and the desired meaning is made clear and unambiguous. It must be recognised, however, that whilst the doctrine of sanctity of life may oppose any treatment which shortens life, this need not be true of the guiding principle of allowing treatment. The guiding principle of allowing treatment provides an obvious and simplistic aim for the law, one that remains free of the confusion that can be caused by subjective assessments.

1.5.3 – BEST INTERESTS:

The term 'best interests' is perhaps one of the most frequently used terms in medical law cases, especially in relation to children and incompetent adult patients. In *Re J (A Minor)(Wardship: Medical Treatment)*[50] Taylor LJ stated that it was settled law that the prime

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[49] J. Keown, 'Restoring Moral and Intellectual Shape to the Law After Bland' (1997) 113 LQR 481, at pp.499-500

[50] [1990] 3 All ER 930

and paramount concern of the court when dealing with children must be the best interests of the child in question[51]. In relation to incompetent adults Butler-Sloss LJ stated that:

> "Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent had been completely given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient."[52]

It would appear clear, therefore, that the best interests of the patient will be one of the main influences upon whether or not treatment is lawful. Consequently, it would be unwise to attempt to identify any structure to the law in this area without accepting the possibility that best interests will be the decisive concern. It is for this reason that one of the guiding principles suggested in this thesis is that of best interests.

The guiding principle of best interests seeks to ensure that treatment will only be given if it benefits the individual in question in some way. It is important to note that for this guiding principle to apply there must a truthful examination of the specific interests of the individual patient involved. It is possible that the courts will use the term 'best interests' in relation to a less individualistic assessment of interests which comes closer to a blanket approach. If this is the case then it may not be the guiding principle of best interests which applies. Rather, it will be another guiding principle which applies and the reference to best interests will be nothing more that a judicial smokescreen designed to hide the reality of the law.

1.5.4 – DOCTOR PROTECTION:

One of the main criticisms that is levelled towards medical law is that it is too ready to adopt, without question, the opinions and decisions of medical professionals.[53] Such criticisms

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[51] ibid, at 943

[52] *Re MB (Medical Treatment)* [1997] 2 FLR 426, at 432

[53] It has been argued that to leave decisions purely to the medical profession would be an unjustified derogation from an area of legitimate public concern, see J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.22

usually stem from *Bolam v. Friern Hospital Management Committee*[54] which decided that a doctor would not be negligent so long as he was acting in accordance with an accepted body of medical opinion. Whilst *Bolitho v. City and Hackney Health Authority*[55] held that this would only be the case if the body of opinion was logical, it did little to reduce such criticisms due to the rarity of cases where medical opinion was held to be illogical. Montgomery argues that:

> "The most plausible explanation for [the continued use of the *Bolam* test] lies in the acceptance by the judiciary that doctors are altruistic, working under considerable pressure in the public interest and generally undeserving of liability"[56]

Whilst Lord Woolf accepts that, in the past the courts have given too much deference to the medical profession he argues that this is no longer the case.[57] He argues that the approach has shifted from one of 'doctor knows best' to 'doctor only knows best if he acts reasonably and logically and gets his facts right'. Lord Woolf argues that whilst medical opinion is one of the most important sources of evidence it is the courts which constitute the final arbiters.[58]

Lord Woolf has stated that when the medical profession faces a problem in deciding whether or not treatment is lawful then they can rightly expect the court to provide an answer and, in doing so, define what is lawful and unlawful behaviour.[59] The question is whether or not, in determining such issues, the court will go beyond simply finding the dominant medical opinion or claiming that all medical opinions are valid. A wholesale adoption of the guiding principle of doctor protection would represent a desire, on the part of the court, to abdicate its

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[54] [1957] 2 All ER 118

[55] [1997] 4 All ER 771

[56] J. Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition', at p.378

[57] Lord Woolf LCJ, 'Are the Courts Excessively Deferential to the Medical Profession' (2001) 9 Med L Rev 1, at p.1

[58] ibid, at p.13

[59] Lord Woolf MR, 'Medics, Lawyers and the Courts' (1997) 16 CJQ 302, at p.303. Lord Woolf has also argued that the rising number of questions relating to medical ethics shows that there is a real disagreement and uncertainty within the profession and that the court is best suited to providing answers, see Lord Woolf LCJ, 'Are the Courts Excessively Deferential to the Medical Profession', at p.4.

decision-making responsibility to the medical profession. If this guiding principle is dominant then the role of the courts in shaping the law will be minimal and amount to little more than rubber-stamping the opinions of doctors.

1.6 – STRUCTURE:

Throughout this introduction there have been indications as to the structure which will be adopted in the discussion that follows. It is now necessary to set out, in some detail, how the discussion will proceed. As has already been stated, the purpose of this discussion is to search for guiding principles adopted in court decisions. There will, therefore, be constant discussion and development of these principles throughout this thesis, culminating in an attempt to find a coherent system throughout the diverse issues raised by the questions relevant to the ability to treat.

The method by which this enterprise will be carried out will be an analysis of court decisions (including an analysis of the judicial interpretation of statutory provisions) in relation to the more controversial issues related to the ability to provide and receive treatment. It has been stated that in defining the content of medical law, the core matters are clear but the boundaries are more blurred. The same is true of the way in which the law deals with problems that arise. In relation to the central core of the law governing the provision of treatment, the issues are settled; it is only once one looks at the more controversial cases that the law is less clear and, arguably, less well ordered.

Chapters 2 and 3 will look at when doctors will be able to provide general forms of treatment. The issues discussed will apply to all types of treatment rather than to specific procedures only. The discussion of such issues is important for two reasons. Firstly, these issues will serve to explain the law relating to the ability to provide most forms of treatment. Secondly, they serve to provide a basis from which it is possible to discuss issues relating to more specific forms of treatment. This part of the discussion will look at the law relating to children before moving on to discuss how the approach changes once the patient reaches maturity. The issues that will be of importance here include competency, both for adolescent and mature patients, alongside the power of consent and the role of proxy decision makers.

After discussing these general treatment issues Chapters 4 and 5 will build upon this foundation and look at issues relating to specific forms of treatment. It is submitted that these procedures can only be fully understood when viewed against the background provided by the earlier chapters. In essence this portion of the discussion deals with areas of treatment where the application of the guiding principles may differ from the application adopted in relation to general treatments. There are two specific areas of treatment to be looked at, namely the creation of life and the ending of life. Hence there will be discussion of the availability of assisted reproductive techniques and abortion as well as the legality of euthanasia and the withholding of life-saving treatment.

After discussing both general and specific treatment issues this thesis will then turn to the task of looking for a logical and coherent structure which can be used to explain the law and predict the outcome of future cases. Chapter 6 will attempt to pull together everything that has been discussed throughout this thesis and develop a theory which will cover all of these issues. It will also be the task of this chapter to answer the main question of this work: ‘Is there a coherent structure to the law governing the availability of treatment?’

PART II

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GENERAL TREATMENT ISSUES

CHAPTER 2:

A MATTER OF CHILDHOOD & ADOLESCENCE

The way in which the law approaches the medical treatment of children is of importance for a number of reasons. Firstly it must be accepted that children are generally more vulnerable than adults. Due to this vulnerability the law is required to protect children from harm that may be inflicted upon them by others. Furthermore, there is the general social concern for the well being of children. This is epitomised by the strong public outrage that is exhibited towards child murderers and paedophiles.[1] In a very real way children represent the future and society seeks to protect them from risks that it would allow adults to endure.

Generally, medical treatment can be provided if it is thought to be in the child's best interests so long as the parents, the court, or the child, if competent, consents.[2] Whilst the need for a belief that the child's interests demand treatment indicates that the guiding principle of best interests applies, the fact that consent is also required indicates the principle of self-determination. It should be noted though that the consent does not always come from the child. The discussion that follows will assess how these, and the remaining, guiding principles are applied in the cases and whether or not they really are the main force in this area of the law.

There are two main areas which need to be considered. Firstly the possibility that the child will be viewed as competent to provide consent must be looked at. This is generally referred to as adolescent autonomy and it will be necessary to ascertain when a child will be seen as competent, and the extent of the power that this competency provides. The second area to be

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[1] A more recent example of such concern can be found in the disgust that has met the Beslan school siege, see W. Rees-Morgan, 'Beslan is Russia's 9/11: It Will Change The World', *The Times*, 6th September 2004

[2] J. Herring, *Family Law* (London: Longman, 2001), p.359

looked at covers those children who are not seen as competent to provide consent for their own treatment. Whilst this will cover the majority of child patients it is useful to look at this issue after discussing adolescent autonomy, as any child who claims to have competency but fails to prove his claim will then be treated in the same manner as the incompetent child.

2.1 – ADOLESCENT AUTONOMY:

2.1.1 – ACQUIRING AUTONOMY:

A person might be forgiven for thinking that until a child reaches the age of majority they have no ability to provide consent to medical treatment. This belief, however understandable in its existence, is erroneous. The law recognises that some patients under the age of 18 may have the ability to provide consent to medical treatment. This ability is tiered according to the age of the patient. For the 16-18 year old the Family Law Reform Act 1969, s.8, provides automatic ability to provide consent to treatment. It has been stated that this puts the 16-18 year old minor in the same position as the adult patient.[3] To some extent this is correct, as the competence required to consent to medical treatment is presumed for these minors, just as it is for adult patients. However, as will be discussed shortly, the extent of the power possessed by these patients is less than that of adults.

For the child who is under 16 years of age the ability to provide consent to medical treatment is a more complex issue. The seminal case, *Gillick v. West Norfolk and Wisbech Area Health Authority*[4], involved a mother who was challenging a Department of Health memorandum that permitted doctors to provide contraceptive advice to minors under the age of 16 without parental consultation. If this challenge had been accepted the result would have been that no

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[3] I. Kennedy & A. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.645

[4] [1986] AC 112

child under the age of 16 could ever authorise any form of medical treatment however minor.[5] Lord Fraser stated that this suggestion "seems to me so surprising that I cannot accept it in the absence of clear provisions to that effect".[6] Lord Fraser then went on to say that there was no good reason to hold that a child with sufficient understanding should not be capable of expressing a valid and effective consent to medical treatment.[7] In making this decision Lord Fraser placed emphasis upon the fact that it would be unrealistic of the courts to ignore the fact that parental control is generally relaxed as the child increases in age and understanding.[8]

Lord Fraser's judgment seems to place the welfare of the child at the forefront. It was stated that the best judges of the child's welfare will generally be the parents but that this need not always be true.[9] It was also stated that the only practicable approach is to trust doctors to act in accordance with what they think is in the best interests of the patient.[10] Whilst this could represent an application of the guiding principle of protecting doctors this is tempered by the fact that Lord Fraser expressly stated that doctors could not totally disregard the wishes of other parties.[11] This seems to suggest that the main guiding principle to be applied in relation to adolescent autonomy is that of best interests.

It must be asked whether the concepts of 'welfare' and 'best interests' are synonymous or two distinct ideas. When considering the 'welfare' of the child the courts are required to consider the ascertainable wishes of the child.[12] In contrast to this, when the courts refer to 'best interests' they have little, if any, difficulty in disregarding the wishes of the child. Yet the

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[5] Taken to its most extreme, but undeniable, conclusion this would mean that a child who grazes his knee at school could not have a plaster applied without parental approval.
[6] [1986] AC 112, at 169
[7] ibid
[8] ibid, at 171
[9] ibid, at 173
[10] ibid, at 174
[11] ibid
[12] Children Act 1989, s.1(3)(a)

requirement that the child's wishes be considered when looking at welfare only applies in certain circumstances[13] and is qualified so that the child's wishes must be considered in light of both age and level of understanding possessed.[14] Due to this it is submitted that the practical distinction between 'best interests' and 'welfare' is minimal.[15] Hence, a true focus upon either 'welfare' or 'best interests'[16] demonstrates an application of the guiding principle of best interests, a principle which assesses the ascertainable interests of the patient in order to decide whether or not treatment should be available in order to further those interests.

Lord Scarman took a different approach to that of Lord Fraser and seems to place more importance upon the guiding principle of self-determination. One of the arguments put forward was that the memorandum adversely affected the rights of parents. In dispensing with this proposition Lord Scarman stated that:

> "As a matter of law 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."[17]

This seems to suggest that once the child possesses sufficient understanding, and therefore has the competency to consent to treatment, the parent's right to consent to treatment ends. The result of this would be that the child's right to determine what should happen to him is absolute once he has the requisite understanding. In essence the child would be in the same

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[13] ibid, s.1(4) which states: "The circumstances are that – (a) the court is considering whether to make, vary or discharge a section 8 order and the making, variation or discharge of the order is opposed by any party to the proceedings; or (b) the court is considering whether to make, vary or discharge an order under Part IV" The orders in question are residence, contact, prohibited steps and specific issue orders under s.8 and care and supervision orders under Part IV.

[14] ibid, s.1(3)

[15] As will be seen shortly the test for competency is also based upon age and understanding so the effect of the qualification, if it is the guiding principle of best interests that applies here, would be to make the two concepts virtually identical in their practical effect.

[16] The real distinction is one of usage; whilst the courts refer to welfare when talking about children they use the term best interests in relation to adults. This may be due to a desire to differentiate between adults and children, at least on a semantic level.

[17] [1986] AC 112, at 188-189

position as the competent adult, or ‘normal’ patient referred to in Chapter 1, and treatment would only be lawful if the child’s consent were obtained. Whether or not this is true will be discussed shortly, for now it is sufficient to recognise that Lord Scarman’s judgment strongly supports the guiding principle of self-determination which safeguards the autonomy of the patient through the requirement of consent.

From what has already been said it should be clear that understanding is the key factor in determining whether or not a child will be seen as competent. The question that must be asked is what must the child understand in order to possess sufficient competency? Kennedy and Grubb argue that the cases have required a very high level of understanding.[18] It is certainly true to say that the majority of cases have involved children who were eventually held to be incompetent. The first indicators, as would be expected, come from the *Gillick* case itself. Both Lord Fraser[19] and Lord Scarman[20] referred to the need to understand what is being proposed by the doctor. Lord Scarman went beyond this though and stated that mere understanding of the nature of treatment is insufficient, there must also be an understanding of the moral and family questions that may arise.[21] Whilst it has been argued that this should be limited to the immediate treatment discussed in *Gillick*, that of contraception,[22] this seems to ignore the fact that such questions could be raised by many other medical treatments.

Since *Gillick* a number of cases have attempted to clarify what is required in order for a minor to be competent. The first point to note is that the courts, in *Re R (A Minor)(Wardship: Medical Treatment)*,[23] have rejected the idea that the child can fluctuate between competency

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[18] I. Kennedy & A. Grubb, *Medical Law*, p.647
[19] [1986] AC 112, at 169
[20] ibid, at 188
[21] ibid, at 189
[22] I. Kennedy & A. Grubb, *Medical Law*, p.647
[23] [1991] 4 All ER 177

and incompetency; it is an all or nothing test.[24] Whilst this shows that competency must be a permanent state it does little to explain what understanding is required. In addressing this issue, Lord Donaldson accepted Lord Scarman's rejection of simply understanding the nature of treatment and stated that what the law actually required was:

> "A full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and, equally important, the anticipated consequences of a failure to treat."[25]

In *Re S (A Minor)(Consent to Medical Treatment)*[26] the court went even further and stated that understanding that the result of refusing treatment would be certain death was insufficient. Instead it was held that the child had to comprehend the manner of the death and the pain that would be involved.[27] The same approach was adopted in *Re E (A Minor)(Wardship: Medical Treatment)*[28] where a child was held to be incompetent due to the fact that he did not comprehend the manner and process of his death, nor the extent of suffering that would have to be endured by both him and his family.[29]

The child's experience of life will also be a major consideration as this will affect the ability to assess the importance of information he receives and understand what will happen to him. Both Stephen Brown J[30] and Johnson J[31] have held that a child had led too 'sheltered' a life to allow an informed decision to be reached. In both instances the child was a member of a devout Jehovah's Witness family and the courts held that being raised in this culture resulted in an overly protective upbringing. Stephen Brown J stated that bringing a child up in this

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[24] ibid, at 187
[25] ibid
[26] [1994] 2 FLR 1065
[27] ibid, at 1076
[28] [1993] 1 FLR 386
[29] ibid, at 391
[30] *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810
[31] *Re S (A Minor)(Consent to Medical Treatment)* [1994] 2 FLR 1065

way was not to be criticised, instead he approved of the fact that the child had been subjected to sensible disciplines.[32] It appears that the court was congratulating the parents on the way they had raised their child but then holding that it meant she could not be competent. In effect the courts are saying that the possession of worthwhile character traits may result in lack of competence. Similarly, a child who hoped for a miracle that would save her life was incompetent because she did not accept that death was an inevitable consequence.[33] Surely hope is a good thing for a child who is facing death to have? Surely the knowledge that a miracle would be required to save her life indicates that she knew the normal course of events would result in her death?

It should be noted that all of the cases discussed above have involved children who are attempting to withhold consent to treatment. Setting aside the question of whether or not a competent child can withhold consent, there are a number of points raised by this. From the absence of cases involving children wishing to consent it can be ascertained that there are usually no competency problems encountered when the child supports the proposed treatment. Yet when the child does not consent the courts will continually find ways to reject the claim he is competent. Whilst Herring summarises the comprehension requirements as the need to understand the nature of condition and treatment, the moral and family issues raised, life experience, constant mental state and the ability to weigh information appropriately[34] the courts have gone even further. It is incredibly hard for a child to show the required understanding and it appears that this will only be the case when he is acquiescing to treatment.

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[32] [1998] 2 FLR 810, at 813
[33] [1994] 2 FLR 1065, at 1073-1074
[34] J. Herring, *Family Law*, pp.360-361

Whilst it is possible to argue that the above cases represent an attempt to apply the guiding principle of doctor protection through abdicating the decision of what should happen to the doctor,[35] this is dispelled by *Re W (A Minor)(Medical Treatment).*[36] In that case there were two possible courses of action supported by medical opinion, only one of which was opposed by the child. If there are multiple medical opinions it is hard to see how the principle of protecting doctors can apply. An alternative argument would be that the courts are attempting to preserve the interests of the child in all cases, this, however, can be dispensed in a similar manner as there is frequently more than one valid opinion as to what the child's welfare demands.

It is submitted that what these cases actually represent is an attempt to apply the guiding principle of allowing treatment. This principle seeks to use all possible paths to ensure that access to the most promising form of treatment remains available. The principle of allowing treatment does not look at whether the interests of the patient favour treatment, rather it is assumed that the treatment is of value. In effect the doctrine of adolescent autonomy has provided another possible source for consent to treatment and is not designed to protect the child's autonomy or interests as was indicated by *Gillick* itself. This is further supported by the limits that are placed upon the way adolescent autonomy can be exercised. As will be seen shortly, the competent child can say yes to treatment but has no power to say no.

2.1.2 – EXERCISING AUTONOMY:

In *Re R (A Minor)(Wardship: Medical Treatment)*[37] the court was faced with a 15-year-old girl, with a history of family problems and disturbed behaviour, who was refusing to consent

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[35] G. Douglas, 'The Retreat from Gillick' (1992) 55 MLR 569, p.576
[36] [1992] 4 All ER 627
[37] [1991] 4 All ER 177

to the administration of anti-psychotic drugs. Lord Donaldson stated that consent was merely a key which unlocked the door so as to allow the doctor to treat.[38] He stated that:

> "In the ordinary family unit where a young child is the patient there will be two keyholders, namely the parents, with a several as well as joint right to turn the key and unlock the door"[39]

When the child is competent to consent to treatment for themselves then they can be seen as receiving their own key to the door, but just like the mature child who obtains the key to the family home, the parents are not forced to give up their keys. The result is that if the competent child refuses to consent to treatment then it is open to the doctor to seek consent from another party who has parental responsibility. There is also the possibility that the court could provide consent when both parents and child refuse to do so.

This decision seems to move a long way from the self-determination based decision of Lord Scarman in *Gillick.* Whilst Lord Scarman referred to the parent's right of determination terminating once the child had sufficient understanding to be competent, Lord Donaldson held that determination and consent were not the same.[40] It was stated that the idea of determination was wider than consent and would involve the parent being able to effectively refuse consent. This parental ability to withhold consent ceases once the child is competent to give an effective consent that cannot be overridden by the parents. Due to this the parent is no longer able to determine the future of the child, the parent can however have an important, undeniable, influence upon that future.

Re R would seem to support the idea that the guiding principle that operates in relation to adolescent autonomy is that of allowing treatment. The imagery of lock and key goes a long

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[38] ibid, at 184

[39] ibid

[40] ibid, at 185

way towards representing the concept of allowing a route of access through which the doctor can treat the child. The idea of multiple keyholders reinforces this, as treatment can be made lawful by numerous persons. However, an alternative view would be that what the court is really doing is seeking to protect the doctor and his clinical judgment. In justifying the distinction between determination and consent Lord Donaldson placed importance upon the fact that if the parent lost the right to consent then the doctor who incorrectly decided that the child was incompetent could be sued for trespass or even prosecuted for assault. He stated that this was an intolerable dilemma for the doctor and one that had to be avoided by the law.[41]

It has been argued by some academics that *Re W (A Minor)(Medical Treatment)*[42] offers more support for the principle of protecting doctors. In this case Lord Donaldson expressed regret at the use of the lock and key analogy as a key could be used to lock a door as well as unlock it.[43] This demonstrates that if the lock and key analogy had been taken to its conclusion the child should be able to refuse consent, but similarly so should the parent. The image of the lock and key, therefore, failed to achieve the end originally envisaged by the court and needed to be replaced. In preference he compared consent to a flak jacket. The important difference with the flak jacket is that if given by one party it cannot be taken away be another, further to that a doctor will only need one flak jacket to be safe from the threat of litigation. The analogy of the flak jacket, which talks about protecting doctors, has led a number of critics to state that in *Re R* and *Re W* the court's main concern was accepting the clinical judgment of the doctors in question.[44] It must be remembered though that the flak jacket was an attempt to replace an alternative which produced undesired consequences. The flak jacket analogy was

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[41] ibid
[42] [1992] 4 All ER 627
[43] ibid, at 635
[44] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16 LS 84, p.85

not created simply because the court wanted to create a stronger, doctor protection centred, image, rather it came about through the need to replace the flawed analogy of the lock and key.

A much more convincing argument is that *Re W* provides support for the guiding principle of allowing treatment. The important point is that in this case the clinical judgment of the doctors was split and the course of treatment which the child favoured was in fact supported by an accepted body of medical opinion.[45] The court seems to have given no regard to any alternative course of action though and merely opted for that which posed the greatest chance of success. When there are multiple clinical opinions it becomes difficult to see the law as wholly concerned with the protection of doctors. Instead there must be some importance placed upon allowing treatment whenever possible.

The best way to approach this problem is to view the law as primarily applying the principle of allowing treatment. The principle of doctor protection is then applied so as to ensure that the desired treatment can proceed without any risk of litigation. It is submitted that this approach best represents the case law in this area when viewed as a whole. Whilst it has been argued that the flak jacket analogy is clearly an attempt to protect doctors this ignores the fact that it was designed to replace an unworkable alternative that was much more focused upon allowing treatment. The result of making the principle of protecting doctors subsidiary to that of allowing treatment is that the doctor's clinical judgment is only protected by the court if it expresses a preference for treatment. This reduced principle of doctor protection is best seen as a consequence of a desire to allow treatment rather than any real desire to protect a doctor's clinical judgment.

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[45] As was stated earlier, this demonstrates that the guiding principle of allowing treatment cannot be that of doctor protection as this would not provide a method of choosing between different medical opinions.

Many academics have argued that the right to give consent cannot logically be separated from the converse right to withhold it.[46] Whilst Douglas describes *Gillick* as a landmark decision she views *Re R* as "a disturbing example of where a court has arguably failed to hold balance between the interests of the child, the parent and/or society at large".[47] She states that the courts are attempting to move back towards the notion of parental powers as opposed to duties.[48] Thornton, who describes the case law as a retrograde step, supports this position[49] whilst Kennedy speaks less flatteringly and states that the result is to drive a coach and horse through *Gillick*.[50] Brazier and Bridge however state that whilst the judicial reasoning can be criticised the end result, saving the child's life, is harder to dispute.[51] Indeed, this could be one area of the law where the courts decide the end result first and then look for judicial reasoning to support it. The criticisms of the reasoning all assume that consent is the main factor, yet as has already been shown this is not the reality. When the cases are seen as an application of the guiding principle of allowing treatment they fit together to form a whole, *Re R* and *Re W* no longer represent a reversal from *Gillick*.

The courts have also considered the importance of the child's wishes when they desire to withhold consent. In *Re R* it was held that whilst the views and wishes of the competent child are important, and indeed their importance increases as his understanding increases, they do not prevent consent being obtained from an alternative source.[52] Support for this can be found in *Re M* which stated that whilst the refusal of the patient is important it is not

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[46] For an example of such arguments see R. Thornton, 'Multiple Keyholders – Wardship and Consent to Medical Treatment' [1992] CLJ 34

[47] G. Douglas, 'The Retreat from Gillick', p.569

[48] ibid, p.570

[49] R. Thornton, 'Multiple Keyholders – Wardship and Consent to Medical Treatment', p.37

[50] A. Kennedy, 'Consent to Treatment: The Capable Person' in C. Dyer (ed), *Doctors, Patients and the Law* (Oxford: Blackwell, 1992), p.60

[51] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy', p.84

[52] [1991] 4 All ER 177, at 187

decisive.[53] What this means is unclear, if the wishes of the child cannot be a bar to treatment then how can they be of any real importance? Perhaps Brazier and Bridge address this issue best when they state that the courts are only ever confronted with cases that involve the risk of death or severe permanent damage and that in such cases any philosophy of autonomy must yield to the pragmatism of preserving life and health.[54] Some approval of this can be found in *Re W* when Lord Donaldson states that children should be given what decision making powers are prudent but that:

> "Prudence…does involve avoiding risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them."[55]

As Brazier and Bridge state, the child is only free to make the wrong decision when that decision is to consent to treatment.[56] The level of importance placed upon the child's wishes, and the idea that they should be disregarded if the refusal of treatment involves too great a risk, once more reinforces the idea that in this area of the law the principle of allowing treatment is dominant.

There must be some residual role for the guiding principle of best interests though regardless of the fact that the main principle applied is that of allowing treatment.[57] The reason for this is that only treatment in the child's interests should be provided. This residual role will be looked at more fully in the next section as it applies equally to both the incompetent and competent child. In relation to the concept of adolescent autonomy the notion of best interests

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[53] [1999] 2 FLR 1097, at 1097

[54] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy', p.89

[55] [1992] 4 All ER 627, at 638

[56] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy', p.88

[57] Whilst the guiding principle of doctor protection has some background role to play it has already been argued that this is only a consequential role. As a result of this it offers little help in understanding which principles determine the outcome of cases. It is submitted that a similar application of doctor protection will always be present as without it there would never be any ability to apply another principle.

seems to have little influence. A child will only be seen as competent if he desires treatment, for those who wish to refuse it there is no assistance offered by adolescent autonomy.

2.2 – TREATING THE INCOMPETENT CHILD:

When we turn to the treatment of the incompetent child we are really considering the majority of children. Whilst a child can be seen as competent, it has already been shown that the benchmark for this is very high. The vast majority of children will not be seen by the courts as having the requisite understanding to enable them to consent to their own treatment. Further, it has been shown that there is no ability for a competent child to withhold consent to medical treatment. The competent child who is opposed to treatment will be treated in the same manner as the incompetent child. The issues that are to be discussed here arise by virtue of the fact that the patient is a minor who cannot, or will not, provide consent.[58]

2.2.1 – WHO CAN BE A PROXY:

When children are not competent to provide consent to their own medical treatment it becomes necessary to find some alternative method to authorise such treatment. The alternatives would be to either accept that treatment should be available without the need for authorisation or that treatment could never be provided. Neither of these extreme suggestions seems satisfactory so it becomes obvious that there must be some tool to provide the requisite authority. The main tool used for this purpose is the power of proxy consent. This allows for somebody other than the child to provide consent to the treatment.[59]

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[58] A large number of issues which could be discussed here apply equally in relation to adult patients who are incompetent. These issues arise by virtue of the incompetence rather than due to the status of the patient as a minor and will not be discussed here.

[59] It should be noted that the power of proxy consent is only available in relation to children and cannot be exercised over an incompetent adult. As will be discussed in the next chapter, any suggestion that the medical treatment of an incompetent adult can be authorised by virtue of the consent of another person has been rejected.

It is possible to identify a general link between the power to act as a proxy and the possession of parental responsibilities. Hence a mother and a father, who possesses parental responsibility, will be able to provide proxy consent. Yet just as parental responsibilities are not limited to the biological parents of the child, neither is the power of the proxy. In short, anybody who is in possession of parental responsibility[60] will be able to provide proxy consent to medical treatment. In relation to children who have been taken into the care of a local authority that authority will also possess parental responsibilities[61] and have the right to provide proxy consent.

The courts also retain the right to provide consent to medical treatment in relation to incompetent children. There are a number of possible methods by which the courts may provide authorisation to the medical treatment of children. The first option is to make a prohibited steps order to prevent a certain course of action being taken.[62] The second possibility is to make a specific issue order so as to give authorisation to the procedure in question.[63] Thirdly there is the option of making the child a ward of court.[64] The result of this is that the court must make all decisions relating to that child's life, no matter how minor. Due to this it has been stated that the courts would rather make use of the alternatives to wardship.[65] The final option is for the court to exercise its inherent jurisdiction so as to authorise the proposed medical treatment.

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[60] The possession of parental responsibility is governed by the Children Act 1989, ss.2(1), 4, 5(6) and 12(2)

[61] Children Act 1989, s.44(4)(c)

[62] ibid, s.8(1). Whilst this would represent the opposite of providing consent to treatment it could be used to prevent one parent consenting to a non-therapeutic procedure, such as religious circumcision, which was opposed by the other parent.

[63] ibid

[64] Supreme Court Act 1981, s.41

[65] I. Kennedy & A. Grubb, *Medical Law*, p.777

Kennedy and Grubb provide a number of possible justifications for the use of proxy consent in relation to children.[66] The first of these is the idea that parents represent the most appropriate repository of the power involved in proxy consent. Support for this suggestion is taken from the Australian case of *Secretary, Department of Health and Community Services v. JWB and SMB.*[67] The second possible justification provided is that it represents the parent's right of absolute control over the child. The final suggestion offered is that parents are under a duty to provide medical treatment for their children and that proxy consent is a necessary element for the successful fulfilment of this duty. They argue that *Gillick v. West Norfolk and Wisbech Area Health Authority*[68] supports this proposition. There are a number of problems with these justifications however.

One problem that applies to all of these justifications is that the power of the proxy, as has already been stated, is not possessed solely by the parent. It is possible to overcome this hurdle though by including all people with parental responsibility under the term 'parent'. For the first justification the idea that a person is suitable to possess the power of the proxy simply because they have parental responsibility seems dubious. Parental responsibility does not ensure that a person has any real involvement in the child's life or understanding of their needs and feelings. The second possible justification seems to be less plausible in modern society than it would have been in a more old fashioned society which regarded children as the property of their parents. The shift of judicial and parliamentary thinking from parental rights to parental responsibilities seems to make any reference to the rights of parents over children illogical. *Gillick* is an example of this shift and refers to how the powers of the

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[66] ibid, pp.774-775

[67] (1992) 175 CLR 218

[68] [1986] AC 112

parent only exist in so far as they are needed to allow the parent to carry out their responsibilities and duties towards the child.[69]

Of the three justifications suggested by Kennedy and Grubb, the final one seems to be the most supportable as it appears to fit in, better that the other two do, with the modern concept of parental responsibilities as opposed to parental powers. It also remains child focused as opposed to being concerned with the power of the proxy and the entitlement to possess such power. Whilst it could be argued that the mere existence of proxy consent indicates an application of the principle of allowing treatment, this would be a dubious assertion to make without an analysis of the exercising of the manner in which this power can be exercised.

2.2.2 – THE PROXY'S POWER:

The idea behind the existence of proxy consent is that the proxy determines what is in the best interests of the child and authorises such treatment as best serves the child's welfare. Both the courts[70] and parliament[71] have reinforced this on numerous occasions. The clearest judicial statement on this issue has come from Lord Donaldson in *Re J (A Minor)(Wardship: Medical Treatment)* when he said "the parents owe the child a duty to give or to withhold consent in the best interests of the child and without regard to their own interests".[72] Later in the same case it was stated that "the choice is one which must be made solely on behalf of the child and in what the court or parents conscientiously believe to be in his best interest".[73] These two statements make it clear that the role of the proxy is to safeguard the interests and welfare of

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[69] [1986] AC 112, at 170

[70] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and *Re B (A Minor)(Wardship: Sterilisation)* [1987] 2 All ER 206

[71] Guardianship of Infants Act 1886, s.6, Guardianship of Infants Act 1925, s.1, and Children Act 1989, s.1(1)

[72] [1990] 3 All ER 930, at 934

[73] ibid, at 936

the child in question. In *Re S (A Minor)(Medical Treatment)*[74] this position was reinforced when Thorpe J stated that the test must always remain the welfare of the child in question.[75] Wilson J has made it clear that this is not a question relating to the rights and interests of the parent, nor can the rights of the child be subsumed into those of the parent.[76] The proxy's power is designed to protect the rights and interests of the child, rights which are separate from those of the parent.

The question that needs to be addressed therefore is how should the proxy decide what is in the best interests of the child. The first point to note is that not only are we not concerned with the interests of the parent, but we are not concerned with the viewpoint of the parent either. In *Re J (A Minor)(Wardship: Medical Treatment)*[77] the child had been born prematurely, was suffering from severe brain damage and epilepsy. It was likely that the child would be deaf and blind, incapable of even limited intellectual abilities and would develop serious quadriplegia. It was also probable that the child would die before it reached adolescence. The question was whether or not the child should be ventilated or resuscitated should breathing cease, which it had already done on two occasions. Lord Donaldson stated that the life of the disabled child should not be judged in comparison to that of the normal child.[78] Further to that he pointed out that it is possible that a handicapped child may find his quality of life acceptable whilst in the imagination of the non-handicapped person it would be intolerable.[79] This focus upon the viewpoint of the child, as opposed to that of the adult, implies that the guiding principle of best interests could apply here. However, the ability of

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[74] [1993] 1 FLR 376
[75] ibid, at 380
[76] *Re C (A Child)(HIV Testing)* [2000] Fam 48, at 61
[77] [1990] 3 All ER 930
[78] ibid, at 936
[79] ibid, at 938

the court to assess what the child in question would think of the life he will lead is both questionable and problematic.

Despite this difficulty the approach was supported in *Re B (A Minor)(Wardship: Medical Treatment)*[80] where the court was confronted with parents who wished to withhold consent to the treatment of their newly born child. The child suffered from Down's syndrome and had an intestinal blockage which required surgery that was opposed by the parents. If surgery were not provided the child would die within a few days. The argument proposed by the parents was that, due to the Down's syndrome, it would be kinder to the child if she were allowed to die. The court rejected this argument and held that it was in the best interests of the child to consent to the operation. Importance was placed upon the fact that if the operation was carried out the child would be able to have as happy a life as could be expected by any child with Down's syndrome.[81] It was also stated that in cases like this the question that must be asked is:

> "Whether the life of the child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is so imponderable that it would be wrong for her to be condemned to die."[82]

The issue of allowing children to die will be covered more fully in Chapter 5. It is, however, important to note that an extremely low standard of life needs to be reached before it can be shown that it is in the child's interests to allow him to die. This would appear to support the presumption in favour of preserving the child's life if possible, a presumption which has a large amount of judicial support although it is accepted that it is rebuttable.[83] The European Court of Human Rights has stated that "the regulatory framework of the United Kingdom was

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[80] [1990] 3 All ER 927

[81] ibid, at 929

[82] ibid

[83] For examples of such support see *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 916 and *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906, at 938

firmly based on the duty to preserve the life of the patient, save in exceptional circumstances."[84] The result of this is to question whether we are really looking at the guiding principle of best interests. It would seem more likely that the focus upon the viewpoint of the child is a tool used by the law to prevent parents withholding consent in all but the most extreme of scenarios. Once again we see the application of the guiding principle of allowing treatment whenever possible.

An important issue to deal with in relation to children is whether or not it is possible to refuse medical treatment on the basis of beliefs.[85] The courts have firmly rejected that doctors should automatically opt for a more risky procedure due to the fact that it would be religiously acceptable whilst a safer procedure would not.[86] Lord Donaldson even went so far as to state that opposition to treatment on the basis of beliefs of any nature was irrational.[87] Whilst he pointed out that this was only a personal opinion that did not affect competency or validity, it certainly demonstrates a worrying position. Whilst an irrational refusal by a competent person will still be protected by the law,[88] it will soon become apparent that, in so far as children are concerned, the courts have a tendency to overrule decisions made on the basis of beliefs. This could indicate that Lord Donaldson's view represents the reality when dealing with children. The question that must be asked is whether there are any situations when beliefs will be a valid reason for refusing medical treatment on behalf of the child?

There have been a number of cases, mostly involving Jehovah's Witnesses, where parents, and the children in question, have desired to withhold consent due to such beliefs. In *Re E (A*

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[84] *Glass v. United Kingdom* [2004] 1 FLR 1091

[85] Normally such beliefs are of a religious nature, but this need not always be the case. *Re C (A Child)(HIV Testing)* [2000] Fam 48 is an example of non-religious beliefs. Here the beliefs were as to the nature of the condition and the merits of the conventional treatments.

[86] *Re S (A Minor)(Medical Treatment)* [1993] 1 FLR 376, at 380

[87] *Re W (A Minor)(Medical Treatment)* [1992] 4 All ER 627, at 637

[88] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649

Minor)(Wardship: Medical Treatment)[89] the court accepted that the religious beliefs were deeply, and genuinely, held by the child as well as by the parents. It was also pointed out that the child was very close to the age at which he would be able to effectively withhold consent to treatment. As a result of these considerations it was stated that the judge should be slow to intervene and override the child's beliefs.[90] Yet Ward J appears to have had little difficulty in doing exactly that. Firstly it was decided that the child's upbringing had conditioned him to believe that the suggested treatment was unacceptable, as a result of this the child's will was not fully free.[91] Some importance was also placed upon the possibility that the strength of the child's belief would diminish in the future.[92] Finally Ward J stated that:

> "There is compelling and overwhelming force in the submission…that this court, exercising its prerogative of protection, should be very slow to allow an infant to martyr himself"[93]

As a result of these considerations, it was decided that the welfare of the child, when viewed objectively, supported only one possible conclusion; that the hospital should be at liberty to provide treatment.[94]

The ease with which Ward J appears to have dispensed with the need to respect the wishes of the child seems to reinforce the suggestion that the guiding principle at operation here is that of allowing treatment. This is especially clear from the reference to how hospitals should be at 'liberty to treat'. Whilst this statement could be seen as giving doctors the freedom to do as they wish, this freedom only exists if the doctor desires to treat the patient. There is also the

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[89] [1993] 1 FLR 386
[90] ibid, at 393
[91] ibid
[92] ibid
[93] ibid, at 394
[94] ibid

clear implication that treatment should always be available. The suggestion that the child's will was not free appears to contradict the way the child was described by the court as having a deeply held and genuine belief. Whilst the decision is couched in terms of welfare and best interests, it would seem that the presumption in favour of preserving life, both its existence and quality, is what really underlies this decision.

Having already seen that the courts are willing to authorise treatment when the beliefs of the child are opposed to it, there is no surprise in the fact that they take the same approach to the parents' beliefs. In *Re C (A Child)(HIV Testing)*[95] Wilson J expresses the opinion that the courts should be slow to overrule the wishes of the parents.[96] Yet this need for caution seems to have the same impact as that in *Re E*, once more the court manages to provide consent despite the opposition of the parents. Johnson J, in *Re O (A Minor)(Medical Treatment)*,[97] authorised the treatment of a premature baby in such a way as was contrary to the parents' religious beliefs. In doing so he stated:

> "My duty…required me to give directions that will have the consequences of ensuring that whenever the medical need arise she will receive the transfusion of blood or blood products that medical advice dictates"[98]

This seems to offer clear support for the suggestion that allowing treatment is the main guiding principle at operation in this area of the law. Whilst there is some indication from this extract that the protection of clinical judgment is to be considered as well, the focus is clearly upon the provision of treatment.

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[95] [2000] Fam 48
[96] ibid, at 58
[97] [1993] 2 FLR 149
[98] ibid, at 153

In *Re T (A Minor)(Wardship: Medical Treatment)*[99] there can be found some moderation of this preference for treatment. The patient, a child born with a life-threatening liver defect, was recommended for a liver transplant which the parents opposed on the basis that it would cause pain and distress. Despite the medical opinion that the transplant was required for the child to survive the court held that it was not in the child's best interests to authorise the treatment. In reaching this decision the court emphasised that the child would require constant after-surgery care from the parents and that the willingness and ability to provide this had to be considered.[100] Whilst it has already been stated that we are not concerned with the interests of people other than the patient, this case demonstrates that they may be of importance if they impact upon the interests of the child.

Re T appears to cause problems for the application of the guiding principle of allowing treatment. It has already been indicated that the presumption in favour of treatment will cease to operate in extreme cases. In such cases the interests of the child must be so opposed to treatment as to overcome the presumption in favour of treatment. It is submitted that in such instances it is a negative application of the guiding principle of best interests which is decisive. Normally when a child's interests are referred to it is to look for what those interests demand. It is possible, however, to carry out the reverse analysis and look at what those interests reject. It is this use of the principle which is of importance in these extreme cases. Yet, can this really be seen as one of those extreme cases? It seems doubtful that this case is any more extreme than any of the others that have already been considered. Perhaps it is best to look at this as an anomaly.[101] The court certainly expressed the hope that treatment would

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[99] [1997] 1 All ER 906

[100] ibid, at 915-916

[101] One possibility is that this is an application of the guiding principle of protecting doctors as the parents in question were members of the medical profession. Yet some doctor's thought that treatment should be given and there is no logical reason to automatically prefer the opinion of the parents.

be sought after the parents had time to think the matter over without the pressure of litigation.[102] This indicates that the court still focused upon treatment, even though they did not enforce it.

2.2.3 – SOLVING DISPUTES:

The final question which must be asked is how will the courts approach cases where there are disputes, either between proxies or between a proxy and the medical profession, as to what should be done. It has been argued that:

> "A doctor taking steps to administer life-saving treatment such as a blood transfusion to the child against the wishes of its parents could rely upon the common law…the current judicial climate is such that we believe a decision taken in good faith in the best interests of the child would, save in very unusual circumstance, be upheld by the courts."[103]

Whilst it seems reasonable to claim that in emergency situations the doctor should be able to treat the child without the parent's consent, the court's approach to this appears to be less positive than might at first be thought.

In *Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)*[104] Dame Butler-Sloss P stated that there are certain matters which should always be brought before the court if those with parental responsibility cannot agree. The named issues were circumcision, sterilisation and change of surname although it was accepted that this was not a conclusive list.[105] None of those issues could be classed as emergencies though, nor could they be seen as involving life-saving treatment in the majority of cases. It is important to note, however, that this dealt with disagreements between those with parental responsibilities as opposed to

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[102] ibid, at 916

[103] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), pp.314-315

[104] [2000] 1 FLR 571

[105] ibid, at 577

between a proxy and a doctor. If one proxy is willing to provide consent to medical treatment then, at least in emergency scenarios, that will probably be sufficient to make the treatment lawful. If this is true then the principle of allowing treatment appears very strong in this instance as the focus is purely upon obtaining authorisation for the treatment of the child.

When we turn to look at disputes between proxies and doctors the answer appears to come from *R v. Portsmouth Hospitals NHS Trust, ex p. Glass*.[106] In this case Lord Woolf stated that where it was not possible for parents and doctors to agree on a course of treatment then, if the conflict relates to a grave matter, it ought to be brought before the court.[107] This has now been affirmed by the European Court of Human Rights in *Glass v. United Kingdom*[108] where it was stated that the legal framework required such matters to be solved by the intervention of the court, except in emergencies. This seems to reject the application of the guiding principle of protecting doctors in the sense that it does not offer automatic sanction to clinical opinion.[109] The fact that disputes have to go to court says little else about which principles apply. It does, however, indicate that parents have a valid role to play and cannot be ignored when making decisions as to treatment.

Once a matter is brought before the court the question remains as to what approach will be adopted to resolve the dispute. It has been suggested that they should only overrule the parent's decision if it is unreasonable.[110] The courts have rejected this and made it clear that the reasonableness of the parent's decision is of no consequence.[111] The courts have been prepared to overrule a parent's refusal even when it was accepted that it was based on a

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[106] [1999] 2 FLR 905

[107] ibid, at 910

[108] [2004] 1 FLR 1091

[109] It could however be argued that it ensures certainty and, through the need for court sanction, the threat of litigation is removed. This however is as much a benefit to the patient as it is to the medical team.

[110] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.314

[111] *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906, at 916

genuinely held belief of what was in the child's best interests which was both reasonable and valid.[112] Instead the court's role is to come to its own decision of what is in the child's best interests, a decision which should not simply accept that of either doctor or parent.[113] Whilst the courts have accepted that the views expressed by the parents are important,[114] cases where a parent's desire to refuse treatment is given effect by the court are rare to say the least, and it has already been seen that the way in which the courts interpret the child's interests heavily favours the provision of treatment.

So far the discussion has focussed upon cases where the doctors have desired to proceed with treatment and the parents have either been opposed to that treatment or uncertain as to whether it should be provided. Now it is necessary to look at how the courts approach the reverse scenario where doctors favour non-treatment but the parents are not willing to condone such a course of action. The first case which needs to be looked at, *Re J (A Minor)(Wardship: Medical Treatment),*[115] did not involve the scenario described above, yet Lord Donaldson MR stated that:

> "No one can *dictate* the treatment to be given to the child, neither court, parents nor doctors… The doctor can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C… The court or parents for their part can refuse consent to treatment A or B or both, but cannot insist on treatment C."[116]

Whilst this statement was obiter dicta it clearly addressed the question as to whether or not doctors can be forced to provide treatment which, in their judgement, should not be provided.

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[112] An example of such an overruling is *Re B (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 927

[113] *Re B (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 927, at 929

[114] *Re C (A Child)(HIV Testing)* [2000] Fam 48, at 58

[115] [1990] 3 All ER 930

[116] ibid, at 934

In another case of the same name[117] this question was the fundamental issue. In that case Lord Donaldson made the following statement:

> "I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient."[118]

Both Balcombe LJ[119] and Leggatt LJ[120] supported Lord Donaldson MR on this point, as did Sir Stephen Brown P in *Re C (Medical Treatment).*[121] This line of cases seems to question the primacy of the guiding principle of allowing treatment. Whilst it could be seen as supporting the principle of doctor protection this is undermined by the way the courts stated that the prime and paramount consideration had to be the best interests of the child.[122] It was also stated, however, that the high respect the courts have for the sanctity of life demands that there be a strong presumption in favour of doing everything possible to preserve life unless the circumstances are exceptional.[123] Hence, it is submitted that the guiding principle operating here is still that of allowing treatment as counteracted by the principle of best interests. Whilst the principle of allowing treatment may not be as strong as originally thought, it remains the starting point of the law.

2.3 – SUMMARY:

It would appear that when we look at how the law deals with the medical treatment of children the guiding principle which is applied is mainly that of allowing treatment. This may represent the concern that society has for children and the way in which they are seen as the

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[117] *Re J (A Minor)(Wardship: Medical Treatment)* [1992] 4 All ER 614
[118] ibid, at 622
[119] ibid, at 625
[120] ibid, at 626
[121] [1998] 1 FLR 384, at 389-390
[122] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 934 and *Re C (Medical Treatment)* [1998] 1 FLR 384, at 390
[123] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 934

future of humanity. As a society we are very protective of children and a child's death can be seen as a failure to offer sufficient protection. Hence, whilst other guiding principles may operate in a subservient manner, it is that of allowing treatment which takes priority in relation to children.

Looking at adolescent autonomy it can be seen that the initial focus was upon the interests and rights of the child. The later cases disregarded this though and used adolescent autonomy as a tool through which the number of parties capable of consenting to treatment was increased. The fact that there is no competency to withhold consent to treatment reinforces this idea that it has been redesigned to give effect to the principle of allowing treatment. Once the principle of allowing treatment has been satisfied there is then a highly limited application of the guiding principle of protecting doctors designed to protect the clinical judgment of the doctor only in so far as it supports treatment.

In relation to the incompetent child, it can once more be seen that the ideas and notions involved could superficially represent a pure application of the guiding principle of best interests. Yet, once again, this merely hides the reality of the law. On closer examination it can be seen that allowing treatment is again the starting point for the court. This principle works in conjunction with that of best interests and whilst judicial reasoning appears to place this at the forefront that is not the case. There is a strong presumption in favour of treatment and it is only when the interests of the child are opposed to it to an extreme extent that the principle of best interests will be strong enough to override that of allowing treatment.

The fact that the courts tend to talk in terms of interests and rights can cause confusion as it hides the real motivation, that of allowing treatment. Whilst this motivation is admirable in relation to children, few people would like to hear of children being allowed to die due to parental opposition to medical treatment, it would be less acceptable in relation to adults. Childhood, in general, is seen as a time of learning and growth, yet such learning occurs in a controlled environment such as a school. The law's approach to the treatment of children creates a similar safe environment. Whilst the competent child can learn about how to make such decisions, his ability to make mistakes is curtailed. Similarly the law protects the child from damage which may unwittingly result from the actions of a well-meaning parent. What is questionable is the constant attempt to hide behind the principle of best interests; whilst this concept has a long established usage it does not represent the legal reality.

CHAPTER 3:

ADULTHOOD & INHERENT COMPETENCE

When considering the medical treatment of adults it is necessary to distinguish between two categories of patient. Firstly there is the competent adult who has the necessary competency or capacity to decide which treatments they desire to receive. The second category of patient shall, at least for the purposes of this thesis, be referred to as the incapacitated patient and covers all patients who are incapable of providing consent to treatment. Whilst the term ‘incompetent’ is widely used to describe these patients it is submitted that it is too narrow to be accurate. ‘Incompetent’ implies that the patient lacks the capacity to understand, yet the patient could have a potential to understand that is temporarily suspended due to one of a number of possible reasons, unconsciousness for example.

Unlike in relation to children, society does not actively seek to protect adults from the consequences of their own actions. Much greater importance is placed upon the protection of an adult’s freedom to determine what treatment he receives.[1] If the courts were to take a different approach to this, in relation to the availability of medical treatment, then it would be necessary to provide some justification for this divergence from the attitudes of society. The way in which the courts approach the question of when doctors can treat competent patients will provide an important insight into how important the freedoms and rights of adults really are, and how far the law is willing to recognise and protect them.

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[1] It must be accepted, however, that there is no ability to demand treatment which the doctors are not willing to provide, see *Re J (A Minor)(Wardship: Medical Treatment)* [1992] 4 All ER 614

3.1 - THE COMPETENT ADULT:

The starting point when discussing the medical treatment of competent adults comes from Lord Donaldson's judgment in *Re T (Adult: Refusal of Medical Treatment).*[2] This case involved a woman who had been brought up as a Jehovah's Witness and, whilst not a practising member of that religion, refused to consent to a blood transfusion. In relation to the right to determine what treatment an adult should receive it was stated that:

> "An adult patient who… suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."[3]

This statement makes the importance of consent in relation to the medical treatment of adults clear.[4] Without such consent any form of touching, no matter how minor, will be unlawful and constitute both a criminal offence and a tort.

The purpose of this section of the thesis is to ask three main questions. Firstly, when will an adult be held to lack the soundness of mind required to make the obtaining of his consent essential to the lawfulness of the treatment? Secondly, are there any limits placed upon what a competent adult can consent to? In essence this is asking whether or not there any treatments for which consent will be insufficient to make them lawful? Finally, are there any areas of treatment where the refusal of a competent patient will not necessarily prevent lawful treatment?

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[2] [1992] 4 All ER 649

[3] ibid, at 652-653

[4] The American jurist, Cardozo J, made a statement with similar meaning in *Schloendorff v. Society of New York Hospitals* (1914) 211 NY 125 at 129-130, when he said that: "Every human of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."

3.1.1 - THE TEST FOR COMPETENCY:

It has already been shown that in relation to patients under the age of 16 the law presumes that they are not competent to give consent. It is then for the child to prove that he possesses the necessary competency. The courts' approach to this demonstrates that the main focus is upon allowing treatment.[5] In relation to adults the situation is practically reversed. The law presumes that adults are competent to consent to treatment[6] and if the doctors desire to treat against the patient's wishes they must show that he lacks the requisite competency. Even if the patient is found to be incompetent there is nobody who can provide consent on his or her behalf. Hence the justification for treatment must come from some other legal principle.[7]

The courts have made it clear that in deciding whether or not an individual patient is competent they are not concerned with the best interests of the patient,[8] rather the sole issue is capacity. This means that the courts should not decide whether or not the patient is competent to refuse treatment based upon whether or not they view treatment as required to fulfil the patient's interests. Capacity may, however, depend upon the procedure involved. Lord Donaldson has stated that the capacity possessed must be commensurate with the gravity of the decision and that the more serious a procedure is the greater the level of capacity that will be required.[9] It could be argued that it is the consequences rather than the procedure itself which are of importance. If this is the case then a minor procedure with serious consequences

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[5] For the child who wishes to oppose treatment it is very hard to show sufficient capacity, and even if they manage to do that there is still no ability to prevent others from authorising the treatment.

[6] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 661

[7] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 552, makes it clear that the *parens patriae* jurisdiction, which used to allow the courts to consent on behalf of the patient, has been revoked.

[8] *B (Adult: Refusal of Medical Treatment), Re* [2002] 2 All ER 449, at 455

[9] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 661

would require a higher level of capacity than a serious procedure with minor consequences.[10] Skegg states that capacity to give legally effective consent depends upon the capacity to understand and come to a decision and the capacity to communicate that decision.[11] In *Re C (Adult: Refusal of Medical Treatment)*[12] the court attempted to create a definitive test for adult capacity and stated that:

> "For the patient offered amputation to save life, there are three stages to the decision: (1) to take in and retain information, (2) to believe it and (3) to weigh that information balancing risks and needs."[13]

Whilst that case involved the refusal of a life saving amputation there is no reason to believe that the test was intended to be limited to that scenario. The need for understanding has been criticised on the basis that it may depend upon the amount of information provided by a doctor who may not want the patient to be found to be competent.[14] Similarly the belief requirement appears to throw great importance upon the clinical judgment of the doctor. If taken to its logical conclusion this would mean that a patient, who doubted the doctor's assertion that the procedure was the only viable option to prevent loss of life, would be incompetent. The approach taken in *Re C,* however, goes some way to moderate this. In that case the patient was a paranoid schizophrenic who doubted the opinion of the doctors and even had delusions that he was, himself, a qualified surgeon. Despite this the court held that the patient had, in 'his own way', believed the information he had been given.[15]

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[10] *Re MB (Medical Treatment)* [1997] 2 FLR 426 could be seen as an example of this as the procedure in question was nothing more than an injection but the consequences would have been the inability to carry out a caesarean delivery and the resultant death of the unborn child.

[11] P.D.G. Skegg, *Law, Ethics and Medicine* (Oxford: Clarendon Press, 1984), p.48

[12] [1994] 1 All ER 819

[13] ibid, at 822

[14] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), p.333

[15] [1994] 1 All ER 819, at 824

Whilst the *Re C* test was unequivocally accepted in *Re JT (Adult: Refusal of Medical Treatment),*[16] a case involving a patient who was found to be competent despite mental disabilities and severe learning problems, an adapted version created by the Law Commission[17] was utilised in *Re MB (Medical Treatment).*[18] Butler-Sloss LJ stated that incapacity occurs when:

> "(a) The patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;
>
> (b) The patient is unable to use the information and weigh it in the balance of the process of arriving at the decision."[19]

It can be seen that the requirement that the patient believes what the doctor tells him has been removed. The impact of this will be minimal at most given the lenient way in which it was applied in *Re C*. It is submitted that in order for a patient to lack the required belief he would probably have failed to comprehend the information and retain it. The reference to the patient being 'unable' to comprehend counters the criticism of capacity depending upon what the doctor tells the patient. It is not the same to say that a patient must be able to understand the information and to say that the patient must understand all relevant information, only the latter of these alternatives depends upon the communication of information to the patient.[20] Whilst the test for competency is facing reform under the Mental Capacity Bill 2004, it is submitted that the effect of these reforms will be minimal.[21]

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[16] [1998] 1 FLR 48

[17] Law Commission, *Mental Incapacity* (London: HMSO, 1995) Law Com No 231

[18] [1997] 2 FLR 426, at 433

[19] ibid, at 437

[20] The *Re MB* formulation, which was practically identical to the Law Commission's test, has subsequently been approved as the correct approach in a practice direction, *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2001] 2 FLR 158, at p.159.

[21] Under s.3(1) a patient will be seen as incompetent if they are unable to understand and retain relevant information and then use it as part of the decision making process. This appears to be the exact same test as that applied in *Re MB (Medical Treatment)*. The presumption that patients have the necessary capacity to decide for themselves is maintained under s.3.

Unlike in relation to children, the courts do not seem to take every opportunity to declare that an adult patient is incompetent. *Re C* itself provides an example of this as it is extremely doubtful, due to the delusions, that the patient would have been held to be competent if he had been a child. This could be explained on the basis that when the case reached the court the patient had already begun to recover and the immediate risk of death had been diverted. The same cannot be said of *Re JT* where there was a report that the patient believed that a liver transplant would become available before she died.[22] The chance of this actually happening was slim at best and this had been explained to the patient. Regardless of this continued belief the patient was still held to be competent to withhold consent. This can be contrasted with *Re S (A Minor)(Consent to Medical Treatment)*[23] where a child was held to be incompetent due to the belief that a miracle would save her life. Similarly *Re W (Adult: Refusal of Treatment)*[24] held that a patient would not be incompetent due to a lack of understanding as to the exact mechanism of his death should he refuse to consent. The opposite approach has been taken in relation to children who must not only understand that they will die, but also how they will die and the suffering that will be felt by both the patient and their loved ones.[25]

This apparent reluctance to utilise all possible excuses to declare an adult patient incompetent would appear to indicate that in relation to adults we are not concerned with the principle of allowing treatment. Instead the courts are focusing upon the self-determination principle by reinforcing the need for consent unless the patient really does lack the capacity to provide it. This may be the result of the social attitude towards the freedom of adults. Unlike children, who are viewed as being in need of protection, adults are perceived as having the right to

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[22] [1998] 1 FLR 48, at 50
[23] [1994] 2 FLR 1065
[24] [2002] EWHC 901
[25] *Re E (A Minor)(Wardship: Medical Treatment)* [1993] 1 FLR 386

make their own mistakes if they so wish. This freedom is generally only limited when it begins to impact upon the lives of other people.[26]

This approach to protecting the freedom of adults unless their actions impact upon others could be used to explain why the law approaches pregnant women in a different manner. *Re T* suggested that the adult's right to withhold consent to treatment may not apply to pregnant patients.[27] It will be shown later that this was incorrect though and that the foetus has no legal rights until it is born.[28] *Re MB* made it clear that a competent pregnant woman cannot be compelled to undergo treatment even if refusal would result in the death of the foetus.[29] Yet in *Re MB* the patient was held to be incompetent due to a needle phobia which prevented her from undergoing surgery.[30] In this case, however, the woman actually desired that treatment be given but found herself unable to endure the use of needles each time treatment was initiated. Due to this fact the decision reached may seem less controversial than might be initially thought.

In *Re T* a number of reasons were given for holding that the patient lacked the capacity to withhold consent. Amongst these reasons was the fact that she was 34 weeks pregnant and anxious as to the baby's health.[31] This seems to imply that any woman who cares for her baby's health will be incompetent if they attempt to refuse treatment which will benefit the foetus. It must be noted that it was assumed that the woman cared for her child; there was no investigation into this issue. The language of *Re T* places a great deal of importance upon

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[26] Examples of such limits can be seen in the torts of negligence, occupier's liability and nuisance. For such torts it is necessary to show that the claimant has suffered some loss as a result of the actions of the defendant before liability will exist.

[27] [1992] 4 All ER 649, at 653

[28] See below at section 4.3.2 – Legal Protection of the Foetus.

[29] [1997] 2 FLR 426, at 438

[30] This case also provides a thorough discussion of a number of other cases, mostly unreported, where pregnant patients were held to be incompetent so that treatment could be authorised, see ibid, at 434-435

[31] [1992] 4 All ER 649, at 660

sanctity of life, a principle which supposedly represents the social interest.[32] The effect of these two cases is to create a façade of respect for autonomy behind which the reality of the law seeks to provide treatment so as to protect the foetus from harm. It seems that the courts will willingly view a pregnant patient as incompetent so as to offer that protection despite the fact that the foetus has no rights of its own.

3.1.2 – THE EXTENT OF THE POWER OF CONSENT:

The position of the law is that it is consent which makes touching of any form, medical or otherwise, lawful. Cameron states that:

> "In general it is necessary before carrying out an operation or any other surgical or medical procedure or even an examination to obtain the consent, expressed or implied, of the person concerned otherwise the practitioner could render himself liable to a claim for damages for assault."[33]

The courts have reaffirmed this point and made it clear that treatment without consent could constitute both a trespass and a crime.[34] An important question is whether or not there are any procedures of a medical nature to which a competent adult cannot provide consent sufficient in itself to render the procedure lawful.

There have been a number of criminal law cases looking at the ability of an adult to consent to a physical assault. In *Attorney General's Reference (No 6 of 1980)*[35] the court stated that an essential element of the crime of assault was that it was done contrary to the wishes of the victim but that, if public interest demanded it, the existence of consent may not prevent it being a crime.[36] It was then stated that it was not in the public interest to allow the infliction

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[32] ibid, at 661
[33] J.A. Cameron, *Medical Negligence: An Introduction* (Edinburgh: Law Society of Scotland, 1983), p.13
[34] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 653
[35] [1981] QB 715
[36] ibid, at 718

of actual bodily harm for no good reason.[37] In *R v. Donovan*[38] the court addressed the issue of caning for sexual pleasure. Swift J stated that:

> "If an act is unlawful in the sense of it being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it."[39]

Similarly the courts have held that it is not possible to provide effective consent to homosexual acts of sadomasochism.[40] All of these cases accept that there are certain scenarios that will be lawful if consented to. Medical procedures are generally seen as falling within this set of exceptions.

There are, nonetheless, some procedures of a medical nature which may remain unlawful regardless of the presence of consent. Skegg suggests that one such procedure would be an amputation which was not required for medical purposes.[41] This would certainly be caught by the idea that public interest does not favour the infliction of harm for no good reason. Similarly the law prohibits the circumcision of females[42] unless it is carried out for valid medical reasons.[43] Another example of how public interest makes a consensual medical activity unlawful can be found in relation to assisted reproduction and how there are a number of procedures that can never be lawful.[44]

The examples given thus far will, at most, be rare in practice, an example of more practical importance may be found in relation to the treatment of mental disorders. Under the Mental

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[37] ibid, at 719

[38] [1934] 2 KB 498

[39] ibid, at 507

[40] *R v. Brown* [1994] 1 AC 212. Contrast this with *R v. Wilson* [1997] QB 47 where the courts saw no problem in a wife consenting to being branded by her husband, an act they saw as being little different from tattooing.

[41] P.D.G. Skegg, *Law, Ethics and Medicine*, p.38. Skegg also questions whether organ donation can be lawful as it provides the donor with no medical benefit. It is certainly clear that the current position of the law is that such donation will be lawful if consent is given or if it is in the best interests of an incompetent donor.

[42] Female Genital Mutilation Act 2003, s.1(1)

[43] ibid, s.1(2)

[44] Human Fertilisation and Embryology Act 1990, ss.3-4

Health Act 1983, some treatments can only be carried out if the consent of the patient is accompanied by the supporting opinions of a registered medical officer as well as two appointed persons, each of whom must have consulted people who have knowledge of the patient's condition.[45] The procedures covered by these provisions are operations aimed at destroying brain tissue, or the functioning thereof,[46] and the surgical implantation of hormones to reduce the male sex drive.[47] The special treatment of these procedures can be justified on the basis that they involve the potential to do a great deal of harm to a patient who may receive little benefit. One of the justifications for the special treatment of the mentally ill patients is that they may pose a risk to the public. It is possible, therefore, to say that the treatment of mental conditions is for the benefit of the public rather than being solely for the benefit of the patient. Despite this, the risk of severe harm to the patient demands greater safeguards than might normally apply. The limits placed upon the ability to consent to treatment seem to suggest that medical procedures should be restricted to those which do some noticeable good.[48] Where such good is lacking, or outweighed by harmful results, their availability is seriously curtailed. This may indicate that where the principle of allowing treatment is applied, which is not the case here, it is limited to treatments designed to improve the health of the patient.

3.1.3 – THE ABILITY TO REFUSE TREATMENT:

Competent adult patients are usually seen as being free to refuse medical treatment as they see fit. The adult's right to refuse treatment extends, at least in theory, to cover situations where

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[45] ss.57(2)-(3)

[46] s.57(1)(a)

[47] Mental Health (Hospital, Guardianship and Consent) Regulations 1983, r.16(1)

[48] Lord Keith has stated that "the object of medical treatment and care is to benefit the patient", see *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860

death is a likely, or even certain, consequence of that refusal.[49] This ability to refuse treatment exists regardless of whether or not the decision is based upon rational reasons, irrational reasons, or is devoid of any reasons whatsoever.[50] Lord Donaldson has stated that:

> "This right of choice is not limited to decisions which others might regard as sensible. It exists not withstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."[51]

There is no ability to disregard the refusal of a competent patient on the basis that it lacks logic unless it is so extreme as to demonstrate that the patient lacks the capacity to understand the information provided. In relation to this, Kennedy and Grubb claim that it is possible to differentiate between a religious belief, such as the Jehovah's Witness' approach to blood transfusions, and the belief that blood is a poison because it is red in colour. This distinction is made on the basis that the latter belief could be demonstrated to be indisputably incorrect.[52] In *X NHS Trust v. Ms T*,[53] Charles J referred to the distinction suggested by Kennedy and Grubb and went on to hold that the patient, who had refused blood transfusions due to a belief that her blood was evil and would contaminate any new blood given to her, was incompetent due to that belief.

Re T (Adult: Refusal to Medical Treatment)[54] can be seen as providing three 'get-outs' through which the court may disregard the competent patient's refusal of consent to treatment. The first of these has already been looked at and questions the capacity of the patient to make the decision. The second option is to claim that there has been some undue influence placed

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[49] The reality of this ability to refuse life saving treatment will be more fully considered in the Chapter 5.

[50] This is preserved under s.1(4) of the Mental Capacity Bill 2004 which refers to such decisions as 'unwise' decisions.

[51] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 653

[52] I. Kennedy & A. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.626. The problem with the suggested distinction is that it ignores the fact that for many people the existence of a God, and therefore the whole basis of religious beliefs, can also be demonstrated to be incorrect.

[53] [2004] EWCH 1279

[54] [1992] 4 All ER 649

upon the patient and that this has overridden his ability to make a decision. It does not matter how strong the influence is, what is important is the impact it has upon the patient's ability to come to his own decision.[55] In effect the question is whether the decision is really the patient's, albeit influenced by others, or if it is a decision which has been forced upon the patient by someone else. Finally the court may decide that the scope and basis of the refusal of consent is such that it was never intended to cover the situation in question.[56] It should be pointed out that this is not the same as assumed consent.[57] The idea of assumed consent would allow a doctor to decide that had the patient known the situation in question would arise they would have consented.

Just as there are some procedures that can never be effectively consented to, there are some for which even the competent adult will not be able to withhold consent. One example of such procedures is the treatment of contagious diseases. Under the Public Health (Control of Diseases) Act 1984 it is possible to order a person who is suffering from one of a number of 'notifiable' diseases, including cholera, typhus and smallpox,[58] to receive a medical examination if it is in the interests of the patient, the patient's family or the general public.[59] It is also possible to force the patient to enter hospital if the existing circumstances prevent proper care from being taken and there is a serious risk of others becoming infected.[60] Brazier and Harris point out that the result of this is that the patient loses any effective choice in relation to treatment, liberty and privacy due to the fact that the legislation overrides

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[55] ibid, at 662

[56] ibid

[57] This option was expressly ruled out despite the contrary suggestion in *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129, at 134. What the court decides is that the refusal does not apply and the patient must then be approached in the same manner as any other patient who is not capable of either giving or withholding consent.

[58] The full list of notifiable diseases is set down in s.10 and in the Public Health (Infectious Diseases) Regulations 1998, r.3 and sched.1

[59] s.35

[60] s.37

practically all individual liberties.[61] Under the Act it also becomes an offence to knowingly expose others to the possibility of infection with a ‘notifiable’ disease.[62] Brazier and Harris argue that this is justified as there is no real reason to treat the deliberate or reckless infection of others with such diseases differently to the deliberate infliction of violence upon others when the consequences can be just as harmful, if not more so.[63]

Two more examples can be found in the treatment of mental conditions.[64] Under the Mental Health Act 1983, s.58, any administration of medicine lasting longer than three months, or the administration of ECT[65], requires either the patient’s consent or the supporting opinion of an appointed registered medical officer.[66] The officer can either certify that the patient is incompetent and cannot therefore give consent, or that the patient is competent and has refused consent but should be treated regardless of such refusal. By providing another source of consent which can override a patient’s refusal the law makes that refusal pointless as it cannot prevent treatment. In emergency scenarios these special requirements are removed, similarly the requirements of s.57 explained above are also removed, and it becomes even easier to treat without the consent of the patient in question.[67]

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[61] M. Brazier & J. Harris, ‘Public Health and Private Lives’ (1996) 4 Med L Rev 171, p.175

[62] s.17

[63] M. Brazier & J. Harris, ‘Public Health and Private Lives’, p.177

[64] Mental Health Law is facing reform under the Draft Mental Health Bill 2004. Whilst the proposed reforms will remove the distinction between detained and informal patients, so far as the ability to treat is concerned, it has been argued that informal patients are already subject to a number of pressures which counteract their right to withhold treatment and places them in the same position as detained patients. See P. Bartlett & R. Sandland, *Mental Health Law: Policy and Practice*, p.343

[65] The application of s.58 is extended to cover ECT by the Mental Health (Hospital, Guardianship and Consent) Regulations 1983, r.16(2)

[66] The use of special safeguards for certain treatments such as ECT is preserved under the Draft Mental Health Bill 2004, Part 5.

[67] s.62

Furthermore, in relation to detained patients[68] there is also a general ability to provide treatment to the patient without their consent. Under s.63 the responsible medical officer may authorise any treatment not covered by the special requirements already set out so long as it is a treatment of the mental condition for which the patient has been detained.[69] Whilst this may seem to be quite a narrow power of compulsory treatment the courts have consistently interpreted it in a broad manner and given the doctors greater freedom to treat without consent than might be initially thought. It should be noted that the definition of treatment under the Mental Health Act 1983 is quite broad and includes nursing, care, habilitation and rehabilitation.[70] The courts have taken this even wider though and included procedures such as force-feeding,[71] seclusion[72] and even detainment[73] so long as it can be described as preventing the condition from deteriorating. In *B v. Croydon Health Authority* it was stated that the definition of treatment was wide enough to include a range of acts ancillary to the core treatment of the disorder.[74]

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[68] Under the Mental Health Act 1983, s.3 a patient can be admitted to hospital for treatment if he suffers one of a number of mental conditions of a degree or nature that make treatment appropriate. The treatment must, generally, provide hope of either alleviating the condition or preventing it from deteriorating further. It is also a requirement that admission is necessary for the patient's safety or health, or the safety of others, and that treatment would not be provided without the patient being detained.

[69] The Draft Mental Health Bill 2004, s.4, creates a Mental Health Tribunal and proposes a whole new scheme for governing the availability of such treatments. Under s.14 the first stage is that the Secretary of State will be requested to determine whether or not a patient should be examined. In order for a patient to be liable for examination he must satisfy a number of conditions laid out in s.9: 1) he must be suffering from a mental disorder which is of a degree or nature that warrants treatment, 2) there must be appropriate treatment available which is necessary to protect either the patient or others and, 3) unless the risk posed to others is serious, there must be no possibility of treatment apart from under the Bill. If an examination is ordered then, under s.15, it must determine that the same conditions have been satisfied and whether or not detainment is necessary. According to s.16 this will make the patient liable for assessment as either a resident patient or a non-resident patient. Under s.25 the assessment must once again determine whether the conditions are satisfied and what treatment is necessary or whether further assessment is needed. An application to the Tribunal must be made under s.35 in order to authorise treatment or further assessment.

[70] s.145(1)

[71] *B v. Croydon Health Authority* [1995] 1 All ER 683

[72] *R (on the application of Colonel Munjaz) v. Ashworth Hospital Authority* [2002] EWHC 1521

[73] *Reid v. Secretary of State for Scotland* [1999] 2 AC 512

[74] [1995] 1 All ER 683, at 687

The courts have also interpreted the need for the treatment to be aimed at the specific mental disorder for which the patient has been detained in a broader manner than might be expected. In *R (On the Application of B) v. Ashworth Hospital Authority*,[75] Dyson LJ seemed to limit this expansion by making it clear that the ability to provide treatment under s.63 only extended to treatment of the condition for which the patient was liable to be detained. At the same time though it was decided that if the treatment of another condition could be seen as necessary for the proper treatment of the condition for which the patient was detained then the treatment would be available.[76] Hence, if a patient can be detained for the treatment of condition A, but the treatment of condition B will help that of A, then no consent will be required for the treatment. *B v. Croydon Health Authority* stated that alleviating the symptoms of the condition is as much a part of the treatment as relieving the underlying cause.[77] In this case a refusal to eat was classified as a symptom of the mental condition so force-feeding was seen as treatment available under the act. Again this can be seen as making it easier to treat a patient who refuses consent to treatment.

In *Tameside and Glossop Acute Services Trust v. CH*[78] the court allowed a non-consensual caesarean section to be classed as treatment of the mental condition. The justifications for this were that an ancillary reason for the procedure was to prevent deterioration in mental health, that it was necessary to allow proper treatment of the mental condition and that necessary medication could not be administered during the pregnancy.[79] It has been argued that as the court in the case was provided with only two alternatives, namely an adult suffering from a mental condition and a dead baby, or a healthy mother caring for a healthy

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[75] [2003] 4 All ER 319
[76] ibid, at 333
[77] [1995] 1 All ER 683, at 688. This is also supported by *Re KB (Adult)(Mental Patient: Medical Treatment)* (1994) 19 BMLR 144
[78] [1996] 1 FLR 762
[79] ibid, at 773

child, it is hardly surprising that they permitted the treatment.[80] This seems to ignore the fact that the court could, if they had wished to do so, have simply held that the patient was incompetent and declared the treatment lawful without the need for any recourse to the Mental Health Act 1983. This judgment has the effect of deliberately widening the range of procedures covered by s.63. Not only will acts ancillary to the core treatment be available, but so will treatments for which the mental condition is only an ancillary concern and the real purpose is wholly unrelated to the mental condition for which the patient is liable to be detained.

Whilst the proposed reforms of Mental Health law represent a whole new method of providing treatment for mental disorders, the effect upon the ability to treat is less than might initially be thought. There is no reason to believe that the new definition of treatment[81] will be interpreted to be narrower than that provided under the existing legislation. Further to that, the basis for the ability to treat without consent is still the risk of harm to the patient or others. Similarly there are still restrictions placed upon those treatments which can be seen as causing more harm than good. Hewitt argues that a consolidation of the case law would probably achieve the same end result as the suggested reforms[82] and it is submitted that this assertion is correct.

The shared element of contagious diseases and compulsory treatment of mental health patients is the perceived threat posed to people other than the patient. This is also seen in the approach taken in relation to the competency of pregnant women: if the foetus is threatened it becomes more likely that capacity will be lacking. It would appear therefore that whilst the

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[80] P. Bartlett & R. Sandland, *Mental Health Law: Policy and Practice* (Oxford: Oxford University Press, 2nd, 2003), p.355

[81] Draft Mental Health Bill 2004, s.2(7)

[82] D. Hewitt, 'Between Necessity and Chance' (2004) 154 NLJ 584, p.585

principle of self-determination is generally applied in relation to competent adults, underlying this there is a desire to protect people from harm. So long as the patient is the only person who is affected by the decision as to whether or not to accept treatment the law will not intervene. However, the law tries to prevent such choices harming, or adversely affecting, others who have no choice in the matter.[83] In relation to the extent of the ability to consent this is demonstrated in the limits upon what can be consented to. In relation to the ability to refuse consent it can be seen in an application of the principle of allowing treatment when the failure to do so may cause harm to others. Whilst a patient will generally be allowed to harm himself by refusing treatment, the law will not allow the infliction of such harm upon others, nor will it allow the use of treatments which can provide no benefit to the patient.

3.2 - THE INCAPACITATED ADULT:

3.2.1 - DEFINING THE INCAPACITATED PATIENT:

The traditional method, adopted by most academic authorities, of approaching the issues raised in relation to patients who are incapable of giving consent is to separate them into two distinct groups. The first group covers those patients who are usually competent but are, for some reason or other, incapacitated at the time when the need for consent to be obtained arises. A typical example of such a patient would be a victim of a traffic accident who may be incompetent because of the accident and therefore unable to consent to any treatment that is required as a result of that accident. Alternatively the incompetency could be induced through the abuse of alcohol or drugs, or even due to excessive fear on the part of the patient. In relation to such patients the need for emergency treatments can cause problems as there is nobody to authorise such treatments on the patient's behalf. The second group would cover

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[83] Whilst it would be possible to argue that relatives are always subject to adverse emotional effects the law will not view these as sufficient to justify an overriding of the wishes and freedoms of the patient who wishes to refuse treatment.

people who can be described as long-term incapacitated patients. Such patients include those with learning difficulties that prevent the sufficient level of competency ever being achieved. In essence these patients are those who would persistently fail to meet the competency tests set out above. It is worth remembering, however, that a patient could be competent in relation to one form of treatment yet incompetent in relation to another form.

An alternative, and more workable, method of viewing incapacitated patients is in the form of a continuous scale. At the one extreme there is the fully competent adult patient who has the absolute right to refuse or accept treatment. At the opposite end of the scale you find the patient in a persistent vegetative state and the long-term unconscious patient, who are not only incapable of giving effective consent but cannot even express their wishes and desires relating to treatment. Between these two extremes there can be found a wide variety of patients of varying abilities to understand the proposed treatment and provide consent.[84] If it is possible to look at the patients concerned with involuntary treatment as belonging to a continuous scale then it may also be possible to view the way the law treats such patients as a scale. It would certainly be true to say that there is no suggestion that doctors should be able to provide all treatments that can be seen as being in the interests of a short-term incapacitated patient[85] but that a wider range of treatments must be made available as the length of incapacity increases.[86] The advantage of this is that it allows the law to be seen as a whole rather than attempting to fit individual patients into fixed categories. It also accepts that such categorisation is extremely difficult given the fact that, in practice, doctors are faced with a range of scenarios, each slightly different to the other, rather than a finite set of distinct possibilities.

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[84] For a visual representation of this scale see Figure 3 in Appendix A

[85] P.D.G. Skegg, *Law, Ethics and Medicine*, p.101

[86] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 566

It is necessary at this point in the thesis to identify the broad types of patient that will need to be dealt with in relation to the treatment of incapacitated patients. A number of these patient types have already been indicated in the above discussion, yet it is useful to mention them again for reasons of clarity. The first type of patient in the spectrum of incapacity is the adult with reduced capacity. The lack of capacity could occur for any number of reasons, including a temporary loss of ability through the influence of some chemical substance. Depending upon the level of capacity required for the procedure in question this reduced capacity may become a temporary incompetence which will render the patient unable to give effective consent. The second type of patient that will be encountered will be the short-term unconscious adult. It is possible to liken this patient to the temporarily incompetent as there is the almost certain prospect of capacity returning some time in the not too distant future and this may impact upon what treatment will be available whilst the incapacity exists. The third type of patient will cover those suffering from mental conditions. Whilst the existence of a mental condition will not necessarily mean that the patient will lack capacity to decide what treatment to accept, such incapacity may be one result of that condition.[87] The fourth type of patient is the permanently incompetent who, unlike the temporary incompetent, has no realistic hope of capacity returning, or developing, and this will impact upon the ability to treat. Finally, the fifth type are patients who are either in a persistent vegetative state or are in a long-term unconscious condition. Such patients will be totally incapable of expressing their desires and opinions, let alone providing legally effective consent.

3.2.2 - TREATING THE INCAPACITATED PATIENT:

It is important to make it clear at the outset, that this section of the discussion is only concerned with the treatment of physical conditions. When it comes to mental conditions the

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[87] P.D.G. Skegg, *Law, Ethics and Medicine*, p.56

capacity of the patient has little, if any, effect upon the law. If the requirements of the Mental Health Act 1983[88] are satisfied then the incapacitated patient suffering from a mental condition will be treated, for that condition, in the same way as the competent adult with the same condition. It is in relation to the treatment of physical conditions that the approach to treatment may differ depending upon capacity. It has already been shown, however, that the way the courts interpret the provisions of the Mental Health Act 1983 result in a very wide application of the ability to treat without consent. It is therefore possible that some physical treatments will be brought within the scope of the treatment of mental conditions. This section will ignore this possibility and focus purely upon the common law ability to provide treatment of physical conditions when the patient lacks the capacity to provide consent.

In relation to short-term incapacitated patients, especially those who are unconscious, there is a distinct lack of English case law. Despite this Lord Brandon has confidently stated that:

> "The common law would be seriously defective if it failed to provide a solution to the problem to such an inability to consent. In my opinion, however, the common law does not fail."[89]

It is possible to refer to two Canadian cases which probably represent the approach the English courts would take in similar situations. In *Marshall v. Curry*[90] the patient was undergoing a consensual hernia operation. Whilst the patient was unconscious the surgeon decided that it was necessary to remove one of the patient's testicles. The question was whether or not the surgeon had been justified in carrying out this procedure despite the fact that no consent had been given. The court reinforced the principle that consent should always be obtained prior to treatment and stated that consent should not be implied in such

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[88] Namely that the patient poses a risk to himself or to others. If this is not the case then the principles which apply will be the same as those relating to all other forms of treatment not caught by the Mental Health Act 1983 as discussed below.

[89] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551

[90] [1933] 3 DLR 260

scenarios.[91] It was suggested to the court that it was possible to see the doctor as the representative of the patient and that because of this he had the authority to consent on the behalf of the patient. Chisholm CJ rejected this proposition, stating:

> "I think it is better, instead of reverting to a fiction, to put consent altogether out of the case, where a great emergency which could not be anticipated arises, and to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient… Is it not better to decide boldly that apart from any consent the conditions discovered make it imperative on the part of the surgeon to operate."[92]

The court held that in this case the surgeon's actions had been justified due to the essential need to proceed with the treatment and the fact that it would have been unreasonable to postpone until consent could be obtained.

In *Murray v. McMurchy*[93] the Canadian courts were confronted with a patient who had undergone a caesarean operation to deliver her child. During the caesarean procedure the walls of the uterus were found to contain a number of tumours. Due to this the surgeon tied the fallopian tubes to prevent the hazards of future pregnancies. Looking at the question of whether the surgeon possessed the necessary authority MacFarlane J stated that:

> "If it were necessary in the sense that it would be, in the circumstances, unreasonable to postpone the operation until a later date, I would say that… the surgeon would have that authority… There are times under circumstances of emergency when doctors must exercise their professional skill and ability without the consent that is required in the ordinary case."[94]

In this case the court held that the surgeon had not been justified in proceeding without the patient's consent. Whilst it was accepted that any future attempts at conceiving a child would be subject to increased risks it was made clear that this was not a situation where there was a

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[91] ibid, at 274

[92] ibid, at 278

[93] [1949] 2 DLR 442. The case of *Devi v. West Midlands Regional Health Authority* [1980] CLY 687 provides an English Equivalent of this Canadian case where the same result was reached

[94] ibid, at 444

necessity for an immediate decision.[95] A similar English case, *Williamson v. East London and City Health Authority*,[96] involved a doctor who, whilst replacing a leaking breast implant, discovered lumps and performed a mastectomy. It was held that whilst the procedure was necessary, consent should have been obtained. In *Marshall* the testicle was diseased and dangerous to the patient's health. The same cannot be said of *Murray* or *Williamson* where the risks for the patients involved were not immediate. Rather the patients could be informed of the risks involved and given the opportunity to consent to the procedures being performed at a later date.

The approach developed in the above cases is known as the doctrine of necessity and has been applied to a broader range of incapacitated patients than those with which the initial cases were concerned. A great deal of focus has been placed upon the idea that the postponement of treatment must be unreasonable. Skegg states that this is a preferable approach to simply saying that the need for consent can be disregarded whenever it is necessary to do so.[97] It is submitted that, in relation to short-term incompetents, in order for it to be unreasonable to postpone there must be an immediate need for treatment. Both Canadian judges went to some length to explain that the ability to proceed without consent was an exception to the normal position. This exception was justified because of the immediate necessity of the procedure. In *Marshall v. Curry* the judge referred to the need for the procedure to be carried out as being imperative.[98] In *Murray v. McMurchy* the justifying situation was described as being one of emergency.[99] The need for an emergency scenario under English law was confirmed by Lord

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[95] ibid, at 454. It is interesting to note that the existence of future risks was accepted despite there being medical doubts as to the surgeon's diagnosis.
[96] (1998) 41 BMLR 85
[97] P.D.G. Skegg, *Law, Ethics and Medicine*, p.104
[98] [1933] 3 DLR 260, at 278
[99] [1949] 2 DLR 442, at 444

Goff, in *F v. West Berkshire Health Authority*,[100] who stated that in the case of a person of sound mind there would ordinarily have to be such an emergency before the doctrine of necessity would authorise an action which would otherwise be unlawful.[101] The result of this focus upon the need for an emergency is that the guiding principle of self-determination remains foremost despite the fact that the patient cannot provide the consent required to protect his autonomy. By insisting upon the need for an emergency the courts have ensured that the patient's right to self-determination is protected so long as there is no immediate risk. This is further supported by the fact that necessity cannot authorise a treatment to which the patient is known to be opposed, or one which goes beyond that required before the patient recovers his capacity to decide.[102]

In *F v. West Berkshire Health Authority* the House of Lords applied the doctrine of necessity to a long-term incompetent. The patient in question was a 36-year-old woman suffering from severe mental disabilities, which meant she had a mental age of between four and five. Medical staff wanted to sterilise the patient as she had entered into a sexual relationship and it was thought that any resultant pregnancy would have a disastrous effect upon her condition. Lord Brandon said:

> "In my opinion, the solution to the problem which the common law provides is that a doctor can lawfully operate on, or give treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in [their] best interests."[103]

Whilst this statement was made in relation to the treatment of all incapacitated patients it has already been shown that in relation to the short term incapacitated adult there needs to be

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[100] [1989] 2 All ER 545
[101] ibid, at 565
[102] ibid, at 566
[103] ibid, at 551

some form of emergency. In relation to more long-term incompetents there is no such requirement. Lord Goff made this clear when he stated that:

> "In the case of a mentally disordered person, as in the case of a stroke victim, the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury."[104]

Lord Goff also stated that where the state of affairs giving rise to the incapacity is permanent or semi-permanent there is no point in waiting for the patient to recover so that consent can be obtained.[105] The effect of this is that as the length of the incompetency increases it becomes ever easier to justify the treatment in question and the requirement that there must be an urgent need for treatment is reduced. Consequently, the longer a patient is likely to be incompetent the closer we get to allowing any treatment that is in the interests of the patient.[106]

This application of the doctrine of necessity, and the increased importance of best interests, to long-term incompetents was reinforced in *Tameside and Glossop Acute Services Trust v. CH.*[107] In that case Wall J stated that where a patient is incapable of making a rational decision about the suggested treatment the law must ensure that the patient's interests are protected.[108] It is important to note the shift away from referring to the patient's rights. Here we are not concerned with the right of the patient not to be treated without his consent. Rather we are looking at what will provide the most benefit to the patient. Whilst this may take into account what the patient desires it has already been shown, in relation to children,

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[104] ibid, at 566

[105] ibid, at 567

[106] Under the Mental Capacity Bill 2004, s.1(5), all patients who lack capacity will be treated according to their best interests. Whilst this may appear to undermine the argument presented in this thesis it is submitted that this is not the case. According to s.4, the possibility of regaining capacity remains important, as do the ascertainable wishes of the patient. The result of this is that there is no reason to believe that the approach taken by the courts will be different, to any real extent, to that currently adopted. Whilst the terminology used by the courts may differ, with necessity being used less frequently, the outcomes will probably be the same.

[107] [1996] 1 FLR 762

[108] ibid, at 768

that this will not be determinative. Wall J then stated that where the patient could not communicate a decision then treatment would be lawful so long as it was:

> “(a) Necessary to save the life or preserve or prevent a deterioration in the physical or mental health of the patient, and
> (b) In the patient’s best interests.”[109]

The increased focus upon best interests in relation to long-term incompetent patients appears to reflect the approach taken by the courts in relation to the treatment of minors. In support of this Butler-Sloss has stated that:

> “In considering the scope of best interests it seems to us that they have to be treated on similar principles to the welfare of the child since the court and the doctor are concerned with a person unable to make the necessary decision for himself.”[110]

In the previous chapter, however, it was argued that whilst the courts talk about best interests in relation to children they are actually applying the principle of allowing treatment. A similar approach for adults can be seen in *Airedale NHS Trust v. Bland*[111] when Lord Goff stated that in relation to treatments which will prolong the life of the patient the best interests will usually require that treatment be given.[112] It is possible therefore to argue that the approach of the courts in relation to adult incompetents begins by focusing upon the principle of self-determination but moves through best interests and towards allowing treatment as the length of incompetency increases. This could be justified on the basis that the longer the patient is incompetent the less important it is to respect his right to autonomy and freedom of choice. For a patient who has no mental ability to make decisions there can be no real need to respect his right to make those decisions. An alternative justification would be that as the

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[109] ibid, at 679
[110] *Re MB (Medical Treatment)* [1997] 2 FLR 426
[111] [1993] 1 All ER 821
[112] ibid, at 868

patient approaches a permanent state of incapacity he becomes, in terms of mental ability, more like a child and, therefore, the law treats him in a similar manner.

One important issue that remains to be discussed is the ability to provide non-therapeutic treatments. The majority of cases dealing with incompetent adults involve the use of sterilisation for non-therapeutic purposes. The Canadian court, in *Re Eve*,[113] indicated that such procedures could never be lawful without the consent of the patient. La Forest J said that:

> "The grave intrusion into a person's rights and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can be gained from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person."[114]

The English courts have rejected this extreme approach though and have accepted that in certain circumstances the procedure can be in the interests of the patient and would therefore be lawful.[115] Heilbron J, however, suggested that sterilisation should be the last option and that other procedures, including abortion, would be preferable.[116] This provides further support for the idea that the principle of allowing treatment does not authorise treatments which can be seen as doing more harm than good. This can be seen in the way that the courts are prepared to leave the decision of whether or not to provide a therapeutic sterilisation in the

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[113] (1986) 31 DLR (4th) 1

[114] ibid, at 32

[115] For examples of cases where treatment was deemed to be lawful see; *Re B (A Minor)(Wardship: Sterilisation)* [1987] 2 All ER 206, *Re D (A Minor)(Wardship: Sterilisation)* [1976] 1 All ER 326, *Re M (A Minor)(Wardship: Sterilisation)* [1989] 1 FLR 182, *Re P (A Minor)(Wardship: Sterilisation)* [1988] 2 FLR 497. Whilst these cases all relate to minors the principles of law are the same for adult patients

[116] *Re D (A Minor)(Wardship: Sterilisation)* [1976] 1 All ER 326, at 334. This need to look at the availability of less restrictive treatment options is maintained under s. 1(6) of the Mental Capacity Bill 2004.

hands of the medical profession.[117] Conversely, they have stated that in relation to non-therapeutic treatments the courts should always be consulted.[118]

The link between the approach taken to the treatment of adults and children has already been identified. In relation to children it was submitted that the application of the principle of allowing treatment gave way to the principle of best interests in extreme circumstances. It is submitted that the same applies to adults and that non-therapeutic treatments constitute one of the extreme scenarios where it is possible for best interests to indicate that treatment should not be carried out. It is possible to see *Re A (Male Sterilisation)*[119] as an example of this. The patient involved was a 28-year-old Down's syndrome sufferer whose mother was worried that he might impregnate somebody. Whilst the court accepted that concern for the welfare of the girls who may become pregnant was admirable[120] they declared that the treatment would be unlawful. The basis for this declaration was that the treatment in question carried no obvious benefit for the patient. The court rightly pointed out that for men there are no direct physical consequences from sexual activity that could be prevented by way of sterilisation.[121]

3.4 - SUMMARY:

It is possible to view the ability to treat adult patients as a scale based upon the capacity of the patient in question.[122] In relation to an adult with full capacity the guiding principle of self-determination applies. This is represented by the need for the consent of the patient in order for treatment to be lawful. The ability of the patient to consent to treatment is limited only by the idea that treatment must provide the patient with some benefit. A refusal of consent will

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[117] *Re GF (Medical Treatment)* [1992] 1 FLR 293, at 295
[118] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551-552
[119] [2000] 1 FLR 549
[120] ibid, at 556
[121] ibid, at 557
[122] Figure 3 in Appendix A provides a representation of this scale.

be determinative unless there is a risk of harm being caused to others in which case the principle of allowing treatment will be applied.

As the capacity of the patient reduces, the law recognises that there must be some ability to make treatment available without consent and the focus of the law moves towards an application of the guiding principle of allowing treatment. For the short-term incompetent there is recognition that the condition is temporary and therefore an emergency is required to override the need for consent. In relation to the permanent incompetent the ability to treat is almost absolute and becomes the same as for children. This results in an application of the principle of allowing treatment with the notion of best interests acting to prevent treatment in extreme cases.

PART III

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SPECIFIC TREATMENT ISSUES

CHAPTER 4:

THE PROCESS OF BIRTH

The availability of treatments relating to birth and reproduction raise a number of major, controversial, issues and can be seen as an exception to the general approach to adult patients. In relation to abortion there are the conflicting concepts of foetus rights, paternal rights, and the right of a woman to control what happens to her own body.[1] Arguments such as gay and lesbian rights, and the state's role in determining what qualities make someone capable of being a parent, are met when looking at assisted reproduction techniques.[2] Religious, moral and social beliefs permeate the multitude of varying opinions that exist in relation to such issues.

Whereas other areas of medical law are rarely affected by statute law, the same is not true of the issues to be discussed here.[3] In contrast to this there is a remarkable lack of case law, which is usually prolific in medical law matters. It could be argued that an increased reliance upon statute would result in greater certainty, yet this is far from the case. The statutory provisions leave a large degree of discretion to decision-making bodies and the medical profession. It is for this reason that the manner in which the courts approach the interpretation of the relevant legislation is of utmost important if an understanding of the law is to be reached.

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[1] Some academics have even gone so far as to describe the foetus as an invasive organism that is attacking the mother, see G Douglas, *Law, Fertility and Reproduction* (London: Sweet & Maxwell, 1991), p.17. This seems to place the foetus in the same category as a parasite or disease, a suggestion that most people will find abhorrent.

[2] This will not include surrogacy as the issues raised by this, whilst important, are not really medical in nature.

[3] It has been argued that the importance of statute law, and therefore the involvement of Parliament, is greater here than in any other area of medical law, see A. Kennedy & I. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.1215

4.1 – ASSISTED REPRODUCTION:

4.1.1 – STATUTORY BACKGROUND:

In relation to assisted reproduction the Human Fertilisation and Embryology Act 1990, the result of recommendations by the Warnock Committee, governs the legality and availability of all medical activity involving human gametes[4] and embryos.[5] Under the Act a statutory authority, the Human Fertilisation and Embryology Authority (HFEA), was created[6] and given the responsibilities of reviewing information and developments, advertising available services and providing appropriate advice.[7] The Authority also has the task of licensing activities involving human gametes and embryos.[8]

Kennedy and Grubb accurately describe the Act as separating such activities into three categories;[9] those which are illegal and cannot be licensed, those which are illegal unless there is a licence, and those which are legal without a licence. Firstly, it will never be legal to place a non-human embryo or gamete into a woman,[10] or place a human embryo into an animal.[11] Further to that no embryo can be used or stored after the appearance of the primitive streak,[12] or in a prohibited manner.[13] The Act permits the HFEA to grant licences

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[4] According to s.1(4) the term gamete refers to live human gametes except an egg undergoing fertilisation.

[5] Under s.1(1) an embryo is defined as a live human embryo where fertilisation is complete, which is the case when a two cell zygote exists, it also includes an embryo undergoing fertilisation.

[6] s.5. The existence of the HFEA is one reason for the reduced amount of cases in this area of the law. Through its role of granting licences for treatment, storage or research the HFEA assumes the duty of having to decide what the law permits and what it excludes. In relation to designer babies, Lord Phillips has stated that Parliament has placed the choice of what selection of characteristics should be allowed in the hands of the HFEA, see *R (Quintavalle) v. Human Fertilisation and Embryology Authority* [2003] 3 All ER 257, at 271. The same is true of other areas of assisted reproduction treatments and research. Wall J has stated that this is an area where the courts have only a very limited role to play, see *Evans v. Amicus Healthcare Ltd; Daley v. Midland Fertility Services Ltd* [2003] 4 All ER 903, at 956. The role of the courts, whilst still important, has effectively been reduced to using judicial review procedures to look at either the existence of consent or the validity of decisions taken by the HFEA.

[7] s.8

[8] s.9

[9] A. Kennedy & I. Grubb, *Medical Law*, p.1222

[10] s.3(2)

[11] s.3(3)

[12] ibid, s.3(4) states that this occurs at 14 days

for treatment, storage and research.[14] Such licences are required for the legal creation, storage and use of gametes or embryos.[15] The need for effective consent is of major importance here and will be discussed in depth shortly. No licence will be required where the woman is being treated using the sperm of a man who is being treated with her.[16] In *U v. W (Attorney General Intervening)*[17] the court attempted to provide some clarity on the matter of what constituted a couple being treated together by stating that "what has to be demonstrated is that…the doctor was responding to a request for that form of treatment made by the woman and the man as a couple".[18] Yet this definition still leaves a lot to be desired. Whilst the position of the married couple is clear, there is no guidance as to non-married couples. Although the Civil Partnerships Bill 2001, s.2(1)(c), suggested a requirement of six months cohabitation that focuses upon the past whereas what is really important here is the future of the relationship.[19]

4.1.2 – CONSENT:

The main requirement for any use or storage of human gametes is the consent of the donors involved. The Act makes it clear that consent may specify how embryos are to be used, how long gametes and embryos are to be stored and what is to happen to them should the donor die.[20] Further to that it is made clear that the gametes of a donor should not be used for any purpose unless expressly consented to.[21] Any consent given can be withdrawn or varied at any point until the gamete or embryo is used.[22] In order for any consent given to be valid

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[13] s.4(2)
[14] s.11(1)
[15] ss.3(1) & 4(1)
[16] s.4(1)b
[17] [1998] Fam 29
[18] ibid, at 40
[19] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), p.71. It should be noted, however, that this requirement is not contained in the Civil Partnerships Bill 2004 which replaces the 2001 Bill.
[20] sched. 3, para. 2
[21] ibid, paras. 5-8
[22] ibid, para. 4

there must have been a suitable opportunity to receive proper counselling and information.[23] The effect of this is to place a high degree of importance upon the consent of the parties involved. As a result of this focus upon consent it would seem that the appropriate guiding principle is that of self-determination.[24] Whether or not that is that case will depend upon how the courts approach the issue of consent.

The importance of consent was reinforced in *Evans v. Amicus Healthcare Ltd*[25] by Justice Wall. In this case two women desired to use the embryos which had been created with the sperm of their ex-partners despite the fact that both partners were opposed to the continued use or storage of those embryos. Wall J stated that:

> "A reading of the Act and the Code of Practice seems to me amply to justify the submission… that the two most important principles to be found in the act are (1) the welfare of any children born by treatment under its provisions and (2) the requirements of consent from those participating in the treatment."[26]

It was also made clear, that without the consent of all gamete providers involved, a clinic could not lawfully use the embryos created.[27] The suggestion that the consent requirements could be an unjustified infringement of the women's right to a private life was rejected as being necessary for the protection of all the gamete providers involved.[28] The judgment implies that, unlike for general treatments, the law looks at more than just the immediate patient.[29] Assisted reproduction necessarily involves more than one party, all of whose interests must be looked at. In order to ensure that all of the donors are considered, both

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[23] idid, para. 3

[24] This can only be the case if the patient is competent to provide consent. For the purposes of this chapter it is generally assumed that the patient is competent.

[25] [2003] 4 All ER 903

[26] ibid, at 916

[27] ibid, at 934

[28] ibid, at 955

[29] This case has undergone an appeal which has been rejected by the Court of Appeal, see *Evans v. Amicus Healthcare Ltd* [2004] 3 All ER 1025.

Parliament and the courts have rigorously enforced the need for consent. Whilst we usually refer to the rights of the woman[30] the law also considers the donors' interest in having some control over the use of their genetic material.

The issue of consent is also important in relation to the availability of the posthumous use of donated gametes. In *R v. Human Fertilisation and embryology Authority, ex p. Blood* [31] the court refused to accept that the need for consent could be bypassed by viewing the treatment as a situation where the man and woman were being treated together. In the Court of Appeal, Lord Woolf stated that it was not possible to see a person who is dead as being treated with someone else.[32] It certainly seems strange to say that a dead person could be receiving treatment. Whilst it was true that, prior to the death, the couple were being treated together the court was correct in saying that this was no longer the case. Lord Woolf was of the opinion that the Act indicated that posthumous use of sperm required the special safeguards represented by the need for consent.[33]

In *Centre for Reproductive Medicine v. U* [34] the husband had initially consented to the posthumous use of his sperm but then, after encouragement by the clinic, varied the consent so as to prohibit such use. The court rejected a claim based upon undue influence, stating that it did not matter how strong the pressure was so long as it did not overbear the patient's independence, which had not happened in this case.[35] This was approved upon appeal where

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[30] It is all too easy to focus purely upon the desires and feelings of the woman or couple desiring treatment. Frequently this will result in the interests of all other participants being overlooked. The focus upon consent helps to overcome this problem.

[31] [1997] 2 WLR 807

[32] ibid, at 816

[33] ibid, at 816

[34] [2002] 1 FLR 927

[35] ibid, at 936-937

Hale J stated that the courts should be slow to apply the concepts of misrepresentation and undue influence so as to supply consent which would not otherwise be had.[36]

It is possible to see this as an application of the guiding principle of doctor protection due to the way in which it removed any threat of litigation and implicitly sanctioned the clinic's attempts to discourage posthumous use. An alternative, and more accurate, approach is to see it as a reinforcement of the idea that it is the guiding principle of self-determination which applies in relation to treatments involving adults. This is evidenced by the fact that the importance that is placed upon consent, by both the statute and the courts, is immense. Hale J was respecting the importance of consent and individual autonomy rather than attempting to sanction the actions of the clinic. Wall J also stated that the welfare of the child was important to assisted reproduction issues, it is in the next section where this can be seen as being of most influence.

4.1.3 – ACCESS ISSUES:

In relation to assisted reproduction treatments one of the major issues which has to be dealt with is the decision of who should have access to treatment. There is the question as to whether or not there is a right to have children[37] and if so then who possesses it and how far does it extend? At the same time it must be noted that these forms of treatment involve high costs and the NHS cannot afford to provide treatment for everybody who would like to receive it.[38] This creates the need for doctors to decide who should be treated and who should not. Whilst access issues are always controversial they raise additional concerns in relation to assisted reproduction. We are not simply looking at who will benefit from the treatment the

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[36] *U v. Centre for Reproductive Medicine* [2002] EWCA Civ 565

[37] McLean supports the existence of such a right, see S.A.M. McLean, 'Women, Rights and Reproduction' in S.A.M. McLean (ed), *Legal Issues in Human Reproduction* Aldershot: Gower, 1989), p.255

[38] It could also be argued that not everyone deserves access to assisted reproductive techniques and that considerations as to parenting ability are valid even without the justification of limited resources.

most or the duration for which those benefits will be enjoyed. Rather we are faced with questions relating to who should be allowed to become a parent through IVF treatment.[39] Cusine points out that we are not simply looking at legal issues but social and ethical matters.[40] Harris points out that Fertility treatment is the only area of law where the doctor is required, by law, to make such decisions.[41] This obligation is contained in s.13(5) of the Human Fertilisation and Embryology Act 1990, which states:

> "A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth."[42]

When it comes to fertility treatment the law has made it clear that the courts are not simply looking at the desires of the parent but also at the interests of the resultant child.

It cannot be said that the need for doctors to make such decisions is free of controversy. McLean argues that the interests of the future child should be disregarded in comparison to those of the woman wishing to receive treatment:

> "Whilst not denying that reproductive freedom has significance for both sexes, for the married and the unmarried, for the lesbian and the homosexual and for any resulting children, it remains crucial that any policy designed to expand or contract reproductive choice honestly confronts the fundamental point that the primary bearers of interests in human reproduction remain women."[43]

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[39] It must also be remembered that as a consequence of deciding who can be parents doctors are deciding what children will exist. This raises concern as to eugenics and is another reason why access issues are so controversial. Perhaps the best way of approaching this issue would be to adopt the approach the courts use when deciding whether or not they should let a newly born child die due to its disabilities. This issue will be discussed fully in chapter 5. For now it is sufficient to say that in such circumstances the courts ask whether or not the child's life would be so awful that the child should be allowed to die, see *Re B (A Minor)(Wardship: Medical Treatment)* [1990] 1 All ER 927, at 929.

[40] D. Cusine, *New Reproductive Techniques: A Legal Perspective* (Aldershot: Gower, 1988), p.118

[41] J. Harris, 'Rights and Reproductive Choice' in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000), p.6. It could be argued that the same questions are asked in relation to abortion. It is submitted, however, that those decisions are medical in nature as it is the health of the mother of the child to be looked at. In relation to assisted reproduction this is not always the case.

[42] Note however that the HFEA has recently announced that it will no longer require the doctor to look at the need for a father, see footnote 56.

[43] S.A.M. McLean, 'Women, Rights and Reproduction', p.215

This ignores the fact that the child must also be seen as a primary bearer of interest, after all it is the child's life which will be affected the most as its very existence hinges upon whether or not treatment is available. It has already been suggested that the only way to view this area of law is to look at all involved rather than just at the immediate patient, the importance of the interests of the future child reinforce this submission.

Another argument that is usually promoted is that there is no justification for restricting access to fertility treatments to those who doctors decide will be good parents due to the fact that no such monitoring is carried out in relation to those who become parents naturally. The response to this is that the increased role of the authorities in the child's creation requires an acceptance of responsibility towards that child.[44] Further to that, any restrictions placed upon natural reproduction would constitute an unjustifiable intrusion into peoples' private lives. Harris rejects this on the basis that the authorities become involved in natural birth without any such considerations being looked at.[45] The flaw of this argument is that once the child has been conceived through natural means it can never be in the interests of that child for the doctors to refuse to assist in its delivery. However, it might be thought that there are valid situations where the potential life of the child would be so awful that the child should not be deliberately created so as to enter that situation.[46]

Despite the academic arguments as to the acceptability of looking at the potential welfare of the resultant child the courts have made it clear that such considerations are valid. In *R v.*

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[44] M Warnock, *A Question of Life: The Warnock Report on Human Fertilisation and Embryology* (Oxford: Basil Blackwell, 1985), p.10

[45] J. Harris, 'Rights and Reproductive Choice', p.6

[46] In reality these considerations are carried out in relation to normally conceived children. For many parents the decision to procreate is a deliberate one and they will have considered whether or not they can afford to have a child and whether they are ready to be parents. The only real difference is in who looks at such considerations, whilst it is the parents in relation to non-assisted reproduction it is the doctor once assistance is required.

Ethical Committee of St Mary's Hospital, ex p. H[47] the patient had already made numerous adoption applications, each of which had been refused due to the fact that H had a history of prostitution and brothel running and because she had demonstrated a poor understanding of the role of foster parents. As a result of these refusals the patient decided to seek fertility treatment, but when the reasons for adoption refusal came to the attention of the Hospital they refused to proceed. At trial it was argued that this had been an unfair decision which no reasonable doctor could have reached. Schiemann J rejected this argument, although there were some concerns over the manner in which the hospital had tried to hide the real reasons for refusal from the patient.[48] This seems to firmly accept that the interests of the child must be considered; we are not simply looking at what the potential mother wants but at what the needs of the future child demand.

Another case of some importance here, *R (On the Application of Mellor) v. Secretary of State for the Home Department*,[49] involved a life prisoner who had married somebody he met whilst in prison and was applying for access to fertility treatment. Whilst the case was actually decided on the basis of whether or not prisoners had a right to found a family whilst in prison there also appears to be some ulterior motivation. Lord Phillips referred to the case of *X v. UK*[50] to show that the European Court of Human Rights has accepted that the right could be limited by the needs of prison security so as to refuse conjugal rights. Lord Phillips also referred to *Hamer v. UK*[51] and *Draper v. UK.*[52] These cases held that a refusal to allow marriage could amount to an infringement of the prisoners rights as marriage could be carried out in such a way as to pose no threat to prison security. Surely fertility treatment, just like

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[47] [1988] 1 FLR 512
[48] ibid, at 519
[49] [2001] 3 WLR 533
[50] (1975) 2 DR 105
[51] (1979) 4 EHRR 139
[52] (1980) 24 DR 72

marriage, can be carried out in such a manner as to pose no threat to prison security? Despite this Lord Phillips refused the application on the basis that there was no right of a prisoner to use artificial insemination[53] and due to the punitive aspect of deprivation essential to imprisonment.[54] Bearing in mind the marriage cases, this decision appears questionable and it is highly possible that Lord Phillips was also considering the interests of the child which would result from the treatment.

The importance that is placed upon the welfare of the child makes it clear that the guiding principle of best interests operates here alongside that of self-determination. As Butler-Sloss stated:

> "The Act laid a heavy emphasis upon the welfare of the children resulting from treatment, even if the adults consented, the treatment could not be embarked upon unless account has been taken of the welfare of any resultant child"[55]

Whilst the principle of self-determination protects the donors it cannot protect a foetus that has no ability to exercise autonomy and has no legally enforceable rights. The best interests principle protects the child by looking at whether, once consent has been obtained, treatment should be allowed at all.[56] Even though the child does not currently exist it is possible for the principle to take account of its interests despite the fact that they have to be predicted.

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[53] [2001] 3 WLR 533. at 547

[54] ibid, at 549

[55] *Leeds Teaching Hospital NHS Trust v A & B* [2003] 1 FLR 1091

[56] It must be noted though that what the welfare of the child requires may change as public opinion changes about the suitability of different members of society to be parents. This is evidenced by recent developments whereby treatment will now be offered to single women on the same basis as couples. Whilst the HFEA chairman specifically stated that the different treatment of single women was outdated, see C. Hall, 'IVF Rights Extended to Single Women', *The Telegraph*, 22nd January 2003, it has been argued that this is just another step on the 'primrose path to perdition' and that the fact that single parents exist does not mean that society should actively try to create them, see T. Dalrymple, 'The Fact That There are Single Mothers Doesn't Make it Right', *The Telegraph*, 21st January 2004.

4.1.4 – DESIGNER BABIES:

Another major issue in relation to assisted conception is the possibility of selecting the characteristics of the child that will result from treatment. There are a number of reasons why a parent might want to have access to such opportunities. Holm identifies three categories of potential patients as: infertile couples wanting to screen for chromosomal abnormalities, couples with a known risk of genetic disease wanting to avoid abortion, couples wanting to choose a child with specific characteristics.[57] It is usually the last category that attracts the greatest social criticism.

In June 2003 the first designer baby, Jamie Whittaker, was born in the United Kingdom yet this was not the result of treatment within England, as in order to obtain treatment the couple had to go to America.[58] The baby was designed so as to provide a compatible tissue donor for his brother. Some have argued that this should be acceptable but that it would be wrong to permit parents to choose the child's characteristics for more aesthetic reasons.[59] McCarthy however argues that sex selection for social reasons should be an accepted part of reproductive freedoms[60] and that it is uncertain that it will lead to genetic enhancement.[61] The HFEA, however, has recently confirmed that sex selection for social reasons will not be available in this country following an investigation which found that the majority of the public did not support the idea.[62]

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[57] S. Holm, 'Ethical Issues in Pre-implantation Diagnosis' in J. Harris & S. Holm (eds), *The Future of Human Reproduction*, p178

[58] C. Blackstock, 'Matched And Hatched, Britain's First 'Designer Baby' Born To Save Brother', *The Guardian*, 19th June 2003

[59] 'Jamie's Legacy', *The Observer*, 22nd June 2003

[60] D. McCarthy, 'Why Sex Selection Should be Legal' (2001) 27 J Med Ethics 302, at p.303

[61] ibid, at p.306

[62] C. Boseley, 'Public Outrage Prompts Ban on Baby Sex Selection', *The Guardian*, 12th November 2003

Whilst the Whittaker family were refused permission to have the required treatment in the United Kingdom the HFEA granted permission to the Hashmi family. This decision to grant a licence permitting tissue typing was challenged in the courts. At first instance it was held that the treatment could not be available as only treatment aimed at assisting women to have children could be permitted under the Act and this did not cover tissue typing.[63] On appeal Lord Phillips, Lord Justice Schiemann and Lord Justice Mance unanimously overturned this decision. The argument that tissue typing could not help a women carry a child to term was rejected, as concern that the foetus may not be a tissue match could constitute an impediment.[64] It was stated that such impediments were not limited to physical factors but could also include psychological concerns that could reduce the mother's capacity, or willingness, to carry the child to term.[65] In authorising the procedure importance was placed upon the fact that the embryo was already undergoing pre-implantation genetic diagnosis to ensure it was healthy. Mance LJ stated that the legality of tissue typing could not depend upon whether it was carried out in conjunction with PGD.[66] This appears perfectly correct; if a procedure is unlawful then it should always be so and mere opportunism should not make an otherwise unlawful activity acceptable?

The Court of Appeal, having held that tissue typing could help the woman carry the child to term, provided two reasons for allowing the use of such procedures. Firstly it was pointed out that the Act expressly permits research into methods of detecting genetic diseases and that it was improbable that Parliament had intended for the use of the results of such research to be

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[63] *R(Quintavalle) v. HFEA* [2003] 2 All ER 105, at 111

[64] *R(Quintavalle) v. HFEA* [2003] 3 All ER 257, at 270 & 284. The case is now being appealed in the House of Lords and the decision of that court will have an important impact upon this area of the law.

[65] If this is the case then what is the difference between a woman who will abort a foetus if it is not a tissue match and a woman who will seek an abortion because of the child's sex or hair colour.

[66] [2003] 3 All ER 257, at 286

unlawful.[67] This would seem to indicate the application of the guiding principle of permitting treatment whenever possible. The second reason relied upon s.13(5) though and places the focus back on the welfare of the child. Mance LJ pointed out that s.13(5) involved a wider concern for future children and siblings and that it could include positive effects as well as negative.[68] Applying that to the case it was possible to hold that tissue typing was, in fact, in the interests of both the future child and the siblings. Having already accepted that it is necessary to consider all of the parties involved, this case seems to support the argument that this area of law is governed by a combination of the principles of self-determination and best interests. Once the consent of the donors has been obtained the interests of all concerned, and especially the future child, must be considered.

4.1.5 – SUMMARY:

Due to the wide range of issues looked at in relation to assisted reproduction it is useful to provide a summary at this point. When the guiding principles identified in chapter one are applied to the issues raised in assisted reproduction we find that the law uses the same approach adopted for the general treatment of adults coupled with best interests. Whilst self-determination protects the adult's autonomy and focuses upon the need for consent, the best interests principle looks at what is required for the child's welfare. The approach taken by the courts can only be understood, however, once it is accepted that they look beyond the immediate patient and consider all parties involved. Hence the consent of all gamete providers is the first requirement for lawful treatment. Once that is obtained the welfare of the whole family unit, which would result from such treatment, must be considered.

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[67] ibid, at 269 & 283

[68] ibid, at 283 & 286-287

4.2 – ABORTION:

4.2.1 – STATUTORY BACKGROUND:

The starting point when looking at abortion legislation is the Offences Against the Person Act 1861, which made it an offence to deliberately bring about a miscarriage.[69] The law left a loophole, however, whereby a child could be killed during the delivery process. In an attempt to cover this scenario the Infant Life (Preservation) Act 1929 was enacted. Section 1(1) made it an offence to intentionally destroy the life of a child that was capable of being born alive. The only defence available was that it was carried out in good faith for the purpose of saving the mothers life. Whilst the term 'capable of being born alive' is not defined in the Act the courts have held that it relates to the ability to survive independent of the mother and is reached once the foetus develops the ability to breathe.[70]

The effect of the Abortion Act 1967, as amended by section 37 of the Human Fertilisation and Embryology Act 1990, is to make the procuring of a miscarriage legal[71] so long as a number of preconditions are satisfied. In doing this the Act provides defences to both the Offences Against the Persons Act 1861[72] and the Infant Life (Preservation) Act 1929.[73] In order for an abortion to be legal it must be carried out by a registered practitioner with the support of opinions formed in good faith by two such practitioners.[74] These opinions must hold that one of the four grounds proscribed by s.1(1) is satisfied.[75] The grounds are that termination is

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[69] ss.58-59

[70] *C v. S* [1998] QB 135. Under s.1(2) a child is presumed to be capable of being born alive once it reaches 28 weeks.

[71] Under the s.4(1) a doctor is under no obligation to participate in the performance of an abortion if he can show that he has a conscientious objection to it. This provision protects the religious, ethical or moral beliefs of doctors who may not be in favour of abortions in certain scenarios or on a more general level.

[72] s.1(1)

[73] s.5(1)

[74] s.1(1)

[75] The law operates differently in relation to an emergency scenario. So long as there is one opinion, formed in good faith, that the abortion is urgently required to either save the woman's life or prevent grave permanent injury then no second opinion is needed, s.1(4), and conscientious objection is not available, s.4(2).

needed to prevent grave permanent physical injury, that the risk to life would be greater should pregnancy continue, that there is a substantial risk that the child will have a serious handicap and, so long as the foetus is under 24 weeks old, that there is a risk of greater injury to the physical or mental health of the mother, or any existing child, should the pregnancy continue. Under s.1(2) the actual or reasonably foreseeable environment of the woman must be considered when looking at the risks to her physical or mental health.

4.2.2 – ABORTION ON DEMAND:

Douglas argues that no woman should be forced to take on the responsibility and risk of pregnancy, for the benefit of a foetus, unless she is willing to do so.[76] Further to that, it has been argued that access to safe, legal abortions on demand is a prerequisite for the full and equal participation of women in society.[77] The important question is whether or not the law actually allows abortion on demand. Under the Abortion Act 1967 an abortion is available so long as the continuation of pregnancy would involve greater risk to the life of the mother[78], create a risk of grave permanent injury[79] or involves a foetus which would be severely handicapped.[80] If the foetus is less than 24 weeks old then a risk of injury to mental or physical health will also suffice.[81] It is generally accepted that pregnancy will always carry greater risks than non-pregnancy and it could therefore be argued that abortion on demand is available.

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[76] G Douglas, *Law, Fertility and Reproduction*, pp.17-18

[77] S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto Press, 1997), p.1

[78] s.1(1)(c)

[79] s.1(1)(b)

[80] s.1(1)(d)

[81] s.1(1)(a)

There is, however, a recent case which indicated that an abortion will not always be the best course of action. In *Re SS (Medical Treatment: Late Termination)*[82] a schizophrenic woman wanted a termination but frequently changed her mind due to her mental condition. The court held that due to the fact that the foetus was now 23 weeks old it was not in the best interests of the patient to allow the abortion to proceed. This decision was based on the fact that none of the expert witnesses could say that a termination would be less damaging and traumatic that a normal delivery.[83] This was despite the fact that the child would have to be taken into care immediately, partially due to the risk that the mother would kill it, and that this would be extremely distressing for the mother.

Whilst this case was based around the premise of only treating mentally incompetents in a way which is in their best interests it also serves to show that it will not always be the case that an abortion will be less risky than the continuation of the pregnancy. It is somewhat doubtful what application this will have in relation to the competent patient who can be treated without the involvement of the courts. In *Re SS* it was not really possible to say that she consented to the termination, hence the courts fell back upon best interests. For the competent patient the issue of consent, both consent to termination and refusal of consent to continued pregnancy, is likely to be decisive. Whilst the abortion will only be available if the requirements for good faith opinions held by the doctors are satisfied, it is consent which will be the ultimate factor. If the patient desires to have an abortion then, bearing in mind the undeniable risks that are inherent in pregnancy, it is unlikely that at least one of the grounds for abortion will not be satisfied, especially if it is within the first 24 weeks. Hence, so long as the patient is competent, the starting point is the same as for general treatments, namely

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[82] [2002] 1 FLR 445
[83] ibid, at 452

self-determination. If the patient is not competent then whilst allowing treatment and best interests will both apply it is the latter which will be decisive. The restrictions placed upon when an abortion will be lawful indicate that there is also a tertiary application of the principle of best interests so as to prevent treatments which would harm the foetus. The same has already been seen in relation to assisted reproduction and the competency of pregnant women.

So long as two doctors have a good faith opinion that one of the grounds is satisfied it is highly probable that an abortion will be available. Whilst the courts are willing to look at whether or not the opinion was formed in good faith it is highly unlikely that they will be asked to do so, only one case to date has done so.[84] In that case it was held that it was not necessary to show that the opinion was one which could not have been reached by other doctors, as an illogical opinion could still be held in good faith.[85] It was important however that the medical evidence indicated that the decision was not reached in good faith.[86] This would appear to be an application on the guiding principle of protecting the judgment of doctors. It is, at current, a one-off case however which appears to fall outside of the general pattern identified. It should also be looked at in context; the validity of the doctor's opinion is only an issue if the patient desires an abortion.

Sheldon argues that the way in which the Abortion Act 1967 is interpreted by doctors is being constantly liberalised.[87] Abortions which would have originally been refused are now being routinely performed. According to Tooley the most important question which must be asked

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[84] *R v. Smith* [1974] 1 All ER 376 although the forthcoming Cleft Palate case will also have an impact here.
[85] ibid, at 381
[86] ibid
[87] S. Sheldon, *Beyond Control: Medical Power and Abortion Law, p.2*

is 'which patients should we select for termination?'[88] A case which will be of great importance, once it has been decided, involves a claim against the police for failing to bring charges against a doctor for carrying out what is alleged to have been an illegal abortion.[89] The abortion in question was carried out under s.1(1)(d) which relates to children who will be seriously handicapped. The child in question would have had a cleft palate if the pregnancy had come to full term. The case argues, and understandably so, that this does not qualify as a serious handicap. It could be argued that, in some instances, doctors may demonstrate a tendency to accept, or even promote, an exaggeration of the seriousness of the child's condition. This would be supported by the way Harvard referred to a child with Down's Syndrome as being 'seriously deformed'.[90] This tendency could reinforce the importance of the patient's refusal to continue with the pregnancy. The decision of the court in this case will be of great importance as it will establish whether or not the courts are willing to analyse the validity of the opinions formed by doctors and go beyond simply asking whether that opinion was formed in good faith. If the case succeeds then the interests of the foetus may be of increased importance in the future.

4.3 – FOETUS RIGHTS:

4.3.1 – WHAT IS THE FOETUS:

A great deal of debate focuses upon the question of what the foetus is and when it attains interests worthy of legal protection. Whilst Catholics argue that this is the case from the moment of conception, others argue that this only happens upon birth. The more moderate

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[88] The Medical Protection Society, *The Abortion Act 1967* (London: Pitman Medical, 1969), p.9

[89] S. Womack, 'Curate's Victory on Cleft Palate Abortion' *The Telegraph*, 2nd December 2003. This case has been delayed so as to await the outcome of a police investigation, see E. Day, 'Curate Postpones Cleft Palate Late Abortion Action' *The Telegraph*, 9th May 2004.

[90] J.D.J. Harvard, 'Legal Regulation of Medical Practice – Decisions of Life and Death: A Discussion Paper' (1982) J Roy Soc Med 351, p.354

argument, one that is both more acceptable and supportable, is that the foetus is under constant development from the moment of conception until the moment of birth and that at some point during this development it becomes worthy of protection. The problem is that nobody seems to be able to agree when this should happen. One suggestion is that the ability to breathe is what matters,[91] yet Fortin discards this as just one development amongst many and argues in favour of the development of brain activity.[92] The problem with Fortin's argument is that the suggested alternative to the ability to breathe is just another single development amongst many. It seems reasonable to say that the protection offered to the unborn child should increase as the pregnancy approaches completion. Mason supports this when he states that the "rights of the potential 'creature in being' vis-à-vis the actual human being must increase as its potential approaches fruition".[93] This also recognises the undeniable fact that the interests of the foetus must be weighed against the rights of the mother. Thus, the further the foetus is from being a fully-fledged human, the fewer legally protected interests it should have. The ability to breathe becomes an important stage in this development because it is at this point that, according to the law, the child is capable of being born alive. Douglas submits that the law reflects a compromise which recognises the gradually increasing significance of the foetus as it develops but also gives weight to the fact that such development occurs in the womb of a living woman rather than an 'electrically-powered incubator'.[94]

When considering what status the law attaches to the foetus it is essential to look at *Attorney General's References (No. 3 of 1994).*[95] Whilst this case was not directly concerned with

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[91] *C v. S* [1988] QB 135
[92] J.E.S. Fortin, 'Legal Protection for the Unborn Child' (1988) 51 MLR 54
[93] K. Mason, 'Abortion and the Law' in S.A.M. McLean (ed), *Legal Issues in Human Reproduction,* p.57
[94] G Douglas, *Law, Fertility and Reproduction*, p.28
[95] [1998] Cr App R 91

medical law it addresses the status of the foetus during pregnancy. Lord Mustill rightly discarded the suggestion that the foetus was identical to the mother and defined the relationship between the mother and foetus as follows:

> "There was, of course, an intimate bond between the foetus and the mother, created by the total dependence of the foetus on the protective physical environment furnished by the mother, and on the supply by the mother through the physical linkage between them of the nutriments, oxygen and other substances essential to foetal life and development. The emotional bond between the mother and her unborn child was also of a very special kind. But the relationship was one of bond, not of identity. The mother and the foetus were two distinct organisms living symbiotically, not a single organism with two aspects. The mother's leg was part of the mother; the foetus was not."[96]

Hence the foetus must be seen as distinct from the mother who carries it, yet totally reliant upon her in every way. This seems to accurately represent the status of the foetus, whilst it is not a part of its mother it cannot survive on its own. Having denied that the foetus was a part of the mother Lord Mustill then went on to reject the possibility that the foetus was a person, instead he described it as a unique organism.[97] The way the law deals with the foetus reflects this unique nature of its existence.

4.3.2 – LEGAL PROTECTION OF THE FOETUS:

Mason argues that it is necessary to differentiate between any rights possessed by the foetus *per se* and any rights of the resultant child which take account of its foetal existence.[98] It is also possible to identify a third area, that of quasi-rights of the foetus. This category, as will be explained later, covers the legal provisions which offer protection to the unborn foetus without providing it with accepted human rights. Through a combination of these three categories it can be seen that the interests of the foetus gain more respect as it develops and

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[96] ibid, at 99

[97] ibid

[98] J.K. Mason, *Medico-Legal Aspects of Reproduction and Parenthood* (Aldershot: Dartmouth, 2nd, 1998), p.144

approaches its birth. This explains why, when a foetus is involved, the principle of best interests is applied so as to protect that foetus.

Looking at the existence of legal rights possessed by the foetus *per se* there are a number of cases which serve to illustrate the approach of the courts to this issue. The starting point appears to be the possible qualification created by Lord Donaldson in *Re T*.[99] This indicated that the only possible qualification to the need for consent from a competent adult would be in the case of a pregnant woman who refuses treatment which is necessary to safeguard the health of the foetus. In *Re S (Adult: Refusal of Treatment)*,[100] Stephen Brown LJ agreed to give a declaration dispensing with the need for the consent of a competent woman so that the doctors could carry out a caesarean section to deliver her baby. Whilst there have been a number of other cases authorising non-consensual caesarean sections they have all related to incompetent patients. The main problem with the judgment of Stephen Brown LJ is that it contains no reasoning and is based on no valid authority.

The position has now been made clear by *St George's Healthcare NHS Trust v. S*.[101] Judge LJ accepted the complexity of the situation when he stated that the interests of the foetus could not be disregarded on the basis that in refusing treatment the woman is only refusing treatment for herself.[102] Despite that, it was still held that whilst pregnancy increases the personal responsibility of a woman it does not diminish her entitlement to undergo medical treatment, neither is the right to refuse treatment diminished simply because that refusal may seem repugnant.[103] Whilst the result of this decision is to prohibit non-consensual treatment

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[99] [1992] 4 All ER 649
[100] [1992] 4 All ER 671
[101] [1998] 3 WLR 936, the same result was also reached in *Re MB (Medical Treatment)* [1997] 2 FLR 426
[102] [1998] 3 WLR 936, at 953
[103] ibid, at 957

of pregnant women, it should be noted that Judge LJ seemed to express some disgust at the mother's refusal of consent. The court was keen to emphasis that the viable foetus was not lifeless and was certainly human.[104] Essentially the court accepted that there was a hierarchy of rights and interests that had to be respected. Whilst the foetus has the need of medical assistance that need cannot prevail over the rights of the parent.[105]

The fact that this appeal took place after the baby had been delivered by a caesarean section permitted by the original court could indicate that the best interests of the child were protected in practice whilst the mother's autonomy was theoretically reinforced.[106] Alternatively it could be argued that judgments sought to protect the doctor's clinical judgment as to what was required. At first instance the doctors were permitted to carry out the treatment they deemed necessary. Once that procedure had taken place the appeal held that the rights of the mother should have been respected. At that point though it was too late to make any practical difference, the procedure had been carried out and the child was born. It is submitted that it is the first argument that is correct and that whilst those interests no longer override adult autonomy they are still important. This has been seen in relation to the competency of pregnant women.

Another case of importance here is *Re F (In Utero),*[107] which involved an attempt by a local council to make a foetus a ward of court so that they could ensure its safe delivery and upbringing. May LJ held that the court had no jurisdiction to grant the order yet expressed that if the jurisdiction had existed it would have been used in this case.[108] The main reason

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[104] ibid, at 952
[105] ibid, at 957
[106] After the appeal decision though this option would no longer be available to first instance courts hearing future cases as the court would be bound, by this decision, to respect the mother's refusal of consent.
[107] [1988] Fam 123
[108] ibid, at 138

for the refusal of the request to make the foetus a ward of court was the fact that it would, of necessity, have required the liberties of the mother to be restricted.[109] The general position, therefore, appears to be that the foetus has no legal rights until it is born. This has been confirmed by the cases of *Paton v. British Pregnancy Advisory Service Trustees*[110] and *C v. S*.[111] The former of these cases provides the most definitive explanation when it states that in English law it is not possible for the foetus to have rights of its own until it is born and has a separate existence from the mother.[112] This reinforces the suggestion that it is the autonomy of the pregnant woman that is the main focus of the law. This is protected through an application of the guiding principle of self-determination and the need for the woman's consent prior to any treatment.

Despite the fact that the courts have refused to accept that the foetus is capable of possessing rights which can be relied upon during the pregnancy, there are a number of statutory provisions which do offer some degree of protection. These are what were referred to earlier as quasi-rights of the foetus which, whilst they are not rights as such, do offer some protection. Under the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929 the foetus received absolute protection subject only to the right to life of the mother.[113] Whilst the law on abortion now provides a defence against these provisions they still serve to indicate the value the law places upon the foetus. In addition there are two other legislative provisions worth noting. Firstly, no research can be carried out on an embryo, or foetus, older than 14 days.[114] Further to that, an abortion based upon the fact that the mother is under risk of injury to physical or mental health, although not grave injury or

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[109] ibid, at 135
[110] [1979] QB 276
[111] [1988] QB 135
[112] [1979] QB 276, at 279
[113] Infant Life (Preservation) Act 1929, s.1(1)
[114] Human Fertilisation and Embryology Act 1990, ss.3(3)(a), 3(4)

death, can only be carried out if the foetus is under 24 weeks old.[115] Whilst the level of protection offered by these provisions is limited they indicate that the foetus does have some interests which the law is concerned in protecting.

Whilst the courts have refused to accept that there are any rights which can be exercised by the foetus there is the possibility that some events that occur during the pregnancy can give rise to an action by the child after birth. As Lord Hope stated:

> "For the foetus, life lies in the future, not the past. It is not sensible to say that it cannot ever be harmed, or that nothing can be done to it which can ever be dangerous. Once it is born it is exposed, like all other living persons, to the risk of injury. It may also carry with it the effects of things done to it before birth which, after birth, may prove to be harmful."[116]

This gives rise to the idea that the rights of the newborn child can take into account events occurring during the foetal existence. One example of rights operating in this manner is found in *Re D (A Minor)*[117] where the courts accepted that the activities of the mother during the pregnancy could result in the child being made a ward of court as soon as it is born.[118] The House of Lords made it clear that it was permitted to look at events taking place prior to the child's birth in deciding what was now in its best interests. Hence it can be seen that whilst the interests of the foetus cannot override the autonomy of the mother during pregnancy, as that would effectively give the foetus rights stronger than those which would be possessed by the child after birth, they are still of importance to the law. It is for this reason

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[115] Abortion Act 1967, s.1(1)(a)

[116] *Attorney General's Reference (No.3 of 1994)* [1998] Cr App R 91, at 116

[117] [1987] AC 317

[118] Another example of this, whilst not relevant to the availability of treatment, is statutory and is found in the Congenital Disabilities (Civil Liability) Act 1976. Section 1 provides that if a child is injured in the womb then that child will be capable of claiming damages once it has been born. Heilbron J stated that such claims crystallise upon the birth of the child, it is only at this date that the child acquires the status of legal persona and can exercise a legal right, see *C v. S* [1988] QB 135, at 140.

that, when treatment will affect a foetus, the principle of best interests will be applied to help determine the availability of that treatment.

4.4 – PATERNAL RIGHTS:

Having already detailed the way the courts have officially rejected any attempts to restrict the activities of the mother on behalf of the foetus it may be obvious that any attempt to do so on behalf of the father will automatically fail. To say that the foetus can have no rights capable of overriding the mother's would be nonsensical if the courts were then to permit the rights of the father to do exactly that. It must be remembered that whilst the foetus' life is endangered by the actions of the mother the most that can be claimed by the father is that he will not have a child. Mason has argued that genetics alone cannot give the father rights equal to those of the mother due to the drastically disproportionate nature of the effort, both physical and mental, involved in the production of offspring.[119] Fortin states that many people would accept that the law should not enable a father to force his estranged wife or girlfriend to bear an unwanted child.[120] That being said though, there are frequent arguments in favour of paternal rights relating to the protection of the foetus. Such arguments usually attempt to establish that the father should have some right to prevent any abortion of the foetus.

Three cases are of importance in relation to the concept of paternal rights. The first of these is *Paton v. British Pregnancy Advisor Service Trustees*.[121] In this case a father attempted to obtain an injunction designed to prevent the mother from having an abortion. The court rejected the claim and explained, without any qualifications that it was neither possible nor desirable for the court to use injunctions such as this to control behaviour within the

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[119] K. Mason, 'Abortion and the Law', p.59
[120] J.E.S. Fortin, 'Legal Protection for the Unborn Child', p.71
[121] [1979] QB 276

matrimonial relationship.[122] The judge pointed out that the Abortion Act 1967 gave no right of consultation to the father and that he was possessed of no legal right, enforceable in either law or equity, by which he could prevent his wife's abortion.[123] He also stated that the law of England provides the father with no right to have a say in the destiny of a child he fathers.[124] The judgment focused clearly on the lack of any right supporting the father's claim compared with the mother's right to self-determination.

The second case involves the same parties and facts but was heard by the European Commission of Human Rights.[125] After losing his case in the English courts Paton attempted to claim that his rights under the European Convention of Human Rights were being infringed. The judgment stated that:

> "In the present case the Commission, having regard to the right of the pregnant woman, does not find that the husband's and potential father's right to respect for his private and family life can be interpreted so widely as to embrace such procedural rights as claimed by the applicant, i.e. a right to be consulted, or a right to make applications, about an abortion which his wife intends to have performed on her."[126]

The Commission refused to accept that the father's right to respect for family life, limited as it is by the need to respect the rights of others, could prevent the mother from having an abortion.[127] The father is dealt with in a similar way to the foetus. Whilst the court did not reject that he had a legitimate interest, they refused to acknowledge the existence of any rights capable of overriding those of the mother. Some importance was placed upon the fact that the abortion was carried out to prevent harm to the mother's health, yet it has already been shown that this is quite a low threshold to overcome.

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[122] ibid, at 280
[123] ibid, at 281
[124] ibid, at 282
[125] [1981] 3 EHRR 408
[126] ibid, at 417
[127] ibid, at 416

In *C v. S*[128] the matter of whether or not a father could prevent his wife from having a legal abortion was not actually raised. However Heilbron J did state that the husband or father is not entitled to disclosure of information, consultation or a right of veto.[129] Further to that, Sir Donaldson MR, on appeal, stated if he had been called to decide on this matter then a great deal of weight would have had to be given to the decision of *Paton v. British Pregnancy Advisory Service Trustees*.

The legal position is accurately summarised by Douglas who states that there is no requirement to consult the father prior to an abortion let alone give him a right of veto. Douglas also states that "the mother, and only the mother, of the foetus has the right to decide whether or not to seek an abortion".[130] This appears to be a true description of the current position under the Abortion Act 1969. This would fit in well with the idea that the guiding principle of self-determination operates in a manner which places the autonomy of the mother above the interests of the foetus and denies the father any rights at all. The father in this instance must be distinguished from the assisted reproduction gamete donor who has a direct, physical, involvement in the treatment. Whilst it may be beneficial to the relationship between mother and father if the decision to abort is reached jointly, there is no legal requirement that this should be the case. It could be argued that whilst the child will benefit from being born it will experience what will probably be a permanent rift between the parents and will discover that its mother never wanted it to be born in the first place. It is hard to see how this could ever be in the best interests of the child.

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[128] [1988] QB 135
[129] ibid, at 139
[130] G Douglas, *Law, Fertility and Reproduction*, p.82

4.5 – SUMMARY:

Just as the law relating to assisted reproduction represents the normal approach to competent adults combined with an application of the principle of best interests, the same is true of the approach to abortion, although best interests may not be as strong. The reduced importance of the best interests principle, when compared to assisted reproduction, can be explained due to the fact that the result would be to force the mother to endure a pregnancy she does not desire. In contrast, the application of the principle in relation to assisted reproduction only prevents the woman from becoming pregnant, which is an end that she desires but is not naturally capable of achieving. The same justification can be used to explain why the father has no rights in relation to abortion whilst a gamete donor retains control. In relation to abortion there must be a consent-refusal combination whereby the woman consents to the abortion whilst at the same time refusing to give consent to the continuation of her pregnancy. Whilst in relation to assisted reproduction incompetent adults are not likely to be encountered, it has been seen that in relation to abortion the essential principle applicable to such patients is that of best interests. By looking at abortion in this way it is possible to explain how the law can accept that foetuses have interests, albeit not rights as such, but still override them. When faced with a conflict of the mother's right to self-determination against the foetus' interests, the mother's autonomy will usually prevail.

CHAPTER 5:

DEATH & THE ENDING OF LIFE

So far the discussion has focused upon when the law permits treatment to be provided so as to prolong the life, or improve the health, of the patient. Yet the question of when treatment can be provided carries with it the counter question of when treatment should be withheld. It has already been submitted that the courts operate a preference in favour of preserving life, yet this presumption is rebuttable. It is the scenarios and conditions which justify this rebuttal that are to be looked at now. It is of no real value to say that the courts prefer treatment unless it is possible to understand when they will accept that treatment ought to be withheld.

In addition to the question of when treatment can be withheld it is also important to look at when active treatment that results in the shortening of life will be permitted. Normally medicine is seen as a tool for lengthening life and improving health, yet it also carries with it the power and potential to drastically shorten life. It must be asked: when, if ever, will it be lawful to use medical knowledge and expertise in a manner which will bring the patient's life to an end or hasten that death? Only when these questions have been answered will it be possible to understand how the guiding principles apply to the provision of treatment when death is approaching.

5.1 – REFUSING LIFE-SAVING TREATMENT:

In chapter 3 it was explained that in relation to competent adult patients the law requires consent prior to medical procedures being carried out. There are only a limited number of scenarios whereby a doctor can enforce treatment without the patient's consent and it is submitted that all of these exceptions are designed to prevent harm to others. This focus upon the need for consent demonstrated the application of the guiding principle of self-determination. The question to be addressed now is whether or not the courts will continue to respect the patient's right to refuse treatment when that refusal carries with it the almost certain consequence of death.

In *Airedale NHS Trust v. Bland*[1] the judges were not confronted with a patient who wished to refuse life-saving treatment but still thought it necessary to comment on the law in relation to such a patient. Lord Goff stated that:

> "The principle of self determination requires that respect must be given to the wishes of the patient so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so."[2]

Lord Keith supported this statement when he said that in relation to a conscious patient of sound mind the law sees such a person as being at liberty to decline treatment even if the result of doing so will be death.[3] Such comments, however, were obiter dicta and could have been disregarded by a court faced with a patient actually wishing to refuse life-saving treatment.

In *Re B (Adult: Refusal of Medical Treatment)*[4] the patient, Ms B, was paralysed from the neck down and suffering from respiratory problems. After she requested that the ventilator be turned off psychiatrists diagnosed her as incompetent and her request was disregarded. At this point she expressed relief that she would not die but at a later point she reasserted her initial request. Butler-Sloss stated that "the right of the competent patient to request cessation

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[1] [1993] 1 All ER 821

[2] ibid, at 866

[3] ibid, at 860

[4] [2002] 2 All ER 449

of treatment must prevail over the natural desire of the medical and nursing professions to keep her alive."[5] It was also stated that where the medical team involved felt that they could not carry out the patient's request it was their duty to find a team which could do so.[6] Whilst the doctors and nurses involved were not criticised for desiring to keep the patient alive it was made clear that this desire had no legal force. This fits well with the idea that, in relation to competent adult patients, it is the principle of self-determination which applies. It rightly ensures that a decision to refuse consent to treatment must be adhered to and, through the duty placed upon doctors to find a team willing to obey the instructions, that it is the patient rather than the medical staff that must make this decision. If there were no protection of the right to refuse treatment in such situations then it would make a mockery of the idea that adults have the right to determine their own treatment. It would be pointless to say that an adult has the right to refuse treatment if, when that refusal has the greatest impact, it has no weight.

The approach taken in *Bland* and *Re B* to the adult patient's right to refuse treatment places importance upon the patient's competency.[7] Butler-Sloss reinforced this by stating that the question of whether a refusal should be respected is one of competency rather than perceived best interests.[8] Having decided that a competent patient could effectively refuse life-saving treatment Butler-Sloss had to decide whether Ms B was competent. It would have been relatively easy for Butler-Sloss to rely upon the patient's relief at not dying, combined with the psychiatric report diagnosing Ms B as incompetent, so as to disregard the refusal of treatment. This possibility was rejected however, and importance was placed upon the fact

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[5] ibid, at 457

[6] ibid, at 475. This does not mean that a patient may demand treatment which the doctors are not willing to provide, rather its application is limited to the refusal of treatment.

[7] One factor which supports this is the fact that the majority of the judgement of *Re B* was concerned with whether or not Ms B was competent rather than whether or not a competent adult should be able to refuse life-saving treatment.

[8] *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449, at 455

that the doctors had been treating Ms B as if she was competent, coupled with the clarity of Ms B's oral evidence. This appears to be perfectly correct as it had been some time since the last psychiatric report and the fact that the medical team had been dealing with Ms B as if she were competent strongly suggests that, in their opinion, she was competent. Further to that, it is one thing to express relief at finding yourself alive when you expected to be dead, it is another to want to continue to live in a condition you find intolerable. One medical expert argued that in order to refuse rehabilitative treatment the patient would need to have some experience of it. This extreme form of informed refusal was rejected and it was stated that to impose such a requirement would be unrealistic.[9] If such a doctrine had been accepted then it would be impossible for most patients to ever refuse treatment. This result would have constituted an unacceptable infringement upon the autonomy of competent adults.

Re B clearly demonstrates that a competent patient can effectively refuse life-saving treatment and that the courts will not regard a patient as incompetent purely so that such treatment can be provided. This once more asserts that the guiding principle when dealing with competent adults is that of self-determination. One question that remains to be asked though is whether an effective refusal can be given in anticipation of some later incompetency. In relation to such advance directives, Montgomery states that:

> "At [their] core lies a statement of the patient's wishes made while they were competent, in contemplation of future circumstances about which they have views which they fear may be ignored"[10]

It has been argued that, in practice, consent to treatment is frequently given in advance.[11] An example of this would be a patient who consents to the surgical removal of a diseased kidney;

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[9] ibid, at 465

[10] J. Montgomery, 'Power Over Death, The Final Sting' in R. Lee & D. Morgan (eds), *Death Rites: Law and Ethics at the End of Life* (London: Routledge, 1994), p.41

[11] R. Francis & C. Johnston, *Medical Treatment; Decisions and the Law* (London: Butterworths, 2001), p.22

the consent in such a case will probably be given some hours before the procedure takes place. It seems illogical, therefore, to reject the validity of advance directives as a means of refusing consent in a similar manner. Lord Keith has stated that:

> "[The liberty to decline treatment] extends to the situation where a person, in anticipation of his… entering into a condition such as PVS, gives clear instructions that in such an event he is not to be given medical care… designed to keep him alive."[12]

It is clear that if advance directives are to be respected then certain conditions must be fulfilled so as to ensure their validity. Francis and Johnston list these requirements as: capacity to refuse, freedom from vitiating influence, intention to cover situation in question and possession of knowledge of nature and effect of decision.[13] Whilst the majority of these requirements reflect those attached to a valid consent, the need for knowledge goes further. Competency can be seen as including the ability to understand, but normally the lack of actual knowledge will not render the consent invalid.[14] It has rightly been suggested that, despite there being no legal requirements to the effect, it would be good practice to record advance directives in writing and review them frequently[15] so as to ensure that they represent the patient's current feelings.[16]

Advance directives can be seen as another application of the guiding principle of self-determination. It has already been seen that in relation to the treatment of adult patients who are temporarily incompetent there will generally need to be an emergency before treatment

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[12] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860

[13] R. Francis & C. Johnston, *Medical Treatment; Decisions and the Law*, p.22

[14] It has, however, been argued that informed refusal is more important than informed consent as the patient who dies due to a misinformed decision to withhold consent to treatment will have no opportunity to bring legal action, see S. Hornett, 'Advance Directives: A Legal and Ethical Analysis' in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998)

[15] ibid, pp.23-24, see also J. Montgomery, 'Power Over Death, The Final Sting', p.43

[16] The validity of advance directives will be secured under the Mental Capacity Bill 2004. Under s.25 an advance directive will be valid so long as the patient is incompetent and has not withdrawn the directive or acted in a manner which is contrary to its content. An advance directive will be capable of covering life-saving treatments so long as this is expressly referred to, see s.26(5).

without consent can be lawful. It was submitted that this demonstrated the courts' desire to respect the patient's right of autonomy despite the current inability to exercise that right. It is argued that the same motivation is in operation here. The courts accept that adult patients have rights and that, where it is possible to do so, the best way to protect these rights is to limit what can be done without the patient's consent. The respect for the validity of advance directives, just like the requirement of emergency, helps to achieve this.

5.2 – WITHHOLDING TREATMENT:

In determining when treatment can be withheld or withdrawn from incompetent patients one of the main concepts is that of medical futility. Jecker and Pearlman identify the following possible definitions for medical futility: that the treatment is useless or ineffective, that it fails to offer a minimum quality of life or medical benefit, that it cannot achieve the patient's aims or that it does not offer a realistic chance of survival.[17] It has been stated that:

> "When the primary aim of the health carer is to preserve life, futility only has a role to play when life can no longer be preserved… However, matters become altogether more complicated when the doctor assumes the role of quality of life provider – futility then assumes a role which is far less clear cut and this is particularly so when decisions are made as to life or death."[18]

It is this more complex scenario with which this section of the thesis is concerned. Here we are not talking about patients who are in the undeniable and irreversible process of dying, rather we are looking at patients who would survive if treatment were provided. If futility is to be the guiding concept in deciding that non-treatment will be lawful then it will be necessary to identify when the law will view a particular treatment as futile.[19]

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[17] N.S. Jecker and R.A. Pearlman, 'Medical Futility: Who Decides?' (1992) 152 Arch Intern Med 1140, p.1140

[18] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.473

[19] For an illustration of the possible approaches see Figure 4 in Appendix A.

5.2.1 – NON-TREATMENT OF HANDICAPPED INFANTS:

Re B (A Minor)(Wardship: Medical Treatment)[20] involved a child that suffered from an intestinal blockage and Down's syndrome. The intestinal blockage could be cured, but without treatment the child would certainly die. The parents were opposed to the treatment and thought that the child should be allowed to die. Contrary to some descriptions of Down's syndrome,[21] Templeman LJ stated that the child would lead the normal, relatively happy, life of any child with Down's Syndrome should treatment be provided.[22] He also stated that it was the duty of the court to decide:

> "Whether the life of the child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die."[23]

This clearly indicates a presumption in favour of treatment as, if there is any uncertainty, preference is to be given to maintaining life. It also seems to set a very high benchmark in relation to what future the child must face before treatment can be lawfully withheld. The test is clearly based upon the quality of the life that the child will lead and this must be assessed from the point of view of the child rather than the healthy parent.

Keown identifies two types of quality of life, the first he refers to as 'quality of life' and the second as 'Quality of Life'.[24] Whilst the former involves looking at the life which the treatment offers in order to assess the value of the treatment, the latter involves assessing the value of the patient's life itself and would be unacceptable.[25] It is submitted that the courts are assessing the value of the patient's life, but from the point of view of the patient and for

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[20] [1990] 3 All ER 927
[21] In *R v. Arthur* (1981) 12 BMLR 1, Farquharson J described it as an appalling handicap.
[22] [1990] 3 All ER 927, at 929
[23] ibid
[24] J. Keown, 'Restoring Moral and Intellectual Shape to the Law After Bland' (1997) 113 LQR 481
[25] ibid, p.503

the sole purpose of deciding whether or not the proposed treatment has value for that patient.[26] What the courts are not doing is deciding that certain people should not survive due to their condition regardless of the possibility of treatment. Such an approach would favour active destruction of such lives, a possibility that has been ruled out by the courts.

Whilst the general approach of *Re B (A Minor)* has been adopted in later cases, the terminology used has changed. In *Re J (A Minor)(Wardship: Medical Treatment)*[27] the patient was a baby who was born very prematurely and suffered from brain damage. The evidence was that the child would be blind, deaf, dumb and quadriplegic but fully capable of feeling pain in the normal manner. Lord Donaldson clearly disapproved of the language used in *Re B (A Minor)*[28] and made it clear that the court was not dealing with a right to impose death, rather it was a right to choose a course of action which would fail to avert it.[29] It could be argued that there is little practical difference between the two alternatives. However, by focusing upon the fact that doctors are failing to save, rather than condemning to death, the court distances this scenario from active euthanasia and murder. The language used is an essential indicator of what activities will be acceptable. The test espoused by Templeman LJ was reworded as follows:

> "What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to the medical treatment should be taken which *as a side*

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[26] *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 is an example of this. One of the major factors was that the treatment offered Ms B no hope of recovery and that her quality of life would be extremely poor. The court did not view Ms B's life as having no value, rather the treatment was regarded as offering a quality of life which was unacceptable to the patient. It must be remembered that Ms B was competent though so the decision was her own rather than the courts.

[27] [1990] 3 All ER 930

[28] ibid, at 938

[29] ibid, at 936. A similar approach can be found in *Re C (A Minor)(Wardship: Medical Treatment)* [1989] 2 All ER 782, at 787, where the judgement given at first instance was reworded to prevent the idea that the child would be killed.

> *effect* will render death more or less likely. This is not a matter of semantics. It is fundamental”[30]

It was stated that the law involves a balancing exercise that has to be adopted in determining what the interests of the child demand, yet it was denied that *Re B (A Minor)* created a yardstick for this exercise.[31] Balcombe LJ made no reference to a balancing act but stated that it was not possible to create a test that would apply to all cases other than that of best interests.[32] Despite this, it is still the pain and suffering of the child’s life which will indicate that treatment is not required by his best interests.[33]

It should not be thought that, simply because the courts are focusing upon the best interests of the patient, the guiding principles applied when a child is going to die are different from that discussed in relation to the general treatments discussed in chapter 2. It was pointed out in that part of the thesis that whilst the guiding principle of allowing treatment dominated that area of the law, the guiding principle of best interests could operate to prevent treatment in extreme cases. It is submitted that the same approach applies here. It has already been shown that *Re B (A Minor)* indicates a preference in favour of treatment and the same is true of *Re J*. The guiding principle of best interests operates in a more negative manner than might initially be thought: rather than authorising treatment, it prohibits it. Where the interests of the child indicate that treatment should be provided this only serves to reinforce the result of allowing treatment. If the interests of the child favour neither treatment nor non-treatment then treatment will be favoured by the court. It is only when an analysis of the child’s best interests strongly indicates that treatment ought to be withheld that it will outweigh the presumption in favour of treatment and the preservation of life. Whilst the

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[30] [1990] 3 All ER 930, at 938
[31] ibid
[32] ibid, at 942
[33] ibid, at 938

notion of best interests is not, in itself, purely negative, the manner in which the courts apply it results in a focus upon its negative potential. Hence, when looking at whether or not a child should be allowed to die the courts start from the position that treatment should be given and then looks at the best interests of that child to determine whether they indicate that the treatment should be withheld.[34]

5.2.2 – WITHDRAWAL OF TREATMENT FROM ADULTS:

In relation to incompetent adults the leading case, *Airedale NHS Trust v. Bland*,[35] involved a patient who had sustained severe chest crush injuries during the Hillsborough disaster. As a result of these injuries Anthony Bland was left in a persistent vegetative state with no hope of recovery. The PVS condition has been described as "a twilight zone of suspended animation where death commences while life, in some form, continues".[36] It is clear that a PVS patient is not dead according to the law; as the brainstem still functions then the patient must still be alive.[37] After Anthony's condition had persisted for three and a half years the doctors decided to ask the court whether it would be lawful to withdraw his treatment.

The first hurdle that the court had to overcome was the possibility that the cessation of treatment would be classed as murder.[38] The court attempted to avoid this possibility by classifying the removal of treatment as an omission. Whilst it is easy to understand how the

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[34] Non-treatment has also been authorised in the following cases; *Re J (A Minor)(Wardship: Medical Treatment)* [1992] 4 All ER 614, *Re C (A Baby)* [1996] 2 FLR 43, and *Re C (Medical Treatment)* [1998] 1 FLR 384

[35] [1993] 1 All ER 821

[36] R. Francis & C. Johnston, *Medical Treatment; Decisions and the Law*, p.127

[37] *NHS Trust A v. M; NHS Trust B v. H* [2001] All ER 801, at 807. With the improvement in medical technology over the last few decades the traditional definition of death, that of cardio-respiratory failure, can be seen as increasingly inappropriate. As Lord Lane has said: "A person's heart can now be removed altogether without death supervening; machines can keep blood circulating… until a new heart can be implanted in the patient, and… a ventilating machine can [breathe] for him", see *R v. Malcherek; R v. Steel* [1981] 2 All ER 422, at 426-427. To combat this the idea of brain death has been adopted. Brain death occurs when the brainstem, that area of the brain which is least susceptible to damage from oxygen deprivation and is responsible for the most basic of operations such as controlling the heart and lungs, has ceased to function.

[38] Any act that brings about the end of a patient's life, or shortens that life to any extent, will be murder if the requisite intention exists.

failure to provide treatment in the first place can be an omission, it is harder to understand how the active removal of treatment such as life support machines and feeding tubes can also be an omission. Lord Goff said that there was no real difference between deciding to turn off a life support machine and the decision to never provide it in the first place.[39] It was also made clear, however, that if somebody other than the doctor were to turn off a life support machine then it would be properly classified as an act.[40] Finnis argues that this reliance upon the distinction between acts and omissions resulted in the law becoming misshapen and irrational.[41] He does however accept that there must be some situations in which it is wrong to sustain the patient indefinitely.[42] The court's approach to the distinction between acts and omissions seems to be somewhat artificial. If it is an act for one person to do something then there seems to be no logic in saying that it is an omission for someone else to do it. Surely whether something is an act or an omission should not depend upon who perpetrates it. Despite this illogicality, the distinction is extremely useful in allowing the doctor to cease treatment that is no longer in the patient's interests.[43] Without the distinction between act and omissions the law of murder, as it currently exists, could not permit withdrawal of such treatment and would fail to protect the dignity and interests of the patient.

Simply classifying the withdrawal of treatment as an omission was not, of itself, sufficient to prevent it being seen as murder. An omission can still lead to a charge of murder if there is a duty to act to prevent the death. It is obvious that any doctor is under a professional duty to

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[39] [1993] 1 All ER 821, at 867

[40] ibid, at 868

[41] J. Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 LQR 329, p.333. Keown argues that *NHS Trust A v. M; NHS Trust B v. H* [2001] All ER 801 was the perfect opportunity to restore shape to the law, see J. Keown, 'Dehydration and Human Rights' (2001) 60 CLJ 53, p.56. Butler-Sloss, however, held, at 80, that the reasoning of Bland was in accordance with the jurisprudence of the European Court of Human Rights and refused to overturn it.

[42] J. Finnis, 'Bland: Crossing the Rubicon?', p.335

[43] It has been argued that the interests of the vegetative patient change over time. Whilst initial treatment is required for the purpose of diagnosis, continued treatment after diagnosis might be seen as futile, see R. Francis & C. Johnston, *Medical Treatment; Decisions and the Law*, p.131

treat a patient so as to maintain their life and health, yet this does not necessarily mean that the duty requires action regardless of the consequences. Lord Goff provided the example of a patient who was suffering from terminal cancer alongside some other treatable condition, he stated that:

> "The doctor who is caring for such a patient cannot… be under an absolute obligation to prolong his life by any means available to him, regardless of the quality of the patient's life."[44]

He continued by providing the following statement as to when the doctor's duty would no longer require treatment to be provided:

> "If the justification for treating a patient who lacks capacity to consent lies in the fact that the treatment provided is in his best interests, it must follow that the treatment may… be discontinued where it is no longer in his best interests."[45]

Whilst Lord Goff focused upon the interests of the patient, Lord Keith preferred to rely upon what the medical profession thought would be appropriate. He stated that:

> "A medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit."[46]

Kennedy and Grubb criticise this reliance upon the *Bolam* test as being unnecessary.[47] They argue that the same conclusion could have been reached purely upon best interests, as Lord Goff did. It is certainly true to say that a reliance purely upon best interests would have been better from the point of view of avoiding the suggestion that the courts are merely abdicating the decision to the medical profession. This was one concern of their Lordships, who stated

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[44] [1993] 1 All ER 821, at 868

[45] ibid, at 869

[46] ibid, at 861

[47] I. Kennedy & A. Grubb, 'Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult' (1993) 1 Med L Rev 359, at 363

that all such cases should be brought before the courts,[48] a requirement that has since become part of a practice direction.[49] The *Bolam* test may not significantly reduce the focus upon best interests though as the doctor should be looking at this when deciding what treatment to provide.

An additional problem the court faced in *Bland* was that the only treatment which was being provided to Anthony Bland was artificial hydration and nutrition by way of nasogastric tube and that it was this feeding which was to be withdrawn. It has been argued that it is unrealistic to classify such feeding as a form of medical treatment and that, therefore, it should not be governed by the doctor's duty to provide medical care.[50] Finnis, for example, argues that not everything that doctors do is directed towards achieving the goals of medical treatment and that there were no specialist skills involved in what the doctors were doing.[51] Keown questions what the feeding was designed to treat and argues that doctors do many things which are not medical in nature.[52] Lord Keith, however, stated that it was necessary to look at the whole regime, of which artificial feeding was a part, and argued that this regime was properly seen as medical treatment.[53] Lord Goff argued that the overwhelming evidence showed that the medical profession viewed artificial feeding as a form of medical treatment.[54] Lord Lowry supported this position and stated that this was the view of medical professionals worldwide.[55]

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[48] [1993] 1 All ER 821, at 862

[49] *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2001] 2 FLR 158

[50] It is argued that the result of this is the paradox that it will be lawful for a doctor to stop feeding but not somebody else, see R. Francis & C. Johnston, *Medical Treatment; Decisions and the Law*, p.133

[51] J. Finnis, 'Bland: Crossing the Rubicon?', p.335

[52] J. Keown, 'Restoring Moral and Intellectual Shape to the Law After Bland', p.491

[53] [1993] 1 All ER 821, at 861

[54] ibid, at 871

[55] ibid, at 876

The court also stated that the artificial feeding being provided to Anthony was indistinguishable from the provision of a life support machine.[56] Keown disagrees with this analogy for two reasons.[57] Firstly he states that ventilation is designed to stabilise, treat and cure whilst the same cannot be said of artificial feeding. Secondly he argues that whilst ventilation replaces the patient’s ability to breath, artificial feeding does not replace the ability to digest food. Yet this criticism is undermined if it is accepted that artificial feeding can be seen as replacing the ability to swallow and that ventilation does nothing to help the body use the oxygen contained in its blood.

It would possibly have been preferable to describe the doctor’s duty as wider than simply covering the exercising of his medical expertise in the provision of medical treatment. If the court had viewed the doctor’s duty as covering all care offered to the patient then it would not have been necessary to adopt the controversial view of feeding as a form of medical treatment.[58] Instead it would have been possible to permit doctors to cease such feeding without even having to address the question as to whether or not feeding is a form of medical treatment. Whilst not removing all controversy from the court’s decision this tactic may have overcome one area of contention.

Regardless of the language that was used, be it best interests or *Bolam* test, the court’s decision seems to rely upon the submission that Anthony Bland’s condition was such that continued treatment was not in his interests. The court was very keen to point out that the question was not one of whether it was in the patient’s interests to die, rather it was whether

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[56] ibid, at 871

[57] J. Keown, ‘Restoring Moral and Intellectual Shape to the Law After Bland’, pp.491-492

[58] I. Kennedy & A. Grubb, ‘Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult’, p.367

the prolongation of life was in his interest.[59] This once more seems to indicate that the courts are not condemning the patient to die, rather they are considering whether the patient should be allowed to die. It has been argued that it is wrong to claim that the withdrawal of treatment does not constitute a cause of death.[60] It is suggested here that this argument is correct as the failure to act, or the decision to stop acting, can have consequences just as much as acting. However, that does not mean that the court desires that result, merely that it is a consequence of the decision. It is submitted that *Airedale NHS Trust v. Bland* confirms the argument that the guiding principle at operation here is that of allowing treatment, with a coinciding application of best interests. The court clearly agreed with the proposition that the assumption must be in favour of treatment but that this might be outweighed when balanced against the poor quality of the patient's life.[61] If non-treatment, or withdrawal of treatment, is ever to be permissible then the only acceptable way to justify it is by way of the interests of the patient. Whilst the presumption in favour of treatment protects the sanctity which society attaches to human life the analysis of best interests attempts to ensure that this is not taken to the extent that it becomes unbearably burdensome to the patient.

After *Bland* it was argued that the life of an adult received greater protection than the life of a child:[62] whilst the non-treatment of infants was based purely upon quality of life the decision in *Bland* was limited to the PVS condition. A number of cases following Bland operated to

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[59] [1993] 1 All ER 821, at 869

[60] I. Kennedy & A. Grubb, 'Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult', p.366. Frey argues that it is possible to see the doctor's decision as a part of the cause and that it is not necessary to see any one event as the whole cause, see R.G. Frey, 'Distinctions in Death' in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide* (Cambridge: Cambridge University Press, 1998), p.23.

[61] [1993] 1 All ER 821, at 866

[62] Possible reasons for this can be found in J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.504, and range from greater importance being given to a life which has been lived to a fear that the definition of what is intolerable would constantly be widened.

expand the ability to withdraw treatment to less certain diagnoses of the PVS condition.[63] In *Frenchay Healthcare NHS Trust v. S*[64] the patient was described as being in a state of deep unconsciousness but the medical evidence as to the existence of a PVS condition was far from clear.[65] Despite this the court still held that treatment could be withdrawn, as its continuation was not in the patient's best interests. In *Re H (A Patient)*[66] the medical evidence was unanimous to the effect that not all of the requirements for PVS were satisfied. Sir Stephen Brown stated that "in this instance, it may be that a precise label is not of significant importance".[67] He also stated that whilst the conditions for PVS were not satisfied it was, nonetheless, possible to describe the patient's condition as a vegetative state that was permanent.[68]

As long-term incompetents are treated the same as children during life it would seem logical that the same applies when death is at hand. Kennedy and Grubb can be seen as supporting this when they argue that, in relation to non-PVS patients, the court should adopt the same approach as that used for children.[69] In *Re R (Adult: Medical Treatment)*[70] the court accepted this suggestion and placed the non-treatment of adults on the same path as that of children. The patient involved had been seriously mentally disabled since birth and suffered from cerebral palsy and epilepsy. The doctors responsible for R's treatment felt that a DNR order was appropriate but its legality was questioned. Sir Stephen Brown held that the overriding principle is the same for adults as for children and that it was the duty of the court to

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[63] Other cases, apart from those discussed, demonstrating this tendency include; *Re G* [1995] 2 FCR 46 and *Re, D (Medical Treatment)* [1998] 1 FLR 411

[64] [1994] 1 WLR 601

[65] ibid, at 608

[66] [1998] 2 FLR 36

[67] ibid, at 38

[68] ibid, at 39

[69] I. Kennedy & A. Grubb, 'Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult', p.369

[70] [1996] 2 FLR 99

determine whether the patient's life would be so afflicted as to be intolerable.[71] The result of this is that for all adults, rather than just for PVS patients, the court applies firstly the principle of allowing treatment and then that of best interests in a negative manner so that it operates to prevent treatment being given in a manner which could be seen as undignified.

5.3 – EUTHANASIA:

One of the main problems with euthanasia, as a concept, is that different people use it to refer to different things.[72] By looking at the involvement of the doctor and the patient's participation in the decision making process it is possible to identify a number of types of euthanasia:

1. Passive Voluntary – Patient's refusal of treatment results in doctor not acting.
2. Passive Non-Voluntary - Doctor does not act but does so without patient involvement.
3. Passive Involuntary – Patient requests treatment but the doctor does not respond.
4. Active Voluntary - Doctor acts in response to patient's request to die.
5. Active Non-Voluntary - Doctor acts without either request or opposition.
6. Active Involuntary - Doctor acts despite patient wanting to live.

For the purposes of this thesis the term euthanasia will be used to refer to active euthanasia designed to benefit the patient.[73] There will be no discussion of involuntary[74] forms of euthanasia which, it is submitted, are not really worthy of discussion as medical treatments,

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[71] ibid, at 108

[72] Keown states that there is no universally agreed definition and that this is one of the main causes of confusion over the issues involved, see J. Keown, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002), p.9

[73] This approach can be seen as gaining support from statements made by Lord Goff who has defined euthanasia as actively causing death to avoid or end the suffering of the patient, see *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 867

[74] Whilst some support the distinction between involuntary and non-voluntary euthanasia, for an example see J. Keown, *Euthanasia, Ethics and Public Policy*, p.9, others question this separation. Some academics even question that there is a distinction between voluntary and non-voluntary euthanasia, see J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p. 529.

but are more adequately described as falling wholly within the remit of the criminal law of murder.

5.3.1 – DOUBLE EFFECT & MERCY KILLINGS:

The first issue to be looked at is the doctrine of double effect. This doctrine justifies the provision of treatment that will have a positive medical impact upon the patient, usually by way of pain relief, but will also have the consequential side effect of shortening the patient's life.[75] On the acceptability of such forms of medical treatment Lord Donaldson said:

> "The use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so."[76]

Lord Goff, in *Airedale NHS Trust v. Bland*, also supported the acceptability of such treatments.[77] In the criminal case of *R v. Adams*[78] a doctor was charged with administering large doses of heroin and morphine to a patient prior to her death. In his summing up to the jury Devlin J stated that:

> "If the first purpose of medicine… could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve the pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer."[79]

It is submitted that there are two important distinctions between lawful and unlawful treatment. The first of these is the effect of the treatment in question. If the treatment carries

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[75] Keown states that the requirements for double effect are; the act is not bad in itself, the bad consequence is not a means of achieving the good consequence, the bad consequence is not intended but may be foreseen, there is a sufficiently serious reason for allowing the bad consequence, see J. Keown, *Euthanasia, Ethics and Public Policy*, p.20. There is some doubt, however, as to whether or not it is possible to distinguish between intention and foresight in the way proponents of double effect claim, see J. Griffiths, A. Bood & H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998), p.161

[76] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 938

[77] [1993] 1 All ER 821, at 868

[78] [1957] Crim LR 365

[79] ibid, at 375

with it the possibility of benefit then it may be lawful. This raises the question of what type of outcomes will be classified as being of benefit to the patient? Lord Keith has stated that:

> "The object of medical treatment and care is to benefit the patient. It may do so by taking steps to prevent the occurrence of illness, or, if an illness does occur, by taking steps towards curing it. Where an illness or the effects of an injury cannot be cured, then efforts are directed towards preventing deterioration or relieving pain and suffering."[80]

Lord Brandon has stated that treatment can only be in the interests of the patient, and therefore seen as beneficial to the patient, if it achieves one of three ends, namely; saving life, ensuring improvement or preventing deterioration.[81] It would be wrong to argue that causing death could be seen as falling within the notion of reducing suffering[82] as this would almost certainly be a case of instigating deterioration rather than preventing it. To hold otherwise would be to distort the doctrine and the result would be the legalisation of euthanasia.

It has already been suggested that the principle of allowing treatment is limited according to the definition of treatment. Lord Keith and Lord Brandon's definitions of treatment focus upon the need for treatment to provide some benefit to the patient. They also make it clear that this benefit can only be provided through saving the patient's life, reducing their pain or preventing the deterioration of the condition. It is suggested that the same approach applies in relation to the principle of allowing treatment. In order for the principle to support treatment it is necessary for it to offer a benefit in one of the ways identified by Lord Keith and Lord Brandon. The potential that any particular treatment has to offer a benefit to the patient is determined on a blanket basis. This means that the interests of the individual patient are not

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[80] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860

[81] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551

[82] Pabst Battin argues that in some instances the only way to reduce pain is to render the patient unconscious and that, for the patient, this is the same as death and, therefore, mercy killing in such circumstances ought to be allowed, see M. Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (Oxford: OUP, 1994), p.105. If, however, there is no difference between death and unconsciousness then maintaining the patient in an unconscious state cannot harm them.

considered when determining whether or not the treatment is, prima facie, beneficial. Those interests will be important, however, when the principle of best interests is applied in order to determine whether or not the principle of allowing treatment ought to be set aside. If the beneficial effect is present then a concurrent disadvantage will not necessarily make the treatment unlawful. It is submitted that the doctrine of double effect supports this limitation upon the definition of treatment as it only permits treatment that has a positive impact upon the continued, albeit shortened, life of the patient.

The second important distinction relating to double effect is based upon the intention of the doctor providing treatment. Any treatment administered with the intent of causing the patient's death will be unlawful. However, should the intention be to alleviate the pain and suffering of the patient, then the fact that life may be shortened will not prevent treatment being lawful. If the intention of the doctor is to cause the death of the patient then the doctrine of double effect no longer applies. In such instances the term of mercy killing is frequently adopted, yet it must not be forgotten that such events constitute both active euthanasia and murder. Lord Goff has stated that it will never be lawful for a doctor to administer treatment which is designed to end the patient's life. This remains true regardless of the extent of the suffering and pain which may give rise to the decision to administer such treatment.[83] Ognall J stated that if the primary purpose of treatment is to end life then the doctor is guilty of murder regardless of the motivation which drove him to that act.[84] It is clear that the law does not permit doctors to act in a manner which is designed to end the patient's life.

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[83] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 867

[84] *R v. Cox* (1992) 12 BMLR 38

It has been argued that whilst the concept of 'mercy killing' has not been adopted into legislation, the courts have shown a reluctance to convict doctors of a crime which carries a mandatory sentence of life imprisonment.[85] This can be seen in the way that doctors are charged with assisted murder rather than murder itself. This allows the courts to exercise sentencing discretion rather than having to impose the mandatory life sentence. In *R v. Cox*[86] the doctor was found guilty of attempted murder but was not sent to jail, rather he was given a suspended sentence. Further to this, Dr Cox was never stuck off by the General Medical Council but was allowed to continue to practice medicine. It would appear, therefore, that Dr Cox managed to escape without any real punishment whatsoever.

It is submitted that the leniency that is offered to doctors who engage in mercy killing is not demonstrative of its acceptability. As has already been shown, the courts have constantly reasserted the fact that deliberate killing or shortening of life is unacceptable. Rather it is an admission that the motives and pressures that drive the doctor's decision may be noble. Whilst motive will not affect the legality of the act[87] it may be of import when considering the sentencing should the verdict be guilty. It should not be thought that this is an indication of a desire to legalise euthanasia. Whilst the arguments for the decriminalisation of euthanasia are abundant and highly emotive,[88] the courts have made it clear that it is currently seen as murder and if that is to change it must come through parliament[89] rather than through the

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[85] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.531

[86] (1992) 12 BMLR 38

[87] ibid

[88] Hendin criticises many pro-euthanasia writers for using extreme cases, which are claimed to be typical, to sway public opinion. Yet he uses exactly the same technique to oppose the decriminalisation of euthanasia, see H. Hendin, *Seduced by Death* (London: WW Norton, 1998). Hendin's work has also been criticised for a number of other flaws including the misrepresentation of opinions expressed in interviews, see J. Griffiths, A. Bood & H. Weyers, *Euthanasia and Law in the Netherlands*, p.23

[89] It has been suggested that euthanasia occurs in practice and that the law should be used to regulate it, as is the case in the Netherlands, rather than simply prohibit it. Keown opposes this though by arguing that it is wrong to say that something should be legalised simply because the law is broken and points out that if doctors are

courts as it did in the Netherlands.[90] As the leniency shown to doctors does not effect the legality of their actions it is submitted that it does not impact upon the application of the guiding principles. It would be different if the courts were saying that the act was wrong but then attempting to find ways around the doctors' guilt,[91] but that is not the case here.

5.3.2 – THE UNIQUE SCENARIO OF CONJOINED TWINS:

Re A (Children)(Conjoined Twins: Surgical Separation)[92] involved conjoined twins, Jodie and Mary, who were born to parents who did not feel capable of authorising a separation. Jodie could survive independent of Mary, but if they were not separated she would die within a few weeks. For Mary, on the other hand, separation could only hasten an inevitable death. The result of this was that in order to save Jodie the doctors had to act in a manner which could constitute the murder of Mary through euthanasia. The case is interesting because it combines a treatment with a positive outcome and one with a negative result in not only the same case, but also the same procedure. The court was faced with having to use the law to find a solution to an extremely difficult issue that had never been envisaged. Not only that, but due to the combination of positive and negative effects it could impact upon the principles applied to all other areas of medical law.

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willing to flout the law of murder there is no reason to believe they will adhere to guidelines and regulations, see J. Keown, *Euthanasia, Ethics and Public Policy*, p.63.

[90] Keown argues that there is little sense in which euthanasia can be said to be controlled in the Netherlands though, and that all it demonstrates is the validity of the slippery slope argument, see J. Keown, 'The Law and Practice of Euthanasia in the Netherlands' (1992) 108 LQR 51, pp.77-78. It has been argued, however, that there is no evidence that the number of non-voluntary terminations is increasing in the Netherlands, see J. Griffiths, A. Bood & H. Weyers, *Euthanasia and Law in the Netherlands*, p.26. Frey criticises the slippery slope argument for failing to look at the risks involved in not legalising euthanasia, see R.G. Frey, 'The Fear of a Slippery Slope' in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide*, p.57

[91] An example of this was seen in relation to pregnant women desiring to refuse treatment. Whilst the courts accept that women retain the right to refuse treatment, they are continually found to be lacking in the competence required to make that refusal binding.

[92] [2000] 4 All ER 961

When deciding what treatment children should receive the courts constantly refer to the need to look at what the child's interests require. Ward LJ pointed out that this is only the first stage in the process and it will always be subject to a second question as to the legality of the procedure.[93] In relation to the first question, the court held that whilst the separation procedure was in the interests of Jodie, it was not in the interests of Mary. The only gain for Mary would be the acquiring of the bodily integrity and dignity which is natural for all humans.[94] It was accepted that this was purely illusory though, as Mary would be dead before she could enjoy this gain.[95] It is certainly hard to see how a person can benefit from increased integrity and dignity if they will never have the opportunity to experience it. Having decided that the interests of the two children were in conflict the question was how to resolve that conflict. Ward LJ stated that:

> "Given the conflict of duty I can see no other way of dealing with it than by choosing the lesser of the two evils and so finding the least detrimental alternative. A balance has to be struck somehow."[96]

In carrying out this balancing act it was made clear that it was not possible to balance one right to life against the other, as both were equal.[97] The child's quality of life, both current and potential, could be taken into account when looking at the value of the treatment.[98] It was held that this fell in favour of Jodie, as Mary would die with or without treatment.[99] The final factor to be balanced was the ability to exercise the right to life. The court stated that the doctors were the only people who could help Jodie, but that nobody could help Mary.[100] The result of this balancing exercise indicated that the separation should be carried out. The

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[93] ibid, at 994
[94] ibid, at 998
[95] ibid
[96] ibid, at 1006
[97] ibid, at 1010
[98] ibid. The court also accepted Keown's distinction between 'quality of life' and 'Quality of life' and the fact that only the former was acceptable.
[99] ibid
[100] ibid

consequence of this is that it was possible to say that, on the whole, the treatment was beneficial to those involved despite the fact that it would have a negative impact upon Mary. Bainham has argued that the balancing exercise represents a more respectable and convincing approach than that which was adopted in previous cases,[101] where the courts have simply denied that the problem arose.[102] If Bainham's accusation that the courts have previously ignored the problems caused by conflicting interests is accurate then his praise for the approach adopted in *Re A* appears to be justified, as any attempt to deal with these problems will be better than simply ignoring their existence. It is submitted that the same principles apply here as in relation to other children. The starting point remains the principle of allowing treatment and an analysis of best interests is undertaken in order to see whether or not this should be rebutted. The only difference here is that more than one child was involved and the interests had to be balanced.

The next question was whether or not the treatment would be lawful in the sense that it might be seen as murder.[103] The court rightly rejected the suggestion that the operation could be seen as an omission similar to the withdrawal of treatment. Ward LJ thought that such a classification would be utterly fanciful.[104] Brooke LJ pointed out that the separation would involve numerous invasions of Mary's body, that these could only be classed as positive acts and that it would bear no resemblance to the discontinuance of artificial feeding.[105] To say that the separation was an omission would have been to stretch an already artificial distinction beyond the bounds of all logic. Any suggestion that the doctors would not intend to kill Mary

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[101] The cases referred to by Bainham are *Birmingham City Council v. H (A Minor)* [1994] 2 AC 212 and *Re T and E (Proceedings: Conflicting Interests)* [1995] 1 FLR 581. Whilst neither of these cases involved conjoined twin they did involve the conflicting interests of multiple children.

[102] A. Bainham, 'Resolving the Unresolvable: The Case of the Conjoined Twins' (2001) 6 CLJ 49, p.52

[103] Normally this question never has to be considered and the question of best interests will determine whether or not the treatment will be lawful.

[104] [2000] 4 All ER 961, at 1003

[105] ibid, at 1027

was also dismissed, Brooke LJ stated that the death of Mary must be intended as the doctors were aware of its virtual certainty.[106] Too frequently intention is confused with desire, it is possible to intend a consequence without desiring it.[107] Whilst the doctors did not desire to kill Mary it was one of their intended consequences as its certainty, combined with their awareness of it, meant that they must have considered it and it would be unrealistic to say that they did not intend it, although unhappily so. Robert Walker LJ rejected the suggestion that the doctrine of double effect could apply as that required that all the consequences, both positive and negative, be aimed at the same person.[108]

The consequence of this was that the separation would be seen as murder unless there was a defence available. Ward J considered the idea that private defence could apply and described Mary as inflicting a fatal harm upon Jodie which the doctors could act to prevent.[109] The court though, preferred a defence of necessity.[110] Brooke LJ stated that the requirements for the defence were that: the act was needed to avoid inevitable and irreparable damage, no more should be done than is reasonably necessary, the evil inflicted should not be disproportionate to the evil avoided.[111] Ward LJ stated that there is no reason the doctors could not use a similar balancing act to that used in relation to best interests to decide what treatment would be justified by necessity.[112] The outcome of this was that the separation would be justified as the evil of two twins dying was greater than the evil of one dying earlier and one living a long

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[106] ibid, at 1029

[107] An example of this is a person who attacks somebody because he is under threat of force. Whilst that person intends to inflict the injury he does not desire to do so.

[108] ibid, at 1063

[109] ibid, at 1017. This idea is supported by Rogers, see J. Rogers, ‘Necessity, Private Defence and the Killing of Mary’ (2001) Crim LR 515, p.524

[110] The problem with the use of necessity is that it risks confusion with the doctrine of necessity which serves to authorise treatment which is in the best interests of an incompetent patient. The two terms are not the same and should not be confused and this is a real danger following *Re A*.

[111] [2000] 4 All ER 961, at 1052

[112] ibid, at 1016

and healthy life.[113] This is yet another example of how the principle of allowing treatment is limited to those treatments which have a positive effect. The balancing exercise of necessity helps to determine whether or not a positive effect is possessed by the procedure in question and, therefore, whether treatment will be permissible.

5.3.3 – ASSISTED SUICIDE:

Whilst it has been shown that doctors are not permitted to actively end or shorten a patient's life, the question remains as to whether they can take the halfway step of helping a patient end their own life. Montgomery argues that it is possible to assert that English law recognises a limited right to die.[114] He bases this argument upon the fact that the law no longer punishes suicide or attempted suicide. The reason for the decriminalisation of suicide and attempted suicide was not an acceptance of any right to die however, rather it was due to the futility and harshness of punishing people who had attempted to take their own lives.[115] This is evidenced by the fact that whilst suicide is no longer a criminal offence, the Suicide Act 1961, s.2(1), preserves the offences of aiding, abetting, counselling or procuring a suicide or attempted suicide.[116] Due to this Montgomery accepts that it may be more appropriate to argue that the law recognises the right to be allowed to die rather than a right to die.[117]

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[113] The judges were keen to make it clear that the procedure was only valid because of the unique combination of facts involved in the case. Ward LJ stated that it could only be an authority in the following situation: "It must be impossible to preserve the life of X without bringing about the death of Y, that Y by his… very continued existence will inevitably bring about the death of X… that X is capable of living an independent life but Y is incapable… of viable independent existence", see ibid, at 1018.

[114] J. Montgomery, 'Power Over Death, The Final Sting', p.37

[115] *R (Pretty) v. DPP* [2002] 1 AC 800, at 825. Kasimar states that: "The fact that we no longer punish suicide or attempted suicide does not mean that we *approve* of the acts or that we *recognise* that an individual's right to *self-determination* or *personal autonomy* extends this far", see Y. Kasimar, 'Physician Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia' in J. Keown (ed), *Euthanasia Examined*, p.229

[116] *Attorney General v. Able* [1984] 1 All ER 276, at 288, provides a definition for the offence. Under s.2(4) of the Act a prosecution can only be brought with the express permission of the DPP.

[117] J. Montgomery, 'Power Over Death, The Final Sting', p.40

In *R (Pretty) v. DPP*[118] the claimant suffered from a progressive and degenerative terminal illness that would result in a distressing and humiliating death. The DPP had been asked to provide a guarantee that Mr Pretty would not be punished should he assist his wife in taking her own life.[119] When the DPP refused to provide such a guarantee it was argued that the claimant's rights, under the ECHR, were being violated, primarily because the right to life[120] involves a right to die. Lord Steyn stated that the existence off such a right had to be approached with scepticism due to the varied attitudes of the states subject to the ECHR.[121] Lord Bingham provided a stronger argument by relying upon the language of the Convention rather than its cultural background and held that it reflected the sanctity which western society attaches to life and that because of this it was not possible to see it as providing a right to die or enlist assistance in dying.[122] He stated that:

> "It is not enough for Mrs Pretty to show that the United Kingdom would not be acting inconsistently with the Convention if it were to permit assisted suicide; she must go further and establish that the United Kingdom is in breach of the Convention by failing to permit it."[123]

Whilst Lord Bingham accepted that a patient's condition may mean that the positive obligation to preserve life may be weakened, this was not the same as accepting that there exists a right to be assisted in taking ones own life.[124]

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[118] [2002] 1 AC 800. This case has now been affirmed by the European Court of Human Rights in *Pretty v. United Kingdom* (2002) 35 EHRR 1

[119] In actuality the court held that the DPP did not possess the power to provide this guarantee. Lord Steyn held that whilst s.2(4) of the Suicide Act 1961 enabled the DPP to exercise his discretion in deciding whether or not to prosecute this could only be done in relation to past events, see [2002] 1 AC 800, at 867.

[120] European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), Article 2, which states: "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

[121] [2002] 1 AC 800, at 833

[122] ibid, at 810

[123] ibid, at 814

[124] ibid, at 813. Dworkin, however, argues that as the law accepts that there is a right to refuse life saving treatment it ought to permit patients to request either euthanasia or physician assisted suicide, see G. Dworkin, 'The Nature of Medicine' in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide*, p.4.

The court also made it clear that the right to respect for family and private life[125] could not apply as this protected how people choose to live, not how they choose to die.[126] The court held that even if this was not the case the protection of life was a sufficient justification for any breach. Lord Steyn held that the right to freedom of belief[127] was never intended to give anyone the unfettered right to do anything they wished in pursuance of their beliefs.[128] Whilst this appears perfectly true it leaves unaddressed the issue of who decides which belief motivated actions are worthy of protection. Another argument that was suggested was that, by refusing to guarantee that the husband would not be prosecuted, the DPP was inflicting inhumane and degrading treatment.[129] The court found it impossible to accept this and said that Mrs Pretty's suffering was a result of her condition not the inability of her husband to assist her in dying.[130] It may be possible, in certain circumstances, for a failure or refusal to act to constitute inhumane or degrading treatment, but it is hard, however, to see how that could be the case here and saying that it is the medical condition which causes the suffering is accurate. By rejecting all of these rights based arguments the court placed great importance upon preserving the patient's life. In this case the preservation of life could not be achieved by providing treatment, rather it had to be through withholding treatment. As has already been stated, the principle of allowing treatment is limited according to the definition of treatment. As a result of this it can be seen as prohibiting any procedure, like assisted suicide as was the case here, which may not be properly classed as medical treatment designed to benefit the patient.

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[125] ECHR (1950), Article 8

[126] [2002] 1 AC 800, at 822

[127] ECHR (1950), Article 9

[128] [2002] 1 AC 800, at 836. The example he gives is a person who believes that animal testing is wrong and then decides to attack an animal testing centre or its staff.

[129] ECHR (1950), Article 3

[130] [2002] 1 AC 800, at 815

This case illustrates a great reluctance to accept that assisted suicide should be seen as acceptable. It could be suggested that the result was reached prior to the reasoning being carried out rather than the reasoning leading to the conclusion. This reluctance was reinforced by the court's view that there was no real difference between a right to assisted suicide and a right to euthanasia.[131] Keown supports this view and argues that it can be extremely difficult to decide where assisted suicide ends and euthanasia begins.[132] Griffiths argues that psychiatrists are already carrying out assisted suicide and that it cannot be controlled if it is kept secret. He argues that whilst the Dutch system has flaws it is at least attempting to confront the problem.[133] Keown, however, doubts the extent to which assisted suicide is practised[134] and Hendin criticises attempts to legalise either assisted suicide or euthanasia before the public have a proper understanding of the implications.[135] He also argues that a doctor who suggests suicide as an option, or accepts a request for assistance too readily, gives a clear signal that he believes the patient should not continue to live.[136] Whilst Dworkin accepts such a risk, he argues that it can be just as harmful to keep patients alive when they genuinely want their life to end.[137]

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[131] ibid, at 811

[132] J. Keown, *Euthanasia, Ethics and Public Policy*, p.33. Keown refers to the giving of medicine for the purpose of suicide and asks when it becomes euthanasia. Is it when the drugs are passed to the patient, when the doctor places them in the patient's mouth, or when he forces them down her throat?

[133] J. Griffiths, 'Assisted Suicide in the Netherlands: The *Chabot* Case' (1995) 58 MLR 232, p.249. One argument is that such behaviour occurs in all modern medical systems and that simply saying that it is morally and legally wrong does nothing to control it, see J. Griffiths, A. Bood & H. Weyers, *Euthanasia and Law in the Netherlands*, p. 21

[134] J. Keown, *Euthanasia, Ethics and Public Policy*, pp.61-62

[135] H. Hendin, *Seduced by Death*, p.24

[136] ibid, p.185. Dworkin, on the other hand, points out that if a doctor can manipulate a patient into requesting assisted suicide the same influence could be used to manipulate a patient into refusing life-saving treatment, see G. Dworkin, 'Public Policy and Physician Assisted Suicide' in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide*, p.67.

[137] R. Dworkin, *Life's Dominion: An Argument About Abortion and Euthanasia* (London: HarperCollins, 1995), p.197. It has also been argued that it would be an insufficient excuse to say, to a patient wishing to die, that no assistance could be offered because of the risk of another patient, in an unrelated instance, being exposed to abuse, see G. Dworkin, 'Public Policy and Physician Assisted Suicide', p.70.

5.4 – SUMMARY:

It is submitted that when a patient is approaching death in a natural manner, meaning that the time of that death is not being advanced by medical intervention, the guiding principles that are applied to determine whether treatment should be provided are primarily the same as those which would be applied to the availability of general treatments throughout his or her life. Hence for children and incompetent adults the principles are those of allowing treatment as counteracted by a negative application of best interests. For competent adults it is the principle of self-determination which will be determinative.

The guiding principle which seems to apply in relation to double effect, mercy killing and assisted suicide is that of allowing treatment. Whilst this may seem strange when the law actually prohibits treatment, it is argued that the principle operates as a two edged sword. Whilst it provides justification for treatments which provide a benefit to the patient it also serves the purpose, through defining what will be classed as medical treatment, of prohibiting treatments which provide no benefit and could be seen as falling outside the realm of medicine. The Hippocratic Oath supports the idea that euthanasia and assisted suicide are not ethically acceptable and states: "To please no-one will I prescribe a deadly drug, nor give advice which may cause his death".[138]

The definition attached to treatment seems to greatly favour the preservation of life. Whilst the doctrine of double effect authorises treatments that shorten life it does so only where the reduction of suffering is the primary aim. The courts view the role of doctors as concerned with improving life. Whilst this can be done by reducing pain or lengthening life it cannot be

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[138] Whilst it could be argued that the Hippocratic Oath is outdated, for example it rejects payment for a physician's work and for teaching others the profession, similar statements can be found in the Declaration of Geneva and the International Code of Medical Ethics.

done by deliberately shortening that life. It is for this reason that the administration of a lethal injection would be unlawful, as would other euthanasia techniques. Hence, when the patient is approaching death, through either a medical condition or personal choice, it is the principle of allowing treatment which determines when a doctor will be free to offer assistance in the form of medical intervention aimed at ending life. When an application of the principle of allowing treatment indicates that a course of action will not be medical treatment then it becomes an issue of the criminal law, usually murder or assault.[139]

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[139] Figure 5 in Appendix A provides a visual representation of how the guiding principles apply when life comes to an end.

PART IV

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DRAWING CONCLUSIONS

CHAPTER 6:

A COHERENT STRUCTURE?

Having analysed how the courts apply the guiding principles identified in Chapter 1 to a range of issues throughout a patient's life it is now necessary to ask whether or not there is a coherent structure to the approach the courts adopt in dealing with the diverse patients they are confronted with. It is clear, from what has been said in earlier chapters, that it cannot be argued that the same principles apply to all issues. Yet this does not mean that there is no structure to the law, just that the structure must explain why different principles apply. It is submitted that there is a graduated structure to the law and that it is capable of dealing with the variety of patients involved and providing a greater understanding of court decisions than could otherwise be achieved. Whilst a number of cases have been seen as reversals from previous decisions,[1] or somehow lacking logic,[2] it is argued here that once it is understood which principles are being applied it becomes easier to see the law as a logical whole.

6.1 – THE GUIDING PRINCIPLES REVISITED:

Whilst an attempt to define the guiding principles was made in Chapter 1 it has become apparent that the definitions provided were, in the majority, overly simplistic. A number of the principles consist of more that one role, each of which must be understood if a theory of how the law operates is to be arrived at. Further to that, in a number of scenarios the principles act in partnership one with another so it is also necessary to look at how these interrelationships work. As a result of this the first task, prior to attempting to identify any

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[1] One example of such an argument can be seen in Thornton's criticism of *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177 which she describes as a retrograde step from *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112, see R. Thornton, 'Multiple Keyholders – Wardship and Consent to Medical Treatment' [1992] CLJ 34, p.37

[2] Keown has described *Airedale NHS Trust v. Bland* [1993] 1 All ER 821 as lacking logic and has stated that the courts have missed opportunities to restore both moral and logical shape to the law, see J. Keown, 'Dehydration and Human Rights' (2001) 60 CLJ 53, p.56

theory that would serve to explain the law, is to expand upon the existing definitions and fully explain how each principle operates and the impact it has upon the law as a whole. Once this has been done it will be possible to attempt to identify a structure which holds the law together.

6.1.1 – SELF-DETERMINATION:

The guiding principle of self-determination is the most simplistic of all the principles and differs least from the definition provided in Chapter 1. The aim of this principle, to protect the autonomy of the patient, is achieved through a strict enforcement of the requirement of consent and, conversely, through the respect that is given to any refusal of consent. This principle only applies, in its entirety, in relation to a competent adult patient whose choices will not have adverse physical consequences for other people. The consideration for the way others will be affected explains why certain procedures, such as the treatment of contagious diseases, can never be effectively refused and why, if more than one adult patient is directly involved, such as in artificial reproduction, the consent off all those individuals will be required before the treatment can be lawfully administered.[3]

The respect in which individual autonomy is held by the law, and society generally, also explains why, in relation to short-term incompetents, the law requires that there be some emergency before treatment can be provided without the patient's consent.[4] If there is a reasonable possibility that an adult who has temporarily lost the ability to satisfy the competency requirements will regain that ability, before the condition to be treated causes unreasonable harm, then the law will try to limit what can be done to that patient whilst the

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[3] It could be argued that another example of this exists in relation to organ transplantation where the donor must consent to the removal of the organ and the donee must consent to its insertion.

[4] *F v. West Berkshire Health Authority* [1989] 2 All ER 545

incompetence continues. If the procedure suggested is not urgently required then the respect for the patient's autonomy, albeit temporarily suspended, demands that it be delayed until the patient can decide the matter for himself. Only procedures which cannot be delayed, without unreasonable consequences, can be lawfully administered whilst the patient is incompetent.

6.1.2 – ALLOWING TREATMENT:

Turning to the principle of allowing treatment it must be accepted that the principle is not as simple as was suggested in Chapter 1, rather it is possible to identify two distinct, and opposing, applications. Firstly the principle can be used to provide authorisation for medical treatment. This role can be seen in relation to the treatment of both children and incompetent adults. It has been argued herein that the concept of adolescent autonomy is not designed to give absolute effect to the developing autonomy of a child as he approaches adulthood. Rather it is a tool whereby the possible sources for consent are increased by giving the competent child the ability to provide that consent.[5] Support for this submission can be found in the fact that whilst a competent child can provide consent to treatment he will have no ability to give a definitive refusal.[6] Hence adolescent autonomy cannot be seen as an application of the principle of self-determination as the child has no real ability to determine what treatment will be received, rather it must be the principle of allowing treatment which applies.

Similarly, in relation to long term incompetent adults, and some patients receiving treatment for mental conditions, it is possible to identify this permissive role of the principle of allowing treatment. It is submitted that as the duration of a person's incompetence increases the way that person will be treated becomes more like they way the law approaches issues relating to

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[5] *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112
[6] *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177

children. Whilst judges talk of the patient's interests there is a clear presumption in favour of permitting treatment so as to prevent loss of life or deterioration of health. This presumption means that whilst the courts refer to interests they are in reality applying the principle of allowing treatment and patient interests are used as a smokescreen to hide this fact.

The second role assumed by the principle of allowing treatment has the opposite effect to its permissive application. Whilst it may seem confusing, the principle of allowing treatment also operates to prevent certain procedures. In order to permit treatment it is necessary to define what will be classed as medical treatment. In doing this, the principle also defines what will not be seen as medical treatment and will, therefore, be prohibited. Generally this definition requires that some form of identifiable benefit is offered by the procedure and that this benefit outweighs any concurrent detriment. The requisite benefit may be offered by way of preventing illness, curing illness, preventing deterioration or reducing pain and suffering.[7]

It has been shown that consent cannot authorise an infliction of harm which would otherwise be a criminal offence[8] but that medical procedures are generally seen as an exception to this rule. By excluding certain procedures from the realm of medicine this application of the principle leaves them firmly within the criminal law and the result is that they can never be lawfully carried out regardless of the wishes of the patient. This element of the principle generally acts in conjunction with the principle of self-determination so as to place limits upon what a person can consent to. It has been submitted that support for this limiting role of the principle could be found in the Hippocratic Oath. As that oath provided, at least in part, the basis for the principle, it seems logical that it should also be a source for any limits upon it.

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[7] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860

[8] *R v. Donovan* [1934] 2 KB 498

6.1.3 – BEST INTERESTS:

The principle of best interests also operates upon two levels. The first, and perhaps the most obvious, operates to justify a medical procedure on the basis that the interests of the patient demand its administration. Whilst the courts frequently talk in terms of best interests, or welfare in relation to children, it has already been argued that this does not demonstrate any application of this principle. Rather, due to the presumption in favour of treatment, a reference to best interests will usually represent an application of the principle of allowing treatment. Whilst it could be argued that the presumption is that treatment is in the patient's interests, it is submitted that it goes beyond this and is based more on a desire to preserve life than protect patient interests. Due to the strength with which the presumption in favour of treatment operates, the positive aspect of best interests does nothing more than offer further support to a conclusion that would have been reached without its application.

Whilst it has been submitted that the preference in favour of allowing treatment means that the positive aspect of the best interests principle does not normally apply, this does not mean that the interests of the patient are not being considered when deciding whether or not treatment should be provided. Whenever the permissive element of the principle of allowing treatment operates it does so in conjunction with a negative application of the principle of best interests. This aspect of the principle looks at the interests of the patient in order to decide whether or not the presumption in favour of allowing treatment should be rebutted. This will only be the case in extreme scenarios, simply saying that the patient's interests neither support nor oppose treatment will be insufficient, as will be a slight opposition to treatment.

This negative aspect of the principle of best interests can also be seen in relation to treatments which will have an impact upon a foetus, whether by creating that foetus, deliberately destroying it, or inadvertently causing harm through the medical treatment of its mother. The interests of the foetus, and the resultant family, must be considered in relation to assisted reproduction.[9] Further to that there are only a limited number of scenarios in which an abortion will be legally available.[10] Even when the treatment in question is aimed at the mother, the courts manage to overrule the autonomy of the patient by finding ways to view the mother as incompetent.[11] Hence the negative element of best interests also operates here to limit the availability of treatment and the freedom of adults to receive or refuse treatment as they see fit.

6.1.4 – DOCTOR PROTECTION:

The guiding principle of doctor protection also consists of two very different aspects. The first, and most controversial, is the protection of clinical judgement. This would seek to abdicate all decisions to the medical profession without regard for whether or not the patient desired the suggested treatment, or for the possibility that there may be another medical opinion which contradicted the value of the treatment in question. It could be argued that the *Bolam* test is an example of this as it justifies a doctor's actions if they are supported by a body of medical opinion regardless of whether or not there is another opinion opposed to it.[12] This is, however, moderated by *Bolitho v. City and Hackney Health Authority*[13] which held that the court could still disregard a body of opinion if it lacked logic. It is submitted that this aspect of the doctor protection principle is not applied by the courts in relation to the issue of when it will be possible to provide treatment. This is clear from the way that certain issues

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[9] Human Fertilisation and Embryology Act 1990, s.13(5)

[10] Abortion Act 1967, s.1(1)

[11] The best example of this is *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 where one reason for the patient being seen as incompetent was that whilst she cared for her unborn child she was not capable of consenting to the treatment necessary to avoid harming that child.

[12] *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118

[13] [1997] 4 All ER 771

have to be brought to the court[14] and how the courts have asserted that they have to come to their own decision as to the right course of action.[15]

The secondary aspect of doctor protection, conversely, can be found in relation to every area of the law. This aspect of the principle seeks to protect doctors from litigation which might otherwise limit their ability to provide treatment. This principle is only applied in order to allow doctors to give effect to the application of the other guiding principles and therefore does little to decide whether or not treatment should be provided. Rather it offers protection from legal action once the court has applied the guiding principles in the appropriate manner. An example of this can be found in the requirement that certain, controversial, matters are always brought before the court. The effect of this is to make it clear to all parties involved that the courts are in favour of the application of treatment, or the withholding of treatment, and to remove the threat of future litigation.

6.2 – A THEORY OF MEDICAL LAW:

6.2.1 – IMPORTANT FACTORS:

There are three important factors that have to be considered in order to understand the approach taken by the law. Whilst it is the guiding principles, as defined above, which decide the outcome of cases, it is submitted that these factors help to determine and explain which principle, or principles, will be applied by the courts. The first factor to be considered is the competency and maturity of the patient. To a large extent competency and maturity are related concepts for as a child matures his competency to make decisions increases. Similarly, if an adult lacks maturity, to the extent that he may be considered mentally

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[14] For example; non-therapeutic sterilisation of infants, see *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551-552

[15] *Re B (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 927, at 929

handicapped, it is likely that he will also lack competency. It must be remembered, however, that even if a child has reached an unusual level of maturity, exceeding that of the normal adult, that child will still be incapable of refusing medical treatment. Hence competency can also relate to biological age. If the patient in question is recognised as having the competency to both accept and reject treatment then this will have a strong impact upon which principles apply and the result will generally be that the principle of self-determination is decisive.

The second factor of importance looks at whether or not the treatment will have any direct, physical, impact upon anyone other than the patient. Whilst the law accepts that competent adults should be free to do as they wish there is an attempt to minimise the harm that is done to others. This does not mean that relatives can ask for a patient's refusal of consent to be overlooked simply because it will cause them emotional harm. The consideration of physical effects for others can be seen in the way treatment for contagious diseases can be carried out without consent[16] and how non-consensual treatment for mental conditions can be justified due to the risk posed to the public.[17] Another example can be seen in how the consent of all gamete donors is required in relation to assisted reproduction and how the interests of the resultant family must be considered.

The final factor encompasses the desires of the patient and the aims of the treatment in question. The desire to die must be distinguished from the desire not to undergo any treatment which would prolong an unacceptable quality of life. Similarly the withholding of such treatment has to be separated from the provision of treatment which is designed to bring the patient's life to an end. Whilst the act of suicide itself is not illegal, any attempt to aid it

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[16] Public Health (Control of Diseases) Act 1984
[17] Mental Health Act 1983, s.3(2)(c)

is,[18] as is any action deliberately designed to end life. The effect of this is that the courts are extremely likely to apply the guiding principles in a prohibitive manner when the treatment in question will have the consequence, and aim, of killing the patient. The consequences of treatment are not necessarily decisive though, as it is the aim and desire involved which will decide whether or not treatment is lawful. Hence, through the doctrine of double effect, treatment that shortens life, but is administered to reduce pain, may be lawful.

6.2.2 – AGAINST DISTINCT PATIENT CLASSIFICATION:

The easiest way to explain how the guiding principles apply to the range of scenarios discussed in this thesis is to view each issue as distinct from the others. By doing this it becomes possible to identify which principles apply to the issue in question. Figure 1 provides a graphic tool for working out which guiding principles apply to a patient depending upon their characteristics and the treatment involved. Under this system each patient can be identified as falling into one of a finite number of distinct categories. By working through a series of relatively straight-forward questions each patient is assigned to one of five categories and, from there, it is a relatively simple task to work out which principles will be applied in order to decide whether or not treatment should be provided.

There are numerous advantages to this distinct classification system. Perhaps the most obvious is that it is relatively simplistic. Not only is the system easy to understand, it is also easy to apply. The style and shape of the model is familiar to most people as it adopts a typical flow chart design. Added to this familiarity is the fact that the questions involved are generally easy to answer as there are no subjective issues looked at.[19] Further to that, the

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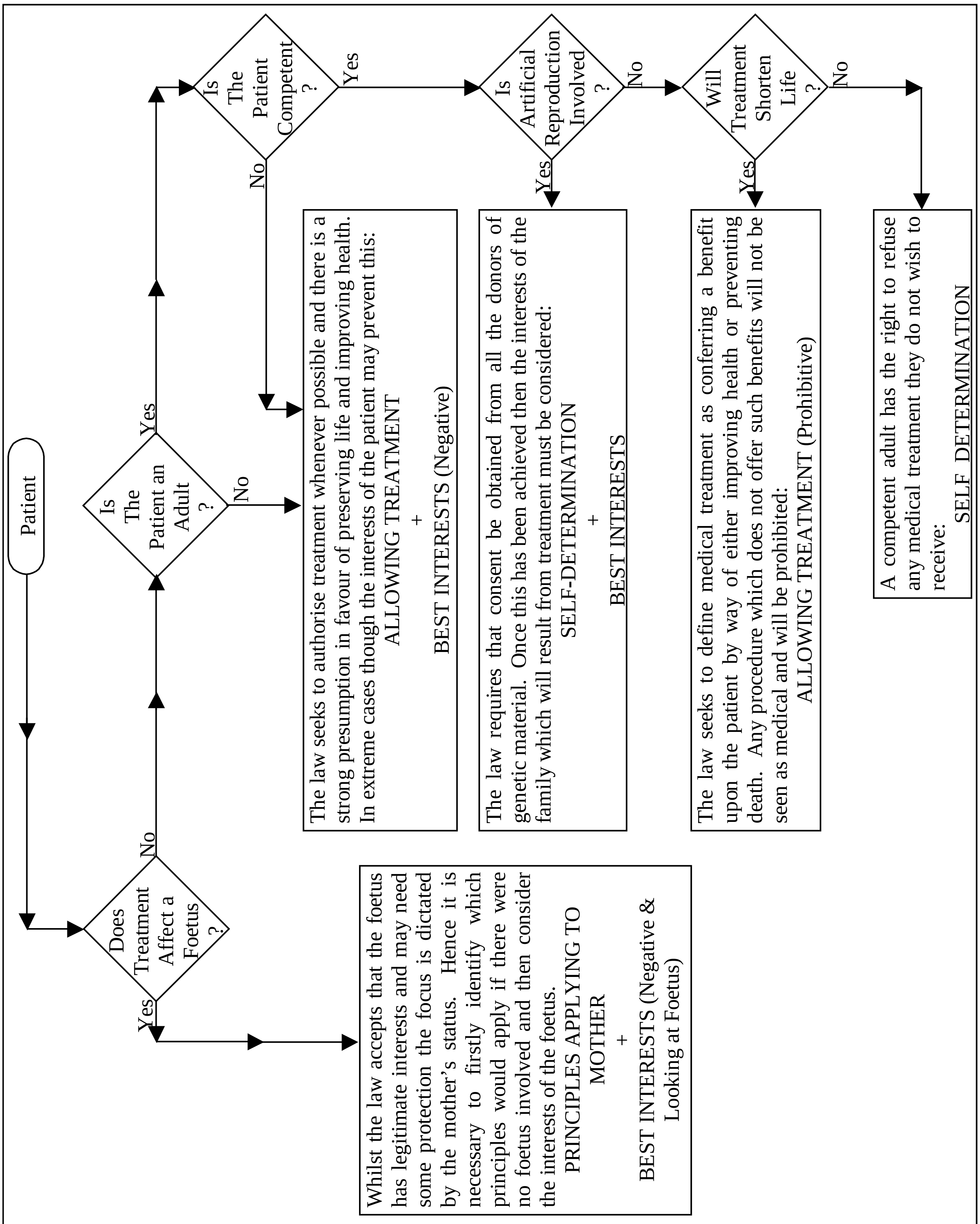
[18] Suicide Act 1961, s.2(1)

[19] By this it is meant that the definitions of concepts such as competency and adulthood do not change depending upon who the patient is.



Whilst the law accepts that the foetus has legitimate interests and may need some protection the focus is dictated by the mother's status. Hence it is necessary to firstly identify which principles would apply if there were no foetus involved and then consider the interests of the foetus.

PRINCIPLES APPLYING TO MOTHER
+
BEST INTERESTS (Negative & Looking at Foetus)

The law seeks to authorise treatment whenever possible and there is a strong presumption in favour of preserving life and improving health. In extreme cases though the interests of the patient may prevent this:

ALLOWING TREATMENT
+
BEST INTERESTS (Negative)

The law requires that consent be obtained from all the donors of genetic material. Once this has been achieved then the interests of the family which will result from treatment must be considered:

SELF-DETERMINATION
+
BEST INTERESTS

The law seeks to define medical treatment as conferring a benefit upon the patient by way of either improving health or preventing death. Any procedure which does not offer such benefits will not be seen as medical and will be prohibited:

ALLOWING TREATMENT (Prohibitive)

A competent adult has the right to refuse any medical treatment they do not wish to receive:

SELF DETERMINATION

Notes: 1. In relation to the foetus it is necessary to note that the interests of the unborn child remain subsidiary to whichever principles would apply to the mother if she were not pregnant.
2. In all instances there is a consequential application of the principle of doctor protection so that doctors can act, without fear of litigation, in order to give effect to the other principles applied.

Figure 1 – Distinct Patient Categorisation Model

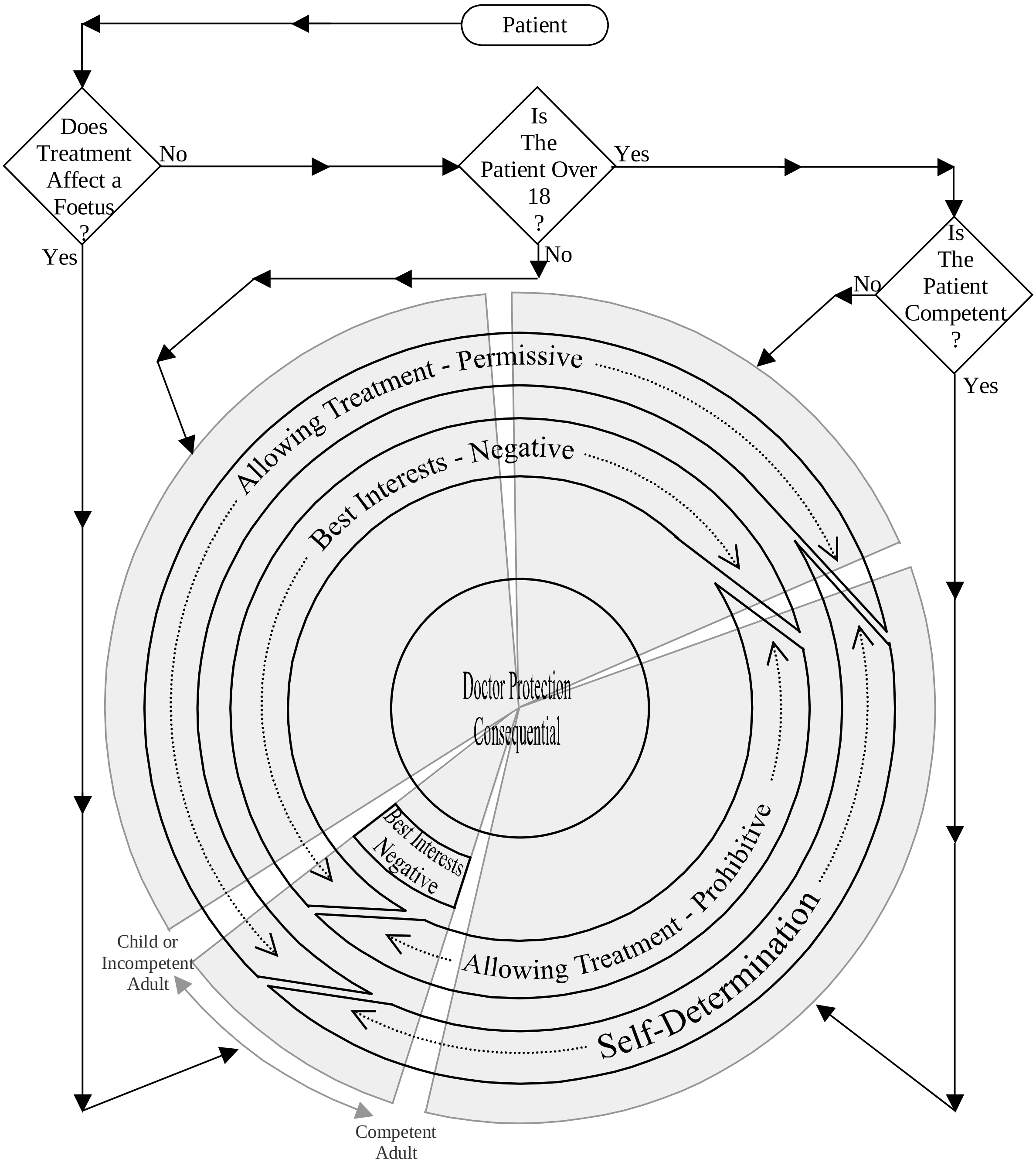
model makes it very clear which principles should be applied as there is no blurring between categories and it is extremely easy to come to definite conclusions. These benefits make the distinct classification system an extremely attractive option as an explanation for the way the law operates.

There are, however, a number of substantial disadvantages to this system and, it is submitted, these outweigh the benefits which are to be gained from it. These disadvantages are actually based upon the supposed benefits of the concept of distinct patient classification, resulting in the very value of the concept being undermined. The fact that the system provides definitive answers due to there being no blurring between categories is in itself a weakness. It has already been argued that it is not really possible to look at patients as distinct types, rather each patient is unique and tends to fall into a spectrum of infinite possibilities. As a result of this, the distinct classification system can be seen as overly simplistic and fails to represent the reality of both the scenarios doctors are confronted with and the decisions judges have to make. Further to that, due to the fact that each category is distinct from all others, any movement between categories must be sudden and absolute. Once more this fails to represent the reality where patients can lose or gain competency over time. One final problem with this model is that, by separating patients into distinct groups, it breaks the law down into segments and fails to provide a way for viewing it as a whole.

6.2.3 – A MORE REALISTIC APPROACH:

In order to create a theory that more realistically represents the range of patients and scenarios that doctors and judges are faced with it is necessary to accept that it is not possible to pigeonhole patients into a limited number of categories. Instead of distinct patient classification the theory must be based upon a more graduated approach which views all patients as part of a continuous scale. An example of such a scale was seen in relation to competent and incompetent adults, who cannot be treated as two distinct groups, and is represented by Figure 3 in Appendix A. By adopting a circular scale to explain all of the issues discussed, and their interrelations, it becomes possible to view the law as a single coherent whole rather than a series of isolated scenarios. Through the use of key questions it is then possible to work out which portion of this scale will cover the specific patient in question. It is submitted that it is possible to identify such a scale, starting with the newborn child and then passing through childhood followed by the incompetent adult until the competent adult is reached at the other end of the spectrum. Figure 2 represents this concept, which will be referred to as Graduated Guiding Principle Identification.

At the beginning of the spectrum, where the treatment of children is concerned, the guiding principles which apply are those of allowing treatment and best interests. Whilst the permissive element of the principle of allowing treatment constitutes the starting point in deciding whether or not treatment will be lawful, the negative aspect of best interests assumes a secondary role of limiting this presumption in favour of treatment. Whilst a child may be competent to give effective consent to treatment it has already been argued that this is simply another example of the principle of allowing treatment and does not represent an application of the principle of self-determination. It may, however, be true to say that allowing a child to consent to treatment is akin to training him in how to be an adult. Once a child reaches the age of eighteen then, as long as he is not a long-term incompetent, he will have the absolute power to either consent to or refuse treatment. Through adolescent autonomy the child is allowed to become accustomed to this power without having to endure the risk of harm or irrecoverable loss which would result from giving that child an unrestricted right to refuse treatment. In essence the law avoids making the eighteen-year-old patient learn from his own



Notes:	1.The solution to each route of questions leads to a segment of the scale rather than a definite answer. This accepts that answers to question such as 'Is the patient competent?' will not always be a clear-cut 'yes' or 'no'. 2.The segment relating to treatments involving foetuses takes into account the fact that the potential parents may not be competent adults. 3.In relation to assisted reproduction the principle of Self-Determination protects all of the adult parties involved in the procedure. 4.In relation to abortion the principle of Self-Determination only looks at the pregnant woman, all other adults have no rights recognised under English law.

Figure 2 – Graduated Guiding Principle Identification

mistakes by giving him some ability to learn through relatively harmless experiences in a controlled environment.

In relation to long-term incompetent adults, such as those in a persistent vegetative state, the principles which apply are the same as in relation to children. This may be due to the fact that as an adult's incompetency increases he becomes more like a child, in that he is incapable of making decisions for himself and needs, to some extent, to be protected by others. However, as the duration, and extent, of the incompetency lessens the influence of the principle of best interests diminishes until it disappears totally. Similarly the role of the principle of allowing treatment also changes. From a primary role of permitting treatment it moves towards a minor role of defining and prohibiting procedures which can confer no benefit upon the patient. In contrast, the principle of self-determination starts to assume an increasingly important role until, when the patient approaches full competency, it is the primary principle applied with the prohibitive aspect of allowing treatment operating as a secondary principle. It is important to realise that this is a gradual change rather than the sudden jump which would have been provided by the distinct classification model. Competency operates upon different levels and a patient who may be incompetent in relation to one procedure may have the requisite understanding to consent to another. Similarly the short-term incompetent is given some respect for his autonomy whilst the law recognises that in certain instances treatment without consent will be necessary.

For the fully competent adult, at the other end of the spectrum to the child patient, the principle of best interests will usually have no role to play at all. Under the distinct classification model it was submitted that the only principle which applied to a competent adult was that of self-determination unless the result of treatment would be to shorten life. It is submitted now that there is no need to distinguish between procedures which will shorten life and those which will not. The prohibitive aspect of the principle of allowing treatment applies in all instances so as to decide whether the procedure can ever be consented to. Whilst there will be no problem in relation to the vast majority of procedures the principle must still apply in order to cover those few procedures which fail to fall within the definition of medical treatment. One example of a procedure that will not be lawful, but does not shorten the patient's life, is non-therapeutic female circumcision.[20] It is of no use to say that the principle only applies when the procedure in question falls outside the definition of medical treatment as it is the application of the principle which provides the definition in the first place.

It is submitted that treatments involving foetuses form a bridge joining the two ends of the scale. Whether the treatment involved is designed to create a foetus, destroy it, or is wholly unrelated but involves a patient who is pregnant, the law remains primarily focused upon the status of the adults involved. Whilst this will usually be the mother, it also covers gamete donors in assisted reproduction cases. The result of this is that the primary principles applied are the same as would be applied to the patient if there were no foetus involved. When a foetus is concerned though there is also a tertiary application of the principle of best interests. This is most visible in relation to the availability of assisted reproductive techniques where, even if the consent of all the adults involved is obtained, the interests of the resultant child and family must also be considered.[21] It can also be seen, although in a weakened form, in relation to abortion and other treatments which may have side-effects for an unborn child. It

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[20] Female Genital Mutilation Act 2003, s.1(1)

[21] Human Fertilisation and Embryology Act 1990, s.13(5)

has been shown that an abortion will only be lawful in a number of scenarios,[22] whilst the interpretation of these scenarios is wider than might be initially thought they still show some concern for the protection of the foetus. Similarly the courts are more likely to view pregnant women as incompetent than would be the case if they were not pregnant.

Whilst the main principles which apply vary depending upon where the patient fits within the spectrum the consequential role of doctor protection applies to all patients. Whilst it does not drive the courts in reaching their decisions, this application of the guiding principle of doctor protection is just as important as any other principle. Without the freedom that is offered by removing the threat of litigation it would not be possible for doctors to proceed with the treatments necessary to give effect to those guiding principles which decide when treatment will be available. Whilst the fullest form of doctor protection, the unquestioning acceptance of clinical opinion, is never applied the weaker form of the principle is applied in relation to all patients.

6.3 – FINAL SUMMARY:

Finally, it is submitted that, far from being an ad-hoc collection of unrelated decisions, the law in relation to when it will be possible for doctors to provide treatment to a patient, does adhere to a logical structure. It is argued that the theory of Graduated Guiding Principle Identification can be used to both explain how and why the law approaches certain issues and to accurately work out how future cases are likely to be decided. For the theoretical ‘normal’ patient referred to in Chapter 1 the power of consent is absolute and there will never be any threat to the autonomy which that protects. For the majority of people though there is certainly some point during their lives when one or more of the other guiding principles will

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[22] Abortion Act 1967, s.1(1)

apply. Even for the competent adult there is the prohibitive aspect of the principle of allowing treatment, thereby placing limits upon what can be consented to. Whilst the principles which apply will vary depending upon the exact circumstances of the case they do so in a manner which, contrary to many academics, is both logical and consistent.

PART V

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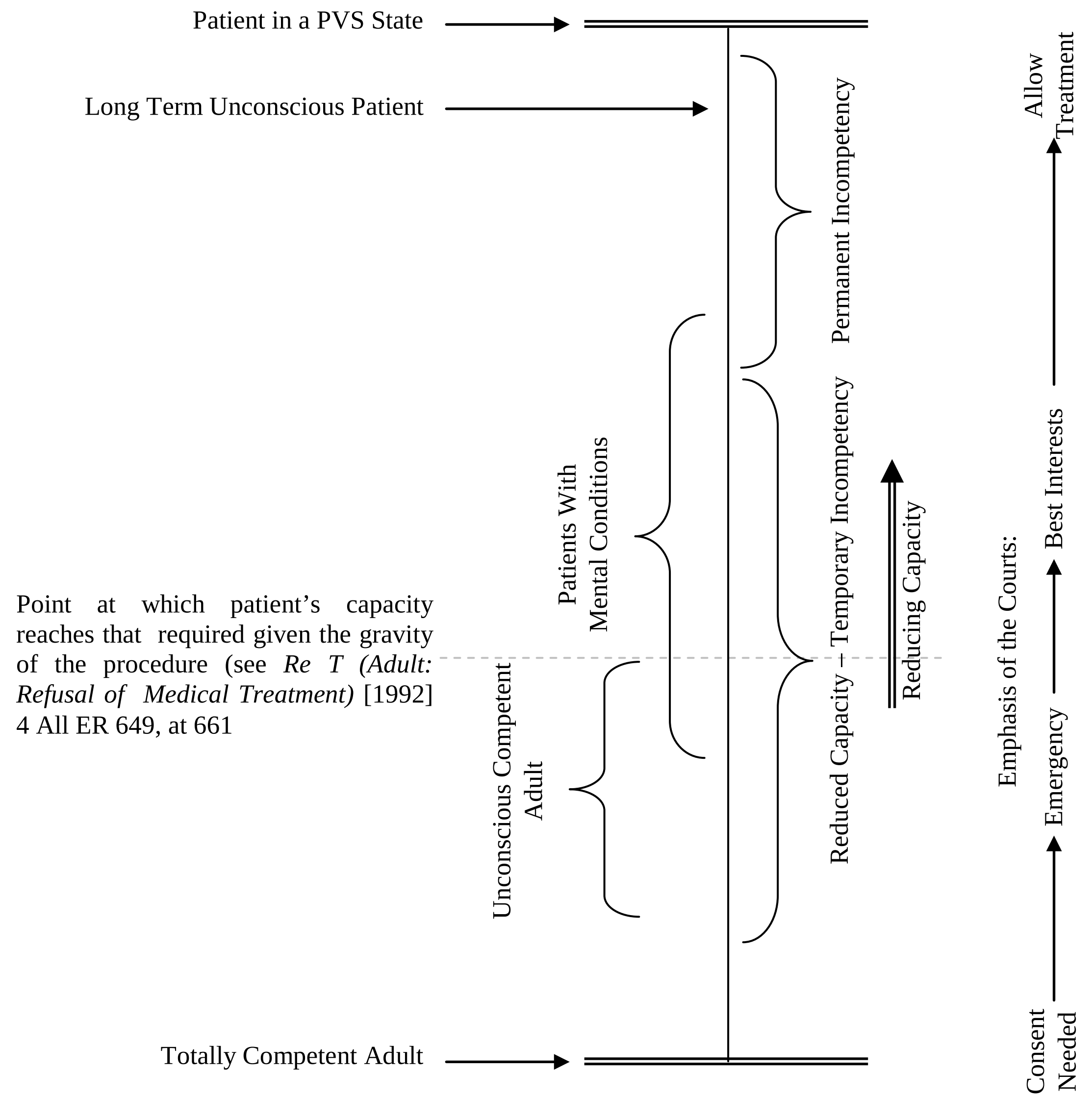
APPENDICES

APPENDIX A:

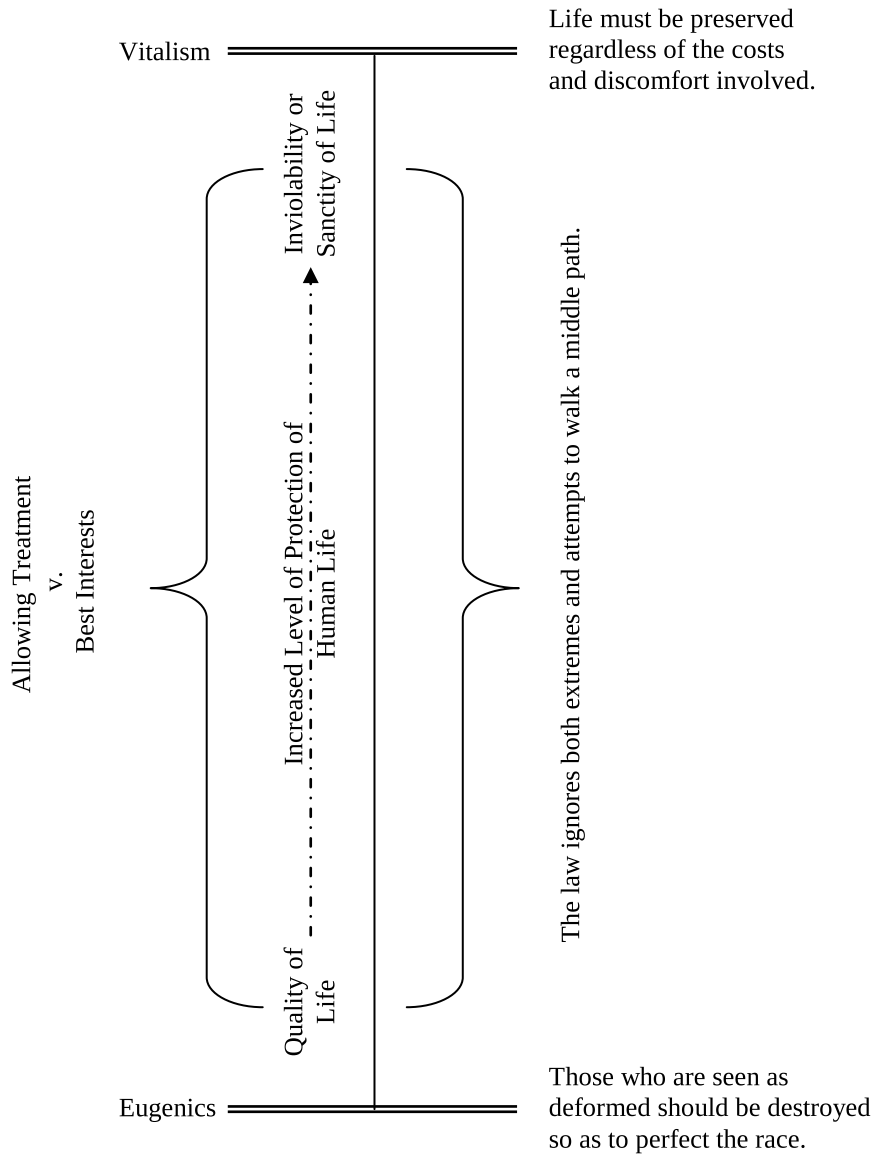
SUPPLEMENTARY FIGURES



Point at which patient’s capacity reaches that required given the gravity of the procedure (see *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649, at 661

Notes: 1. Whilst a patient who lacks competency to decide may also be in an unconscious state, that incompetency will not impact upon the ability to treat, so such a patient has not been depicted here.
2. An adult may have reduced capacity for any number of reasons including: fear, drugs, pain or confusion.
3. It is possible for a mental condition to leave the patient with sufficient capacity to determine his own treatment but this will not always be the case.
4. The Long-term unconscious patient’s condition approaches the same legal position as that of the PVS patient, although here there may be greater hope of recovery.
5. The unconscious competent patient is shown on the competent side of the diagram as his potential for competency will impact upon the availability of treatment.

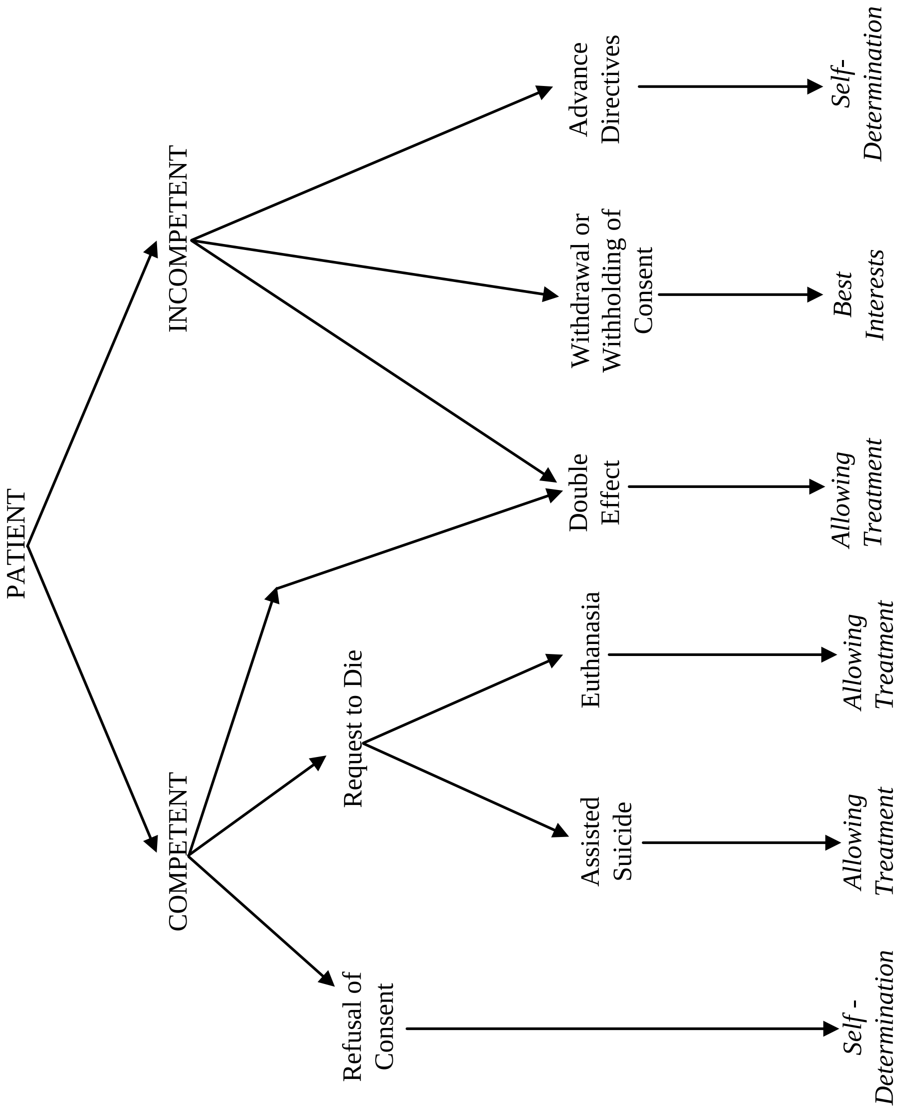
Figure 3 - The Capacity-Incapacity Scale



Notes: 1. In this instance Quality of Life involves looking at different types of life as having different worth, it is the worth of the life that is assessed in determining whether treatment should be given rather than the worth of the treatment involved.

2. The Terms 'Inviolability of Life' and 'Sanctity of Life' are the same concept, the former term merely expresses it in language which reduces the religious undertones that are usually associated with the idea of sanctity.

Figure 4 – From Eugenics to Vitalism



Notes: 1. The principle of allowing treatment is limited according to the definition of treatment. The law sees treatment as providing some medical benefit in the form of either reducing pain or prolonging life. Whilst the principle allows such treatments it prohibits procedures which can be seen as lacking such qualities.

2. Whilst advance directives have to be made whilst competent they only become of real importance once the patient is incapacitated and can no longer refuse consent without the use of such measures.

3. The principle of best interests operates in a negative sense so as to override the normal presumption in favour of treatment rather than to encourage that presumption.

4. *Italics* indicate the guiding principle that applies.

Figure 5 – The Dying Patient

APPENDIX B:

BIBLIOGRAPHY

BOOKS & ARTICLES:

P.S. Appelbaum, C.W. Lidz, J.W. Berg & L.S. Parker, *Informed Consent: Legal Theory and Clinical Practice* (Oxford: Oxford University Press, 2nd, 2001)

A. Bainham, 'The Judge and The Competent Minor' (1992) 108 LQR 194

A. Bainham, 'Resolving the Unresolvable: The Case of the Conjoined Twins' (2001) 6 CLJ 49

P. Bartlett & R. Sandland, *Mental Health Law: Policy and Practice* (Oxford: Oxford University Press, 2nd, 2003)

H. Biggs, 'Euthanasia and Death with Dignity: Still Poised in the Fulcrum of Homicide' [1996] Crim LR 878

J.L. Black-Branch, 'Being Over Nothingness: The Right to Life Under the Human Rights Act' [2001] EL Rev 22

R. Bluglass, 'Psychiatry' in M. Powers & N. Harris (eds), *Medical Negligence* (London: Butterworths, 1990)

D. Brahams, '"Informed Consent" – The Thin End of The Wedge' (1985) 135 NLJ 201

D. Brahams, 'Unwanted Hysterectomies' (1993) 342 The Lancet 361

M. Brazier, 'Reproduction Rights: Feminism or Patriarchy?' in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000)

M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16 LS 84

M. Brazier & J. Harris, ‘Public Health and Private Lives’ (1996) 4 Med L Rev 171

H. Brooke, ‘Capacity to Consent’ in M. Powers & N. Harris (eds), *Medical Negligence* (London: Butterworths, 1990)

J.C. Burley, ‘The Price of Eggs: Who Should Bear the Costs of Fertility Treatments’ in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000)

J.A. Cameron, *Medical Negligence: An Introduction* (Edinburgh: Law Society of Scotland, 1983)

D. Cusine, ‘Legal Issues in Human Reproduction’ in S.A.M. McLean (ed), *Legal Issues in Human Reproduction* Aldershot: Gower, 1989)

D. Cusine, *New Reproductive Techniques: A Legal Perspective* (Aldershot: Gower, 1988)

M. Davis, *Textbook on Medical Law* (London: Butterworths, 2nd, 1998)

G Douglas, *Law, Fertility and Reproduction* (London: Sweet & Maxwell, 1991)

G. Douglas, ‘The Retreat from Gillick’ (1992) 55 MLR 569

G. Dworkin, ‘Public Policy and Physician Assisted Suicide’ in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide: For and Against* (Cambridge: Cambridge University Press, 1998)

G. Dworkin, ‘The Nature of Medicine’ in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide: For and Against* (Cambridge: Cambridge University Press, 1998)

G. Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988)

R. Dworkin, *Life’s Dominion: An Argument About Euthanasia and Abortion* (London: HarperCollins Publishers, 1993)

C. Dyer, ‘Father Fails in Attempt to Stop Girlfriends Abortion’ (1987) 294 BMJ 631

C. Dyer, ‘Who Decides for Those Who Can’t’ (1991) 302 BMJ 1352

M. Evans, ‘Against the Definition of Brain Stem Death’ in R. Lee & D. Morgan (eds), *Death Rites: Law and Ethics at the End of Life* (London: Routledge, 1994)

D. Feldman, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 2nd, 2002)

D. Feldman, ‘Human Dignity and Legal Values – Part I’ (1999) 115 LQR 682

D. Feldman, ‘Human Dignity and Legal Values – Part II’ (2000) 116 LQR 61

H. Fenwick, *Civil Liberties and Human Rights* (London: Cavendish Publishing, 3rd, 2002)

J. Finnis, ‘Bland: Crossing the Rubicon?’ (1993) 109 LQR 329

J.E.S. Fortin, ‘Legal Protection for the Unborn Child’ (1988) 51 MLR 54

J.E.S. Fortin, ‘Sterilisation, The Mentally Ill and Consent to Treatment’ (1988) 51 MLR 634

M. Fox, ‘A Woman’s Right to Choose? A Feminist Critique’ in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000)

R. Francis & C. Johnston, *Medical Treatment; Decisions and the Law* (London: Butterworths, 2001)

C Francome, *Abortion Freedom: A Worldwide Movement* (London: George Allen & Unwin, 1984)

R.G. Frey, ‘Distinctions in Death’ in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide: For and Against* (Cambridge: Cambridge University Press, 1998)

R.G. Frey, ‘The Fear of a Slippery Slope’ in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide: For and Against* (Cambridge: Cambridge University Press, 1998)

J. Glover, ‘Eugenics: Some Lessons from the Nazi Experience’ in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000)

S. Goldbeck-Wood, ‘Europe is Divided on Embryo Regulations’ (1996) 313 BMJ 512

J. Griffiths, ‘Assisted Suicide in the Netherlands: The *Chabot* Case’ (1995) 58 MLR 232

A. Grubb & D. Pearl, ‘Sterilisation and the Courts’ (1987) 46 CLJ 431

A. Halpin, *Rights & Law Analysis & Theory* (Oxford: Hart Publishing, 1997)

J. Harris, ‘Rights and Reproductive Choice’ in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000)

C. Heginbotham, ‘Sterilizing People with Mental Handicaps’ in S.A.M. McLean (ed), *Legal Issues in Human Reproduction* Aldershot: Gower, 1989)

H. Hendin, *Seduced by Death* (London: WW Norton, 1998)

J. Herring, *Family Law* (London: Longman, 2001)

T.E. Hill, *Autonomy and Self Respect* (Cambridge: Cambridge University Press, 1991)

S. Holm, ‘Ethical Issues in Pre-implantation Diagnosis’ in J. Harris & S. Holm (eds), *The Future of Human Reproduction* (Oxford: Clarendon Press, 2000)

S. Hornett, ‘Advance Directives: A Legal and Ethical Analysis’ in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998)

J.D.J. Harvard, ‘Legal Regulation of Medical Practice – Decisions of Life and Death: A Discussion Paper’ (1982) J Roy Soc Med 351

C. Heneghan, ‘Consent to Medical Treatment’ (1991) 337 The Lancet 421

D. Hewitt, ‘Between Necessity and Chance’ (2004) 154 NLJ 584

R Huxtable, ‘Separation of Conjoined Twins: Where Next for English Law’ [2002] Crim LR 459

N.S. Jecker and R.A. Pearlman, ‘Medical Futility: Who Decides?’ (1992) 152 Arch Intern Med 1140

Y. Kasima, ‘Physician Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia’ in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998)

A. Kennedy, ‘Consent to Treatment: The Capable Person’ in C. Dyer (ed), *Doctors, Patients and the Law* (Oxford: Blackwell, 1992)

I. Kennedy & A. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000)

I. Kennedy & A. Grubb, ‘Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult’ (1993) 1 Med L Rev 359

J. Keown, ‘Dehydration and Human Rights’ (2001) 60 CLJ 53

J. Keown, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002)

J. Keown, ‘Restoring Moral and Intellectual Shape to the Law After Bland’ (1997) 113 LQR 481

J. Keown, ‘The Law and Practice of Euthanasia in the Netherlands’ (1992) 108 LQR 51

D. Lamb, *Death, Brain Death and Ethics* (London: Croom Helm, 1985)

R. Lee & D. Morgan, 'Sterilisation and Mental Handicap – Sapping the Strength of the State' (1988) 1 J Law & Soc 229

Lord Lester & D. Oliver, *Constitutional Law and Human Rights* (London: Butterworths, 1997)

N. Lowe & S. Juss, 'Medical Treatment – Pragmatism and the Search for Principle' (1993) 56 MLR 865

B. Mahendra, 'Consent & Capacity in Medical Treatment' (2001) 151 NLJ 939

B. Markesinis, S. Deakin & A. Johnston, *Markesinis & Deakin's Tort Law* (Oxford: Clarendon Press, 5th, 2003)

T.M. Marteau, 'Sex Selection: "The Rights of Man" or the Thin Edge of a Eugenic Wedge' (1993) 306 BMJ 1704

J.K. Mason, *Medico-Legal Aspects of Reproduction and Parenthood* (Aldershot: Dartmouth, 2nd, 1998)

J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002)

J.K. Mason, & R.A. McCall Smith, *Law and Medical Ethics* (London: Butterworths, 5th, 1999)

K. Mason, 'Abortion and the Law' in S.A.M. McLean (ed), *Legal Issues in Human Reproduction* Aldershot: Gower, 1989)

A. McCall Smith, 'Ending Life' C. Dyer (ed), *Doctors, Patients and the Law* (Oxford: Blackwell, 1992)

D. McCarthy, ‘Why Sex Selection Should be Legal’ (2001) 27 J Med Ethics 302

S.A.M. McLean & G. Maher, *Medicine, Morals & The Law* (Aldershot: Gower, 1983)

S.A.M. McLean, *A Patient’s Right to Know* (Aldershot: Dartmouth, 1989)

S.A.M. McLean, ‘Women, Rights and Reproduction’ in S.A.M. McLean (ed), *Legal Issues in Human Reproduction* Aldershot: Gower, 1989)

A.I. Melden, *Rights and Persons* (Oxford: Basil Blackwell, 1977)

D. Meyers, ‘Selective non-Treatment of Handicapped Infants’ in S.A.M. McLean (ed), *Legal Issues in Human Reproduction* Aldershot: Gower, 1989)

M. Minow, ‘Interpreting Rights’ (1987) 96 Yale Law Journal 1860

J. Montgomery, ‘Power Over Death, The Final Sting’ in R. Lee & D. Morgan (eds), *Death Rites: Law and Ethics at the End of Life* (London: Routledge, 1994)

J. Montgomery, ‘Time for a Paradigm Shift? Medical Law in Transition’ (2000) 53 CLP 363

D. Morgan & R.G. Lee, *Blackstone’s Guide to the Human Fertilisation and Embryology Act 1990: Abortion and Embryo Research, The New Law* (London: Blackstone, 1991)

D Morris, ‘Assisted Suicide Under the European Convention on Human Rights: A Critique’ [2003] EHRLR 65

K.McK. Norrie, *Family Planning: Practice and the Law* (Aldershot: Dartmouth, 1991)

K.McK. Norrie, ‘Sterilisation of the Mentally Disabled in English and Canadian Law’ (1989) 38 Int & Comp LQ 387

M. Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (Oxford: Oxford University Press, 1994)

K. Paterson, ‘Introduction’ in K. Paterson (ed) *Law & Medicine* (Bundoora, Australia: La Trobe University Press, 1994)

N. Poplawski & G. Gillett, ‘Ethics and Embryos’ (1991) 17 J Med Ethics 62

G. Robertson, ‘Informed Consent to Medical Treatment’ (1981) 97 LQR 102

J. Rogers, ‘Necessity, Private Defence and the Killing of Mary’ (2001) Crim LR 515

J. Saunders, ‘Medical Futility: CPR’ in R. Lee & D. Morgan (eds), *Death Rites: Law and Ethics at the End of Life* (London: Routledge, 1994)

S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto Press, 1997)

S. Sheldon & S. Wilkinson, ‘Conjoined Twins: The Legality and Ethics of Sacrifice’ (1997) 5 Med L Rev 149

P.D.G. Skegg, ‘A Justification for Medical Procedures Performed Without Consent’ (1974) 90 LQR 512

P.D.G. Skegg, *Law, Ethics and Medicine* (Oxford: Clarendon Press, 1984)

P.D.G. Skegg, ‘Medical Procedure and the Crime of Battery’ [1974] Crim LR 693

K. Standley, *Cases & Materials on Family Law* (London: Blackstone, 1997)

H. Teff, ‘Consent to Medical Procedures: Paternalism, Self Determination or Therapeutic Alliance’ (1985) 101 LQR 432

R. Thornton, ‘Multiple Keyholders – Wardship and Consent to Medical Treatment’ [1992] CLJ 34

J. Waldron, *Theories of Rights* (Oxford: Oxford University Press, 1984)

M Warnock, *A Question of Life: The Warnock Report on Human Fertilisation and Embryology* (Oxford: Basil Blackwell, 1985)

S. Wheatley, 'Human Rights and Human Dignity in the Resolution of Certain Ethical Questions in Biomedicine' [2001] 3 EHRLR 312

G. Williams, *The Sanctity of Life and the Criminal Law* (London: Faber & Faber, 1958)

W.J. Winslade, 'Surrogate Mothers: Private Right or Public Wrong' (1981) J Med Ethics 153

Lord Woolf LCJ, 'Are the Courts Excessively Deferential to the Medical Profession' (2001) 9 Med L Rev 1

Lord Woolf MR, 'Medics, Lawyers and the Courts' (1997) 16 CJQ 302

'Informed Consent' (1987) 3 J Med Def Union (3) 24

'Vasectomy – Consent and Confidentiality' (1987) 3 J Med Def Union (3) 24

PUBLICATIONS:

Law Commission, *Mental Incapacity* (London: HMSO, 1995) Law Com No 231

Secretary of State for Health, *Mental Health Act Code of Practice'* (London: Department of Health, 1999)

The Medical Protection Society, *The Abortion Act 1967* (London: Pitman Medical, 1969)

World Health Organisation, *Promotion of The Rights of Patients in Europe* (London: Kluwer Law International, 1995)

Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity) [2001] 2 FLR 158

Practice Note (Official Solicitor: Persistent Vegetative State: Withdrawal of Treatment) [1996] 4 All ER 766

The Declaration of Geneva (As Amended at Stockholm, 1994)

The Hippocratic Oath

The International Code of Medical Ethics (As Amended at Venice, 1983)

NEWSPAPER REPORTS:

C. Blackstock, 'Matched And Hatched, Britain's First 'Designer Baby' Born To Save Brother', *The Guardian*, 19th June 2003

C. Boseley, 'Public Outrage Prompts Ban on Baby Sex Selection', *The Guardian*, 12th November 2003

T. Dalrymple, 'The Fact That There are Single Mothers Doesn't Make it Right', *The Telegraph*, 21st January 2004

E. Day, 'Curate Postpones Cleft Palate Late Abortion Action' *The Telegraph*, 9th May 2004

C. Hall, 'IVF Rights Extended to Single Women', *The Telegraph*, 22nd January 2003

J. Perrone, 'Designer Babies', *The Guardian*, 5th July 2003

S. Pinker, 'The Designer Baby Myth', *The Guardian*, 5th June 2003

W. Rees-Morgan, 'Beslan is Russia's 9/11: It Will Change The World', *The Times*, 6th September 2004

J. Revill, ''No' to Choosing Your Baby's Sex', *The Observer*, 9th November 2003

S. Womack, 'Curate's Victory on Cleft Palate Abortion' *The Telegraph*, 2nd December 2003

‘Jamie’s Legacy’, *The Observer*, 22nd June 2003