Hospitals and consent to treatment

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Introduction

The Law Commission in 1995 recommended an overhaul of the system for the admission to hospital, treatment and detention of those who lack the capacity to decide their own fate . Ten years later the Mental Capacity Act 2005 received royal assent and came into force in 2007 to right the balance betweendoctorand patient by, fundamentally, enabling individuals with mental disorders to make their own choices in the majority of cases and to place the onus and burden of proof on doctors and others who wish to invoke non-consensual treatment against their wishes . Alongside other notable acts which constitute the legalenvironmentsuch as the MentalHealthAct 2007 there are now strong legal safeguards in place to protect against the horrific abuses of the past. One aspect of the treatment of such individuals which proved to be the least contentious was the ' functional' test for determining capacity which survived the 2007 Act intact. The ' functional' test was discussed extensively in Re C , a case which drew together the strands of the test and indeed proved to be the foundations of the 2005 Act's s. 3 and the presumption that patients have capacity unless proved otherwise under s. 1 . Thorpe J, in upholding a man who had been diagnosed as suffering from paranoid schizophrenia's right to refuse treatment for a gangrenous leg, found clear precedent in two powerful cases from 1993 and observed in his judgement his impressions of the man who, despite delusions of a stellar medicalcareer, was deemed capable to refuse the proposed treatment: " C. himself (the patient) throughout the hours that he spent in the proceedings seemed ordinarily engaged and concerned. His answers to questions seemed measured and generally sensible. He was not always easy to understand and

the grandiose delusions were manifest, but there was no sign of inappropriate emotional expression. His rejection of amputation seemed to result from sincerely held conviction. He had a certain dignity of manner that Irespect."

From the influential judgements of Thorpe J in Re C and B v. Croydon District Health Authority a three-stage test was elicited by the Law Commission which found its way into the 2005 Act : Can the patient take in and retain the informationDoes he/she believe that informationCan he/she weigh that information and make a decisionThe functional test is a modern restatement of the test at common law and continues to be the foundation upon which a test of competency regarding the treatment of a mentally disordered patient is made with recent cases of capacity following the script of the Act strictly . But is this test necessarily the best despite the courts' unanimous application and the lack of disputed cases since 2005This essay will critically discuss the above statement by analysing the functional test's development both pre and post Mental Capacity Act 2005 in part 1 and identifying the key weaknesses in part 2. This essay will argue that the functional test to a significant extent provides protection against arbitrary, non-consensual treatment and despite key weaknesses still surpasses the alternatives identified by the Law Commission .

Part 1

1. 1 The functional test

As noted the functional test is nothing new to medical law and the Mental Capacity Act 2005 simply crystallised into statute what had been prevalent

in case law for some years before with the cases of

In re T. (Adult: Refusal of Treatment) and Re C proving to be particularly influential in shaping the functional test within the 2005 Act . Section 1 of the 2005 Act provides that a patient is presumed to have mental capacity unless proven otherwise. This is, in other words, a “ rebuttable presumption” which arises and acts a safeguard: arguably a powerful disincentive against the “ non-consensual, arbitrary treatment” the statement refers to. Under the Act any such decision to refuse to consent to medical treatment must be dealt with on a balance of probabilities which is the civil standard and indeed a high barrier to cross . The onus of proof is squarely on the complainant unlike the situation previously at common law . Section 2 makes it clear that a personal will lack capacity if “ at the material time” he/she is unable to make a decision because of an “ impairment of, or a disturbance in the functioning of, the mind or brain” . Thus a person’s superficial attributes such as age or appearance will not be considered under this section and it is important to note that the “ impairment” or “ disturbance” referred to in s. 2(1) can be permanent or temporary. Interestingly the Law Commission report points out that this “ diagnosticthreshold”, which requires a person to have a recognised mental disability, comes before the functional element which essentially dilutes any notions of a pure functional test . A good example of such a temporary disorder was demonstrated in Re MB (An Adult: Refusal of Medical Treatment) where MB suffered from a phobia of needles which meant she refused any anaesthetic during a proposed caesarean section which was thought vital to deliver her baby. The Court of Appeal (Civil Division) dismissed the woman’s appeal after the hospital obtained a

declaration that doctors could perform a caesarean . Their Lordships observed that such a condition as she had disabled her from making the decision and, furthermore, other temporary factors such as “ panic brought on by fear” could “ erode” the capacity to make any decision regarding medical treatment .

The Act goes on under section 3 to specify the circumstances under which a person would not be able to make a decision for the purposes of section 2. With four conditions which comprise the heart of the functional test, a person cannot make a decision for himself if he/she is unable to “(a) understand the information relevant to the decision, (b) to retain that information, (c) to use or weight that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)” . There is conflicting dicta regarding whether these elements are cumulative or not but it would seem that more recent authority has settled on the fact that the four elements are not cumulative . Margaret Brazier and Emma Cave sum up the force of these key provisions well:

“ The 2005 Act directs that what must be assessed is essentially the patient’s capacity to understand what is at stake and act on that information.”

1. 2 Case law

Since the Mental Capacity Act came into force in October 2007 there have not been, within the specific context of treatment and decision-making capacity under section 3 of the 2005 Act, any disputed cases at all which would seem to suggest that the functional test is being adopted and applied

consistently and confirms observations that “ capacity is unlikely to be disputed unless others disagree with the outcome” . It is no surprise that of the cases which do cite section 3, which comprises the essence of the functional test, are very diverse including applications by local authorities on where mentally disabled individuals should live , the capacity of mentally disabled individuals to conduct litigation , applications by local authorities to declare that mentally disabled individuals could not consent to sexual relations and even one case which invoked theFamilyDivision’s inherent jurisdiction to prevent the broadcast of a film and the publication of an article about an individual who had dissociated identity disorder and had consented to the film . In the UK then at this present time the problems to be elicited from the functional test are still on a more theoretical rather than practical level. This is an unfortunate development as litigation is often needed to fully understand statutory rules but, as has been pointed out by Mary Donnelly, pre Mental Capacity Act cases remain relevant and will be utilised in the following section to understand the weaknesses of the functional test now enshrined within the 2005 Act .

Part 2: Discussion of the functional test

2. 1 Weaknesses and discussion of the test

As pointed out above it is to pre-2005 Act case law and theoretical problems we must look to in order to map out the weaknesses of the functional test and provoke robust critical discussion. Few authors have discussed these problems but Mary Donnelly’s influential article in the journal ‘ Legal Studies’ in 2009 as well as her book of 2010 have both started to expose the practical flaws and weaknesses which are evident in the 2005 Act’s adoption of the

functional test. A pilot study has also been conducted in England and Wales using the experience of 52 consultants in old age psychiatry which contains some valuable discussion of the Act and its early implementation . These weaknesses will be presented and discussed separately:

(a) The influence of outcomes

It is almost impossible to ignore the fact that outcomes will continue to influence the application of the functional test . This osmosis comes about because only when the outcome of a decision by a mentally disabled individual is challenged will the test come into operation in the context of treatment. Thus, being the raison d’etre of the litigation, it is not surprising to find that many judges, assessors and doctors can succumb to the temptation of disagreeing with an outcome which is undesirable despite the fixed intention of an individual. Margaret Brazier and Emma Cave rightly point out that despite Butler Sloss P warning in B v An NHS Trust that “ it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences,” the same judge then paradoxically stated in Re MB that: “ the graver the consequences of a decision, the commensurately greater the level of competence is required to take the decision” . It is clear that despite the Law Commission’s rejection of an outcome-based approach it is naive to pretend that outcomes can be excluded from the often biased minds of doctors, assessors and even, it would seem, judges.

(b) Irrational decisions

Both Margaret Brazier and Emma Cave rightly identify that the case of Re C

suggests that despite an individual holding strange beliefs or exhibiting bizarre behaviour this should not automatically result in a finding of a lack of capacity to make a decision . As they go on to point out, however, there have been cases where the judge's opinion of such bizarre beliefs has indicated a lack of capacity . One of the factors under s. 3(c) maintains that the individual in question must be able to use and weigh information . Mary Donnelly points out that the ability to reason is an integral part of this factor and thus undermines the liberal account of capacity . Donnelly goes on to point out the case of South West Hertfordshire Health Authority v KB which provides a clear example of a case where a judge confused the ability to reason with the rationality of the decision itself.

(c) Non-judicial assessment

Donnelly also correctly points out that assessor's, often individuals without legal training, are being delegated to carry out legally challenging assessments for capacity in a variety of circumstances . Furthermore, Donnelly concludes that assessors' values and biases are influencing decisions being made which further reinforces the two points made above on outcomes-based decisions and rationality .

(d) The role of undue influence

The final weakness in the functional test which has been identified by Donnelly alone is that there is no satisfactory resolution of the influence of third parties on the will of the individual in respect of the functional test under section 3 of the 2005 Act . Despite there being a clear link between capacity and undue influence in other areas, for example testamentary dispositions, the 2005 Act does not properly address this issue.

Conclusion

In Conclusion the functional test, despite key weaknesses, protects mentally disordered people to a significant extent from arbitrary, non-consensual treatment. The test, now enshrined in the 2005 Act, has not been properly litigated yet: there have, in the four years in which the Act has been operational , been no cases which have invoked the functional test in the area of consent to medical treatment. This could be, as noted above, evidence that the presumption in favour of capacity is working or simply evidence that there have been fewer challenges to capacity in recent years. Further evidence is required to evaluate the lack of cases within this area. Furthermore, the test is also not a purely functional one as there operates a diagnostic threshold which comes into play before it and is an important obstacle for anyone to overcome and which inevitably limits the protection which the test provides .

What is clear from the pre-2005 Act case law is that there are undeniable weaknesses within the ' functional' test which undermine the protection it undoubtedly offers to individuals with mental disorders. The obvious influence of outcomes upon decisions of capacity, the confusion of the ability to reason with the rationality of the decision itself by assessors and judges alike, the unsatisfactory undue influence situation and the non-judicial assessments being conducted by those without legal training all point to a system which is far from perfect but which is better than a purely status based or outcome based system.

Bibliography

1. 0 Books

Brazier, Margaret & Cave, Emma (2007) Medicine, Patients and the Law (4th ed) Penguin Books: London

Donnelly, Mary (2010) Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism Cambridge Uni Press: Worldwide

2. 0 Journals

D. Carson, " Disabling Progress: The Law Commission's Proposals on Mentally Incapacitated Adults' Decision-Making" (1993) J. S. W. F. L. 304.

Donnelly, Mary (2009) ' Assessing Capacity under the Mental Capacity Act 2005: Delivering on the Functional Approach?' Legal Studies 29 p. 464

Fulford, Bill (2010) ' A Pilot Study of the Early Implementation of the Mental Capacity Act 2005 in England and Wales' Medicine, Scienceand the Law 50(3) pp131 – 135

Keywood, Kirsty (2010) ' Vulnerable Adults, Mental Capacity and Social Care Refusal' Medical Law Review 18(1) 103 – 110 at p. 103

3. 0 Reports

Law Commission Report no. 231 Mental Incapacity (1995) HMSO

4. 0 Statutes

Mental Capacity Act 2005

Mental Health Act 2007

5. 0 Cases

A London Local Authority v JH [2011] EWHC 2420 (Fam)

Airedale N. H. S. Trust v. Bland [1993] A. C. 789

B v An NHS Trust [2002] All ER 449

B v. Croydon District Health Authority (1994) 2 2 B. M. L. R. 13;

Banks v Goodfellow (1870) 5 QB 549

D Borough Council v B [2011] EWHC 101 (Fam)

E v Channel Four Television Corp [2005] EWHC 1144 (Fam)

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

F v Riverside Health Trust (1993) 20 BMLR 1

HL v UK (2005) 40 EHRR 32

In re T. (Adult: Refusal of Treatment) [1993] Fam. 95

NHS Trust v T (Adult Patient: Refusal of Medical Treatment) [2004] EWHC 1279

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

Re W (A Minor) (Wardship: Medical Treatment) [1992] 3 WLR 758

Re MB (An Adult: Refusal of Medical Treatment) [1997] 8 Med LR 217

Re C [1994] 1 All ER 819 per Thorpe J at p. 294

Riverside NHS Mental Health Trust v Fox [1994] 1 FLR 614

South West Hertfordshire Health Authority v KB

South West Hertforshire Health Authority v KB [1994] 2 FCR 1051

Tameside and Glossop Acute Services Trust v CH [1996] 1 FLR 762.

T v T [1988] 1 All ER 613 and Re B (A Minor) (Wardship: Sterilization) [1987] 2 All ER 206, HL

V v R [2011] EWHC 822 (QB)

W (Children), Re [2008] EWHC 1188 (Fam)