[1992] 4 All ER 649

Re T (adult: refusal of medical treatment)

Court of Appeal, Civil Division

LORD DONALDSON OF LYMINGTON MR, BUTLER-SLOSS AND STAUGHTON LJJ

22, 23, 24, 30 JULY 1992

James Munby QC and Christopher Butler (instructed by the Official Solicitor) for T.
David Stembridge QC and Stephen Oliver-Jones (instructed by A V S Lewington, Birmingham) for the two health authorities.
Allan Levy QC and Peter Rank (instructed by Smith Partnership, Stoke-on-Trent) for T's father.
Richard Daniel (instructed by Hatchett Jones & Kidgell) for T's mother, who appeared only on 30 July.

At the conclusion of the argument their Lordship's stated that they would give their decision on 24 July 1992 and their reasons therefor on a later date.
24 July 1992. The court announced that the appeal would be dismissed.
30 July 1992. The following judgments were delivered.

LORD DONALDSON OF LYMINGTON MR.

This appeal is not in truth about the 'right to die'. There is no suggestion that Miss T wants to die. I do not doubt that she wants to live and we all hope that she will. This appeal is about the 'right to choose how to live'. This is quite different, even if the choice, when made, may make an early death more likely. It is also about whether Miss T really did choose and, if so, what choice she made.

The public importance of these questions cannot be doubted but this is nothing to do with Miss T as a private individual. She is unconscious and her privacy should be respected. Those who are looking after her have a difficult task and it should not be made more difficult by being harassed by requests for information. Miss T being an adult, it is doubtful whether we have power to make a restraining order of the kind which is often made in the case of children whose medical treatment is in issue before the courts, but I hope and believe that it is in any event unnecessary.

The right to choose

In recent months we have had to review the law in relation to the medical treatment of children (see *Re R (a minor) (wardship: medical treatment)* [1991] 4 All ER 177, [1992] Fam 11 and *Re J (a minor) (medical treatment)* [1992] 4 All ER 614. These decisions have no application to adult patients. An adult patient who, like Miss T, 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. The only possible qualification is a case in which the choice may lead to the death of a viable foetus. That is not this case and, if and when it arises, the courts

will be faced with a novel problem of considerable legal and ethical complexity. This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent (see *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 at 666, [1985] AC 871 at 904–905).

But just because adults have the right to choose, it does not follow that they have in fact exercised that right. Determining whether or not they have done so is a quite different and sometimes difficult matter. And if it is clear that they have exercised their right of choice, problems can still arise in determining what precisely they have chosen. This appeal illustrates both these problems.

The role of consent

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

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

Miss T's history

Miss T's parents separated in 1975 when she was three years old. No doubt there were many reasons, but one was undoubtedly the fact that, whereas Mrs T was a fervent Jehovah's Witness, Mr T emphatically rejected that faith. Initially Miss T continued to live with her father, but six months later she was removed by her mother without her father's consent. In the ensuing proceedings custody

of Miss T was granted to her mother, which is not altogether surprising as she was still very young and was a girl. However the custody order expressly forbade Miss T being brought up as a Jehovah's Witness, the intention being that she should make her own decision when she was old enough to do so. This requirement was only partially met. Miss T was never accepted into that faith by baptism or otherwise and therefore, as the sect has asserted in a statement to the press, '[Miss T] is not and never has been one of Jehovah's Witnesses'. On the other hand Mrs T quite clearly sought in all other respects to bring Miss T up with a view to her becoming a Jehovah's Witness.

In 1989, when Miss T was 17 or 18, she moved from her mother's home to live with her paternal grandmother. A year later she met and began to live with C, who was the father of her baby who was later to be stillborn. During this period, and particularly very recently, Miss T's close relationship with her father which had existed when she was much younger was revived. According to her father they discussed the beliefs of the Jehovah's Witnesses in May or June of this year and she informed him that she was not a Jehovah's Witness. Mr T has also said in an affidavit that 'there has never been anything whatsoever in [Miss T's] actions which led me to believe that she wished to become a Jehovah's Witness'.

On Wednesday, 1 July, when Miss T was 34 weeks pregnant, she was involved in a road traffic accident. She went to hospital where she complained of pain in her right shoulder and in the right side of her chest. She was not initially X-rayed because of her pregnant condition, but was advised to rest and to take an analgesic. She returned to the hospital in the early hours of Saturday, 4 July complaining of increased chest pains. She was X-rayed and diagnosed as suffering from pleurisy or pneumonia. She was prescribed antibiotics and analgesics including pethidine, which is a narcotic drug, and given oxygen. It is at this point that timings become important.

The hospital's patient assessment form contains the entry: 'Religious beliefs and relevant practices. Jehovah's Witness (Ex) but still has certain beliefs and practices.' Whilst this may have been entered initially, this is not certain as the writing is not the same as some other entries such as that of Miss T's name and the name of the consultant. Miss T was admitted to the ward at 6.10 am and given 50 mg of pethidine together with antibiotics at 6.55 am. At that time she was very breathless, was expectorating dirty coloured sputum and complaining of severe chest and shoulder pains. Later during the morning she had a lung scan which did not reveal any abscess but showed a picture which was consistent with pneumonia. No alteration was therefore made in her treatment.

Shortly after 1 pm Miss T was given another dose of pethidine. At 6.30 pm Miss T's mother arrived at the hospital accompanied by C. Later that night, according to information given by the hospital to Miss T's father, Miss T received more pethidine.

Miss T's father arrived at the hospital at 8.30 am on Sunday, 5 July. He observed that his daughter was heavily sedated and that her breathing was extremely laboured. The nursing staff told her father that she had had no rest during the night and was in considerable pain. She was receiving oxygen and had to be raised every 30 minutes to enable her to clear sputum from her lungs, a process with which the father assisted. Miss T's father was anxious as to any complications which might arise from her mother's religious beliefs and spoke to a doctor whom he was unable later to identify. He was told that Miss T did not require a blood transfusion and that there was no need for concern. The situation would be resolved if a transfusion were required. He also noticed a reduction in Miss T's awareness of what was

going on around her and mentioned it to the nursing staff who told him that it was the effect of the drugs.

[1992] 4 All ER 649 at 655

During Sunday morning Miss T's father became so concerned with her apparent condition that he telephoned to his mother (the paternal grandmother) who arrived at 11 am. At 2.50 pm Miss T received the last dose of pethidine before 5 pm when she for the first time spoke of the possibility of a blood transfusion. Meanwhile C and Miss T's sister arrived at the hospital, as did Miss T's mother. Miss T's mother and father had an argument, but not in the presence of Miss T, and agreed that they would not allow their acrimonious relationship to come to her notice. The evidence does not reveal whether this argument was about or involved the topic of blood transfusions.

For some time before 5 pm her mother was alone with Miss T. What passed between them we do not know, because Miss T has never been able to say and the mother, although a party to the proceedings, has never seen fit to give evidence. At 5 pm a staff nurse joined Miss T and her mother and Miss T told the staff nurse that she did not want a blood transfusion, that she used to be a Jehovah's Witness and that she still maintained some beliefs. The staff nurse said that she had thought it strange that this statement should have been volunteered 'out of the blue' moments after her mother had arrived. However, she thought that at that stage Miss T was able to understand what was going on. She sought to 'pacify' Miss T and did not think that there was any problem as Miss T did not need a blood transfusion. At 7.30 pm Miss T's father returned to the ward and thought that her condition was worsening and that she appeared disorientated.

Shortly afterwards Miss T went into labour and at 10.45 pm a decision was reached that she should be transferred to the maternity unit. This involved conveyance in an ambulance for some 200 to 300 yards, during which time Miss T was again alone with her mother. They arrived at the unit at about 11.30 pm. Miss T was then examined by the obstetrics registrar who found her to be in a distressed condition with respiratory pain and contractions. A decision was made that the delivery should be by Caesarian section. Shortly afterwards Miss T told the midwife that she did not want a blood transfusion. Immediately afterwards Dr F saw Miss T and said, 'Do you object to blood transfusions?' She replied, 'Yes.' Dr F said, 'Does that mean that you do not want a blood transfusion?' Miss T said, 'No.' Afterwards Miss T said, 'You can use other things though, can't you, like sugar solutions?' Dr F says that he cannot remember the exact conversation which followed—

'but essentially I said that we could use other solutions to expand the blood, but that they were not as effective as blood at transporting oxygen. I also tried to reassure [Miss T and her father] that blood transfusions were not often necessary after a Caesarian section.'

As Dr F was leaving, the midwife produced a form of refusal of consent to blood transfusions which Miss T signed and the midwife countersigned. The form contemplated that it would also be countersigned by an obstetrician, but it was not so signed. Contrary to what was stated on the form, it was not explained to Miss T 'that it may be necessary to give a blood transfusion so as to prevent injury to my health, or even to preserve my life', nor was the form read or its contents explained to her. She simply signed blindly. Although C has no recollection of the fact, Ward J found that he was present at some time when Miss T was expressing her wish not to have a blood transfusion.

The Caesarian section was performed in the early hours of Monday, 6 July, but unfortunately the baby was stillborn. That night Miss T's condition deteriorated and she was transferred to

the intensive care unit. It appears that, although there had previously been no abscess in Miss T's lungs, one had developed. The situation as it then existed was such that, given a free hand, the consultant anaesthetist in

charge of the unit would unhesitatingly have administered a blood transfusion, but felt inhibited from doing so in the light of Miss T's expressed wishes. Miss T was put on a ventilator and paralysing drugs were administered. She remained sedated and in a critical condition throughout Tuesday, 7 July although she showed some slight improvement.

The first court hearing

On Wednesday, 8 July Miss T's father and C decided to seek the assistance of the court. Quite how they set about it I do not know, but it was an unusual and, in the circumstances, praiseworthy initiative. It was also one which, in all the circumstances, should have been taken by the hospital authorities themselves on the Monday. If Miss T survives, the credit for her survival will be theirs. If she does not, they will have the consolation of knowing that they did all and more than could have been expected of those unfamiliar with the assistance which the court can give in such situations. Their request for assistance was referred to a circuit judge who in turn referred it to Ward J who was sitting in the same circuit centre. This was at about 3 pm. He made immediate inquiries by telephone, but felt that there was insufficient evidence to justify his intervention. On the other hand, he thought the situation was grave enough to justify further investigation. It so happened that Mr Allan Levy QC was appearing before him. Mr Levy has very great experience of cases of this type and Ward J suggested that he be consulted. This initiative again was highly unusual, but wholly commendable.

In the result Mr Levy, junior counsel and their instructing solicitors, together with Miss T's father and C, attended at the judges' lodgings shortly after 11 pm that night. Ward J took evidence on the telephone from Dr F, who had spoken to Miss T in the maternity unit after she had stated for the second time that she did not wish to have a blood transfusion and before she had signed the refusal form. Ward J took a full note of that evidence which we have seen, but it suffices to quote from his judgment:

'[Dr F] told me in summary that [Miss T] was under the influence of the narcotic drug pethidine. Her demeanour late on that Sunday evening was drowsy and detached. He expressed the opinion that she was not fully compos mentis: that she was not fully rational in making an assessment of her medical condition, being unaware how critical her condition was; and that she was not fully rational at the time of signing the refusal. In those circumstances I considered [at 1.30 am] that I had no option but to grant the interlocutory relief that was sought by way of a declaration that in the circumstances, which were then prevailing, it would not be unlawful for the hospital to administer a blood transfusion to [Miss T] despite the absence of her consent because that appeared manifestly to be in her best interests.'

Thereupon Miss T received a transfusion of blood or plasma, it matters not which. Plasma is apparently used to raise the levels of protein in the body and blood to raise the level of oxygen, but both it appears are equally unacceptable to a committed Jehovah's Witness as being, or being derived from, the body tissues of another.

The second court hearing

The matter again came before Ward J on Friday, 10 July for a full hearing at which he heard evidence from the doctors and nurses involved. After referring to a number of authorities, none of which, as he said, were 'quite on the point', although the Canadian decision of*Malette v Shulman* (1990) 77 OR (2d) 417 was

'very close to it', Ward J defined the two questions which he thought he should answer, made findings of fact and answered those questions in the following passage from his judgment:

'In my judgment two questions therefore arise. Firstly, was that refusal to consent which was maintained throughout that period which culminated in the Caesarian section a valid refusal of blood transfusions at the time it was expressed? Secondly, does it remain her settled intention in the emergency which has now arisen where her life may be forfeited if she does not undergo that treatment? As to the first question I make these findings of fact. (1) Although she was under the influence of the painkilling pethidine, she had not lost her mental faculties and she was sufficiently alert, though tired, to be able to understand the questions asked of her and to answer them comprehensively and comprehendingly. Though racked with pain she was still capable of balanced judgment. She was mentally competent and she had the capacity to decide for herself. I recognise that this finding stands in stark contrast to the finding that was implicit in my decision on Wednesday night/Thursday morning. That change of my perception of the case arises from the unhappy fact that [Dr F] had changed his evidence completely. He no longer maintained the stance he had advanced to me on the telephone. He acknowledged in his affidavit now filed in support of the application and repeated in his oral evidence taken on Friday, that "[Miss T's] conscious level was somewhat clouded although she was fully orientated and appropriate in her verbal responses, did not make any inappropriate comments and showed no signs of hallucination. Furthermore, she showed no signs of hesitation in answering my questions regarding blood transfusions and I was therefore satisfied that she was capable of understanding and signing a declaration of refusal of blood products as relating to her subsequent obstetric procedure." (2) I find that [Miss T] reached this decision under the influence of her mother. I cannot find that it was undue influence of the kind which sapped her will and destroyed her volition, but I am satisfied that the pressure of her mother, the very presence of her mother, the mother's fervent belief in the sin of blood transfusion, the patient's desire to please her mother, despite their troubled relationship, all of this contributed to the focus of attention being drawn to blood transfusion before anyone else had ever contemplated its need. Despite all of that I am driven to conclude that the decision was a voluntary one and was not vitiated by any undue influence. (3) As I have indicated, I reject the evidence of the midwife that she read the form to [Miss T]. The midwife gave [Miss T] no explanation at all and I find, like Bristow J in *Chatterton v Gerson* [1981] 1 All ER 257, [1981] QB 432, that this refusal of consent was a refusal in form only and not in reality. (4) None the less the several expressions of refusal to the staff nurse, to [Dr F], to the midwife, refusals maintained in the presence of [Miss T's father] and her boyfriend, whom I accept remained unaware that she had actually signed a form of refusal, were valid refusals which bound and which continued to bind the hospital. I therefore answer my first question in the affirmative and I do find as a result that [Miss T] had the capacity to make a valid refusal of blood on that Sunday afternoon and evening. The answer to the second question is much, much, more difficult and I confess to having agonised all night to reach my conclusions. My difficulty is compounded by the succinctness and cogency of the Official Solicitor's submissions which were made with obvious distaste, but in the due and proper fulfilment of their duties as the guardian

ad litem of this disabled girl. I have expressed a general thanks to all counsel but special thanks should be recorded to the Official Solicitor and to Mr Michael Nicholls of his department for the rapid response to my cry for help and for the superb way in which the Official Solicitor and Mr Butler, who holds his brief, have responded. There is very considerable force in the submission that once a refusal to treatment is expressed and held to be valid and binding on the hospital, as I have found, then that consent or that refusal should continue to prevail and dictate the outcome of this case. If and in so far as there are any presumptions which assist in my conclusions (and I instinctively dislike introducing presumptions in reaching a decision of fact as crucial as this), the presumption that a state of affairs continues until the evidence suggests that it no longer pertains is more to the point than the submission of Mr Levy that the sanctity of life is so vital an interest to protect that, if I am in any doubt, that should take precedence. I cannot approach the case in the way Mr Levy urges. The burden of proof is upon the plaintiff [Miss T's father]. He must satisfy me that it will be lawful to administer a blood transfusion in the circumstances now prevailing and so I ask myself, has [Miss T] evinced a settled intention to refuse a transmission of blood come what may, even if that refusal costs her her life? These factors seem to me to bear upon that decision. (1) [*Miss T's*] *motivation* Though her motivation is irrelevant in the sense that it matters not why she took the decision she did, I find that the reason for her refusal of a blood transfusion arises because it is contrary to the beliefs of the Jehovah's Witnesses. (2) *The depth of* [*Miss T's*] *faith* I regard it as necessary to make findings as to that. I take into account, among other factors, these: (a) she was incarcerated in this belief by her mother during her early teenage years; (b) she has rejected that faith; (c) her own view as expressed to the ante-natal clinic was that she had no religion; (d) as she discussed with her father when they were recently reconciled, she has ceased to be a Jehovah's Witness. He had seen nothing in her lifestyle and her actions which led him to believe that she was then or wished again to become a Jehovah's Witness; (e) she lived a life which is quite contrary to the practices and beliefs of that faith. I accept the evidence of her boyfriend in that regard. There is no evidence that after the mother's appearance on Sunday [Miss T] renounced her adopted lifestyle, sinful as it is in the eyes of the faith. She gave no indication to her boyfriend or to her father that she had repented of her sinful ways and I have no evidence from the mother to suggest that she had; (f) she proclaimed herself to the staff nurse to be an ex-Jehovah's Witness and the notes were recorded accordingly; (g) she had gone to Kingdom Hall only in order to please her mother, that is the evidence of the boyfriend and I accept it. Her adherence to some of the beliefs has been inspired by and is to that extent under some pressure not amounting to undue pressure from her mother; (h) I have no evidence at all from her mother or from any other source that [Miss T's] following of some of the beliefs and some of the practices is so well thought out or deeply considered or sincerely held that the conviction is one which would necessarily lead her to an irrevocable refusal. My conclusion of the strength of her faith is that her convictions are in fact not so deep-seated or so fundamental as to constitute an immutable decision by her as to her way of life or her way of death. In my judgment she remains capable as she has demonstrated herself to be capable of renouncing the tenets of the faith to suit her own chosen way of life. She stands in very stark contrast to Mrs Malette in Canada [see *Malette v Shulman* (1990) 72 OR (2d) 417]. (3) *The manner in which her decision*

was announced The first intimation of it came out of the blue, but I cannot ignore the fact that she has persisted in it. That persistence must however be seen against the background of the following factors: (a) the weakness of her faith as I have found it; (b) the fact that no

explanation was ever offered to her by anyone in medical authority as to the risks that a refusal to have a blood transfusion presented to her health, indeed to her life. I do not enter upon the controversy as to what duty, if any, lay upon the medical advisers to give her that advice: that no explanation whatever was given is an accepted fact in the case; (c) when she raised the question of blood transfusions the only response was to lull her into a sense of false security, both the staff nurse, in her express words, and Dr F in his demeanour and the obstetrics staff nurse explicitly, all sought to indicate that it did not much matter since there appeared to them to be no prospect of a blood transfusion becoming necessary. They had genuinely believed that the risk of a blood transfusion was minimal and they said so. By omission therefore, and it is an understandable though regrettable omission in the circumstances, they did not address the possibility which has now become a reality that a blood transfusion may be a life-saving procedure; (d) [Miss T] was misinformed. The question, as she asked it of Dr F, was a question seeking a reassurance. It was a question bristling with the lingering doubt that some other procedure than the transfusion of blood may be necessary and may be imperative for her health. The answer she was given was false. I do not charge Dr F with deceit, but his reassuring her that there were other means of transfusion was an error. It was perhaps part of his general attempt to calm her fears, but it is a potent indication that there was an underlying fear and she was not properly informed that no alternative was available; (e) there is, to put it negatively, no evidence that she did wish to persist in a refusal of a blood transfusion even if it was at risk to her life. I conclude that in those circumstances the court should proceed with caution in determining whether a generalised refusal, as expressed by [Miss T], is evidence of a settled continuing intention to refuse blood in all circumstances. (4) *Finally*, I have the unchallenged evidence from her father, supported by her boyfriend, with no evidence from the mother to contradict it, that, as I noted in his evidence, "I have no doubt in my mind that [Miss T] would take blood rather than die." There is nothing to contradict that view and much to support it. I find that her refusal does not cover the emergency which has now arisen which was outside her contemplation and the contemplation of others at the time she expressed her opposition to a blood transfusion. I find that the refusal she then gave to the administration of blood was a refusal which took no account of the likely change in her circumstances. I do not find that the refusal as made evinced a settled intention on her part to persist in that refusal even if it is injurious to her health and when the best interests for her health require that blood be transfused to her. Given that she is now at this moment incapable of giving or refusing a consent to the treatment which is necessary in her interests, perhaps to save her life and certainly to advance her cure, I do not find myself satisfied that the refusal is a continuing one, evincing a settled intention on her part to persist in it and accepting, as I do, the father's evidence that she would rather have blood than die, I declare that it shall be lawful for the hospital, in the circumstances prevailing, to administer blood to her, that being in her best interests.'

In essence Ward J found that the physical and mental state of Miss T on the Sunday afternoon and evening were such that, although she was undoubtedly

under the influence of her mother, she was capable of reaching and did reach a decision as to her own treatment. However, he went on to find that Miss T was lulled into a sense of false security by hospital staff and that she was misinformed as to the availability and effectiveness of alternative procedures. Against this background and his assessment of the shallowness of Miss T's acceptance of the beliefs of the Jehovah's Witnesses, he construed Miss T's refusal of treatment by blood transfusion as not extending to the question of whether or not she should receive transfusions in the extreme situation which had arisen. In other words he

concluded that, as to that, Miss T had neither consented nor refused. As Miss T was no longer able to express any view, it was a classic 'emergency' situation in which it was lawful for the doctors to treat her in whatever way they considered, in the exercise of their clinical judgment, to be in her best interests.

The hearing in the Court of Appeal

For the strictly limited purpose of deciding whether Ward J's decision should be affirmed or reversed, it suffices to say that an appellate court should always be slow to reject a trial judge's findings of fact, he having had the advantage of seeing and hearing the witnesses, and that it should be even slower to do so if any findings which it would be minded to substitute would lead to the same result. On that basis I would be content to say, as we did say at the conclusion of the hearing, that the appeal should be dismissed and that we would affirm Ward J's declaration that it would be lawful for the hospital to administer blood to Miss T.

However this appeal has a wider purpose, namely to give guidance to hospital authorities and to the medical profession on the appropriate response to a refusal by an adult to accept treatment. Ward J was faced with a situation which, in the context of an adult patient, is novel to the courts and had little or no guidance from the reported authorities. It would be unfortunate if his findings of facts were regarded as giving any indication of how other such cases should be approached. For my part I think that there is abundant evidence which would have justified this court in substituting findings that Miss T was not in a physical or mental condition which enabled her to reach a decision binding on the medical authorities and that even if, contrary to that view, she would otherwise have been in a position to reach such a decision, the influence of her mother was such as to vitiate the decision which she expressed.

I say this in the light of a number of considerations, the effect of which is cumulative. (a) Miss T had been involved in a road traffic accident four days earlier with effects which were not fully known. (b) She was 34 weeks pregnant and must have been anxious as to the health of her baby. (c) She had developed a severe pneumonia and, whether as a result of the accident or the pneumonia or both, was in severe pain. (d) She had for the previous 24 hours been receiving narcotic drugs and antibiotics and was in a state in which it was necessary to give her oxygen. (e) She appeared to her father to be disorientated and, according to the original evidence of Dr F, to be 'drowsy, detached and not fully compos mentis'. (f) The matrimonial history of father and mother suggests that Miss T's mother is a deeply committed Jehovah's Witness, who would regard her daughter's eternal salvation as far more important, and more in her daughter's best interests, than lengthening her terrestrial lifespan. (g) We do not know what the mother said to Miss T, because she has not chosen to tell the court, but it appears to be the fact that on the two occasions when Miss T raised the issue of blood transfusions, she did so suddenly and 'out of the blue' without any inquiry from hospital staff and immediately following occasions when she had been alone with her mother.

[1992] 4 All ER 649 at 661

Guidance for doctors and hospitals

The fact that, 'emergency cases' apart, no medical treatment of an adult patient of full capacity can be undertaken without his consent creates a situation in which the absence of consent has much the same effect as a refusal. That does not necessarily create any problem for doctors or hospitals. On some occasions it may not be of great importance to the patient's health whether he is treated at that time or perhaps at all. Or it may be a question of choices. The doctor may advise that treatment A is preferable, or much preferable, to treatment B, but that he is prepared to undertake either. The patient may elect for and consent to treatment B

and thereby impliedly decline to consent to treatment A. Again there will be no problem. Where the problem arises is in the comparatively rare situation in which an adult patient declines to consent to treatment which in the clinical judgment of those attending him is necessary if irreparable damage is not to be done to his health or, in some cases, if his life is to be saved. It is only in that context that this appeal may afford guidance to the doctors and hospitals.

If there is a distinction between a failure to consent and a refusal of consent, it is because a refusal can take the form of a declaration of intention never to consent in the future or never to consent in some future circumstances.

The conflict of principle

This situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient's interest consists of his right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life, for if the individual is to override the public interest he must do so in clear terms.

Capacity to decide

The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned. However a small minority of the population lack the necessary mental capacity due to mental illness or retarded development (see, for example, *F v West Berkshire Health Authority (Mental Health Act Commission intervening)* [1989] 2 All ER 545, [1990] 2 AC 1). This is a permanent or at least a long-term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment.

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

patient had the requisite capacity, they are bound by his decision. If not, they are free to treat him in what they believe to be his best interests.

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

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

The vitiating effect of outside influence

A special problem may arise if at the time the decision is made the patient has been subjected to the influence of some third party. This is by no means to say that the patient is not entitled to receive and indeed invite advice and assistance from others in reaching a decision, particularly from members of the family. But the doctors have to consider whether the decision is really that of the patient. It is wholly acceptable that the patient should have been persuaded by others of the merits of such a decision and have decided accordingly. It matters not how strong the persuasion was, so long as it did not overbear the independence of the patient's decision. The real question in each such case is: does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself? In other words, is it a decision expressed in form only, not in reality?

When considering the effect of outside influences, two aspects can be of crucial importance. First, the strength of the will of the patient. One who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful. Second, the relationship of the 'persuader' to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger than would be the case in other relationships. Persuasion based upon religious belief can also be much more compelling and the fact that arguments based upon religious beliefs are being deployed by someone in a very close relationship with the patient will give them added force and should alert the doctors to the possibility—no more—that the patient's capacity or will to decide has been overborne. In other words the patient may not mean what he says.

The scope and basis of the patient's decision

If the doctors consider that the patient had the capacity to decide and has exercised his right to do so, they still have to consider what was the true scope and basis of that decision. If at the time the issue arises the patient still has capacity to decide, they can not only explore the scope of his decision with the patient, but can seek to persuade him to alter that decision. However this problem will usually arise at that time when this *cannot* be done. In such circumstances what the doctors cannot do is to conclude that if the patient still had had the necessary capacity in the changed situation he would have reversed his decision. This would be simply to deny his right of decision. What they *can* do is to consider whether at the time the decision was made it was intended by the patient to apply in the changed situation. It may well have been so intended, as it was in the Canadian

case of *Malette v Shulman* (1990) 72 OR (2d) 417 where the Jehovah's Witness carried a card stating in unequivocal terms that she did not wish blood to be administered to her in *any* circumstances. But it may not have been so intended. It may have been of more limited scope, eg 'I refuse to have a blood transfusion, so long as there is an effective alternative'. Or again it may have been based upon an assumption, eg 'As there is an effective alternative, I

refuse to have a blood transfusion'. If the factual situation falls outside the scope of the refusal or if the assumption upon which it is based is falsified, the refusal ceases to be effective. The doctors are then faced with a situation in which the patient has made no decision and, he by then being unable to decide for himself, they have both the right and the duty to treat him in accordance with what in the exercise of their clinical judgment they consider to be his best interests.

Refusal forms

I was surprised to find that hospitals appear to have standard forms of refusal to accept a blood transfusion and was dismayed at the layout of the form used in this case. It is clear that such forms are designed primarily to protect the hospital from legal action. They will be wholly ineffective for this purpose if the patient is incapable of understanding them, they are not explained to him and there is no good evidence (apart from the patient's signature) that he had that understanding and fully appreciated the significance of signing it. With this in mind it is for consideration whether such forms should not be redesigned to separate the disclaimer of liability on the part of the hospital from what really matters, namely the declaration by the patient of his decision with a full appreciation of the possible terms and emphasised by a different and larger type face, by underlining, the employment of coloured print or otherwise.

Informed refusal

As Ward J put it in his judgment, English law does not accept the transatlantic concept of 'informed consent' and it follows that it would reject any concept of 'informed refusal'. What is required is that the patient knew in broad terms the nature and effect of the procedure to which consent (or refusal) was given. There is indeed a duty on the part of doctors to give the patient appropriately full information as to the nature of the treatment proposed, the likely risks (including any special risks attaching to the treatment being administered by particular persons), but a failure to perform this duty sounds in negligence and does not, as such, vitiate a consent or refusal. On the other hand, misinforming a patient, whether or not innocently, and the withholding of information which is expressly or impliedly sought by the patient may well vitiate either a consent or a refusal.

The role of the courts

If, in a potentially life-threatening situation or one in which irreparable damage to the patient's health is to be anticipated, doctors or hospital authorities are faced with a refusal by an adult patient to accept essential treatment and they have real doubts as to the validity of that refusal, they should in the public interest, not to mention that of their patient, at once seek a declaration from the courts as to whether the proposed treatment would or would not be lawful. This step should not be left to the patient's family, who will probably not know of the facility and may be inhibited by questions of expense. Such cases will be rare, but when they do arise, as was the case with Miss T, the courts can and will provide immediate assistance.

[1992] 4 All ER 649 at 664

Summary

(1) Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so notwithstanding the very strong public

interest in preserving the life and health of all citizens. However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable.

(2) An adult patient may be deprived of his capacity to decide either by long-term mental incapacity or retarded development or by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs.

(3) If an adult patient did not have the capacity to decide at the time of the purported refusal and still does not have that capacity, it is the duty of the doctors to treat him in whatever way they consider, in the exercise of their clinical judgment, to be in his best interests.

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

(5) In some cases doctors will not only have to consider the capacity of the patient to refuse treatment, but also whether the refusal has been vitiated because it resulted not from the patient's will, but from the will of others. It matters not that those others sought, however strongly, to persuade the patient to refuse, so long as in the end the refusal represented the patient's independent decision. If, however, his will was overborne, the refusal will not have represented a true decision. In this context the relationship of the persuader to the patient, for example, spouse, parents or religious adviser, will be important, because some relationships more readily lend themselves to overbearing the patient's independent will than do others.

(6) In all cases doctors will need to consider what is the true scope and basis of the refusal. Was it intended to apply in the circumstances which have arisen? Was it based upon assumptions which in the event have not been realised? A refusal is only effective within its true scope and is vitiated if it is based upon false assumptions.

(7) Forms of refusal should be redesigned to bring the consequences of a refusal forcibly to the attention of patients.

(8) In cases of doubt as to the effect of a purported refusal of treatment, where failure to treat threatens the patient's life or threatens irreparable damage to his health, doctors and health authorities should not hesitate to apply to the courts for assistance.

BUTLER-SLOSS LJ.

I gratefully adopt the summary of facts set out in the judgment of Lord Donaldson MR, which I have read in draft, and I respectfully agree with the general propositions of law which he lays down.

A man or woman of full age and sound understanding may choose to reject medical advice and medical or surgical treatment either partially or in its entirety. A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered (see *Sidaway v Bethlem Royal Hospital Governors*[1985] 1 All ER 643 at 666, [1985] AC 871 at 904–905).

I agree with the reasoning of the Court of Appeal in Ontario in their decision in *Malette v Shulman* (1990) 72 OR (2d) 417 (a blood transfusion given to an unconscious card-carrying Jehovah's Witness). Robins JA said (at 432):

'At issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults, as I have sought to demonstrate, are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual anatomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.'

He excluded from consideration the interest of the state in protecting innocent third parties and preventing suicide. I agree with the principles set out above although I do not believe an English court would give damages in those particular circumstances. Doctors therefore who treat such a patient against his known wishes do so at their peril.

The question may arise as to whether the decision to consent to or reject treatment is made by a patient who has the capacity to make the decision, in other words whether he is fit to make it, or whether he has genuinely made the decision. Even if at the moment of decision the patient is fit to make it, his will may have been overborne by the undue influence of another, or by deception or misinformation of a significant kind. Although the issues of capacity and genuine consent or rejection are separate, in reality they may well overlap, so that a patient in a weakened condition may be unduly influenced in circumstances in which if he had been fit, he would have resisted the influence sought to be exercised over him. The patient may make a decision which is limited in scope, and there may also be the situation where no decision is made and in those circumstances the principle of necessity will apply as set out in the speech of Lord Goff of Chieveley in *F v West Berkshire Health Authority (Mental Health Act Commission intervening)* [1989] 2 All ER 545 at 565–566, [1990] 2 AC 1 at 75–76.

As I understand it, Jehovah's Witnesses accept and take advantage of the same medical treatment as those who do not subscribe to their beliefs and are as anxious as anyone else to recover from any illness from which they may suffer. There is no question of a right to die. This acceptance of medical treatment in its widest sense is subject to the requirement not to accept transfusions of blood or blood derivatives. If Miss T was a baptised and practising member of the Jehovah's Witnesses she would be likely to refuse a blood transfusion or other treatment involving the giving of blood whatever the consequences might be but would accept substitutes if available. It is clear however that, although brought up by her mother in a family subscribing to the beliefs of the Jehovah's Witnesses, Miss T was neither baptised into their faith nor at any time a practising member. Her paternal family is opposed to the sect and some years before these events Miss T had been reunited with her paternal grandmother and her father and for the past two years she had been living in circumstances which would not be approved by the sect.

The questions which arise in this appeal are whether Miss T was fit to make a decision not to have a blood transfusion and whether she made a genuine decision of her own volition or whether her decision is to be impugned by the undue influence of her mother. There is also the question whether she made a decision which was limited in duration and to which she would not have adhered if she

had been alerted to dangers of a refusal to accept blood transfusions or similar blood-based treatment.

Health

Lord Donaldson MR has set out the medical evidence available to us and, in my view, on that evidence it would not have surprised me if there had been a finding that at the relevant times on 5 July, suffering as she was from considerable and continuing pain in her chest, coughing up sputum, on various drugs designed to alleviate pain and to act as sedatives and during the evening suffering contractions in the first stage of labour, she was not in any event fit to make a decision. The trial judge in his careful and anxiously considered judgment, having heard oral evidence, formed a different view, which on this aspect of the appeal I would not seek to upset. However her state of health is extremely relevant to and overlaps the question as to the extent to which the decision was entirely hers.

Undue influence

A most relevant factor in this appeal is the extent and effect of the intervention of the mother who was alone with her daughter immediately before each of the two occasions that Miss T indicated her rejection of a blood transfusion. It is an irresistible inference that before 5 pm the mother had discussed the question of blood transfusions with her daughter because Miss T 'out of the blue' according to the nurse raised the subject. The mother was also alone in the ambulance with her daughter when she was transferred about 11 pm to the labour ward in another part of the hospital shortly before she signed the refusal form. The judge referred to the 'mother's fervent belief in the sin of blood transfusion' and that Miss T had reached her decision under the influence of her mother, but none the less found that Miss T's decision was not vitiated by any undue influence.

Mr Munby QC for the Official Solicitor representing Miss T drew our attention to the line of probate cases which had considered undue influence. Sir J P Wilde summed up to the jury in*Hall* v *Hall* (1868) LR 1 P & D 481 at 482:

'To make a good will a man must be a free agent. But all influences are not unlawful. Persuasion, appeals to the affections or ties of kindred, to a sentiment of gratitude for past services, or pity for future destitution, or the like, these are all legitimate, and may be fairly pressed on a testator. On the other hand, pressure of whatever character, whether acting on the fears or the hopes, if so exerted as to overpower the volition without convincing the judgment, is a species of restraint under which no valid will can be made. Importunity or threats, such as the testator has not the courage to resist, moral command asserted and yielded to for the sake of peace and quiet, or of escaping from distress of mind or social discomfort, these, if carried to a degree in which the free play of the testator's judgment, discretion or wishes, is overborne, will constitute undue influence, though no force is either used or threatened. In a word, a testator may be led but not driven; and his will must be the offspring of his own volition, and not the record of someone else's.'

Hannen P in *Wingrove v Wingrove* (1886) 11 PD 81 at 82–83 described it as coercion:

'The coercion may of course be of different kinds, it may be in the grossest form, such as actual confinement or violence, or a person in the last two days

or hours of life may have become so weak and feeble, that a very little pressure will be sufficient to bring about the desired result, and it may even be, that the mere talking to him at

that stage of illness and pressing something upon him may so fatigue the brain, that the sick person may be induced, for quietness' sake, to do anything. This would equally be coercion, though not actual violence.'

Mr Stembridge QC for the health authorities relied upon the approach of the courts of equity towards the special relationships within the family or within a special group. In*Allcard v Skinner* (1887) 36 Ch D 145 at 183, [1886–90] All ER Rep 90 at 99–100 Lindley LJ said of undue influence:

'As no Court has ever attempted to define fraud so no Court has ever attempted to define undue influence, which includes one of its many varieties. The undue influence which Courts of Equity endeavour to defeat is the undue influence of one person over another; not the influence of enthusiasm on the enthusiast who is carried away by it, unless indeed such enthusiasm is itself the result of external undue influence. But the influence of one mind over another is very subtle, and of all influences religious influence is the most dangerous and the most powerful, and to counteract it Courts of Equity have gone very far. They have not shrunk from setting aside gifts made to persons in a position to exercise undue influence over the donors, although there has been no proof of the actual exercise of such influence; and the Courts have done this on the avowed ground of the necessity of going this length in order to protect persons from the exercise of such influence under circumstances which render proof of it impossible.'

The difference of approach between the courts of law and the courts of equity was described by Scrutton LJ in *Lancashire Loans Ltd v Black* [1934] 1 KB 380 at 404, [1933] All ER Rep 201 at 208 (a case of undue influence by a mother over her daughter):

'Of this "fraud" Lord Hardwicke says [in *Earl of Chesterfield v Janssen* (1750) 2 Ves Sen 125 at 155, 28 ER 82 at 100]: Equity "goes further than the rule of law; which is, that it must be proved, not presumed." The rule of law thus described still prevails in the Probate Court, where it is not enough to prove a relation between testator and beneficiary, which in the Court of Equity would require the beneficiary to displace the presumption of undue influence by proving independent advice to the testator.'

Neither the probate line of cases nor the donor line of cases is appropriate to apply to the present situation which is entirely different and I respectfully agree with the observations of Staughton LJ, whose judgment I have had an opportunity of reading in draft. But the decisions referred to above are helpful to demonstrate that both at law and in equity it has long been recognised that an influence may be subtle, insidious, pervasive and where religious beliefs are involved especially powerful. It may also be powerful between close relatives where one may be in a dominant position vis-à-vis the other. In this case Miss T had been during her childhood subjected to the religious beliefs of her mother and in her weakened medical condition, in pain, and under the influence of the drugs administered to assist her, the pressure from her mother was likely to have a considerably enhanced effect. I find it difficult to reconcile the facts found by the judge with his conclusion that the influence of the mother did not sap her will or destroy her volition. The degree of pressure to turn persuasion or appeals to affection into

undue influence may as Hannen P said in *Wingrove v Wingrove* (1886) 11 PD 81 at 82–83 be very little. In my view the trial judge, dealing as he was with a most difficult and distressing case under the necessity to give a decision immediately, did not sufficiently take into account the degree of pressure required to constitute undue influence in the case of a patient in the

position of Miss T. I agree with Lord Donaldson MR that there is abundant evidence which would justify this court in coming to the conclusion that she was subjected to the undue influence of her mother which vitiated her decision.

Limited refusal—the scope of her decision

The judge based his decision upon this point. In my view on the facts as found by the judge this issue does not arise since she was not able to make a genuine decision. But I can see circumstances in which a patient is unwilling to have certain procedures carried out and says so under the impression that in any event the emergency which would bring those procedures into play will not happen. If the patient has been misled or misinformed he may not have given a genuine consent or refusal. This is not to bring in the doctrine of informed consent which is not the law of this country. But on the present facts Miss T did not want a blood transfusion but she did ask whether there was a substitute treatment and was told, erroneously, I believe, that there was. She was also told in order to calm her down that a blood transfusion was most unlikely and she did not have to face, it appears, the possible serious or even fatal consequences of her decision. Had she been making a genuine decision to refuse the treatment, it would be necessary in a case such as this to find out if the patient had received any advice as to the consequences of a refusal to accept treatment. In *Malette v Shulman* (1990) 72 OR (2d) 417 the answer was clear. It may be less clear in other situations.

In this case I am satisfied that the doctors were justified in disregarding the written instructions of Miss T and of treating her on the basis of an emergency.

I would dismiss this appeal.

STAUGHTON LJ.

An adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment. Thus far the law is clear. The difficulty arises when it is uncertain whether or not the competent adult (as I call her for brevity) does or does not consent to the proposed treatment.

One such occasion will be when the adult is brought to hospital unconscious after an accident, and has had no opportunity to signify whether she consents to treatment or not. In those circumstances treatment can only be justified by the principle of necessity, as stated by Lord Goff of Chieveley in *F v West Berkshire Health Authority (Mental Health Act Commission intervening)* [1989] 2 All ER 545 at 565–566, [1990] 2 AC 1 at 75–76:

'… to fall within the principle, not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person. On this statement of principle, I wish to observe that officious intervention cannot be justified when another more appropriate person is available and willing to act; nor can it be justified when it is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish.'

[1992] 4 All ER 649 at 669

In any individual case there are three possibilities: (a) the patient consents, (b) the patient has expressed no decision and (c) the patient refuses consent. A further complication arises because an apparent consent, or apparent refusal to consent, may not be a true consent or a

true refusal. I use the word 'true' to express the notion that consent, or refusal of consent, may be inoperative in law for one of three reasons; there may perhaps be others, but only these three are relevant to the present case.

The first reason is that the apparent consent or refusal was given as a result of undue influence. It is, I think, misleading to ask whether it was made of the patient's own free will, or even whether it was voluntary. Every decision is made of a person's free will, and is voluntary, unless it is effected by compulsion. Likewise, every decision is made as a result of some influence: a patient's decision to consent to an operation will normally be influenced by the surgeon's advice as to what will happen if the operation does not take place. In order for an apparent consent or refusal of consent to be less than a true consent or refusal, there must be such a degree of external influence as to persuade the patient to depart from her own wishes, to an extent that the law regards it as undue. I can suggest no more precise test than that. The cases on undue influence in the law of property and contract are not, in my opinion, applicable in the different context of consent to medical or surgical treatment. The wife who guarantees her husband's debts or the widower who leaves all his property to his housekeeper are not in the same situation as a patient faced with the need for medical treatment. There are many different ways of expressing the concept that what a person says may not be binding upon him; a Greek poet wrote 'my tongue has sworn, but no oath binds my mind'.

The second reason why an apparent consent or refusal of consent may not be a true consent or refusal is that it may not have been made with reference to the particular circumstances in which it turns out to be relevant. A patient who consents, even in the widest terms, to a dental operation under anaesthetic does not give a true consent to the amputation of a leg. Nor does a patient who refuses consent in some circumstances necessarily give a true refusal of consent to treatment in any quite different circumstances which may arise: an example is to be found in *Werth v Taylor* (1991) 190 Mich App 141.

The third reason is that at the time of apparent consent or refusal the patient may not, for the time being, be a competent adult. Her understanding and reasoning powers may be seriously reduced by drugs or other circumstances, although she is not actually unconscious.

The notion that consent or refusal of consent may not be a true consent or refusal presents a serious problem for doctors. It does not arise so much when the doubt lies between (a) consent and (b) no decision. In such a case the surgeon may lawfully operate, in the knowledge that he can be justified either by consent or by the principle of necessity, whichever is in fact applicable. But what if the choice is, as in this case, between (b) no decision and (c) refusal of consent? The surgeon will be liable in damages if he operates when there is a valid refusal of consent, and liable in damages if he fails to operate in accordance with the principle of necessity when there was no valid decision by the patient. That is the intolerable dilemma described by Lord Bridge of Harwich in *F v West Berkshire Health Authority* [1989] 2 All ER 545 at 548–549, [1990] 2 AC 1 at 52. In *Malette v Shulman* (1990) 72 OR (2d) 417 a Canadian court upheld an award of $20,000 to a patient who had been given a blood transfusion in order to save her life but against her known wishes. I doubt if an English court would have awarded such a sum; but the liability would exist.

[1992] 4 All ER 649 at 670

Some will say that, when there is doubt whether an apparent refusal of consent is valid in circumstances of urgent necessity, the decision of a doctor acting in good faith ought to be conclusive. In this case there was an application at the judge's lodgings at 11 o'clock at night,

a procedure which may not always be available. However, I cannot find authority that the decision of a doctor as to the existence or refusal of consent is sufficient protection, if the law subsequently decides otherwise. So the medical profession, in the future as in the past, must bear the responsibility unless it is possible to obtain a decision from the courts.

In the present case I agree with Lord Donaldson MR and Butler-Sloss LJ that there was no valid refusal of consent, and that the doctors were justified in their treatment of Miss T by the principle of necessity. I would dismiss this appeal.

Appeal dismissed. No order as to costs. Leave to appeal to the House of Lords granted.