[1997] EWCA Civ 3093

IN THE SUPREME COURT OF JUDICATURE
IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
FAMILY DIVISION
PRINCIPAL REGISTRY
(MR JUSTICE HOLLIS)

Royal Courts of Justice
Strand
London WC2
26 March 1997

Before:
LORD JUSTICE BUTLER-SLOSS
LORD JUSTICE SAVILLE
LORD JUSTICE WARD

RE MB

MR R FRANCIS QC (Instructed by Messrs Le Brasseur J Tickle, Kingsway, London, WC2B 5HA) appeared on behalf of the Appellant
MR J GRACE QC (Instructed by Messrs Hempsons, London, WC2E 8NH) appeared on behalf of the Respondent
MR M HINCHCLIFFE (Instructed by The Official Solicitor, Chancery Lane, London) appeared on behalf of the Official Solicitor

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LADY JUSTICE BUTLER-SLOSS: This is the judgment of the Court.

1. This appeal arose from the application by a health authority for a declaration from the High Court that it would be lawful for the consultant gynaecologist to operate upon a young woman, Miss MB, who was 40 weeks pregnant and admitted to hospital on Friday 14th February. Hollis J granted declarations at 9.55 pm on the 18th February and Miss MB appealed to this Court. We heard her appeal in open court at 11.0 pm on the same day. We heard argument from Mr Francis QC for Miss MB, Mr Grace QC for the health authority (the hospital) and Mr Hinchcliffe for the Official Solicitor as Amicus Curiae. We dismissed the appeal. In view of the time when the hearing was completed, about 1.0 am, and the importance of the issues raised, we reserved the reasons for our decision. We directed that the hospital should provide affidavit evidence from the consultant obstetrician and gynaecologist, Mr N, and from the consultant psychiatrist, Dr F, and asked for skeleton arguments from Mr Francis, Mr Grace and the Official Solicitor. We now give our reasons for the decision to dismiss the appeal.

2. Miss MB is aged about 23 and was the mother of one child. She lives with the father of the child she was carrying. According to the affidavit of Mr N, she

attended an ante-natal clinic for the first time on the 23rd December 1996 when she was approximately 33 weeks pregnant. She refused to allow blood samples to be taken since she was frightened of needle pricks. She failed to attend ante-natal appointments on the 6th, 13th and 27th January. She attended the ante-natal clinic on the 3rd February but refused to allow blood samples to be taken. She attended the ante-natal clinic on the 13th February and was examined by Mr N, because the foetus was found to be in the breech position, a footling or incomplete breech presentation. He arranged for her to be given an ultrasound scan which confirmed the position of the foetus. This was an obstetric complication with potentially serious consequences for the unborn child. One possibility was a prolapse of the umbilical cord after the rupture of the membranes which might obstruct the foetal blood supply during the birth and which might cause death or risk of brain damage as a result of the foetus receiving insufficient oxygen. The risk to the unborn child was assessed as 50% although there was little physical danger to the mother. According to Mr. N, because of the risk to the foetus, it was the practice to recommend that a breech presentation by the foot should always be delivered via a caesarian section. An alternative procedure which he carried as a Senior Registrar was epidural anaesthesia during a vaginal delivery to minimise the risk of pushing prematurely with the possibility of an emergency caesarian section. That procedure would also require the use of a needle.

3. After the ultrasound scan Mr N explained to Miss MB the risk to the foetus of a vaginal delivery. She agreed to have a caesarian section. Mr N did not discuss the method of anaesthesia since that was a matter for the anaesthetist. He arranged for Miss MB to be admitted to the hospital on Friday 14th February. According to the extracts from the hospital records, on admission Miss MB signed the consent form for the caesarian section but twice refused to undergo a venepuncture to provide blood samples. On the 15th February the hospital notes recorded that Miss MB was requesting a caesarian section but the hospital required blood samples. Later that evening Miss MB and her partner again requested a caesarian section. On the 16th February Miss MB again signed a consent form for the caesarian section and arrangements were made for the operation to take place. The anaesthetist visited Miss MB in order to insert the veneflon but Miss MB refused and the operation was cancelled. She was not prepared to allow blood samples to be taken nor to undergo anaesthesia by way of injection. A consultant anaesthetist saw her later the same day and suggested anaesthesia by mask without injection. He explained the danger that the patient may regurgitate and inhale stomach contents during the induction of anaesthesia which is increased where anaesthesia is induced by mask. She eventually agreed to allow the mask and the operation was again arranged to take place.

4. The extracts from the hospital records then move to the 18th February. The consultant anaesthetist between 12.45 and 1.45pm fully explained the whole situation to Miss MB, including the risk of aspiration following the use of the mask. She then refused consent for the caesarian section. Mr N saw her at 3.0pm at which time she was refusing to discuss her problems with anyone. He explained the risks to the foetus if she went into labour. He noted:-

"M. does not respond or express any wishes regarding her treatment."

5. Miss MB then went into labour with regular contractions. She was not responding to the midwife or the consultant. Her general practitioner went to talk to her about 7.0pm. He reported that she was happy to go for the operation provided she did not feel or see the needle; did not have an IV line and did not have a catheter `post op'. She agreed to have the operation if those conditions were fulfilled. The consultant psychiatrist Dr F saw her shortly after 8.0pm. She agreed again to have the caesarian section. At 9.0pm she went to the operating theatre and got on the table, but when she saw the mask she pushed it away and refused to consent to anaesthesia. The operation was again cancelled.

6. At this stage the hospital, who had already been in touch with its legal advisers, sought a court order at 9.25pm and Hollis J made the declarations at 9.55pm. Earlier in the day Miss MB had been provided with her own lawyers and she had spoken on the telephone to Mr Francis about 9.0pm. After Hollis J.`s decision Mr Francis again spoke to her and she instructed him to appeal. It was in those circumstances at the request of all parties, including Miss MB, we heard the appeal later the same night. Miss MB was by then not in established labour and she was returned to the labour ward. On the following morning Miss MB signed another consent form and co-operated fully in the operation and the induction of anaesthesia. Mr N delivered a healthy boy by caesarian section on the 19th February.

7. We turn now to the affidavit evidence from Dr F, the consultant psychiatrist. He heard about the problem for the first time on the 18th February and was told by the obstetrician that Miss MB and her partner were in favour of the operation and the problem was purely a question of needle phobia. He saw Miss MB for the first time in the evening of the 18th February in the labour ward with her partner present. The anaesthetist and the midwife were also present.

8. Dr F said that Miss MB knew that there were legal proceedings. She understood that he had been asked to assess her in connection with those proceedings. He was satisfied that she clearly understood the reasons for the caesarian section and accepted them without reservation. The only problem was the difficulty of establishing anaesthesia. Dr F did not think that the full implications of not being able to accept the advice for her and her baby were as clear to her as he would have wished and his impression was that she lacked the capacity to see very far beyond the immediate situation. While Dr F was with her the general practitioner arrived and she agreed to take the mask.

9. Dr F's note reads as follows:-

> "Has now agreed to anaesthetic induction with a gas mask and accepts that a needle will be necessary thereafter. Clearly understands and consents to the need for a caesarian section - it was her irrational fear of needles that has got in the way of proceeding with the operation.

> Although she got this far earlier in the day and then withdrew consent, she now seems to be reconciled to the need to go ahead without further delay.
>
> With regard to her mental state. She is a naive, not very bright, frightened young woman but is not exhibiting a psychiatric disorder."

10. Dr F confirmed that Miss MB was suffering from `the abnormal mental condition` of needle phobia which he described as:-

> "That is the term which is used conventionally... Usually [a phobia] means that the patient suffers from an abnormal fear in relation to some specific object or procedure. Typically encountering that object triggers a panic and the patient`s sole thought is to distance themselves from the object which threatens them. I did not ask how long she had had a needle phobia. It would not be in any way the less valid if it had only developed within the last few days. If [Miss MB] felt that she could not tolerate the thought of a needle penetrating her skin it would be perfectly capable of inducing a panic reaction."

11. In answer to the question from the solicitor for the hospital at about 9.15 pm `was she competent?`, he answered at paragraph 18 of his affidavit:-

> "Away from the need to undergo the procedure, I had no doubt at all that she fully understood the need for a caesarian section and consented to it. However in the final phase she got into a panic and said she could not go on. If she were calmed down I thought she would consent to the procedure. At the moment of panic, however, her fear dominated all."

12. He was told that Miss MB had wanted the operation and to be induced by mask but when she entered the operating theatre and had been confronted by the mask and paraphernalia of anaesthesia in surgery she had panicked again. He said:-

> "It seemed to me that at the actual point she was not capable of making a decision at all, in the sense of being able to hold information in the balance and make a choice. At that moment the needle or mask dominated her thinking and made her quite unable to consider anything else....
>
> Her continued refusal to consent to surgery for some time after she had panicked is not in any way inconsistent with my view that her refusal was due to a sudden flooding panic. I would expect there to be some difficulty in addressing the subject and balancing the two issues for a period of time after the panic."

13. Dr F was also asked whether Miss MB would suffer any long term damage if there was no operation and the child was born handicapped or died:-

> "My answer to the second question was unhesitating. Undoubtedly, I said, I thought it very likely that there would be significant long term damage. Obviously one could not know for certain but I felt that it was very likely."

14. He did not feel that she would suffer permanent damage from the procedure being imposed upon her. It was never a question of her wanting natural childbirth. She wanted the surgical procedure to be over and done with. While he was present the midwife described the caesarian section procedure and the line of incision. She was interested and not distressed by the information and Dr F did not see any reason to suppose that she would suffer any particular short term trauma as a result of the forcible procedure. He had little doubt that the non-consensual nature of the injection would not be a matter of lasting importance to Miss MB.

15. The judge found:-

> "1. Basically the mother agrees to it but she is overcome when the point comes to it by her phobia of needles being stuck in her.
>
> 2. This case probably comes into line with the Kirkwood J case.
>
> 3. It is correct that she is not really capable of considering matters lucidly
>
> so operation should be performed."

16. The judge made the following declarations:-

> 1. It shall be lawful for 2 days from the date of this order notwithstanding the inability of the proposed defendant to consent thereto:
>
> > (i) for the proposed plaintiff`s responsible doctors to carry out such treatment as may in their opinion be necessary for the purposes of the proposed defendant`s present labour, including, if necessary, caesarian section, including the insertion of needles for the purposes of intravenous infusions and anaesthesia;
> >
> > (ii) for reasonable force to be used in the course of such treatment;
> >
> > (iii) generally to furnish such treatment and nursing care as may be appropriate to ensure that the proposed defendant suffers the least distress and retains the greatest dignity.
>
> 2. There be liberty to apply.

On behalf of Miss MB Mr Francis raised 4 issues in his grounds of appeal.

1.The judge was wrong to find on the evidence that the appellant lacked the capacity to consent to or refuse treatment.

2. The judge failed to make a finding as to what were the appellant`s best interests.

3. The evidence did not establish that the proposed treatment was in the appellant`s best interests.

4. It is unlawful at common law to use force on a mentally incompetent patient in order to impose medical treatment on her.

General Principles

17. We start by setting out the basic principles which underpin the proper approach to the issues raised on this appeal.

(1). Subject to (3) below, in general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patient`s consent, see**Collins v Wilcox [1984] 1 WLR 1172 per Goff LJ at page 1177**, cited with approval in **Re F (Mental Patient: Sterilisation) [1990] 2 AC 1**.

(2). A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death, see **Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871 per Lord Templeman at pages 904-905**; see also **Re T (An Adult)(Consent to Medical Treatment) [1993] Fam 95 per Lord Donaldson MR at page 102.**

(3). Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent had been competently given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient: **Re F (supra)**.

Capacity to decide.

18. Problems can arise on the issue of capacity to consent to or refuse treatment. The starting point for consideration of the test to be applied is the decision of this Court in **Re T (supra).** The patient who was pregnant had been involved in a car accident and during hospital treatment required a blood transfusion. **Lord Donaldson MR** reviewed the relevant authorities and said at **page 112**:-

> "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, Re F (Mental Patient) (Sterilisation) [1990] 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."

19. **Thorpe J**, in **Re C (Refusal of Medical Treatment) [1994] 1 FLR 31**, formulated the test to be applied where the issue arose as to capacity to refuse treatment. In that case a man of 68 suffering from chronic paranoid schizophrenia refused to have an amputation of his leg). **Thorpe J** said at **page 36**:-

> "I consider helpful Dr E`s analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, secondly, believing it and, thirdly, weighing it in the balance to arrive at choice. The Law Commission has proposed a similar approach in para 2.20 of its consultation paper 129 `Mentally Handicapped Adults and Decision-Making`."

20. In 1995 the **Law Commission** recommended in **Law Com. No.231 on Mental Incapacity** in paragraphs 3.2-3.23 that a person is without capacity at the material time if he is unable by reason of mental disability to make a decision for himself on the matter in question either because -

> (a) he is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision; or
>
> (b) he is unable to make a decision based on that information.

'Mental disability' was defined as a disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.

21. We turn now to consider some of the caesarian section decisions. In **Tameside and Glossop Acute Services Trust v CH [1996] 1 FLR 762** the patient was

suffering from paranoid schizophrenia and was admitted under **section 3** of the **Mental Health Act 1983**. She was found to be pregnant and that the foetus was in danger if the pregnancy continued. There was overwhelming evidence that she lacked the capacity to consent to or refuse the treatment proposed. **Wall J**, in making the declaration sought under **section 63** of the **Mental Health Act**, set out the general principles which govern non-consensual treatment and applied the three part test, (**the C Test**), set out by **Thorpe J** in **Re C, (supra)**.

22. In **Norfolk and Norwich HealthCare (NHS) Trust v W [1996] 2 FLR 613** the patient arrived at the hospital in labour denying that she was pregnant. She had a history of psychiatric treatment. She was in a state of arrested labour. The obstetrician considered a forceps delivery or a caesarian section had to be performed. A psychiatrist examined her and found she was not suffering from a mental disorder. He was not certain whether she was capable of comprehending and retaining information about the proposed treatment but she continued to deny she was pregnant. He was not sure if she was capable of believing the information about the treatment. He was however of the opinion that she was not able to balance the information given to her.**Johnson J** at **page 616** held that:-

> "although she was not suffering from a mental disorder within the meaning of the statute, she lacked the mental competence to make a decision about the treatment that was proposed because she was incapable of weighing up the considerations that were involved. She was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour made even more difficult for her because of her own particular mental history."

23. The judge was satisfied that the operation was in her best interests and that in the circumstances the court had power at common law to authorise the use of reasonable force.

24. During the hearing of the **Norfolk and Norwich case Johnson J** was asked to make declarations in **Rochdale Healthcare (NHS) Trust v C [3 July 1996] (unreported)**. It was extremely urgent in that the consultant obstetrician considered that the caesarian section had to be carried out within the hour if the foetus was to survive and risk of damage to the patient`s health was to be avoided. The mother had previously had a caesarian section and said she would rather die than have it again. It was not possible to obtain psychiatric evidence in the time available. The obstetrician considered that the patient was fully competent. The judge had very little time and only `the scantiest information` upon which to assess the patient and make a decision. He applied**the C Test** and found that the patient was not capable of weighing up the information that she was given, the third element of **the C test**. He held:-

> "The patient was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able

> properly to weigh-up the considerations that arose so as to make any valid decision, about anything of even the most trivial kind, still one which involved her own life."

25. One may question whether there was evidence before the court which enabled the judge to come to a conclusion contrary to the opinion of the obstetrician that she was competent. Nonetheless he made the declarations sought. In fact the patient changed her mind and consented to the operation.

26. In **Re L [5th December 1996] (unreported) Kirkwood J** was faced with an application on facts similar to the present appeal. This was the decision relied upon by Hollis J. It was an urgent application in respect of a patient `L`in her twenties who had been in labour for some hours and the labour had become obstructed. In the absence of intervention the foetus was at risk and deterioration was inevitable and death would follow. The carrying of a dead foetus would be injurious to the patient`s health and the removal of the foetus by surgical procedure would become necessary. An emergency caesarian section was strongly indicated. `L` wanted her baby to be born alive but she suffered from a needle phobia and was unable to consent to the use of a needle and therefore to the proposed course of treatment. The judge applied **the C test** and said:-

> "that her extreme needle phobia amounted to an involuntary compulsion that disabled `L` from weighing treatment information in the balance to make a choice. Indeed it was an affliction of a psychological nature that compelled `L` against medical advice with such force that her own life would be in serious peril."

27. He held that she was incapable of weighing the relevant treatment information in the balance and thus lacked the relevant mental competence to make the treatment decision. He further held that it was in her best interest to have the operation and he granted the declaration sought by the hospital.

28. In each of the decisions to which we have referred the question of the competence of the woman concerned was in issue and in each case she was found to lack the capacity to consent to or refuse treatment. The only reported decision, to our knowledge, in which the capacity of the patient to decide does not appear to have been specifically raised was **Re S (Adult: Surgical Treatment) [1993] 1 FLR 26**. It was the first occasion upon which this problem was considered by the High Court. It was a life and death situation both for the mother and for the unborn child and a decision was required in minutes rather than hours. It was heard by **Sir Stephen Brown, P**. as a matter of the utmost urgency. The hearing was brief and it was not possible for the mother to be represented. The health authority applied for a declaration that it was lawful for the hospital to carry out an emergency caesarian section operation. The Official Solicitor acted as Amicus Curiae. The patient`s objection to the operation was stated to be on religious grounds. The judge heard brief evidence and said in his judgment at **page 27**:-

"Although this application only came to the notice of the court officials at 1.30pm, it has come on for hearing just before 2.0pm and now at 2.18pm I propose to make the declaration which is sought. I do so in the knowledge that the fundamental question appears to have been left open by the Master of the Rolls in the case of Re T (supra) heard earlier this year in the Court of Appeal, and in the knowledge that there is no English authority which is directly in point. There is, however,some American authority which suggests that if this case were being heard in the American courts the answer would be likely to be in favour of granting a declaration in these circumstances: see Re AC (1990) 573 A 2d 1235 at pp 1240,1246-1248, 1252.

I do not propose to say any more at this stage, except that I wholly accept the evidence of Mr P as to the desperate nature of this situation, and that I grant the declaration as sought."

29. Mr Francis, in his submissions to us, questioned the applicability of **the C test** to all situations and argued that the cause of the disability must be examined so that only disabilities caused by disorder or disability of the mind result in the removal of the patient`s autonomy. He suggested that both in the **Rochdale Healthcare case** and in **Re L** the judge misapplied **the C test** by evaluating competence by reference to the irrationality of the decision. He submitted that the fundamental principle governing competence is that a person should be presumed to be competent unless the court is satisfied that the patient is unable by reason of mental injury or disability to understand the information properly provided in connection with the proposed treatment or is unable to communicate a decision. He also suggested that the problem of Miss MB`s needle phobia had been apparent for some time and there was adequate time for a thorough investigation of her mental capacity to be carried out before the court was called on to make a decision.

Conclusions on Capacity to decide.

30. All the decisions made in the caesarian section cases to which we have referred arose in circumstances of urgency or extreme urgency. The evidence was in general limited in scope and the mother was not always represented as a party. With the exception of **Re S (supra)**, in all the cases the court decided that the mother did not have the capacity to make the decision. In these extremely worrying situations, it is important to keep in mind the basic principles we have outlined, and the court should approach the crucial question of competence bearing the following considerations in mind. They are not intended to be determinative in every case, for the decision must inevitably depend upon the particular facts before the court.

1. Every person is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted.

2. A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be

the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise.

3. Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided it could have arrived at it. As Kennedy and Grubb (Medical Law, Second Edition 1994) point out, it might be otherwise if a decision is based on a misperception of reality (e.g. the blood is poisoned because it is red). Such a misperception will be more readily accepted to be a disorder of the mind. Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision: **Re T (supra), Sideaway (supra) at p. 904** and **Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 A.C. 112, 169 and 186.**

4. A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when

> (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely 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 as part of the process of arriving at the decision. If, as **Thorpe J** observed in **Re C (supra)**, a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one. As **Lord Cockburn C.J**. put it in **Banks -v- Goodfellow(1870) L.R. 5 QB 549 at p.569:-**
>
> > "One object may be so forced upon the attention of the invalid as to shut out all others that might require consideration."

5. The "temporary factors" mentioned by **Lord Donaldson M.R**. in **Re T (supra.)** (confusion, shock, fatigue, pain or drugs) may completely erode capacity but those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent.

6. Another such influence may be panic induced by fear. Again careful scrutiny of the evidence is necessary because fear of an operation may be a rational reason for refusal to undergo it. Fear may be also, however, paralyse the will and thus destroy the capacity to make a decision.

Applying these principles to the facts of this case we find:-

1. Miss MB consented to a caesarian section.

> 2. What she refused to accept was not the incision by the surgeon's scalpel but only the prick of the anaesthetist's needle. Capacity is commensurate with the gravity of the decision to be taken.
>
> 3. She could not bring herself to undergo the caesarian section she desired because, as the evidence established, "a fear of needles ... has got in the way of proceeding with the operation." "At the moment of panic, ... her fear dominated all." "... at the actual point she was not capable of making a decision at all ... at that moment the needle or mask dominated her thinking and made her quite unable to consider anything else."

On that evidence she was incapable of making a decision at all. She was at that moment suffering an impairment of her mental functioning which disabled her. She was temporarily incompetent. In the emergency the doctors would be free to administer the anaesthetic if that were in her best interests.

31. A feature of some of the cases to which we have referred has been the favourable reaction of the patient who refused treatment to the subsequent medical intervention and the successful outcome. Having noted that, we are nonetheless sure that however desirable it may be for the mother to be delivered of a live and healthy baby, on this aspect of the appeal it is not a strictly relevant consideration. If therefore the competent mother refuses to have the medical intervention, the doctors may not lawfully do more than attempt to persuade her. If that persuasion is unsuccessful, there are no further steps towards medical intervention to be taken. We recognise that the effect of these conclusions is that there will be situations in which the child may die or may be seriously handicapped because the mother said no and the obstetrician was not able to take the necessary steps to avoid the death or handicap. The mother may indeed later regret the outcome, but the alternative would be an unwarranted invasion of the right of the woman to make the decision.

32. We have, helpfully, been provided by Mr Francis with the guidelines from the **Royal College of Obstetricians and Gynaecologists** entitled ` **A Consideration of the Law and Ethics in Relation to Court-Authorised Obstetric Intervention'**. They provide an interesting dissertation on the decisions so far made in the courts, a summary of the problems which arise, and give advice to the members of the medical profession who have to meet them. The Committee concluded that:-

> " it is inappropriate, and unlikely to be helpful or necessary, to invoke judicial intervention to overrule an informed and competent woman`s refusal of a proposed medical treatment, even though her refusal might place her life and that of her fetus at risk."

33. In our judgment the advice of the Committee accurately reflects the present state of the law. The only situation in which it is lawful for the doctors to intervene is if it is believed that the adult patient lacks the capacity to decide.

34. So we turn now to consider the best interests of Miss MB.

The Best Interests of the patient

35. Mr Francis submitted that the judge did not find and there was no evidence to find that it was in the mother`s best interests to have the medical intervention. It is in my view implicit in his necessarily short judgment that the judge considered that it was in her best interests. Best interests are not limited to best medical interests.

36. It is clear on the evidence that the mother and the father wanted this child to be born alive and Miss MB was in favour of the operation, subject only to her needle phobia. It must be in the best interests of a woman carrying a full-term child whom she wants to be born alive and healthy that such a result should if possible be achieved. However, there is psychiatric evidence in this case from Dr F, which we have set out above, which strongly supports medical intervention as being in her best interests. That evidence is that she was likely to suffer significant long term damage if there was no operation and the child was born handicapped or died. She would not suffer lasting harm from the anaesthesia being administered to her to achieve a desired result of the safe delivery of her child. She faced with fortitude, but with equanimity, the pain and the risk inherent in the invasive surgery. In considering the scope of best interests, it seems to us that they have to be treated on similar principles to the welfare of a child since the court and the doctors are concerned with a person unable to make the necessary decision for himself, see **Re F (Mental Patient: Sterilisation) [1990] 2 AC 1**. In coming to such a decision relevant information about the patient`s circumstances and background should where possible and if time permits be made available to the judge.

Reasonable Force

37. In a number of first instance decisions the declarations have included that it would be lawful for reasonable force to be used in the course of such treatment. That declaration was granted by Hollis J in the present case and is criticised by Mr Francis. It would however follow, in our view, from the decision that a patient is not competent to refuse treatment, that such treatment may have to be given against her continued objection if it is in her best interests that the treatment be given despite those objections. The extent of force or compulsion which may become necessary can only be judged in each individual case and by the health professionals. It may become for them a balance between continuing treatment which is forcibly opposed and deciding not to continue with it. This is a difficult issue which may have to be considered in greater depth on another occasion. In our view the judge was justified in granting the declaration. All that was involved here was the prick of a needle to enable the first part of the anaesthesia to be given to the patient. In the events which happened, these problems did not arise. Miss MB, on

hearing the decision of this Court then signed the consent form on the following morning and co-operated in the initial administration of the anaesthesia. No force was necessary.

The Unborn Child

38. Mr Grace sought to persuade us that, even if Miss MB were competent, the court can and should take into account the interests of the unborn child and balance them against the mother`s interests. Strictly speaking this delicate and difficult question does not arise as we have found this mother not to have been competent. Nevertheless, and despite by the lack of time not having had the opportunity to hear full and considered oral argument, we have given careful thought to the written submissions and to the material to which reference has been made. Since decisions of this sort invariably have to be made swiftly, we feel obliged to state our conclusions on this issue also.

39. In our judgment the court does not have the jurisdiction to take the interests of the foetus into account in a case such as the present appeal and the judicial exercise of balancing those interests does not arise. The nearest one might get to the view that the unborn child should in these circumstances be considered is to be found in the judgment of **Lord Donaldson MR in Re T (supra) at page 102**:-

> " An adult patient who, like Miss T, suffers from no mental incapacity has an absolute right 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."

40. The situation postulated by him arose later in 1992 in **Re S (supra).** The interest of the foetus prevailed. It is a decision the correctness of which we must now call in doubt. That is not to say that the ethical dilemma does not remain. Nonetheless, as has so often been said, this is not a court of morals. In the light of earlier authority to which we now turn, the position in English law appears clear and contrary to the view expressed by Lord Donaldson and by the President.

41. **In Paton v British Pregnancy Advisory Service Trustees [1979] QB 276**, where a husband made an unsuccessful attempt to obtain an injunction in the High Court to restrain the carrying out of an abortion on his wife, **Sir George Baker P.**said at **page 279**:-

> " The first question is whether this plaintiff has a right at all. The foetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country (I except the criminal law which is now irrelevant) and is, indeed the basis of the decisions in those countries where law is founded on the common law,

that is to say, in America, Canada, Australia and, I have no doubt, in others."

42. This passage was cited with approval in **Re F (In Utero) [1988] Fam.122**.

43. In **C v S [1988] QB 135 Heilbron J** also refused relief to an unborn child, on that occasion named as the second plaintiff, in an attempt by the father to prevent the mother having an abortion. In her judgment the judge cited at **page 140** a number of Canadian decisions both in the High Court and in the Court of Appeal of Canada that an unborn child was not a person and any rights accorded to the foetus were held contingent upon its subsequent birth alive.

44. There was an attempt by a local authority in **Re F (In Utero) supra** to make the unborn child of a mentally disturbed mother a ward of court. This Court upheld the decision of **Hollings J** that the court did not have the power to ward a foetus. In his judgment **Balcombe LJ** considered **section 1 of the Infant Life Preservation Act 1929** and **Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms**, (to both of which we turn below), and found that neither supported the local authority on the issue of wardship of the unborn child. He said at **page 143**:-

> "Approaching the question as one of principle, in my judgment, there is no jurisdiction to make an unborn child a ward of court. Since an unborn child has, ex hypothesi, no existence independent of its mother, the only purpose of extending the jurisdiction to include a foetus is to enable the mother`s actions to be controlled. Indeed that is the purpose of the present action."

45. There are decisions which give some acknowledgment to the effect harmful acts have upon the foetus. **Burton v Islington H.A. [1993] Q.B. 204, 223ff**, recognised the common law right of action in respect of in utero damage. The opinion of the House of Lords on murder or manslaughter of a child due to injury inflicted before birth is awaited: **A-G's Ref. No. 3 [1996] 1 Cr. App. R.351**. In some circumstances an unborn child is deemed to be born when its interests require it: **Villar v Gilbey [1907] A.C. 139.**

46. None of the above decisions lends any support to the proposition that the court should take into account the interests of the unborn child at risk from the refusal of a competent mother to consent to medical intervention.

Statute Law

47. We turn briefly to a number of statutes which deal specifically with the foetus. First in time was the **Offences against the Persons Act 1861** which made it an offence to procure an abortion. Then the **Infant (Life (Preservation) Act 1929** by **Section 1** provided a criminal offence for the intentional destruction of a child, capable of being born alive, before it has an existence independent of its mother.

48. By the **Abortion Act 1967 section 1, (as amended by the Human Fertilisation and Embryology Act 1990)** pregnancies up to 24 weeks may in certain defined circumstances be terminated. Pregnancies after 24 weeks may be terminated where it is necessary to prevent grave injury to the mental or physical health of the pregnant woman. The Act gives precedence to the health of the mother over the unborn child.

49. In **section 1 of the Congenital Disabilities (Civil Liability) Act 1976**, if a child is born disabled as a result of an occurrence set out in **section 1(2)** the child may have a cause of action in respect of the wrongful act, but not against the mother.

50. Although it might seem illogical that a child capable of being born alive is protected by the criminal law from intentional destruction, and by the **Abortion Act** from termination otherwise than as permitted by the Act, but is not protected from the (irrational) decision of a competent mother not to allow medical intervention to avert the risk of death, this appears to be the present state of the law. Moreover, if the competent mother by refusing medical intervention is delivered of a handicapped child, she cannot be sued by that child for her decision not to take steps to protect it at the moment of birth. The **Law Commission** rejected the proposal that a child should be able to have a claim against his mother for injury sustained before birth, (**Law Commission Report No 60**). The statute law does not support Mr Grace`s submission.

The European Commission of Human Rights

51. The question of the rights of the unborn child has been considered in a number of cases in the context of the **European Convention of Human Rights**. In **Bruggemann and Scheuten v Federal Republic of Germany, [1977] 3 EHRR 244,** the Commission considered the relationship between the pregnant woman and the foetus in the context of **Article 8 of the Convention**, the right to respect for private and family life. Two German women challenged the restrictions upon abortion in the criminal law of West Germany. In its opinion the Commission found that there are limits to the personal sphere:-

> "Pregnancy cannot be said to pertain uniquely to the sphere of private life. Whenever a woman is pregnant, her private life becomes closely connected with the developing foetus."

It did not find it necessary to come to a conclusion whether the foetus has rights within **Article 2**.

52. The `right to life` set out in **Article 2** was considered in **Paton v United Kingdom [1980] 3 EHRR 408**. The husband, having failed to obtain an injunction before **Sir George Baker (supra)**applied to the European Commission. The husband asserted that the **Abortion Act 1967** which authorised the termination of his wife`s pregnancy violated several articles of the **Convention**, principally **Article 2**, the right to life, and **Article 8**. In declaring the application inadmissible the Commission was satisfied,

at **paragraph 18** of its decision, that **Article 2** should not be construed as recognising an absolute right to life for a foetus. Since the termination was at 10 weeks; was in accordance with the wishes of the mother and was carried out in order to avert the risk of injury to her physical or mental health, it did not contravene **Article 2(1)**, It stated at **paragraph 19** of its decision:-

> "The `life' of the foetus is intimately connected with, and cannot be regarded in isolation from, the life of the pregnant woman. If Article 2 were held to cover the foetus and its protection under this Article were, in the absence of any express limitation, seen as absolute, an abortion would have to be considered as prohibited even where the continuance of the pregnancy would involve a serious risk to the life of the pregnant woman. This would mean that the `unborn life' of the foetus would be regarded as being of a higher value than the life of the pregnant woman....
>
> 20. The Commission finds that such an interpretation would be contrary to the object and purpose of the Convention."

53. The Commission did not come to a conclusion on the broader issue whether **Article 2** recognises the `right to life' of a foetus at any later stage before birth. It recognised a wide divergence of opinion in different jurisdictions but it did note that:-

    `the national law on termination of pregnancy has shown a tendency towards further liberalisation.'

54. This issue came again before the Commission, in **H v Norway (1990) (N0 17004/90, unreported)**, (a lawful abortion of a 14 week foetus for social reasons) and **Open Door and Dublin Well Woman v Ireland [1992] 15 EHRR 244,** (the suppression of communication of information in Ireland about the availability of abortions in the UK). It held in **H (supra)** that the national laws on abortion differ considerably and in such a delicate area the contracting states must have a certain discretion. That discretion was not exceeded in the case before them. The Commission avoided expressing an opinion about the scope of **Article 2** in relation to the protection of the foetus. The Commission did state however in **H (supra**) that it would not exclude that in certain circumstances it does offer such protection, but did not indicate what those circumstances were.

55. It has not yet become necessary for the European Commission to make a decision about the application of **Article 2** to the foetus at a stage later than 10 weeks. Understandably it has not expressed an opinion on the issue. We do not consider that the this court can gain any assistance on this issue from the opinions of the Commission.

American Authorities

56. The position in the American decisions may not be as clearcut as **Sir George Baker P** suggested it was in **Paton** in 1979. Both in New Jersey in **Raleigh**

Fitkin-Paul Morgan Memorial Hospital v Morgan (1964) 201 A 2d 537, (a blood transfusion) and in Georgia in **Jefferson v Griffin Spalding County Hospital Authority (1981) 274 SE 2d 457**, (caesarian section) the right of self-determination of the competent mother was subordinated to the interests of the viable foetus. In New York a hospital was authorised to give blood transfusions against the wishes of the mother in **Crouse Irving Memorial Hospital Inc v Paddock (1985) 485 NYS**. In **Re Madyyun (1986) 573 A 2d 1259n** the District of Columbia Court of Appeals upheld an order of the trial court requiring the mother to undergo a caesarian section when the pregnancy was at full term and the risk to the foetus was substantial but the risk to the mother minimal.

57. There has however been a significant change of view in that Appeal Court in its 1990 decision. In **Re AC 533 A 2d 611 (DC 1987)** it refused to stay an order of the trial court which had authorised a hospital to perform a caesarian section on a dying woman in an effort to save the life of her unborn child. Both the mother and child died and the matter came back before the Appeal Court **(1990) 573 A 2d 1235** which reversed its previous decision on the rehearing. It criticised the trial judge for not considering the question of the competence of the mother to make the decision and said in its opinion:-

> "We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient`s wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional. This is not such a case....Indeed some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person`s body, such as a caesarian section, against that person`s will."

58. Recognising the 'substantial differences between the **Madyyun** and the present case', the Appellate Court of Illinois in **re Baby Boy Doe (1994),632 North Eastern Reporter 2d Series 32y**deferred `until another day` any discussion of whether **Madyyun** was rightly or wrongly decided and held that a competent woman`s choice to refuse medical advice to obtain a caesarian section during pregnancy must be honoured, even in circumstances where choice may be harmful to her foetus because her rights to bodily integrity and religious liberty were not diminished during pregnancy.

59. The American decisions do not point to a clear conclusion from which this Court might derive assistance. They are inconclusive although we detect in the most recent trend in appellate decisions a move towards the approach of the English courts. **Sir Stephen Brown P** in **Re S (supra)** was invited to rely upon an incomplete reference to **re AC (1990) 573 A 2d 1235** to support a contrary and incorrect conclusion.

Our conclusions on the interests of the unborn child.

60. On the present state of the English law, the submissions made by Mr Grace that we should consider and weigh in the balance the rights of the unborn child, are untenable. The only support in**Lord Donaldson`s** observation in **Re**

T (supra) cannot stand, in our view, against the weight of earlier decisions, which are far more persuasive as to the present state of the law and which are applicable by analogy to the present appeal. The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, chose not to have medical intervention, even though, as we have already stated, the consequence may be the death or serious handicap of the child she bears or her own death. She may refuse to consent to the anaesthesia injection in the full knowledge that her decision may significantly reduce the chance of her unborn child being born alive. The foetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarian section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.

61. We respectfully agree with **Balcombe LJ** in **Re F (in Utero)(supra)** who also considered the possibility of the court being asked to order delivery of the baby by caesarian section. He said at page 144:-

> "If Parliament were to think it appropriate that a pregnant woman should be subject to controls for the benefit of her unborn child, then doubtless it will stipulate the circumstances in which such controls may be applied and the safeguards appropriate for the mother`s protection. In such a sensitive field, affecting as it does the liberty of the individual, it is not for the judiciary to extend the law."

Procedure

62. It might be helpful to make some comments on the practice to be followed when the medical profession feel it necessary to seek declarations from the courts.

1. The court is unlikely to entertain an application for a declaration unless the capacity of the patient to consent to or refuse the medical intervention is in issue.

2. For the time being, at least, the doctors ought to seek a ruling from the High Court on the issue of competence.

3. Those in charge should identify a potential problem as early as possible so that both the hospital and the patient can obtain legal advice.

In this case, for instance, the problem was identified at the ante-natal clinic.

4. It is highly desirable that, in any case where it is not

an emergency, steps are taken to bring it before the court, before it becomes an emergency, to remove the extra pressure from the parties and the court and to enable proper instructions to be taken, particularly from the patient and where

possible give the opportunity for the court to hear oral evidence, if appropriate.

5. The hearing should be inter partes.

6. The mother should be represented in all cases, unless exceptionally, she does not wish to be. If she is unconscious she should have a guardian ad litem.

7. The Official Solicitor should be notified of all applications to the High Court. It would be helpful if, at least for the time being, the Official Solicitor was prepared to continue to act as Amicus Curiae, in cases where he is not asked to be the Guardian ad litem. He will build up a body of expertise which will be most helpful to the judge hearing the application.

8. There should in general be some evidence, preferably but not necessarily from a psychiatrist, as to the competence of the patient, if competence is in issue.

9. Where time permits the person identified to give the evidence as to capacity to consent to or refuse treatment should be made aware of the observations we have made in this judgment.

10. In order to be in a position to assess a patient`s best interests the judge should be provided, where possible and if time allows, with information about the circumstances of and relevant background material about the patient.

Order: Appeal dismissed; no order as to costs, save legal aid taxation of the appellant's costs; liberty to apply for leave to appeal to the House of Lords.