

# The role of the court in ethical decision making

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**ABSTRACT – The medical profession generally is uncertain both as to the circumstances in which the guidance of the courts can be sought in relation to ethical decisions regarding individual patients and the way to go about requesting such guidance. The machinery is under used although the courts encourage its use in all ‘boundary line’ decisions: these are decisions involving competence in its widest sense, including uncertainties as to whether the patient is competent or not and rulings or declarations in respect of those patients who are either temporarily or permanently incompetent by virtue of age, psychological disorder or circumstance.**

Clinicians are attacked in the media on a seemingly daily basis for the decisions they make. With the same frequency the decisions of judges on cases involving difficult ethical questions are featured and subjected to the scrutiny of every journalist, pressure group member and victim who cares to put in his twopenny worth. To many doctors the route by which the difficult decision on a particular patient could travel from their hands to those of the judiciary is a mysterious and unsignposted one. By their very nature the problems that arise may do so in urgent circumstances or circumstances which, if not urgent at the onset, are frequently allowed to become so. Doctors should be aware of the machinery that exists (even in the middle of the night) and how to invoke it.

There is a danger that the doctor will regard the court’s jurisdiction as a weapon for attacking him and forget that in the context of ethical decision making it may well provide him with protection *from* attack. My impression is that there is a climate amongst doctors, first, that seeking the court’s involvement in ethical decision making is something other doctors do but not they, and second, that they do not know how to go about it. In these days of ever-increasing ethical dilemmas that climate should change. This is not to suggest, of course, that the doctor should treat patients with constant reference to the courts – neither party would welcome it or have the resources to cope with it – and in any event most cases of ethical difficulty can be resolved by the experience of the doctor, the sensitive handling of the patient and relatives and recourse to second medical opinion. However, the Court of Appeal has recently

indicated that the court is not overburdened with applications in this field – indeed, they are rare – and clinicians faced with boundary line decisions should err on the side of referring to the court<sup>1</sup>. It is with those boundary line decisions that this article is concerned.

## The nature of the court's jurisdiction

It is axiomatic that the lawfulness of medical treatment is founded upon the consent of the patient or upon the existence of some other lawful authority. The competent patient’s consent or refusal to consent to treatment is final: it does not have to be sensible, rational or well considered. In respect of the child too young to be competent to consent, authority for treatment is generally given by the parent or some other adult able, because of his relationship with the child, to give it. In the event of problems, usually arising either because there is no one with capacity to consent on the child’s behalf or because there is dispute between carers and doctors as to appropriate treatment, the court can give authority by virtue of its statutory or inherent jurisdiction to make decisions on the part of minors – ie it can consent on the child’s behalf. In respect of an adult deemed incompetent, treatment is given in accordance with the clinicians’ assessment of the patient’s best interests. If problems arise it is usually either because there is doubt as to competence or doubt as to the patient’s best interests. The wise clinician will seek the guidance of the court. Unlike the situation pertaining to minors, the court has no power to consent to treatment. Its only jurisdiction in respect of adult patients is a declaratory jurisdiction – ie it can make a declaration that a proposed treatment would be lawful. Such a declaration cannot change the unlawful into the lawful and therefore treatment which a court declares lawful would not have been unlawful if a declaration had not been sought. It follows that there is never any legal requirement to seek a declaration in respect of an adult although in all circumstances of significant ethical controversy it is advisable to do so, and in certain defined circumstances (doubts as to competence; sterilisation procedures; organ and tissue donation; surgical obstetric delivery; withdrawal of treatment for patients in a persistent vegetative state) it is in practice mandatory to do so.

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## Key Points

**The courts encourage applications in respect of boundary line ethical decisions**

**Such applications provide protection and reassurance for doctor, patient and relatives**

**Clinicians should be aware of how to make such applications before emergencies arise**

The court's guidance can be applied for by the patient himself; his carer, whether professionally qualified or not (this of course includes his doctor or his doctor's employers); anybody with a genuine and legitimate interest in obtaining a judgement as a result of their relationship with the patient – this could include a friend but not a 'nosy neighbour'. The declaration sought may be in relation to an immediate treatment plan or to the happening of a future event; it covers all aspects of treatment or care of an individual patient in the widest sense. It is noteworthy that in one case at least the court has criticised a doctor and health authority for leaving it to the patient's father and boyfriend to seek a declaration from the court rather than doing it 'officially' at an earlier stage<sup>2</sup>.

In respect of a child, the welfare of that child is the paramount consideration in deciding whether to give consent for the treatment. In respect of an adult, the court's concern will be to determine the patient's best interests. The original approach of the House of Lords<sup>3</sup> was arguably not to substitute its own view for that of the treating doctor but to act as overseer to ensure that the doctor has assessed the patient's interest in accordance with the appropriate standard of the medical profession. Whilst straightforward enough in theory, in practice such a test does not go far enough: in the context of finely balanced ethical decision making, views equally responsible can conflict and neither can be said to transgress the standards of the profession. In these circumstances the Court of Appeal has introduced a two-stage test<sup>4</sup>: first, they determine whether the treatment falls within the *Bolam* test, ie is of a kind which would be supported by a responsible body of medical opinion<sup>5</sup>; second, they decide whether the proposed treatment is in the patient's best interests and in the event of more than one treatment fulfilling the *Bolam* criteria will, in effect, act as final arbiter.

### Why invoke it?

The main purpose of seeking the court's guidance is protection and reassurance for doctor, patient and family. The clinician's hackles may rise at the suggestion that a judge is somehow in a better position than a treating doctor to make ethical decisions with regard to his patient but such recourse has a number of advantages:

- A court, by the nature of its proceedings, is in a unique position in relation to the evaluation of conflicting evidence from lay and expert witnesses in cool and objective

surroundings and with the time and a degree of detail that would be wholly impracticable in a hospital setting.

- On a pragmatic basis, by asking a court to make the decision, the doctor protects himself from the possible adverse consequences of making it himself, in particular with regard to disciplinary action by his employers; and the Trust protects itself from possible negligence actions.
- Whilst the doctor is in the best position to form a view on medical matters, the best interests of the patient involve far wider ethical issues in which a judge is in at least no worse, and arguably a better, position to make a judgement than a doctor.
- My personal view is that in the interests of the patient, judges will on occasion apply a degree of paternalism in the exercise of their judgement for which a doctor in the present climate could be criticised!

### When to invoke it

It must be borne in mind that there is no room for the court's involvement in compelling a doctor to provide treatment which he does not consider to be in the patient's best interest: broadly speaking, the remedy for the patient is to consult another doctor, not the court. Neither will the court involve itself in broad ethical questions which do not arise in the context of the specific treatment of a specific individual; nor will it become involved in questions relating to treatment of a patient competent to consent since, as stated above, the consent of the patient determines the issue. However, the circumstances of the court's willing involvement, whether in respect of the minor or the incompetent adult, are numerous and relate to all questions arising out of general issues of competence. This article is not the place for detailed analysis of the many issues on which the court has adjudicated but broadly speaking it will make rulings when there is uncertainty as to whether the patient has the capacity to consent, either generally or in specific circumstances; or when guidance is sought in relation to the treatment of a patient plainly incompetent by virtue of age or mental disorder; or when a patient is suffering from temporary incompetence eg by virtue of temporary unconsciousness; or when a competent patient gives an advance directive of arguable relevance to the need for treatment which has arisen and has then become incompetent; or when disputes arise as between family or between treating doctors as to the appropriate treatment for an incompetent patient.

### How to invoke it

How does a doctor go about seeking the court's guidance? The process is not one involving adversarial litigation but one designed to ensure that the patient's best interests are served in circumstances when for some reason he cannot make a decision for himself. It is thus more user friendly than the legal processes with which some doctors will be uncomfortably familiar. Whilst hearings are possible at any hour of the day or night, clinicians

and Trusts are vulnerable to criticism if lack of anticipation results in an emergency application which could have been avoided. The clinician's responsibility is to recognise the problematic clinical picture and kick things into motion; thereafter he can leave it to the lawyers who will advise both on the appropriateness of an application to the court and on the practicalities of doing it. It would seem appropriate that individual Trusts provide clinicians with details of whom to contact. Broadly speaking, a clinician anticipating future problems with regard to consent in the context of NHS treatment should contact the Legal Services Manager at his Trust for guidance as to procedure. In an emergency he should contact the duty administrator who will in turn contact the Trust duty solicitor. If the problem arises in the context of private treatment he should contact his Defence Union where a 24 hour advice service is available.

### The consequences of invoking it

Many doctors regard the law as a process involving three unpleasant consequences: delay, publicity and cost. As far as the first is concerned, the court is there to help and clinicians should therefore be assured that the process is relatively sympathetic and (it is to be hoped) non-time consuming. As far as publicity is concerned, non-publicity orders prohibiting the identification of the patient can be made where it is necessary in the interest of the patient to do so, and the court will need little persuasion that such an order is appropriate; the identity of the hospital and clinicians involved will not be covered by such an order, however, unless necessary to protect identification of the patient. The costs orders made are at the court's discretion: however, if the application is made with the official sanction of the Trust it will not fall upon the shoulders of the individual clinician. The Trust may wish to take comfort from the reflection that if it incurs the costs of such an application it may well save itself the far more significant costs associated with the negligence or disciplinary actions which may follow on the heels of a decision made without the court's involvement!

### References

- 1 *Re SL* 2000 2 FLR 389
- 2 *Re T (adult: refusal of treatment)* 1992 3 WLR 782
- 3 *Re F (mental patient: sterilisation)* 1990 2 AC 1
- 4 *Re SL* (ibid)
- 5 *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582

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