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SERIOUS MEDICAL TREATMENT

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The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."

John Stuart Mill. On Liberty

"An adult patient who…suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment… 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."

As per Lord Donaldson in **Re T (Adult) [1992] 4 All ER 649**

"There is a very strong presumption in favour of taking all steps to prolong life, and save in exceptional circumstances, or where the patient is dying, the best interests of the patient will normally require such steps to be taken. In case of doubt, that doubt falls to be resolved in favour of the preservation of life. But the obligation is not absolute. Important as the sanctity of life is, it may have to take second place to human dignity…"

[Munby J (as he then was)]

R (Burke) v GMC [2004] EWHC 1879 (Admin)

SERIOUS MEDICAL TREATMENT GUIDANCE

17 January 2020 [2020] WLR 641

- READ IT CAREFULLY (not just the procedural section)
- The guidance is “intended to operate until such time as it is superseded by the revised Code”.
- **The fact that certain medical treatments are defined as 'serious' does not determine whether they should be subject to an application to the Court of Protection.**
- There is **no definition of SMT** in this Guidance
- Section 37 Mental Capacity Act 2005 and accompanying Regulation provides the only statutory framework for a definition.

SECTION 37 MENTAL CAPACITY ACT 2005

37 Provision of serious medical treatment by NHS body

- "Applies if an NHS body is proposing to provide, or secure the provision of, serious medical treatment for …("P") who lacks capacity to consent to the treatment";
- "Additionally if the body is satisfied that there is no person, other than one engaged in providing care or treatment for P in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in P's best interests".
- Does not apply to regulated treatment under by Part 4 of the Mental Health Act.
- DUTY on the NHS to instruct an **Independent Mental Capacity Advocate** to represent P, before the treatment is provided;

SECTION 37 Continued…

- If the treatment needs to be provided as a matter of urgency, it may be provided even though the NHS body has not been able to comply with requirement to appoint an IMCA
- DUTY- in providing or securing the provision of treatment for P, the NHS body must take into account any information given, or submissions made, by the IMCA;
- MCA Definition of SMT-

  "37 (6) "Serious medical treatment" means treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations made by the appropriate authority."

REGULATION 4 OF SI 2006/1832

Meaning of serious medical treatment

4.—(1) This regulation defines serious medical treatment for the purposes of section 37 of the Act.

(2) Serious medical treatment is treatment which involves **providing, withdrawing or withholding treatment** in circumstances where—

(a) in a case where a single treatment is being proposed, there is a **fine balance between its benefits to the patient and the burdens and risks** it is likely to entail for him,

(b)in a case where there is a choice of treatments, **a decision as to which one to use is finely balanced**, **OR**

(c) what is proposed would be **likely to involve serious consequences** for the patient.

MCA 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, SI 2006/1832

GUIDANCE: NHS Trust v Y [2018] UKSC 46

Where the Mental Capacity Act 2005 is followed, any relevant professional guidance observed and relevant guidance in the Code of Practice followed, including as to the undertaking of the decision-making process, then, if there is agreement at the end of the decision-making process as to:

- the decision-making capacity of; and
- best interests of the person in question

In principle, medical treatment may be provided to, withdrawn from or withheld in accordance with the agreement, without application to the court, in reliance upon the defence in section 5 MCA 2005.

AN NHS TRUST v Y [2018] UKSC 46

"126. In conclusion, having looked at the issue in its wider context as well as from a narrower legal perspective, I do not consider that it has been established that the common law or the ECHR, in combination or separately, give rise to ***the mandatory requirement, for which the Official Solicitor contends, to involve the court to decide upon the best interests of every patient with a prolonged disorder of consciousness before CANH can be withdrawn****. If the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court. I would therefore dismiss the appeal. In so doing, however, I would emphasise that, although application to court is not necessary in every case, there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such cases."*

[as per Lady Black]

ORDERS

"In every case, **in addition to** any declaration made under section 15(1)(a) *[CAPACITY]* Mental Capacity Act 2005, the court will consider whether the relief sought should be granted in the form of a declaration of lawfulness under section 15(1)(c) *[LAWFULNESS]* and/or a decision under section 16(2)(a) *[ORDER]*. In so doing, the court will have regard to the statutory purpose of section 16(2)(a) as being to empower the court to make a decision on behalf of P in relation to a matter in respect of which P lacks capacity."

SECTION 5 MCA 2005: NECESSITY

- Section 5 Mental Capacity Act 2005 provides a defence against liability for the medical professional(s) carrying out the relevant act (including, where relevant, withholding or withdrawing treatment) where
  - they reasonably believe that the person in question lacks the necessary decision-making capacity and
  - that the act in question is in the person's best interests.

NECESSITY UNAVAILABLE TO THE CLINICIAN

- Necessity may not be a defence if at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:
    - **finely balanced**, or
    - there **is a difference of medical opinion**, or
    - a **lack of agreement** as to a proposed course of action from those with an interest in the person's welfare, or
    - there is **a potential conflict of interest** on the part of those involved in the decision-making process
- Then it is **highly probable** that an application to the Court of Protection is appropriate;
- **MUST ALWAYS** given it consideration.

LIFE SUSTAINING TREATMENT CASES

*"Where any of the matters at paragraph 8 above arise and the decision relates to the provision of life-sustaining treatment an application to the Court of Protection **must** be made. This is to be regarded as an inalienable facet of the individual's rights, guaranteed by the European Convention on Human Rights ('ECHR'). For the avoidance of any doubt, this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration."* [Paragraph 9]

SERIOUS INTERFERENCE WITH CONVENTION RIGHTS

“In any case which is not about the provision of life-sustaining treatment, but **involves the serious interference with the person's rights under the ECHR**, it is "highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of [capacity and] best interests, with [the person] having the benefit of legal representation and independent expert advice." [**Re P (Sexual Relations and Contraception) [2018] EWCOP 10**, see para. 56] This will be so even where there is agreement between all those with an interest in the person's welfare.”

SERIOUS INTERFERENCE WITH CONVENTION RIGHTS

- “Where a medical procedure or treatment is for the primary purpose of sterilisation;
- where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person;
- a procedure for the covert insertion of a contraceptive device or other means of contraception;
- where it is proposed that an experimental or innovative treatment to be carried out;
- a case involving a significant ethical question in an untested or controversial area of medicine.”

DOL / FORCE & OTHER CASES

- “Separately to the matters set out above, an application to court may also be **required** where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in sections 5 and 6 Mental Capacity Act 2005.
- In such a case, the restraint will amount to a deprivation of the person's liberty and thus constitute a **deprivation of liberty**. The authority of the court will be required to make this deprivation of liberty lawful.[*ACCG v MN* [2017] UKSC 22, at paragraph 38]
- It requires to be stated clearly that those providing or commissioning clinical and caring services should approach the Court of Protection in any case in which they assess it as right to do so.”

JUDICIAL ALLOCATION OF SMT

- "Applications in relation to a
  - serious medical treatment decision or
  - in respect of a case involving an ethical dilemma, in an untested area,

  the proceedings (including permission, the giving of any directions, and any hearing) **must be conducted by a Tier 3 judge**,unless the Senior Judge or a Tier 3 judge determines to the contrary."
- In any other case the gatekeeper will have regard, in particular, to:
  - The seriousness of the consequences for P of the proposed treatment decision(s);
  - The seriousness of the interference with the ECHR rights of P involved the proposed treatment decision(s).

BEST INTERESTS: STARTING POINT

"[39] The most that can be said, therefore, is that in considering the best interests of ***this particular patient at this particular time****, decision-makers must look at* ***his welfare in the widest sense, not just medical but social and psychological****; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they* ***must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be****; and they must* ***consult others*** *who are looking after him or interested in his welfare, in particular for their view of* ***what his attitude*** *would be".*

As per Baroness Hale in **Aintree University Hospitals NHS Foundation Trust v James & Others [2013] UKSC 67**

Aintree University Hospitals NHS Foundation Trust v James & Ors

*“[45] The purpose of the best interests test is to consider matters **from the patient's point of view**. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. **We cannot always have what we want**. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament".*

PRINCIPLES DERIVED FROM *JAMES*

- The question is not whether it would be in the patient's best interests to withhold those treatments should they become necessary in order to sustain life. The correct and fundamental question is whether it is in the best interests of a patient, and therefore lawful, to give medical treatment. If the court concludes that the treatment is not in P's best interests then it will not consent to the treatment.
- It sets the goal too high to say that treatment is futile unless it has a "*real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering*". The correct approach is to consider whether the proposed treatment would be futile in the sense of being ineffective or being of no benefit to the patient.

PRINCIPLES DERIVED FROM *JAMES (continued)*

- It is also not appropriate to define "*no prospect of recovery*" to mean "*no prospect of recovering such a state of good health as will avert the looming prospect of death if the life-sustaining is given*". Baroness Hale said at Paragraph 44 that "*where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a good state of health. The patient's life may still be very well worth living*".
- The court must be cautious about making declarations in circumstances which were not fully predictable or were fluctuating.
- The courts have been most reluctant to lay down general principles which might guide the decision. **Every patient, and every case, is different and must be decided on its own facts.**

Salford Royal NHS Foundation Trust v P [2017] EWCOP 23

"(v) It is incumbent on the court ***fully to investigate and consider the values and beliefs of the patient as well as any views the patient expressed when she had capacity*** *that cast light on the likely choice the patient would have made and the factors that the patient would have considered relevant or important".*

*(vi) "****Where the patient's views can be ascertained with sufficient certainty, they should generally be followed … or afforded great respect … though they are not automatically determinative****. '… if the decision that P would have made, and so [his] wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life. … the "sanctity of life" or the "intrinsic value of life", can be rebutted … on the basis of a competent adult's cogently expressed wish".*

[Hayden J, paragraph 29]

OPPOSITION OR RESISTENCE BY P

- Where resistance is consistently expressed it is arguable that wishes should be respected notwithstanding P's lack of capacity.
- This is more likely to be accepted where P recognises that the refusal of treatment would lead to certain death: **Pennine Acute Hospitals NHS Trust v TM (by his litigation friend The Official Solicitor) [2021] EWCOP 8**
- P was homeless on street of Manchester. P declined a below-the-knee, bilateral amputation the only appropriate surgical option. P resisted the option thereafter.

PENNINE ACUTE HOSPITAL NHS TRUST v TM

"TM does not recognise this. As I have been at pains to emphasise, the life force beats very strongly within him. TM wants to live. He has an entirely misguided belief that he will recover without any treatment. ***The pervasiveness of this misguided belief contracts and substantially diminishes the weight that might, in other circumstances, properly be given to consistently expressed wishes****."*

[as per Hayden J, §39]

CASES WHERE P'S WISHES WERE RESPECTED

- **Avon and Wiltshire Mental Health Partnership v WA & Anor (Rev 1)** [2020] EWCOP 37, Hayden J
- **Barnsley Hospital NHS Foundation Trust v MSP** [2020] EWCOP 26, Hayden J
- **Wye Valley NHS Trust v B (Rev 1) [2015] EWCOP,** Peter Jackson J (as he then was)

  "[12] In this case, the Trust and the Official Solicitor consider that a person with full capacity could quite reasonably decide not to undergo the amputation that is being recommended to Mr B, having understood and given full thought to the risks and benefits involved. However, ***the effect of their submissions is that because Mr B himself cannot balance up these matters in a rational way, his wishes and feelings are outweighed by the presumption in favour of life. It is, I think, important to ensure that people with a disability are not – by the very fact of their disability – deprived of the range of reasonable outcomes that are available to others.*** *For people with disabilities, the removal of such freedom of action as they have to control their own lives may be experienced as an even greater affront that it would be to others who are more fortunate."*

CLINICALLY ASSISTED NUTRITION AND HYDRATION

- Treating clinicians are directed to the BMA/RCP Guidance (endorsed by the GMC) 'Clinically assisted nutrition and hydration (CANH) and adults who lack the capacity to consent,' available at www.bma.org.uk/canh
- "CANH refers to all forms of tube-feeding (e.g. via nasogastric tube, percutaneous endoscopic gastrostomy (PEG) or parenteral nutrition). It does not cover oral feeding, by cup, spoon, or any other method for delivering food or nutritional supplements into the patient's mouth."
- clinically-assisted nutrition and hydration (CANH) is a form of medical treatment;
- treatment should only be provided when it is in the patient's best interests;

CANH & ADULTS WHO LACK CAPACITY TO CONSENT

- “Decision-makers must start from the strong presumption that it is in a patient’s best interests to receive life-sustaining treatment but that presumption can be rebutted if there is clear evidence that a patient would not want CANH provided in the circumstances that have arisen;
- all decisions must be made in accordance with the Mental Capacity Act 2005;
- there is no requirement for decisions to withdraw CANH to be approved by the court, as long as there is agreement upon what is in the best interests of the patient, the provisions of the Mental Capacity Act 2005 have been followed, and the relevant professional guidance has been observed; and
- the General Medical Council’s guidance states that a second clinical opinion should be sought where it is proposed, in the patient’s best interests, to stop or not start CANH and the patient is not within hours or days of death.”

[Executive Summary Guidance]

PENNINE ACUTE …TRUST v TM: CAPACITY

- “There are many reasons why TM may not be able to appreciate and understand fully the importance and significance of the proposed treatment.
- this incapacity may be related to the atrophy of the white matter of his brain;
- it may be due to a depressive illness;
- it may even be related to the condition of PML (see above) arising from his HIV.
- But whatever the cause, it is clear to Dr Riste, that the functioning of TM's brain is impaired to such a degree that it renders him unable to weigh and sift the relevant factors involved in making the decision to consent to the amputation.” §36

PENNINE ACUTE …TRUST v TM: CAPACITY

"[35]…I should find that TM had capacity on the basis that the applicant Trust has not demonstrated, on the balance of probabilities, that TM's inability to contemplate the consequences of refusing treatment is because of an impairment of, or a disturbance in the functioning of, the mind or brain. She referred me to ***Kings College Hospital NHS Foundation Trust v C*** *[2015] EWCOP 80. At paragraph 34 of that judgment, Macdonald J refers to the need for 'a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act'."*

CAPACITY: SECTION 3

"[37] It is a misunderstanding of section 3 MCA 2005 to *read it as requiring the identification of a precise causal link when there are various, entirely viable causes. Insistence on identifying the precise pathology as necessary to establish the causal link is misconceived. Such an approach strikes me as inconsistent with the philosophy of the MCA 2005. What is clear, on the evidence, is that the Trust has established an impairment of mind or brain and that has, in light of the consequences I have identified, rebutted the presumption of capacity."*

[as per Hayden J in **Pennine Acute v TM**]

CAPACITOUS ABOUT TO LOSE CAPACITY

Guys And St Thomas NHS Foundation Trust (GSTT) & Anor v R

[2020] EWCOP 4

- R was 39 (+6) weeks pregnant;
- R had a diagnosis of Bipolar Affective Disorder which is characterised by psychotic episodes
- R was detained by Trust S and Trust G&T was responsible for her obstetric care.
- All the treating clinicians agreed: **R had capacity to make decisions as to her ante-natal and obstetric care**;
- There was a substantial risk of a deterioration in R's mental health, such that she would likely lose capacity during labour;
- There was a risk to her physical health, in that she could require an urgent Caesarean section ('C-section') for the safe delivery of her baby but might resist.

Guys & Thomas NHS Foundation Trust v R [2020]

- R had capacity to decide on whether to have a C-Section and decided not to have that. R recognised that both she and her child may die as a result of her decision.
- If a C-Section was required the decision would have to be made in minutes and R would likely require restraint.
- Application was made in the urgent apps list to the VP, R was unrepresented (!?!).
- Despite being capacitous it is unclear whether the application was without notice to her and how that could be justified.
- Counsel was appointed as advocate to the court, not to represent R.
- The Trust applied under the inherent jurisdiction that at the point at which she becomes incapacitous it was lawful to perform the C-section with force if required.

Guys & Thomas NHS Foundation Trust v R [2020]

Does the MCA 2005 apply to a decision taken in anticipation of a loss of capacity in the otherwise capacitous person:

- **Section 16(1) does not apply-**

[28] I am clear that the explicit wording of Section 16 (1) specifically and unambiguously curtails the ambit of the section, limiting its reach to those who lack capacity. This also resonates with a further and central principle of the MCA, namely that the test for capacity is to be regarded not only as *'issue'* but as *'time'* specific:

> *"…if **at the material time** (my emphasis) he is unable to make a decision for himself (section 2 (1) MCA 2005)"*

Guys & Thomas NHS Foundation Trust v R [2020]

- **Section 15(1) does apply-**

*"[32] In contrast to Section 16 (2), the power to make declarations of lawfulness, pursuant to Section 15 MCA, is not expressly curtailed by any requirement of incapacity. Section 15 (1) (see paragraph 23 above) enables the Court both to determine **whether** an individual has or lacks capacity and the lawfulness of any act done or **'yet to be done'**. The wording here contrasts markedly with Section 16 and cannot be said to be explicitly confined to those lacking capacity. On the contrary, this section contemplates consideration and determination of the issue of capacity. Furthermore, there is nothing in Section 15 (1) (c) which inhibits or restricts the Court's declaratory powers to those individuals assessed as lacking in capacity (i.e. on any particular issue)."*

Guys & Thomas NHS Foundation Trust v R [2020]

"There is nothing here, in my judgement, which requires a construction of Section 15 which restricts its declaratory relief to those whom the Court has found to lack capacity. Of course, the section must be construed in the schematic context of the MCA generally. The legislation is intended to protect and guard the autonomy of those who lack decision making capacity in whatever sphere."

"[33] …I am not being asked to authorise medical intervention in relation to a capacitous adult. I am being invited to determine whether, if the adult in question loses capacity, a medical intervention can be authorised which is contrary to her expressed wishes, whilst capacitous. In virtually every application that comes before this Court, relating to medical treatment, the answer to the question posed here would be a resounding 'no'."

Guys & Thomas NHS Foundation Trust v R [2020]

"[35] All this recognises that 'capacity' is not a static concept. It follows that, inevitably, this Court will find itself involved in situations in which an individual may have capacity to take decisions on some issues but not on others and facing circumstances where P may be able to take decisions on one day that he is unable to on another. Manifestly, it is neither practical nor desirable for the Court to resolve questions of fluctuating capacity on a day to day basis. It may, depending on the individual facts, have to make orders which anticipate a likely loss of capacity if it is going to be able to protect P efficiently."

Guys & Thomas NHS Foundation Trust v R [2020]

*"[36] Any declaration relating to an act **'yet to be done'** must, it seems to me, contemplate a factual scenario occurring at some future point. It does not strain the wording of this provision, in any way, to extrapolate that it is apt to apply to circumstances which are foreseeable as well as to those which are current. There is no need at all to diverge from the plain language of the section. In making a declaration that is contingent upon a person losing capacity in the future, the Court is doing no more than emphasising that the anticipated relief will be lawful when and only when P becomes incapacitous. It is at that stage that the full protective regime of the MCA is activated, not before."*

Guys & Thomas NHS Foundation Trust v R [2020]

- Section 16, sections 4A and 4B are unavailable in anticipation of someone losing capacity;
- Any authorisation for a DOL would be reliant of the Inherent Jurisdiction of the High Court, paras. 39-47;
- The court did not consider that R was in the same position as someone who had made an advance decision -

  "I say, at once, that I consider that an Advance Decision, properly constructed, with the appropriate safeguards in place would, in my judgement, be binding on the Court. I do not however, consider that R is in an analogous position. In preparing and drafting a carefully worded Advanced Decision, which is compliant with the statutory safeguards, P will, of necessity, have been required to identify the clear circumstances in which the refusal to comply is made."

Guys & Thomas NHS Foundation Trust v R [2020]

"[63] The caselaw has emphasised the right of a capacitous woman, in these circumstances, to behave in a way which many might regard as unreasonable or "morally repugnant"... This includes the right to jeopardise the life and welfare of her foetus. ***When the Court has the responsibility for taking the decision, I do not consider it has the same latitude. It should not sanction that which it objectively considers to be contrary to P's best interests. The statute prohibits this by its specific insistence on 'reasonable belief' as to where P's best interests truly lie.*** *It is important that respect for P's autonomy remains in focus but it will rarely be the case, in my judgement, that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus. In this case it may be that R's instincts and intuitive understanding of her own body (which it must be emphasised were entirely correct) led to her strenuous insistence on a natural birth...*

Guys & Thomas NHS Foundation Trust v R [2020]

Notwithstanding the paucity of information available, I note that there is nothing at all to suggest that R was motivated by anything other than an honest belief that this was best for both her and her baby. It is to be distinguished, for example, from those circumstances where intervention is resisted on religious or ethical grounds. In the circumstances therefore, it seems reasonable to conclude that R would wish for a safe birth and a healthy baby."

R delivered a healthy baby boy by a natural birth and did not lose capacity in labour. A C-Section was unnecessary.

ANTICIPATORY [NOT REACTIVE] PLANNING

At paragraph 16 the VP joined Keehan J in the guidance for urgent obstetric cases in **NHS Trust & Ors v FG (Rev 1) [2014] EWCOP 30**

"Careful planning and the avoidance of delay, where that is not purposeful, is intrinsic to every case in the Court of Protection, without exception. The focus however is, as Keehan J has emphasised, particularly acute in cases such as this. The need for an informed birth plan, identifying the appropriate support required, reviewed by the Court in a way which permits it properly to be scrutinised and facilitative of representation for P is essential. So too, is the need for a fully transparent process, given the fundamental rights and freedoms that are engaged here. As Keehan J highlights, these rudimentary requirements are a facet of the Article 6 rights of all involved. Moreover, failure to plan in a careful and properly informed manner may jeopardise the health, even the lives of the mother and the unborn baby. Thus, it follows, to my mind, inexorably, the court will need to be involved in a way which anticipates rather than being merely reactive to crisis or emergency."

"The Courts must not pursue the principle of respect for life to the point where life has become empty of real content or to a degree where the principle eclipses or overwhelms other competing rights of the patient i.e. in this case simple respect for her dignity."

[As per Hayden J]

Re O (Withdrawal of Medical Treatment) [2016] EWCOP 24

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