When Can Doctors Treat Patients Who Cannot or Will Not Consent?

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There has been growing recognition in Australia — as in the rest of the Western world — of the right of competent adult patients to make their own medical decisions. This is evident in the development of the common law on 'informed consent'; and also in recent legislation in Australia and the United States that gives statutory force to a patient's common law right to accept or to refuse treatment. If patients are not able to make their own medical decisions, then someone must generally be appointed to decide on their behalf. This may be either a person nominated earlier by the patient; or alternatively, a guardian appointed later by a government body. That person then acts in the patient's place in making the decision.

The emphasis on patients' autonomy in current law leads naturally to the conclusion that if a patient is unable to consent to treatment and no one has been appointed to consent on the patient's behalf, then the doctor may have no lawful authority to administer the treatment. A fortiori, if a competent adult patient *refuses* treatment, fully understanding that without it the patient will die, it would seem neither legally nor ethically justifiable for a doctor to administer treatment, even if it is necessary to save the patient's life. This applies equally whether the patient refuses treatment at the time or by executing an advance directive refusing certain treatment in the future. Nevertheless, in practice, treatment is sometimes given despite the lack, or even refusal, of consent, in what the carers believe to be the patient's 'best interests'.

This paper explores the divergence between what the law appears to allow and commonly accepted medical practice. It suggests various arguments that doctors might advance if they were challenged in giving patients treatment without consent or despite the patient's refusal. The paper then considers, in the light of recent judicial comments in England, North America, Australia and New Zealand, what the response of the courts is likely to be to the doctors' arguments. It concludes that doctors may sometimes have a defence to an action in battery or negligence if they treat a patient who is unable to consent or who has refused treatment. However, the law is by no means clear and, particularly in the case of refusal of treatment, doctors would be well advised to seek the authority of a court or guardianship board before the treatment is given, unless the patient's condition is life-threatening and immediate action is needed.

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THE COMPETENT ADULT PATIENT'S RIGHT TO AUTONOMY

The Common Law

Courts throughout the Western world have increasingly emphasised that competent adult patients are entitled to decide what medical procedures they will have and to refuse treatment they do not want. It is eighty years since Justice Cardozo's much quoted statement that:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[1]

Since then, the notion of patient autonomy has been frequently reiterated in North America,[2] in England,[3] in Australia,[4] and in New Zealand[5] (though in the context of refusal, rather than failure to consent). The courts have accepted that, even if a patient will die without medical treatment, it is an assault for the doctor to give treatment in the face of a competent patient's refusal.[6] Thus, in Canada, a competent Jehovah's Witness recovered damages when given a life-sustaining blood transfusion that she did not want.[7]

The law on self-determination reflects the ethical principle of individual

[1] *Schloendorff* v *Society of New York Hospital* 105 NE 92, 93 (1914).

[2] *Canterbury* v *Spence* 464 F 2d 772 (1972); *Reibl* v *Hughes* [1980] 2 SCR 880; *Nancy B* v *Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385; *Rodriguez* v *British Columbia* (Attorney-General) [1993] 7 WWR 641; *Cruzan* v *Director, Missouri Department of Health* 497 US 261 (1990).

[3] *Sidaway* v *Bethlem Royal Hospital and Maudsley Hospital* [1985] AC 871, 882 (Lord Scarman spoke of 'the right of the patient to make his own decision whether he will or will not undergo the treatment proposed'); *Airedale NHS Trust* v *Bland* [1993] AC 789 at 864 (Lord Goff said that doctors must give effect to the wishes of 'an adult patient of sound mind [who] refuses, however unreasonably, to consent to [life-sustaining] treatment . . . even though [the doctors] do not consider it to be in his best interests to do so'; *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649; *Re C* [1994] 1 WLR 290; [1994] 1 All ER 819.

[4] *Rogers* v *Whitaker* (1992) 175 CLR 479, in which the High Court of Australia quoted with approval the reference of King CJ in *F* v *R* to 'the paramount consideration that a person is entitled to make his own decisions about his life': (1983) 33 SASR 189, at 193.

[5] *Smith* v *Auckland Hospital Board* [1965] NZLR 191; *Auckland Area Health Board* v *Attorney-General (Re L)* [1993] 1 NZLR 235, discussed by P D G Skegg, 'Omissions to provide life-prolonging treatment' (1994) 8 *Otago Law Rev* 205.

[6] In *Nancy B* v *Hotel-Dieu de Quebec* (1992) 8 DLR (4th) 385, it was held that a patient of sound mind may, if properly informed, require that life support should be withdrawn. This decision was cited with approval in *Bland* [1993] AC 789, 864 per Lord Goff. Cf *Rodriguez* [1993] 7 WWR 641, in which the court (by a majority of 5:4) refused to give effect to a patient's request for assistance in dying; that involved, of course, a positive act, rather than the refusal of treatment.

[7] *Malette* v *Shulman* (1987) 47 DLR (4th) 18. Cf the cases discussed in fn 56–58 infra and accompanying text.

autonomy, 'the right to control and determine one's life for oneself'.[8] According to this principle, any decision in exercising that right is a moral decision even if it involves medical treatment. It is not a medical decision. And it is the patient who must decide, not the doctor, although the patient will obviously consider medical advice in making the decision.

Legislation

The growing recognition of patients' rights to autonomy and self-determination is also evident in the legislation that has been passed or is being developed in many jurisdictions to allow people to refuse treatment they do not want, to give directions in advance refusing treatment, and to appoint an agent to make decisions about treatment for them if they should become incapable of making their own decisions.

In Australia, for example, Victoria and the Australian Capital Territory have legislation[9] that gives statutory force to the common law principle that patients are entitled to refuse medical treatment that they do not want.[10] If a competent, adult, properly informed patient clearly indicates to a doctor, in the presence of a witness, that he or she does not want medical treatment, or does not want treatment of a particular kind, for the patient's current condition,[11] then the doctor is protected from liability in acting on that direction.[12] In Victoria, it is also a statutory offence for a doctor to give the patient that treatment; a doctor who gives or continues the treatment may be fined up to $500.[13] Both in Victoria and the ACT (and also in South Australia), a patient may appoint an agent to refuse treatment if the patient becomes incompetent.[14] 'Medical treatment' is defined as an operation or the administration of a drug or procedure. The Acts do not apply to 'palliative care', which is defined as the provision of reasonable pain relief, and food and water.[15]

South Australia and the Northern Territory have similar legislation, under which an adult person of sound mind may refuse treatment or make an advance directive not to be kept alive if he or she suffers from a terminal

[8] Professor Max Charlesworth, Submission to the Social Development Committee of the Victorian Parliament, during its Inquiry into Options for Dying with Dignity, published in the Committee's First Report, *Inquiry into Options for Dying with Dignity* (1987), 39–52. Cf Dr Helga Kuhse: 'it is our ability to choose, or to be self-determining and autonomous, which gives special value to the lives of persons': op cit 94. See too, M Charlesworth, 'Autonomy and the Liberal Ideal', *Bioethics in a Liberal Society* (1993) 10–15.

[9] *Medical Treatment Act* 1988 (Vic); *Medical Treatment Act* 1994 (ACT).

[10] The operation of the Victorian Act is described by Professor David Lanham in *Taming Death by Law*, (1993) ch 4.

[11] Because the refusal is limited to treatment for a current condition, this is not an 'advance directive' in the sense of a 'living will', which can be made at any time and in relation to any condition from which the patient may later suffer. The Victorian Refusal of Treatment Certificate is much more specific than a Living Will.

[12] *Medical Treatment Act* 1988 (Vic) s 9; 1994 (ACT) s 22.

[13] *Medical Treatment Act* 1988 (Vic) s 6 (offence of medical trespass).

[14] *Medical Treatment Act* 1988 (Vic) s 5A; 1994 (ACT) s 13; *Consent to Medical Treatment and Palliative Care Act* 1995 (SA) ss 8–11.

[15] *Medical Treatment Act* 1988 (Vic) s 3; 1994 (ACT) ss 3, 5(2).

illness and loses the ability to communicate such a decision.[16] Similar developments have occurred in the United States with the enactment of the *Patient Self-Determination Act* 1990.[17]

INCOMPETENT PATIENTS

The law upholding the autonomy of competent adult patients does not, of course, apply to *incompetent* patients. But, by way of acknowledging the right of even an incompetent patient not to be treated 'paternalistically' by a doctor, other legislation enables a substitute decision maker to exercise 'autonomy' on the patient's behalf. This may be an agent appointed by the patient, as mentioned earlier. Alternatively, guardianship legislation in many Australian jurisdictions provides for the appointment of a guardian to make decisions for patients who cannot decide for themselves (this paper considers only the Victorian legislation (the *Guardianship and Administration Board Act* 1986) and principally in relation to *refusing* treatment, rather than consenting to it).[18] If the agent or guardian lawfully refuses treatment on behalf of the patient, then that direction is as binding on the doctor as a refusal by the patient.

WHAT HAPPENS IN PRACTICE?

For reasons that will be explained in the next part, even in jurisdictions like Victoria that have guardianship legislation, doctors often treat incompetent patients without applying for a guardian to be appointed. Also, they may withhold or withdraw treatment they consider 'futile', although there is no formal authority from the patient or anyone else to do so.

Moreover, despite the increasing emphasis on the right of competent, adult

[16] *Consent to Medical Treament and Palliative Care Act* 1995 (SA); *Natural Death Act* 1988 (NT). These Acts are limited to the refusal of 'life sustaining measures' (SA) and 'extraordinary measures' (NT) by terminally ill patients, but the refusal can be made at any time; it is not limited to a refusal of treatment for a patient's 'current condition'. Several states also have guardianship legislation enabling a guardian to make decisions for an incompetent patient. In Victoria, a guardian has the same authority to refuse treatment for a patient as an agent appointed by the patient: *Medical Treatment Act* 1988 (Vic) s 5B(2). Note too, s 11 *Bill of Rights Act* 1990 (NZ), which enables a competent patient to refuse medical treatment (this includes life-saving treatment: *Auckland Area Health Board* v *Attorney General* [1993] 1 NZLR 235). The *Consent to Medical Treatment and Palliative Care Act* 1995 (SA) and the *Natural Death Act* 1988 (NT) also enable an adult person of sound mind to refuse treatment or to make an advance directive not to be kept alive if he or she suffers from a terminal illness and loses the ability to communicate such a decision. The Acts are limited to the refusal of 'life-sustaining measures' (SA) or 'extraordinary measures' (NT) when the patient is terminally ill (and, in SA, also when a patient is in a persistent vegetative state), but the refusal can be made at any time; it is not limited to a refusal of treatment for a patient's 'current condition'.

[17] There are a number of articles on this Act in (1992) 1 *Cambridge Quarterly of Healthcare Ethics*, 97–127.

[18] Indeed, the power of a guardian to consent to treatment under the Act is by no means clear and could be the subject of a separate paper.

patients (or their agent or guardian) to make medical decisions, it appears that doctors are sometimes reluctant to follow directions from some of these patients to withdraw, or to not undertake, treatment.[19] The circumstances in which this may occur vary considerably, of course, from 'failed suicide' patients who insist that they still want to die; to patients suffering enormous but short term pain in intensive care before their gradual return to total or substantial health; to patients facing a painful, perhaps lingering, but imminent death; to patients who simply will not agree to have tests or treatment that the doctor recommends.

POSSIBLE RESPONSES OF DOCTORS WHO TREAT *INCOMPETENT* PATIENTS WITHOUT FORMAL AUTHORITY

The responses of doctors who treat incompetent patients without formal authority will obviously be different according to the circumstances, but they may include the following.

Emergency

The first justification for treating an incompetent patient without formal authority from someone authorised to consent on the patient's behalf is the common law doctrine of emergency. Under this doctrine, a doctor who treats a patient without consent will have a defence to an action in battery if the doctor acts reasonably and honestly believes, on reasonable grounds, that the treatment given is necessary to avert a serious and imminent threat to the patient's life or physical or mental health. The doctrine has been strictly construed and should not be relied upon lightly. For example, a Canadian court held that the emergency doctrine would not protect a doctor who believed that it was *convenient*, rather than essential, to perform a procedure on an unconscious patient who could not consent to it at that time, even though the alternative was to perform another operation under general anaesthetic.[20] The 'emergency' must be such as to require immediate treatment to save the patient's life or health.

[19] This paper focuses on doctors' reluctance to follow the directions of patients who have refused treatment. Other writers have expressed concerns about doctors following too readily the advance directives of patients who may not have intended their refusal to cover the situation that has later arisen; see, J Stone, 'Advance Directives, Autonomy and Unintended Death' (1994) 8(3) *Bioethics* 222, especially the poignant description of his sister's experiences on pp 234–6.

[20] See *Murray* v *McMurchy* [1949] 2 DLR 442, in which the Supreme Court of British Columbia said that the emergency principle would not protect a doctor who removed the fallopian tubes of a patient undergoing a Caesarean delivery after he discovered fibroids on the wall of the uterus. This was convenient but not essential to preserve the patient's life, or even health.

Necessity

If a patient's condition is not life-threatening, a doctor who gives treatment without consent might perhaps argue that the principle of necessity is separate from that of emergency and is wider in application, though in view of the sparse authorities, it is not certain whether the two principles are the same or distinct. A principle designated 'necessity' was recently endorsed by Lord Goff in *In Re F*[21] and cited with approval in later English cases.[22] According to Lord Goff, the law recognises a principle of necessity as justification for a doctor acting without a patient's consent where it is 'not practicable to communicate with the assisted person' and 'the action taken ... [is] such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person'.[23] This principle of necessity has three bases: first, if it were not so, patients would be deprived of necessary care; secondly, a doctor has a duty of care once the doctor has assumed responsibility for the care of the patient; and thirdly, there is a 'deemed authority' from the patient.

In so far as Lord Goff's principle of necessity referred to accepted medical practice as the standard for deciding whether a proposed treatment is in a patient's 'best interests',[24] it may be criticised by judges in Australia, who have rejected the '*Bolam* test' (accepted medical practice) as the standard in medical negligence cases.[25] Nicholson CJ, for example, said in *In Re Marion* that he was 'unable to see how a test that may be appropriate in considering whether a medical procedure has been carried out with reasonable care can be applied to circumstances where the medical procedure is to be carried out without the consent of the patient'.[26] Nevertheless, Lord Goff stated the test again in *Bland* as the means of deciding whether it is in a patient's 'best interests' that treatment should be discontinued;[27] and in the New Zealand case *Auckland Area Health Board* v *Attorney General*,[28] Thomas J referred to a 'collegiate decision made by doctors in accordance with "good medical practice" '.[29]

In practice, Victorian doctors have the same latitude as that envisaged by Lord Goff to give incompetent patients routine treatment to which they are

[21] *In re F (Mental patient: sterilisation)* [1990] 2 AC 1; again stated by Lord Goff in Bland [1993] AC 789, 867 to justify withdrawing treatment from a patient.
[22] For example, *Re W (A patient)* [1993] 1 FLR 381.
[23] *In Re F* [1990] 2 AC 1, 75; the test of 'reasonableness' is the so-called 'Bolam' test: 'the doctor must act in accordance with a responsible and competent body of professional opinion': Lord Goff id p 78, citing *Bolam* v *Friern Hospital Management Committee* [1957] 1 WLR 582.
[24] Ibid.
[25] At least in relation to negligence in giving information to patients: see, for example, *Rogers* v *Whitaker* (1992) 175 CLR 479; *Lowns* v *Woods* (1996) Aust Torts Reps 81-376 (CA). In *Howard* v *Adey* [1996] 2 VR 535, on the other hand, Winneke P said that the *Bolam* principle still applies to 'negligent treatment and medical management'; a principle endorsed by Brooking and Callaway JJA.
[26] [1991] FLC 92-193 (FCA) 78294-5.
[27] *Bland* [1993] AC 789, 870.
[28] [1993] 1 NZLR 235.
[29] Id 251.

unable to consent because of a 'disability',[30] under guidelines published by the Guardianship and Administration Board;[31] or because of mental illness.[32] Although the legislation provides for the appointment of a guardian to make decisions on behalf of 'a person with a disability [who] is unable by reason of the disability to make reasonable judgments',[33] for pragmatic reasons, it is accepted that one need not apply to have a guardian appointed in every case where patients are not competent to decide for themselves. Guardians are needed only in special cases; for example, where there is a dispute about the procedure to be undertaken, or the procedure has significant risks, or is ethically contentious.[34] In other cases, doctors may treat the patient without consent or with the informal consent of a carer, provided that that is in the patient's best interests as determined by accepted medical practice.

Best Interests of the Patient

The notion of the patient's 'best interests' has been suggested in some recent English cases as a separate justification from necessity for treating a patient who cannot consent.[35] Indeed, a similar outcome has been reached to that under the Victorian guidelines, despite the lack of guardianship legislation in England.

In the English cases, judges have accepted that it is lawful to treat a patient who cannot consent, provided that the doctor is acting in the patient's best interests and in accordance with a responsible body of medical opinion skilled in the particular field of diagnosis and treatment concerned. In *In Re F (Mental Patient: Sterilisation)*,[36] for example, Lord Goff accepted that treatment could be given to a patient who 'is disabled by mental incapacity from consenting to it', provided that the doctor is acting in the patient's best interests. Similarly, in *Re W (A patient)*,[37] it was held that it was lawful to sterilise a severely disabled patient who could not consent because there was a responsible body of medical opinion that it was in her best interests. In a commentary on this case, Professor Ian Kennedy, a leading English authority

[30] 'Disability' means 'intellectual impairment, mental illness, brain damage, physical disability or senility': s 3(1) *Guardianship and Administration Board Act* 1986 (Vic).

[31] Guardianship and Administration Board (Vic), *Incapacity and Consent for Health Care Guidelines*, 11 Feb 1995.

[32] Under the *Mental Health Act* 1986 (Vic) s 12(1)(aa)(ii), a medical practitioner may consent to treatment for a person who 'is not capable of consenting to that treatment' if the treatment is required immediately in the patient's best interests. The Health Department Victoria in *A Practical Guide to the Mental Health Act* (1992) 13, said that 'the situation of a person who is incapable of consenting or refusing to consent to treatment because of mental illness is an exception to the general rule that no medical treatment should be provided for a person without consent'.

[33] *Mental Health Act* 1986 (Vic) s 22(1)(a),(b).

[34] Guardianship and Administration Board (Vic), *Incapacity and Consent for Health Care Guidelines*, 11 Feb 1995.

[35] The same is true in withdrawing treatment: '[i]n the absence of clear instructions from the patient himself, the decision whether to withhold life-prolonging treatment has to be made in the best interests of the patient': Robert Goff, 'A matter of life and death' (1995) 3 *Med Law Rev* 1, 9; see too, *Bland* [1993] AC 789.

[36] [1990] 2 AC 1, 71.

[37] [1993] 1 FLR 381.

on medical law, said that '[it] is significant in that it is clearly intended to send a signal to Health Authorities and doctors that where all are agreed that treatment is in a patient's best interests, they should go ahead and treat, secure in the knowledge that in satisfying this criterion the treatment will be lawful'.[38]

POSSIBLE RESPONSES OF DOCTORS WHO OVERRIDE THE REFUSAL OF *COMPETENT* PATIENTS

Emergency or Necessity

The principles of emergency or necessity are less likely to avail a doctor if a patient has refused treatment than if the patient has not been able to consent to it. As noted earlier, there is widespread judicial and administrative recognition that in an emergency or by reason of necessity, doctors may often treat incompetent patients without consent. However, it is a substantial leap from saying that a doctor may treat a patient who cannot consent under such a principle, to saying that a doctor may *override a patient's refusal* of treatment. Lord Goff recognised this in *In Re F.*[39] He said that 'intervention cannot be justified [on the necessity principle] ... when it is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish'.[40]

The same may well be true of the emergency doctrine although there is no precise authority on the extent to which it can be applied if a patient has refused, rather than not consented to, treatment. I am not aware of any case in which a doctor has argued the emergency doctrine where the patient is known to have specifically refused a procedure[41] and doctors would be well advised not to rely on the doctrine in such a case.

Assessing Patient as Not Competent to Decide

Instead, they could perhaps consider the second option for doctors to justify treatment without a patient's consent. This is to assess the patient as not being competent to decide so that the patient's wishes are not determinative. It is for the doctor to determine competence in each case and a person may be assessed as competent to decide about some things, such as whether to agree to a physical examination, but not to decide about others, such as whether to refuse complex or contentious surgery, or necessary but invasive life-sustaining measures. Some writers have commented that doctors will more readily assess patients as competent if they agree to the procedure the doctor

[38] Commentary, 'Treatment without consent (Diagnostic Procedure): Adult' [1993] *Med Law Rev* 232, 237.
[39] [1990] 2 AC 1.
[40] [1990] 2 AC 1, 76.
[41] This situation is similar to that in *In the Matter of Alice Hughes* 611 A 2d 1148 (1992) (Superior Court of New Jersey, Appellate Division), discussed in the text accompanying fn 56 infra. However, in that case, the doctor did not rely specifically on the emergency doctrine.

recommends than if they refuse it.[42] For example, one would expect a doctor to assess most carefully the decision-making capacity of an otherwise healthy patient who refuses an appendectomy.[43]

The relevance of competence in this context is illustrated by *Re W (A patient)*,[44] in which the English High Court held that a diagnostic procedure that the patient did not want was nevertheless lawful. The procedure involved a brain scan under general anaesthetic and the doctors agreed that it was in the patient's best interests. The patient did not want it because she hated needles. She made it clear that she would not co-operate with the doctors. The court said, however, that her mental state and associated delusions meant that she was unable to discuss the procedures reasonably and to give a valid consent (or, in this case, a valid refusal!).

However, doctors should not lightly assess patients who do not agree with them as incompetent, so that their wishes may be overridden. The case of *Re W* may be contrasted with another case in which the patient suffered far more extreme delusions but was nevertheless found by a court to be competent to refuse treatment. In *Re C*,[45] the patient was a 68-year-old paranoid schizophrenic at Broadmoor Hospital. He believed that some of the staff had tortured him and that he had once been a great doctor who could cure damaged limbs, including his own, without amputation. When C developed gangrene in his right foot, his doctors recommended an amputation. In their view, there was an 85 per cent chance that he would die without it. He refused and applied to the court for an injunction to restrain the authorities from amputating his foot without his consent. Thorpe J granted the injunction, applying the reasoning of Lord Donaldson *MR in In Re T (Adult: Refusal of Treatment)*:[46] 'Every adult is presumed to have [the] . . . capacity' to decide his own fate and should be allowed to do so unless that presumption is rebutted. 'The patient's right of choice exists *whether the reasons for making that choice are rational, irrational, unknown or even non-existent*'.[47] Thus despite C's low IQ,[48] and his belief that the gangrene would not kill him, that he wanted to go out of the world as he was born, with four complete limbs, and that God did not want him to have the amputation, his will prevailed!

[42] For example, D Lanham, op cit, 106: 'There is a wide gulf between the capacity to accept life-saving medical treatment and the capacity to refuse it' (Professor Lanham was there speaking of capacity in relation to age, rather than general cognitive capacity but the principle would seem to be the same). For a fuller discussion, see M Wicclair, 'Patient decision-making capacity and risk', (1991) 5 *Bioethics* 91, 91–104, esp pp 103–4; and my response: 'Risk-related standard inevitable in assessing competence — Comments on Wicclair' (1991) 5 *Bioethics* 113.

[43] See M Wicclair, op cit 98. Wicclair says that the patient's wishes should be followed if 'no deficits in understanding or reasoning can be identified, and the values and weights that the patient assigns to the various outcomes are consistent with his system of values': ibid.

[44] [1993] 1 FLR 381.

[45] [1994] 1 FLR 782; described by the patient's barristers, R Gordon and C Barlow, 'Competence and the right to die' (1993) 143 *New Law J* 1719.

[46] [1992] 3 WLR 782; [1993] Fam 95. This was a case in which the patient refused a blood transfusion. The patient's refusal was held ineffective as it might have been influenced by pressure from her parents.

[47] [1992] 3 WLR 782; [1993] Fam 95, 112H (emphasis added).

[48] A little over 70, the lowest accepted as 'normal'.

Nevertheless, the possibility of assessing a patient as incompetent gives doctors some scope for administering treatment that the doctor believes is necessary but the patient does not want and may be a useful avenue to contravene the 'unreasonable' wishes of a patient.

Best Interests of the Patient

A third option for doctors to justify treating patients who do not want to be treated is to say that they are acting in the patient's 'best interests'. This smacks, of course, of the currently unfashionable notion of medical paternalism, but many doctors believe that their duty to care for their patient requires them always to maintain life and to offer whatever medical treatment is available. This may be seen as a broad, overriding obligation. Or they may argue that the patient consults them intending that they should make treatment decisions on the patient's behalf.

The application of the best interests approach is best illustrated by the 'failed suicide' cases. Consider, for example, a drug overdose patient admitted to casualty after a domestic dispute. The usual course is to undertake whatever immediate action is necessary to preserve life and then to hold the patient for observation. The patient may well object but that course is still followed despite the patient's lack of consent. If the patient was admitted voluntarily, then there may be an implied consent. If, on the other hand, someone else admitted the patient, no consent can be implied from admission to hospital. Moreover, the patient might even have signed an advance directive refusing life-saving treatment, such as stomach pumping. So what authority do doctors have to treat in these circumstances?

During the initial stages, doctors may perhaps rely on the doctrine of emergency, but as suggested earlier, it is not clear to what extent that principle applies if the patient has refused, rather than not consented to, the treatment. Also, the emergency principle applies, if at all, only when the patient's life or health are directly threatened. The principle of necessity, which, as has been suggested earlier, is wider and not so limited to avoiding an immediate threat to the patient's life or health, also will not prevail over the patient's refusal. A doctor could act under a common law or statutory right to use reasonable force to prevent a person committing suicide;[49] but this, too, would appear to justify treatment only in the initial stages to save the patient's life. It might not

[49] Section 463B of the *Crimes Act* 1958 (Vic) states that 'Every person is justified in using such force as may reasonably be necessary to prevent the commission of suicide or of any act which he believes on reasonable grounds would, if committed, amount to suicide'. This section is not affected by the *Medical Treatment Act* 1988 (Vic) (s 4(3)(a)) so that, even if a person has signed a certificate refusing treatment under that Act for the patient's 'current condition' (such as a drug overdose), or has orally refused treatment under the Act, (oral refusal is allowed by s 5(1)(3) of the same Act) the doctor would presumably be entitled to take reasonable measures to save the patient's life. These provisions have not been judicially considered. In an unreported case in the Supreme Court of Victoria, Fullagar J authorised treatment for a patient who had apparently tried to commit suicide but the patient was not then conscious and the suicide note that his wife said he had signed was not produced in court: *In Re GM Kinney, Application by Talila Kinney* (unreported, Supreme Court of Victoria, 23 December 1988) discussed by me in 'The Fullagar judgment' (1988) 14 *Legal Service Bulletin* 42.

cover later treatment that the doctor believes should be given in the best interests of the patient.

After the first crisis has passed, the doctors should strictly have the patient certified under mental health legislation if they wish to detain and treat the patient further. That is rarely done and there may be doubt whether such a patient falls within the ambit of the legislation.[50] Instead, doctors rely on their view of what is in the patient's best interests, backed by years of experience that patients assisted in this way will thank them later.

As noted earlier, some English judges have been sympathetic towards doctors who believed that they were acting in the best interests of a patient who could not consent when treating without formal authority; and the guidelines of the Victorian Guardianship and Administration Board adopt a similar approach. But a case in which a patient is unable to consent is different from one in which a patient has refused the treatment. Although one may sympathise with doctors who want to treat 'unreasonable' patients against their wishes, the lawful authority for that cannot be found in the patient's best interests alone. Philosophical theory supports the doctor's duty of beneficence, to act in a patient's best interests, as do many codes of professional ethics.[51] The doctor's duty of care to which Lord Goff referred in *In Re F*,[52] also imposes similar obligations. But the law appears to regard autonomy as paramount.

This is evident from both the case law and the legislation mentioned earlier[53] which emphasise the importance of self-determination. In *Bland*, for example, it was held that even the 'fundamental principle . . . of the sanctity of human life'[54] must yield to that of self-determination. Lord Keith stated this in the clearest terms: 'It is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent. . . . such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die'.[55]

Refusal Does Not Cover the Situation That Has Arisen

Perhaps the most promising avenue for doctors to treat patients who refuse treatment may be to argue that, although the patient may have been competent when initially refusing the treatment, the patient did not fully

[50] For example, *Mental Health Act* 1986 (Vic) s 8(1)(a) requires that a person 'appears to be mentally ill' before being detained as an involuntary patient. 'Mentally ill' is defined in s 8(1A) to mean having a 'medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'.

[51] The Declaration of Geneva, for example, contains the undertaking: 'The health of my patient will be my first consideration'. Some codes, on the other hand, acknowledge the right of patients to decide. The Australian Medical Association Code of Ethics, for example, says that doctors should 'respect [their] patients' right to . . . accept or reject advice and to make their own educated decisions about treatment or procedures'.

[52] [1990] 2 AC 1.

[53] See fn 1–7, 12–16 supra and accompanying text.

[54] Per Lord Goff in *Bland* [1993] AC 789, 863–4.

[55] [1993] AC 789, 857; see too per Lord Goff at 864, per Lord Browne-Wilkinson at 877; and per Lord Mustill at 885.

comprehend the situation which has subsequently arisen and so the refusal is now inoperative.

This is illustrated by an American case, *In the matter of Alice Hughes*,[56] in which the plaintiff was a Jehovah's Witness and had refused a blood transfusion by signing a form when she was admitted to hospital and verbally to her treating doctor. During her hysterectomy, she developed complications and she was given a blood transfusion to save her life. She was also given further transfusions after the surgery but, at that time, a temporary medical guardian had been appointed and consented to those procedures on her behalf. When she recovered consciousness, she appealed against the emergency judgment appointing the medical guardian, on the basis that she had made clear her refusal of a transfusion. The court said that, although a competent, adult patient is entitled to refuse life-sustaining treatment, that right operates only if the patient has a clear understanding of the illness and prognosis and the consequences of refusing the treatment. Here, the patient's refusal had been made in anticipation that the hysterectomy would be a routine procedure, in which a blood transfusion was unlikely to be required (and indeed, the doctor had led her to believe that a transfusion would not be required). There was no discussion of what the patient would want if an emergency arose in which she would die without a transfusion. Her refusal therefore did not cover those circumstances and it was justifiable for a medical attorney to be appointed to consent to continuing transfusions.

This outcome may trouble advocates of patient autonomy. Andrew Grubb, for example, remarked in a commentary on the case, that 'there is a danger that courts will impose an unduly high burden upon a patient to make his wishes known in advance of becoming incompetent, thereby depriving the patient of a right of refusal'.[57] This apprehension is, perhaps, borne out by the statement of an English judge in a later case (though he may have taken an unusually conservative line because the patient was a minor).[58] In *Re E (a*

[56] 611 A 2d 1148 (1992), Superior Court of New Jersey, Appellate Division.

[57] Commentary, [1993] *Med Law Rev* 278, 280. Professor Grubb notes several other cases in which refusals of blood transfusions by Jehovah's Witnesses have been held not binding on doctors (p 280); only in *Malette* v *Shulman* (1987) 47 DLR (4th) 18, has a court upheld a patient's refusal of a blood transfusion, '[p]resumably . . . because in that case, unlike the others, the patient had left the explicit instruction "NO BLOOD TRANSFUSION! . . . under any circumstances" ' [1993] *Med Law Rev* 278, 280. Thus, if a patient's instruction is clear and expressed to apply in every case, it will bind doctors even in life-threatening circumstances. In other cases, doctors who treat to save a patient's life will probably be supported by a court, despite Professor Grubb's rhetorical question: 'Can it be seriously doubted that a patient (particularly one who is a Jehovah's Witness) does not appreciate the consequences of refusing a blood transfusion?' Id 281.

[58] There have been other cases in the United States in which courts have endorsed refusals for transfusions for adult Jehovah's Witnesses on the basis of the constitutional guarantees of freedom of religion, despite the cases to the contrary cited by Andrew Grubb (fn 57 supra); see, for example, *In Re Estate of Brooks* 205 NE 2d 435 (1965); *In Re Osborne* 294 A 2d 272 (1972); though contra, *In the Application of Georgetown College* 331 F 2d 1000 (1964) (patient mother of seven-month-old child); *Raleigh Fitkin-Paul Morgan Memorial Hospital* v *Anderson* 201 A 2d 537 (1964) (patient pregnant); and *John F Kennedy Memorial Hospital* v *Heston* 279A 2d 670 (1971), in which the carers' interests were considered: 'A surgeon should not be asked to operate under the strain of knowing that a transfusion may not be administered even though medically required to save his patient'.

minor), the judge ordered that a 15-year-old leukaemia patient, who was a Jehovah's Witness, should be given a blood transfusion despite his refusal (and the refusal of his parents).[59] Although he was 'obviously of sufficient intelligence to be capable of making decisions about his own well-being, there are still a range of decisions the full implications of which . . . [he] was still insufficiently mature to grasp'. Although he said 'he would refuse well knowing he may die as a result', he '[did] not have any sufficient comprehension of the pain he [had] yet to suffer, of the fear that he will be undergoing, of the distress occasioned by that fear but also — and importantly, the distress he will inevitably suffer as he, a loving son, helplessly watches his parents' and his family's distress'.[60] It may, indeed, be difficult for a patient to satisfy a court of this level of anticipation!

Refusal of less specific treatment than a blood transfusion is likely to raise even greater problems in establishing the extent of understanding or 'imagination' that a patient must have in order to be able to make an 'informed' refusal, or one that clearly meets the situation that has arisen. Lord Goff adverted to this problem in *Bland*; although a patient's refusal to give consent, even to a life-saving procedure, was effective when given before he or she became unconscious, 'especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred'.[61]

This is aptly illustrated by a patient admitted to an intensive care unit for painful but short-term care following surgery. Say that this patient's chance of making a full recovery is high but the patient has signed an advance directive, or given other instructions that he or she does not wish to be placed on life-support.[62] The patient stops breathing. What is the doctor to do? One option is to rely on the emergency or necessity doctrines but as noted earlier, it is unclear to what extent those principles may be applied in the face of the patient's known refusal of a procedure. More promising is the path suggested by Lord Goff.[63] The doctor may say that although the patient may have been 'competent' when making the advance directive, that instruction does not cover the case that has arisen.[64] I am not aware of any case in which this argument has been raised in relation to refusal of treatment under legislation

[59] [1993] 1 FLR 386.
[60] [1992] 2 FCR 219, 224.
[61] [1993] AC 789, 864.
[62] Dr David Tuxen, a Melbourne specialist in intensive care, has described some practical difficulties in obtaining a fully 'informed consent' in an advance directive. Although a healthy patient may say in advance that he or she does not wish to be resuscitated, admitted to an intensive care unit etc, that decision may be different if the patient is likely after the intervention to return to full health, or even to medium health after a period of suffering. For this reason, he says, 'whilst . . . it is useful to know of a patient's pre-illness decision about advanced life-support systems, . . . decisions made by patients may be of limited value': 'Dying with Dignity', paper presented at an Intensive Bioethics seminar held by the Monash University Centre for Human Bioethics, December 1993.
[63] See text accompanying fn 61.
[64] The patient's direction might have greater weight if he or she had signed not only an advance directive, but also a 'Values Statement' of the type developed by the Centre for Health Law and Ethics at the University of New Mexico, which might show that the patient's decision accorded with his or her usual attitudes and behaviour. The Values Statement is reproduced in an Appendix to Professor Lanham's book, fn 10 supra.

such as the *Medical Treatment Act* 1988 (Vic) but it would seem appropriate both on general principles and on the wording of the Act.[65]

CONSENT BY RELATIVES, GUARDIANSHIP BOARDS AND COURTS

The examples outlined above indicate a range of situations in which doctors may wish to treat a patient without formal authority or even to override a patient's instructions about treatment on the basis that the patient was not 'competent', or was not able to make the decision in question. However, even if a doctor believes that a patient is not competent to decide, that does not necessarily mean that the doctor is then legally entitled to do whatever the doctor thinks fit. One possibility is to seek consent from relatives. However, although doctors often ask a patient's relatives to consent on the patient's behalf, there is no legal basis for them to authorise treatment unless they have been appointed by the patient under an enduring power of attorney (medical treatment) or the like, or have been appointed by a guardianship board, or a court, to make decisions for the patient.[66]

Alternatively, a doctor may apply to a guardianship board or a court. Guardianship boards are traditionally loath to deprive a person of decision-making power by appointing a guardian unless the person is unable to make decisions and it is necessary to have a guardian appointed. It would, however, be possible, for a limited authority to be granted to a relative for the purpose of consenting to a particular procedure, or to imminent medical treatment generally. A guardianship order is likely to be made in such circumstances, where life-sustaining treatment is needed and there is a disagreement between the patient and the carers, but one should not discount the difficulties for a doctor in seeking official authority to contravene a patient's wishes.

In those jurisdictions that do not have guardianship legislation, such as the United Kingdom, the position is even more problematic. An application would need to be made to a court. The English case, *In re F (Mental patient: sterilisation)* cited earlier[67] indicates that although the English courts will support a doctor's decision on the ground of necessity, that does not apply where the patient has refused treatment. And although the judges in Bland[68] approved the procedure of a declaratory judgment as a method of obtaining

[65] *Medical Treatment Act* 1988 (Vic) s 5(1)(c) requires that 'the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment'. Section 7(3) states that a refusal of treatment certificate ceases to apply if the person's condition has changed to such an extent that the condition in relation to which the certificate was given is no longer current.

[66] See I Kennedy, 'The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors', reprinted in I Kennedy, *Treat Me Right: Essays in Medical Law and Ethics*, (1988) 331, 340; In Re *GM Kinney, Application by Talila Kinney*, unreported, Supreme Court of Victoria, 23 December, 1988.

[67] [1990] 2 AC 1.

[68] [1993] AC 789.

court directions concerning medical treatment,[69] their heavy emphasis on patient autonomy might not lead a doctor to expect the English courts to override a patient's instructions.

CONCLUSION

Despite widespread judicial and legislative emphasis on the right of competent adult patients to make their own medical decisions and the recognition that the principle of patient autonomy is paramount even over the principle of sanctity of life, doctors sometimes believe that it is in their patients' best interests to be treated without their consent. However well meaning the doctor, there are doubts as to whether such treatment is lawful, even when administered to save the patient's life. The defence of necessity, and probably the doctrine of emergency, do not apply if the patient has refused, rather than not consented to, treatment. Doctors may decide that a patient is not competent to decide about the treatment in question, either because of limited cognitive capacity, or insufficient understanding or imagination about the proposed procedure, or they may decide that the patient's refusal does not cover the circumstances that have arisen. But, if the patient is not competent, then except in the limited circumstances of the Guardianship and Administration Board's guidelines, they are not then legally entitled to simply proceed with the informal consent of a relative; strictly, they should wait for a guardianship order or a court order. All of this involves time and cost. It may also prejudice the therapeutic relationship between doctor and patient.

In the end, perhaps the best advice to doctors is pragmatic. If a doctor acts reasonably, or in accordance with accepted practice, and in what the doctor reasonably perceives to be the patient's best interests, the patient is probably unlikely to be successful in proceedings in negligence,[70] though a battery action may be successful. Even if the patient were successful, however, one would expect the damages to be minimal, for it is surely contrary to public policy to penalise a doctor for trying to save a patient's life or health.[71] This is perhaps reflected in the fact that the maximum penalty for giving treatment without consent under the Victorian *Medical Treatment Act* (medical trespass) is a fine of only $500. Thus, at least in 'emergency' cases, doctors may well take the approach of 'treat and damn the consequences'!

[69] Cf the reservations of Thomas J about declarations by a court in *Auckland Area Health Board* v *Attorney-General* [1993] 1 NZLR 235.

[70] Negligence probably requires proof of a medical injury rather than denial of autonomy per se.

[71] It is possible, admittedly, that aggravated damages might be awarded to make the law's recognition of the patient's autonomy effective. Jehovah's Witnesses who have been given blood transfusions against their wishes have been awarded substantial damages and it is doubtful whether that was always due to the court being persuaded that the patient suffered a real 'metaphysical' injury in the light of the patient's religious beliefs.