

THE RIGHT NOT TO RECEIVE MEDICAL TREATMENT

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THE EROSION OF MEDICAL AUTONOMY

The escalation of medical paternalism and the encroaching powers of the medical profession over individuals is one of the most important issues facing those who prefer autonomy to the nanny state. Almost every week a story seems to appear in the newspapers which reminds one how little control patients have these days over medical services, particularly those provided by the National Health Service. Recently, for example, it was revealed that certain surgeons are refusing to perform heart operations on those who continue smoking despite being told to stop. In some cases, this has meant that patients died because they were denied essential life-saving treatment by doctors.

Perhaps one should not be too surprised that the 'right' to treatment under a collectivised health system is a seriously qualified one. More ominous is the recent tendency for it to be regarded acceptable to apply treatment to individuals against their will. Patients are beginning to find themselves in the position, not only of not being given treatment when they want it, but also of being given treatment when they do not want it.

Although the law does not recognise any right to *obtain* treatment which an individual requests where this conflicts with what his doctor considers to be his best interests, it is at least supposed to uphold the right to *refuse* treatment. Under English law, when a practitioner effects the physical invasion of a person's body without that person's prior consent, he commits the tort of battery and can be sued for damages, regardless of the effect on the person's health. However, the circumstances in which this principle may be set aside are increasing to the point where it will soon cease to be a principle and become merely a minor consideration.

The ideological background to this development is informed by theories of society which (a) view with scepticism Mill's idea that an individual knows best about his own feelings and circumstances; and (b) consider there to be little or no area of life into which collective interests do not extend. Already it can happen that, where there is a collective health benefit which can only be achieved at the expense of reducing autonomy, as in the case of water fluoridation, it is autonomy which is surrendered. The American writer Robert Veatch gives philosophical support to this form of coercion by arguing that

[a] duty of justice calling for welfare to be distributed fairly ... could permit violating the autonomy of individuals in special cases where the person already has an unusually great amount of welfare in comparison to others that it can be said to be unfair.¹

But the value of autonomy itself is beginning to be questioned, even when the interests of no other person are at issue. The theologian Paul Ramsey, for example, has argued that



there are medically indicated treatments ... that a competent conscious patient has no moral right to refuse, just as no one has a moral right deliberately to ruin his health. ... Instead of a conscious nondying patient's right to refuse treatment we need to emphasize his free and informed participation in medical decisions affecting him when there are alternative treatments.²

The new intellectual position on medical autonomy has already manifested itself in a number of concrete ways in the context of medical law. For example, legal opinion has shifted in favour of medical practitioners in the context of establishing whether or not consent to treatment was in fact given in any particular case. It used to be thought that the onus of proof was on the doctor, who had to establish a defence analogous to *volenti non fit injuria* (no cause of action arises to someone who voluntarily accepted the risk) to rebut the presumption of battery. Recent court cases suggest that the onus is now on the patient. In a 1980 case it was held that "in order to establish trespass to the person a patient had to show that she did not consent to the operation"³ a view which received approval in a subsequent civil liberties case involving a prisoner who denied that he had consented to being injected with tranquilizers.⁴

There are other ways in which legal practice is biased against the patient in the area of consent. Courts are generally very unkeen on finding doctors guilty of battery, and will tend to take any evidence of consent as sufficient to rebut a charge of battery. Thus in an English case in 1978, a woman who was asked to consent to sterilisation while in labour with the birth of her third child, and who signed the consent form while in a state of exhaustion, was held to have given valid consent and her claim for damages under battery failed.⁵

THE BLANK CHEQUE OF CONSENT

One area of difficulty in relation to consent arises from the fact that the treatment proposed may be technically complicated: what exactly is the patient consenting to? Clearly, an important component in a patient's deciding whether to consent to a course of action is knowing the risks involved. If these are not adequately disclosed, when one might expect them to be, then surely one can not meaningfully give consent? Again, however, the prevailing belief in the virtue of medical paternalism means that doctors need only give their patients very little information in order for consent to be regarded as genuine. In the leading case of *Chatterton v Gerson*, a patient (Miss Chatterton), who lost the use of her right leg as a result of unsuccessful operations to treat pain arising from a previous operation, failed in her claim for battery, although the surgeon was clearly somewhat economical in telling her about the possible risks. The judge argued that consent to surgery was valid so long as the patient was informed in broad terms of the *nature* of the procedure which was intended.

In a relatively old but still influential New Zealand case,⁶ the court went further than this in relieving doctors of a duty to disclose relevant information: it allowed them to *manipulate* patients into giving consent, a technique which would be regarded as fraudulent misrepresentation in certain commercial contexts. The judge in this case stated that, in deciding how much to disclose to a patient, doctors should consider the gravity of the condition to be treated, the importance of the benefits to be expected to flow from the treatment or procedure, and the need to encourage the patient to accept it.

English judges have been very resistant to the idea that consent to treatment might be vitiated where important risks are not disclosed. The legal establishment seems uncomfortable with the idea that fellow professionals acting by their own light should be accused of battery, and the consensus opinion is that any action should normally lie in negligence rather than battery. However, the trouble with claiming negligence in cases of failure to inform is that the doctor is then judged, not by reference to any objective legal standard, but simply by comparison with whatever happens to be 'accepted medical practice'. In other words, if the majority of doctors behave in a certain way, then they cannot be held to be negligent, regardless of the harm their behaviour may be causing. Patients therefore tend to fare little better with negligence than with battery. Thus, for example, Miss Chatterton's attempt to obtain damages for her injury under negligence was as unsuccessful as her claim under battery.

Even if a patient succeeds in proving negligence, it may not get her very far, as she must also establish that any loss for which she is

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seeking damages was caused by the negligence in question, i.e. the lack of disclosure. If the doctor can convince the court that the patient would have agreed to the operation anyway, then the patient will fail at this second stage.

It is often said that American and Canadian courts have been more sympathetic to the notion of patient autonomy in medical battery cases than their British and Antipodean counterparts. Certainly the North American doctrine of 'informed consent', under which the patient allegedly has an inalienable right to be told as much about the risks of a recommended treatment as a 'reasonable' person might expect to be told, has never been endorsed by a British court. However, to suggest that the North American position expresses consumer sovereignty would be to exaggerate the significance of the difference. Even in the particular US court case which established the doctrine of informed consent,⁷ the court held that patients might sometimes become too upset by full disclosure of the risks to reach a rational decision, and that in those situations good medical practice required a degree of concealment.

THE LACK OF IDEOLOGICAL SUPPORT FOR THE CONSENT PRINCIPLE

There is, incidentally, very little reference to consent in codes of medical ethics. Among the duties owed by doctors to the sick, the International Code of Medical Ethics lists the preservation of life, confidentiality and emergency care, but does not mention the need to obtain approval from the patient for any treatment. It does, however, state that "Any act or advice which could weaken physical or mental resistance of a human being may be used only *in his interest*" (my italics). The Declaration of Helsinki's code of ethics for medical research encourages an even more cavalier attitude to the wishes of patients, giving as one of its rules that

If the doctor considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee.

Medical philosophers seem happy to accept limited disclosure by doctors as ethically justifiable. H. T. Engelhardt, for example, maintains that

one can morally defend [the standard of disclosure according to what happens to be accepted medical practice] in terms of the principle of mutual respect. Unless otherwise warned, patients may reasonably expect that practitioners will give that amount of disclosure customary for members of that profession, school, or group ... To give more [disclosure] than a reasonable medical practitioner would give may presuppose a hierarchy of values different from that endorsed by the profession or school. Such an increased disclosure might require a special warning to the patient ...

He concludes that unless individuals have

taken steps to create special expectations and/or special requirements, the [usual standard of disclosure] meets the principles of autonomy and beneficence.⁸

JUDGING WHETHER PEOPLE ARE FIT TO DECIDE

A point of potential weakness in the consent principle arises from the fact that a person who is not conscious cannot be asked whether or not he consents to proposed treatment. This leads to the defence of 'tacit consent' in situations where emergency surgery has to be applied to an unconscious patient. As most people would expect to have life-saving treatment applied in such a situation without first being asked for their consent, it is perhaps reasonable that doctors should generally assume this to be the case, in the absence of evidence to the contrary. On the other hand, it ought to be possible for individuals to make advance arrangements to prevent treatment from being applied when they are unconscious, even where such treatment is ostensibly life-saving.

In a recent case involving a Jehovah's Witness, however, this respect for autonomy was seriously qualified by making the right of refusal conditional on the 'capacity' of the patient to make the appropriate decision. The patient in question was a twenty-year old pregnant woman injured in a road accident, who was admitted to hospital and later given a Caesarean section. Although she twice ex-

pressed her wish to hospital staff that she should not be given a blood transfusion, and signed a refusal form, her father (who was not a Jehovah's Witness) succeeded in his application to the court to have her wishes overridden. The judge, Lord Donaldson, held that the woman had been unduly influenced by her mother in forming her attitude towards blood transfusions, a condition which vitiated her refusal to give consent. In an emergency situation, Lord Donaldson said,

doctors faced with a refusal of consent had to give careful consideration to what was the patient's capacity to decide at the time the decision was made. ... What mattered was that the doctors would consider whether at that time the patient had a capacity commensurate with the gravity of the decision he purported to make. The more serious the decision, the greater the capacity required. ... In some cases doctors would have to consider whether the refusal had been vitiated because it resulted not from the patient's will but from the will of others. ... In that context the relationship of the persuader to the patient, for example, spouse, parent or religious adviser, would be important, because some relationships more readily lent themselves to overbearing the patient's independent will than others did.⁹

The problem with setting aside a patient's views on such criteria, however, is that it allows doctors in principle to override the wishes of a patient whenever these appear unusual, provided only that they can point to someone who may have been influential in determining the patient's views. There is, of course, no corresponding suggestion that consent to treatment should be regarded as invalid where doctors have placed the patient under pressure to agree with their preferred course of action.

Some observers appear not to find this development very disturbing. Does it matter, after all, if people are not allowed to express their eccentricity in the form of refusing to have their lives saved in the way medical science thinks best? Unfortunately, once the principle has been established that people can have treatment forced on them against their wishes by reference to received medical wisdom, there remain relatively few arguments against the same principle being applied in other areas of medicine: inoculation, cancer screening, AIDS testing, pregnancy termination, sterilisation, and so on.

CONCLUSIONS

Changing attitudes with regard to consent undoubtedly result from the intrusion of society's interests into what was previously a private matter for individuals. As the authors of a standard textbook on medical ethics point out,

illness is costly to the community and the individual is not entitled to refuse treatment which may minimise this cost. If death is to be the consequence of refusal of medical treatment, then the community may have to bear the cost of supporting the patient's family. Involuntary treatment is justified in order to avoid this burden.¹⁰

We see therefore what is perhaps the most serious price of collectivising health services. The patient ceases to be the master and becomes the subject, regarded by the medical profession as open to whatever manipulation it happens to consider appropriate, whether for health or cost reasons.

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