

Detained patients and the right to refuse treatment

Paul Bowen*

**R (Wilkinson) v. Broadmoor RMO (1) Mental Health Act Commission (2)
Secretary of State for Health (Interested party) [2001] EWCA Civ 1545**

Court of Appeal (22nd October 2001) Simon Brown LJ, Brooke LJ and Hale LJ

A detained patient's right to refuse treatment to which he or she objects has been greatly strengthened by a recent decision of the Court of Appeal, applying the provisions of the Human Rights Act 1998, although in reaching its decision the Court of Appeal has posed as many questions for the future of the law in this area as it has answered.

Facts

Mr. W is a restricted patient who has been detained at Broadmoor hospital for the last 34 years under sections 37 and 41 Mental Health Act 1983. He has consistently been diagnosed as suffering from a paranoid personality disorder, classified as psychopathic disorder for the purposes of the MHA. In July 1999 he was placed under the care of a new responsible medical officer (RMO), Dr. H, who decided that Mr. W might benefit from a trial of anti-psychotic medication, either because he was suffering from a previously undiagnosed psychotic mental illness or because such medication would ease the more paranoid aspects of his personality disorder. Mr. W made his objection to such medication very clear. Because Mr. W had been subjected to a brief trial of medication in the past, to impose the medication compulsorily Dr. H was obliged by sections 63 and 58 MHA to obtain a supporting second opinion from a psychiatrist appointed by the Mental Health Act Commission (SOAD). A SOAD was appointed, examined Mr. W and agreed with Dr. H that a trial of anti-psychotic medication was 'within the bounds of acceptable medical practice'. On the same day Dr. H, aided by several nurses, forcibly injected Mr. W with anti-psychotic drugs. The procedure was repeated a fortnight later. On each occasion Mr. W struggled as he said he would. Before the procedure could be repeated a third time, Mr. W consulted Scott-Moncrieff, Harbour & Sinclair, solicitors, who obtained an emergency injunction in High Court proceedings for judicial review preventing Dr. H from imposing further such treatment by force.

Dr. H's decision to treat Mr. W was highly controversial. A number of psychiatrists who had examined Mr. W on previous occasions – including a previously appointed SOAD – had been of the opinion that anti-psychotic medication was not clinically justified. Most recently he had been examined by Dr. G, another consultant forensic psychiatrist, who disagreed with the diagnosis of mental illness and considered compulsory medication for Mr. W's personality disorder was not clinically justifiable; that, in any event, Mr. W had capacity to refuse such treatment; and, most seriously, Mr. W suffered from a heart condition that could prove fatal if further medication was imposed upon him by force.

Armed with this evidence, Mr. W's lawyers argued that further treatment would constitute a violation of Mr. W's rights under the European Convention on Human Rights, guaranteed by the

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Human Rights Act 1998 since its coming into force on 2 October 2000. The risk of a fatal heart attack meant that further treatment could violate his right to life, contrary to Article 2 of the Convention. Moreover, the imposition of medication against a detained patient's will was a violation of his right not to be subjected to inhuman and degrading treatment, contrary to Article 3; alternatively, if the level of suffering caused did not reach the necessary threshold for the purposes of an Article 3 violation, the treatment was certainly an unjustified interference with Mr. W's right to respect for his private life, safeguarded by Article 8 of the Convention. That was particularly so, it was argued, because Mr. W had capacity to refuse the treatment, and had refused, so to impose it upon him by force was to override his fundamental right to autonomy or self-determination. Last, Article 14 was also breached because no sufficient reason existed for distinguishing between those capacitated patients who are detained, who can be compulsorily treated, and those who are not, who cannot be treated against their will; even a detained prisoner, provided he is of sound mind, is permitted to refuse treatment, notwithstanding that refusal will lead to his death.

In order to establish this case, Mr. W's lawyers further argued that it would be necessary for the High Court to hear evidence from the relevant experts (Dr. H, Dr. G and the SOAD), a highly unusual procedure in judicial review proceedings. The High Court ruled that the case could be determined upon written evidence alone, since in judicial review proceedings the High Court's role is limited to reviewing the lawfulness of the decision in question, in particular whether it was *Wednesbury* 'reasonable'; it would not (nor could not) decide for itself on the merits of the case whether the treatment should be imposed or not. It was this ruling that Mr. W appealed to the Court of Appeal.

The Court of Appeal's ruling

The Court of Appeal overturned the decision of the High Court and ordered that the relevant experts should attend for cross-examination. In doing so it affirmed that the imposition of compulsory treatment can amount to inhuman and degrading treatment contrary to Article 3 of the Convention, particularly where a patient has capacity to refuse treatment. The Court cited with approval a report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment published in August 2000, which states that '... every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention', other than in 'clearly and strictly defined exceptional circumstances'. In addition, the decision as to whether such treatment may amount to a violation of Articles 2, 3 or 8 was to be taken by the High Court on the merits of the case; the Court was not limited to its usual role in judicial review of deciding whether the decision under review was a reasonable one to reach. The Court could not exercise that function without hearing evidence from the relevant expert witnesses. Indeed, to adopt any other approach would violate Mr. W's right to a fair trial under Article 6 of the Convention.

In reaching its decision the Court of Appeal also considered the current guidance issued by the Mental Health Act Commission to SOADs to be wrong (and, therefore, unlawful, although the Court did not explicitly say so). Under section 58(3)(b) MHA a SOAD should only authorise compulsory treatment if he decides that 'having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition, the treatment should be given'. That, said the Court of Appeal, requires the SOAD to reach his own independent view of the desirability and

propriety of the treatment. However, the most recent MHAC guidance from April 1999 advises SOADs that they should authorise treatment if it is 'reasonable', even if it would not accord with the SOAD's own personal practice. That approach, said the Court of Appeal, was unduly deferential and was incorrect.

Comment

The Court of Appeal's decision is significant in a number of respects, as regards both the rights of detained mental patients and the procedure for bringing challenges under the Human Rights Act 1998.

The role of the SOAD

The most immediate, and possibly most far-reaching, aspect of the Court of Appeal's ruling is in relation to the proper function of the SOAD. The point was made during submissions that over 90% of all SOADs approve the treatment plan proposed by the RMO. The MHAC Biennial Report for 1997-99 discloses that for medication, in 85.3% of cases the SOAD makes no change to the RMO's proposed treatment plan; in 12.8% of cases there is a slight change; in only 1.9% of cases there is significant change. With ECT the figures are more stark: 92.9% no change, 6.4 % slight change, 0.7 % significant change. Reference was made to the passage in Brenda Hoggett's book, 'Mental Health Law', 4th ed., 1996, page 145 in which she had observed:

'This [that over 90% of all SOADs approve the treatment plan proposed by the RMO] is scarcely surprising as both the Commission and the Code of Practice advise that the SOAD's role is to decide whether the proposed treatment is 'reasonable in the light of the general consensus of appropriate treatment for such a condition' and not whether it is what he himself would have done in the circumstances' (ibid, p. 145).'

It was perhaps not surprising that Brenda Hoggett – now Hale LJ, and sitting on this appeal – agreed with the rest of the Court that the MHAC guidance to SOADs did not comply with section 58, which requires the SOAD to exercise his or her own independent professional judgment in deciding whether 'the treatment should be given'. It will be interesting to see if the rate of SOAD approvals will be correspondingly lower in future.

The significance of capacity

The decision of the Court of Appeal goes some way to affording competent detained mental patients the same rights of autonomy and self-determination as other competent members of society enjoy. As will be seen, however, there remains room for further development of this fundamental right.

At common law the right of a capacitated individual to integrity of the person and to self-determination are fundamental human rights (*Airedale NHS Trust v Bland* [1993] A.C. 1, per Lord Goff at 864). Medical treatment is *always* an interference with the first of these rights, the right to integrity of the person, constituting a criminal and tortious assault and battery in the absence of some lawful justification for it (*Re. F* [1990] 2 AC 1, 73-74). The right of autonomy dictates that a capable person's consent to treatment provides lawful justification; by the same token, it also dictates that a capable person's *refusal* to consent must be respected, however drastic the

consequences for the individual concerned. In *Robb v Home Secretary* [1995] Fam. 127, Thorpe J. granted declarations on the application of the Home Office that it was lawful for prison staff and physicians to respect a prisoner's refusal of all nutrition and medical treatment. The prisoner was on hunger-strike. He had been assessed by five psychiatrists and a psychologist, all of whom had agreed he had capacity to consent, and therefore to refuse consent. The judge agreed the following statement of principle (130C-D):

'... the principle of self-determination requires that respect must be given to the wishes of the patient. So that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so.'

By contrast, for patients detained under the Mental Health Act 1983 the right of autonomy has been modified, so that a capacitated person's refusal to accept treatment may be overridden. Indeed, under this statutory scheme a capacitated refusal has no greater significance than the refusal of a patient who lacks capacity.

Section 63 authorises compulsory treatment provided it is 'treatment for the mental disorder from which [the patient] is suffering' and is 'given by or under the direction of the responsible medical officer'. Where section 58 applies (namely for ECT and medication given for a period of more than 3 months), a capacitated refusal may be overridden by the RMO provided a SOAD has certified that 'having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given' (section 58(3)(b)). Neither provision requires either the RMO or SOAD to take into account, or give particular weight to, the fact the patient has capacity.

It was Mr. W's contention that this statutory scheme failed to protect his Convention rights, notably under Articles 3 and 8. Compulsory treatment that was not a therapeutic necessity was both degrading and an invasion of privacy, whether a patient had capacity or not (considering *Herczegfalvy v Austria* (1992) 15 EHRR 437). Moreover, even if medically justified, compulsory treatment of a capacitated patient was degrading and an invasion of privacy. The capacitated patient's right of autonomy should prevail over the doctor, other than where treatment was necessary for the protection of others. Mr. W's lawyers could not cite any directly relevant Convention authority in support of the latter proposition, but relied upon a growing national and international consensus to that effect, including the 2000 report by the European Committee for the Prevention of Torture and Inhuman or degrading treatment, referred to above, which provided, at §41:

'Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorizing treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.'

The Court of Appeal all agreed that treatment that was not a medical necessity would amount to a breach of Articles 3 and 8. They were not, however, unanimous as to the significance of a patient having capacity to refuse consent. Simon Brown LJ considered the fact the patient had capacity to be highly significant, if not determinative. He said that 'the precise equivalence between

incompetent patients and competent but non-consenting patients seems to me increasingly hard to justify' (§29), and went on 'If in truth this appellant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subject to it'. Hale LJ adopted a more cautious approach, saying this (§80):

'I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify. Whether the criteria for non-consensual treatment of the capacitated should be limited to treatment which is for their own safety (as opposed to their health) is a difficult and complex question. Mr Bowen tried to persuade us that there was a developing consensus to that effect. There are indeed indications that the issue of capacity is assuming greater importance in the context of psychiatric treatment. But we have not yet reached the point where it is an accepted norm that detained patients who fulfil the Re MB criteria for capacity can only be treated against their will for the protection of others or for their own safety.'

Brooke LJ did not deal with the issue in his judgment and, accordingly, both Simon Brown LJ and Hale LJ's views are, strictly, *obiter*, and the question whether the Convention prohibits compulsory treatment of capacitated patients except in exceptional circumstances remains for determination on another day. The Court of Appeal's decision goes a long way towards establishing the proposition that a competent patient's right to autonomy is protected by Articles 3 and 8. In this writer's view it is strongly arguable that sections 63 and 58 Mental Health Act 1983 are incompatible with detained patients' Article 3 and 8 rights in that they permit the compulsory treatment of a non-consenting capacitated patient without qualification, rather than limiting such treatment to 'clearly and strictly defined exceptional circumstances'. This would have great significance for the Government's current proposals for reform of the Mental Health Act 1983. A suitable case engaging the point directly will have to find its way before the Courts before such a principle can be established, although it is unlikely to be this case (see postscript, below).

The proper approach in judicial review: merits review, proportionality or 'Super-Wednesbury'?

One key aspect of the Court of Appeal's ruling has an application that goes far beyond the field of mental health law. Having accepted that compulsory treatment that was not a therapeutic necessity would violate Mr. W's Convention rights under Articles 3 and 8 (and, in the light of Mr. W's heart condition, also raised issues under Article 2), the Court had to decide what approach it should take on judicial review in deciding whether the proposed treatment would, in fact, breach Mr. W's Convention rights: was the proper approach the traditional public law *Wednesbury*-type review of the RMO and SOAD's decision, the private law *Bolam/ Bolitho* test of negligence, or did the Human Rights Act 1998 demand a more intense scrutiny than either test allowed? It was argued on Mr. W's behalf that the Court had to reach its own conclusion on the merits as to whether the proposed treatment would violate Mr. W's Convention rights, while the Respondents argued that a 'super-Wednesbury' approach was sufficient, relying upon the decision of Maurice Kay J to that effect in *R v Collins & Ashworth Hospital ex p Brady* [2000] Lloyds LR Med 355.¹

¹ See case comment in *Journal of Mental Health Law*
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The question whether the Human Rights Act 1998 requires the Administrative Court to adopt a more obviously primary decision-making role, at odds with its more traditional review function, has proved to be one of the most intractable thrown up by the Human Rights Act 1998. Successive rulings over the last two years have oscillated between adopting a more intensive 'proportionality' test and the more traditional, deferential *Wednesbury* approach. The House of Lords in *R (Daly) v Home Secretary* [2001] 2 W.L.R. 1622, had recently endorsed the former approach, disapproving the earlier Court of Appeal decision of *R (Mahmood) v Home Secretary* [2001] 1 W.L.R. 840 in which the more deferential test had been preferred. By insisting that the proper approach was to decide the relevant issues on the merits, the Court of Appeal in *Wilkinson* not only disapproved the approach taken in *Brady* but took *Daly* a step further: even in *Daly* Lord Steyn had emphasised that the Human Rights Act did not entail a shift to 'merits' review. However, Lord Steyn had also made clear that 'in law, context is everything', and given the importance of the rights at stake in *Wilkinson* and the fact the Mental Health Act provides no independent judicial scrutiny of treatment decisions, the only way the Court could ensure that Mr. W's Convention rights were protected was by reaching its own conclusions on the merits. It was also relevant that the Courts were already familiar with making their own assessment of the merits of medical treatment both in clinical negligence cases and, more importantly, on applications for 'best interests' declarations in the Family Division.

Simon Brown LJ also considered that a merits-type review was required by virtue of Article 6, distinguishing the recent decision of the House of Lords in *Alconbury* [2001] 2 All ER 929. He noted that the 'Super-Wednesbury' test had been rejected as insufficient for the purposes of Article 13 by the European Court of Human Rights in *Smith & Grady v United Kingdom* (1999) 29 EHRR 493 and commented 'it is difficult to see how it could meet the requirements of article 6 in the present case'.

Wilkinson therefore represents the high water-mark of the Courts' willingness in public law cases, where necessary, to substitute their own decisions for those of the public authority charged with the primary decision-making role by Parliament when they believe them to be incompatible with Convention rights. Again, it remains to be seen whether *Wilkinson* will in future be confined to its own particular facts, or whether it represents a further shift towards 'merits' review of public law decisions engaging human rights issues.

The need for cross-examination

Cross-examination is unusual in traditional judicial review proceedings. The general principle is that cross-examination will be permitted 'where the justice of the case so requires' (*O'Reilly v Mackman* [1983] 2 AC 237, 282D-283A), but such orders are rare, primarily because the traditional role of the Administrative Court is to review the lawfulness of decisions rather than make decisions on the merits, so it does not make primary findings of fact itself. Once the Court of Appeal had decided that the Human Rights Act 1998 compelled it to reach its own conclusions on the merits it followed that it would have to hear all the relevant evidence live, and to allow cross-examination of the experts. Plainly cross-examination will become more commonplace where Convention rights are in issue.

Appropriate forum for challenging treatment decisions

In their respective judgments the members of the Court of Appeal spent some time considering whether judicial review was the appropriate remedy in respect of disputed treatment decisions. On this issue the Court was not as one.

Both Simon Brown and Hale LJ considered that Mr. W could have challenged the proposed treatment plan by an ordinary private law action in tort for assault (as opposed to negligence) against Broadmoor Hospital. Although section 139(1) of the Mental Health Act 1983 would protect individual doctors against a claim for assault (but not negligence), by section 139(4) the hospital itself would be vicariously liable for any assault by its employees. In any event, Mr. W could bring a claim in the High Court under section 7 Human Rights Act 1998 claiming that the Hospital proposed to act in a manner incompatible with his Convention rights. There would be no requirement for permission to proceed with such a claim.

Brooke LJ disagreed. In his opinion the hospital could not be vicariously liable on a claim for assault because of the statutory protection conferred by section 139(1) MHA. Unless a patient could establish bad faith or negligence (in which case section 139 did not apply), the only remedy to a decision to treat was by an application for judicial review. Moreover, although a claim under section 7 Human Rights Act 1998 could be brought in a private law action in the High Court, Family Division, for a 'best interests' declaration (considering *R (P & Q) v. Home Secretary* [2001] EWCA 1151, §120), such a claim would be caught by section 139(2) MHA and would require the leave of the High Court.

Little argument was addressed to the Court on the question as to whether alternative proceedings would be more suitable than judicial review. In future it is advisable that any such claim be brought by way of judicial review *and* a best interests declaration *and* a private law action in tort for assault. The latter remedies can all be sought in judicial review proceedings, so only one set of proceedings needs to be issued.

Such proceedings are not to be issued other than in the most exceptional circumstances, however. Simon Brown LJ struck the following cautionary note:

'I would, however, express the confident hope that challenges of this nature, so far from becoming commonplace, will be rare indeed and will arise only in the most exceptional circumstances. Dr G and others like him will surely hesitate long before being prepared to join issue both with those who have the express statutory responsibility for treating the patient (RMOs) and also, in s.58 cases like the present, those specifically appointed to safeguard the patient's interests (SOADs). SOADs, I should note, are experienced and entirely independent specialists drawn from a panel appointed by the Mental Health Act Commission (MHAC) which was directed by the Secretary of State to discharge on his behalf that function under Part IV of the Act. Courts, after all, are likely to pay very particular regard to the views held by those specifically charged with the patient's care and well-being. I do not go so far as to say that a *Bolam-Bolitho* approach will be taken to their evidence – i.e. that the treatment which they propose will be sanctioned by the court provided only that a respected body of medical opinion would approve it. Certainly, however, courts will not be astute to overrule a treatment plan decided upon by the RMO and certified by a SOAD following consultation with two other persons.'

Post-script

The case is unlikely to go any further as Broadmoor Hospital, the Mental Health Act Commission and the Secretary of State for Health (who applied to be joined to the proceedings as an interested party) have decided not to appeal the decision to the House of Lords. Moreover, the original SOAD authorisation has lapsed, so if Dr. H wishes to impose further such treatment he will need to obtain the agreement of another SOAD – this time applying the less ‘deferential’ approach demanded by the Court of Appeal. Nevertheless, the decision provides a solid platform to build upon for future challenges in this developing area of law.