COMPULSORY CAESARIAN SECTION

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discusses* R v Collins *and its implications in New Zealand

R v Collins, ex parte S [1998] 3 All ER 673 is a recent decision of the English Court of Appeal, in which patient autonomy was strongly reaffirmed. The appeal set aside a High Court order which authorised a compulsory caesarian section on a pregnant woman against her express wishes. The Court of Appeal also granted relief by way of judicial review against the respondents in respect of their decisions to apply ex parte for the woman's compulsory admission under the Mental Health Act 1983.

FACTS

Ms S was a 29-year-old who became pregnant in September 1995. She did not seek ante-natal care until 25 April 1996 when she was approximately 36 weeks pregnant. She then registered as a new patient with Dr Chill, a GP, who diagnosed her as suffering from severe pre-eclampsia, a disorder of pregnancy which manifests itself in high blood pressure with potentially fatal consequences for both mother and child. Dr Chill advised immediate admission to hospital and an induced delivery. S refused, because she wanted to have her baby naturally, in a barn in Wales. She did not care about the risks to herself or to her unborn child and thought it would be better for the baby if it died.

Concerned about S's mental state, Dr Chill called in an approved social worker, Miss Collins, and a psychiatric Registrar, Dr Jeffreys. They tried to persuade S to go to hospital for treatment, but she was adamant in her refusal. Miss Collins felt that she had no choice but to detain S "for assessment" in accordance with s 2 Mental Health Act 1983. Dr Chill and Dr Jeffreys provided the necessary recommendations. S was admitted to hospital where the seriousness of her condition was confirmed.

S continued to refuse treatment and was advised by a solicitor that she was entitled to do so. The hospital made an ex parte application to the Family Division of the High Court for a declaration authorising a caesarian section. Neither S nor her solicitor knew anything about this application.

The application came before Mrs Justice Hogg on 26 April. On the basis of the information given to the Judge, including the incorrect fact that S had been in labour for 24 hours, Hogg J granted the declaration within half an hour. Later that day, when the foetus became distressed, an emergency caesarian section was performed and S gave birth to a healthy daughter.

On 30 April S was seen by another psychiatrist who found no evidence of mental illness. Her detention was terminated. S left hospital alone, rejecting the baby at first, but later decided to keep her.

THE PROCEEDINGS

After her discharge S commenced proceedings in public law and in private law against the social worker and the Health Trusts where she had been treated. Her application for judicial review was lodged outside the time limit, but the Court of Appeal considered the issues of such public importance that it granted leave to move for judicial review. ([1998] 1 FLR 790) Aware that S was also appealing against Hogg J's declaratory order, the Court took the unusual step of joining the two proceedings.

THE DECISION

S succeeded in both proceedings. The Court of Appeal was critical of virtually every step of the medical and legal procedures which had been employed to detain and treat S against her express wishes. The main issues of concern were:

1. the principle of autonomy and its application to pregnant women;
2. the use of Mental Health legislation, and
3. the use of ex parte applications for medical or surgical treatment.

The autonomy principle

The Court of Appeal reiterated the fundamental principle that an adult of sound mind is entitled to refuse medical treatment even when his or her own life depends on it. This principle applies equally to competent pregnant women:

> In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected in a number of different ways ..., an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant. (p 692)

Unless there was a lawful justification, such as incompetence, as was the case in *re MB* [1997]2 FLR 426, the compulsory caesarian section infringed S's autonomy.

The Mental Health Act 1983

The Court found that S was not incompetent. Her capacity to consent was intact. Her thinking process was unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority, but the Mental Health Act could not be deployed to detain people against their will

on those grounds. (p 692) She was detained to treat her physical condition, not her mental disorder. In fact she never received any treatment for her mental condition. The application under the Mental Health Act was therefore unlawful and S's autonomy was infringed.

The ex parte application

The Court found the procedure before Hogg J "so extraordinary and unfortunate" that it felt bound to restate some fairly elementary points about declaratory relief, and provide guidelines for the future. (p 699) It was particularly concerned by the fact that these proceedings had been taken ex parte and without full investigation of the merits.

The Court condemned the use of ex parte applications in these sort of cases, because they are unjust and any resulting declaration would not achieve its purpose. S had not been given notice of the proceedings nor an opportunity to be heard and she was therefore not bound by the order.

Moreover, the application did not fully and frankly disclose all the material facts. Hogg J was told that S was in labour when she was not, and was not told that S's capacity appeared intact, that she had contacted a solicitor and that she had no knowledge of the application. The appeal was allowed and the order was set aside. The caesarian section thus constituted a trespass, rendering the respondents liable to a claim for damages.

THE NEW ZEALAND SCENE

It seems unlikely that a case like *R v Collins* would occur in New Zealand today. The right of a competent adult to refuse medical treatment is also part of our common law, but it is reinforced by s 11 NZ Bill of Rights Act (1990) and Right 7(7) Code of Health and Disability Services Consumers Rights. (Code of Rights.) Besides, the considerable attention given to patient rights since the Cartwright Inquiry in 1988 can leave few health professionals in doubt about the importance of patient autonomy.

The application of this right to pregnant women has not been judicially tested here, but it seems unlikely that their right to refuse treatment will be curtailed in the interests of their unborn children. *R v Collins* reaffirms that a foetus has no separate existence from its mother. The mother's autonomy is determinative until the child is born alive. To accord a foetus rights which restrict the mother's autonomy creates fundamental moral and legal problems. It is a slippery slope with no obvious stopping point.

To go down this slope is nonetheless tempting, particularly when the foetus is viable. A woman's refusal of common treatment in such circumstances seems morally repugnant. Courts overseas have occasionally succumbed to this temptation and overridden the mother's right to refuse treatment in the interests of the unborn child. (England: *Re S* [1993] 1 FLR 26; US: *Jefferson v Griffin Spalding County Hospital Authority* [1981] 274 s 2d 457; *In re Madyyun* [1986] 573 A 2d 1259; Canada: Schulman J in *Winnipeg Child and Family Services Ltd v DFG* [1996] 10 WWR 95 (QB).)

However, they have generally reverted to the principle of patient autonomy, finding no rational or morally acceptable basis upon which to limit this fundamental right of competent adults. In the light of this experience, it seems improbable that a New Zealand Court would override a competent woman's refusal of treatment, no matter what the consequences to the woman or her unborn child.

The New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992 is similar to the English Act. Its purpose is to treat a person's mental condition, not her physical condition. If the competence of a person with a physical illness is in question an application under the Protection of Personal and Property Rights Act, or under the parens patriae jurisdiction, would be possible, though neither will succeed if the person merely has unusual views. Even if her competence were diminished by a mental disorder, she would still retain the right to give informed consent to treatment to the extent of her competence. (Right 7(3) Code of Rights) The principle of autonomy is thus extensively protected in New Zealand.

REMEDIES

Health professionals in New Zealand may be treated less sympathetically than their peers were in England. If a case like *R v Collins* were to arise here, the most likely course of action would be a complaint to the Health and Disability Commissioner alleging a breach of the Code of Rights. The complaints procedure is laid down in Right 10 of the Code and in Part IV of the Health and Disability Commissioner Act (1994). It is a cheap and simple procedure potentially culminating in a hearing before the Complaints Tribunal. (s 45) The Tribunal has the power to grant one or more of a range of remedies, including an award of damages. (ss 54 and 57) However, as the performance of an unlawful caesarean section would constitute a medical misadventure under s 5(6) Accident, Rehabilitation, Compensation and Insurance Act 1993, the Tribunal would have no power to award compensatory damages. (s 52(2) H&DC Act)

Punitive damages would still be a possibility. Section 52(2) Health and Disability Commissioner Act expressly provides for this if the conduct of the health provider was "in flagrant disregard of the rights of the aggrieved person". (s 57(1)(d) H&DC Act.) The Court in *R v Collins* commented that this was not a case where such an award would be appropriate. The respondents were all motivated by a genuine desire to do what was best for S and her unborn child in extremely difficult circumstances. (p 694) Such a benevolent view may be less likely in New Zealand.

A breach of the Code of Rights may also be referred to the relevant health professional body for disciplinary action. (s 45 H&DC Act) Doctors who claim that a woman was incompetent to refuse treatment in the face of clear evidence to the contrary may well be disciplined by the Medical Disciplinary Tribunal.

Criminal prosecution is another option. The performance of a caesarean section against the patient's express wishes is an offence against the person. A charge of wounding or injuring with intent (ss 188 and 189 Crimes Act) may be difficult to defend under ss 61 and 61A Crimes Act, because the operation would have been unreasonable in the light of the woman's express refusal. However, given the range of alternative proceedings already described, a criminal prosecution would seem to serve little purpose.

CONCLUSION

While a case like *R v Collins* seems unlikely in New Zealand, it is nonetheless a salutary warning to health professionals that no matter how unreasonable patients' decisions may be, their right to refuse medical treatment is sacrosanct unless they lack the necessary competence at the time of making that decision. Any attempt to interfere unlawfully with that right may result in legal and disciplinary action which is considerably less forgiving than the Court of Appeal was in *R v Collins*. ❑