

Consent to medical treatment by or for a mentally incapacitated adult: the Hong Kong common law and Part IVC of the Mental Health Ordinance

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ABSTRACT Consent is always required before any treatment may lawfully be performed. In the case of a mentally incapacitated adult who is unable to give valid consent, the question arises as to whose consent is needed to render the treatment lawful. This paper examines firstly the legal position in Hong Kong common law, then the new elements introduced by the Mental Health Ordinance, and finally, the practical implications of the law as it stands for doctors.

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INTRODUCTION

Mental incapacity refers to an inability to make a decision on matters requiring a decision. It may be either temporary or permanent in nature. It may be the result of accident or illness, for instance, Alzheimer's disease. It may be that a person has never developed the capacity to make decisions, for example, a person with learning disabilities. It may also be that a person has the capacity to decide but is unable to communicate. In other words, incapacity may affect any person in any age range and its problems are not limited to the elderly, although the problem may be particularly acute in view of increasing life expectancy and Hong Kong's ageing population. The Hong Kong law on medical decision making for a mentally incapacitated person (MIP) is currently covered by both the common law (explained here using English cases as illustrations) and the Mental Health Ordinance (MHO).

THE COMMON LAW GOVERNING MEDICAL TREATMENT OF A MENTALLY INCAPACITATED ADULT

A general common law principle is that medical treatment of a competent adult is unlawful unless it is given with that person's valid consent.

"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..."¹

The rationale for this is that a competent adult has the right to self-determination. He may refuse beneficial treatment. Effectively, such a benefit may not be imposed on him without his consent.

No proxy consent

In the case where an adult has been rendered unconscious in a traffic accident, it is reasonable to think that a relative's consent would be required before treatment could lawfully proceed. Contrary to common sense, the common law does not recognise proxy consent for medical treatment in such a case. The practice of seeking the consent of a relative prior to treatment is a misconception, as a relative has no legal right to either consent or refuse. In fact, no one has such a right. Thus, in *Re T (Adult: Refusal of Treatment)*² Lord Donaldson said:

"There seems to be a view in the medical profession that in... emergency circumstances, the next of kin should be asked to consent on behalf of the patient and that, if possible, treatment should be postponed until that consent has been obtained. This is a misconception because the next of kin has no legal right whether to consent or to refuse consent."

Although relatives have no legal right to decide

what treatment an incapacitated patient receives, it is still good practice to consult relatives, providing that such consultation causes no delay that may adversely affect the patient. There are two reasons for consulting relatives. Such a consultation may reveal that the patient has already expressed prior choices. It may also reveal background information about the patient, e.g. what he would have chosen had he been capable. As *Re T (Adult: Refusal of Treatment)* Lord Donaldson said:

“This is not to say that it is an undesirable practice [to consult the next of kin] if the interests of the patient will not be adversely affected by any consequential delay. I say this because contact with the next of kin may reveal that the patient has made an anticipatory choice which, if clearly established and applicable in the circumstances... would bind the practitioner. Consultation with the next of kin has a further advantage in that it may reveal information as to the personal circumstances of the patient and as to the choice which the patient might have made, if he or she had been in a position to make it.”

This raises the question of the validity of an advance directive and what obligations it creates. Further, if there is no advance directive, what weight, if any, should a patient's wishes be given in the decision-making process? These issues are not examined in this paper.

Treatment is lawful if it is in the best interests of the patient

In *Re F (Mental Patient: Sterilisation)*³ the House of Lords was confronted with F, a 36-year-old sexually active mentally disabled woman with the verbal capacity of a 2-year-old. Medical evidence suggested that she would be unable to cope with pregnancy, delivery, and childbirth. All contraceptive methods, other than sterilisation, were thought to be inappropriate. As a consequence, sterilisation was considered to be in her best interests but she was unable to give a valid consent. The patient's mother sought a judicial declaration that the proposed sterilisation should be lawful despite F's inability to give a valid consent. The House of Lords held that a doctor may lawfully treat an incapacitated person without consent provided that it is in the best

interests of the patient. Treatment would be in the best interests of the patient if, and only if, it is carried out in order to save life, ensure improvement or prevent deterioration in the patient's physical or mental health. It was further held that whether a treatment is in the best interests of a patient or not depends on what is accepted as appropriate by a responsible body of medical opinion skilled in that particular treatment.

In short, the law allows a doctor to exercise his/her clinical judgement as to what treatment needs to be administered to an incapacitated adult. Relatives have no right to demand any particular form of treatment. In the case of a patient who is dying, relatives have no right to demand that every effort be made to prolong life.⁴ Likewise, if a patient appears to be dying a painful death, relatives have no right to demand that life-sustaining treatment be withdrawn to permit death with dignity. The legal weight the wishes of relatives command in any decision-making process will not be examined in this paper.⁵

Necessity: temporary or permanent

In *Re F (Mental Patient: Sterilisation)*, treatment without consent is justified by the doctrine of necessity. Lord Brandon talks about an example of incompetence arising from 'accident or otherwise'; the patient could neither give nor refuse consent and the operation could not be safely delayed until the patient regained competence. Although the example of an accident is a case of emergency, Lord Goff states that "emergency often gives rise to necessity but it is not a prerequisite". Necessity may therefore arise in the absence of a sudden or unexpected event and it applies to both temporary and permanent incapacity, thus justifying medical intervention satisfying either short-term or long-term needs. Thus, Lord Goff says with reference to temporary incapacity:

“Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness.”

On permanent incapacity, Lord Goff states:

“as in the case of a stroke victim, the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury. When the state of affairs is permanent... action properly taken to preserve the life, health or well-being of the assisted person may well transcend such measures as surgical operation or substantial medical treatment and may extend to include such humdrum matters as routine medical or dental treatment, even simple care such as dressing and undressing and putting to bed.”

The distinction between a temporary and permanent condition, albeit not easy, is relevant in that, if the incapacity is temporary in nature, a doctor can lawfully do no more than deemed reasonable before the patient regains capacity (by which time the patient himself will be able to make his own decision). Permanent incapacity may necessitate a greater range of action. In both situations, treatment is not only lawful, but a duty: it is incumbent on the doctor to take action.

Deciding on the best interests of a patient

In *Re F (Mental Patient: Sterilisation)*, it was said that the best interests of a patient depend on a doctor's clinical judgement. Consequently, the lawfulness of a treatment given to an incapacitated patient does not depend on judicial approval and medical care to a patient can be delivered efficiently without awaiting court approval. In short, we may say the court empowers a doctor to treat an incapacitated patient as he thinks fit, on the basis of the 'doctor knows best'.⁶

Judicial declaration on best interests

Despite this generally hands-off approach, the House of Lords in *Re F (Mental Patient: Sterilisation)* said that sterilisation of an incapacitated person should be placed in a special category. This means that, as a matter of good practice, although not strictly necessary, such operations should be brought before a court for an independent, objective, and authoritative review of the lawfulness of the procedure. The advantages of this are fourfold. First, as sterilisation is an irreversible procedure, it should only be undertaken provided that some independent objective review as to its appropriate-

ness exists. Second, as it is a controversial procedure that deprives a woman of the right to bear children, it should only be undertaken with caution. Third, as a risk exists that the operation might be carried out for improper reasons or motives, e.g. for administrative convenience or to make carers' lives easier or less risky, it should only be undertaken if there exists a mechanism for protecting an incapacitated person from what may be an unwanted interference with their physical integrity. Finally and most importantly, the involvement of the court in decision making, with the incapacitated person properly represented, serves to protect the patient's interests as well as those of the doctor from subsequent adverse criticism.

Since *Re F (Mental Patient: Sterilisation)*, a number of controversial medical decisions have come before the English courts. The courts have been asked to declare whether the withholding or withdrawal of life-sustaining treatment (in the form of artificial nutrition and hydration), termination of pregnancy, sterilisation, and bone marrow donation are in the best interests of certain mentally incapacitated adults. These decisions are likely to be important for guiding future decisions in Hong Kong courts.

MENTAL HEALTH ORDINANCE'S CONSENT SCHEME

The common law governing the lawfulness of a doctor treating an incapacitated adult is relatively simple. Doctors may lawfully treat if treatment is in the best interests of the patient. The best interests of the patient are broadly defined as treatment which saves life, ensures improvement, or prevents deterioration in the physical or mental health of the patient. This broad definition provides considerable latitude for doctors treating patients. This may also explain why there has not been a case in which a doctor acting under the doctrine of necessity has been successfully challenged.

Consent to medical treatment of a MIP who is 'incapable of understanding the general nature and effect of a treatment', and hence unable to give a valid consent, under Part IVC of the MHO, however, is more complex.⁷ Under the MHO, the Guardianship Board has the power to appoint a guardian for a MIP, and the guardian may be given the power, *inter alia*, to consent to treatment on behalf of a MIP. Consent

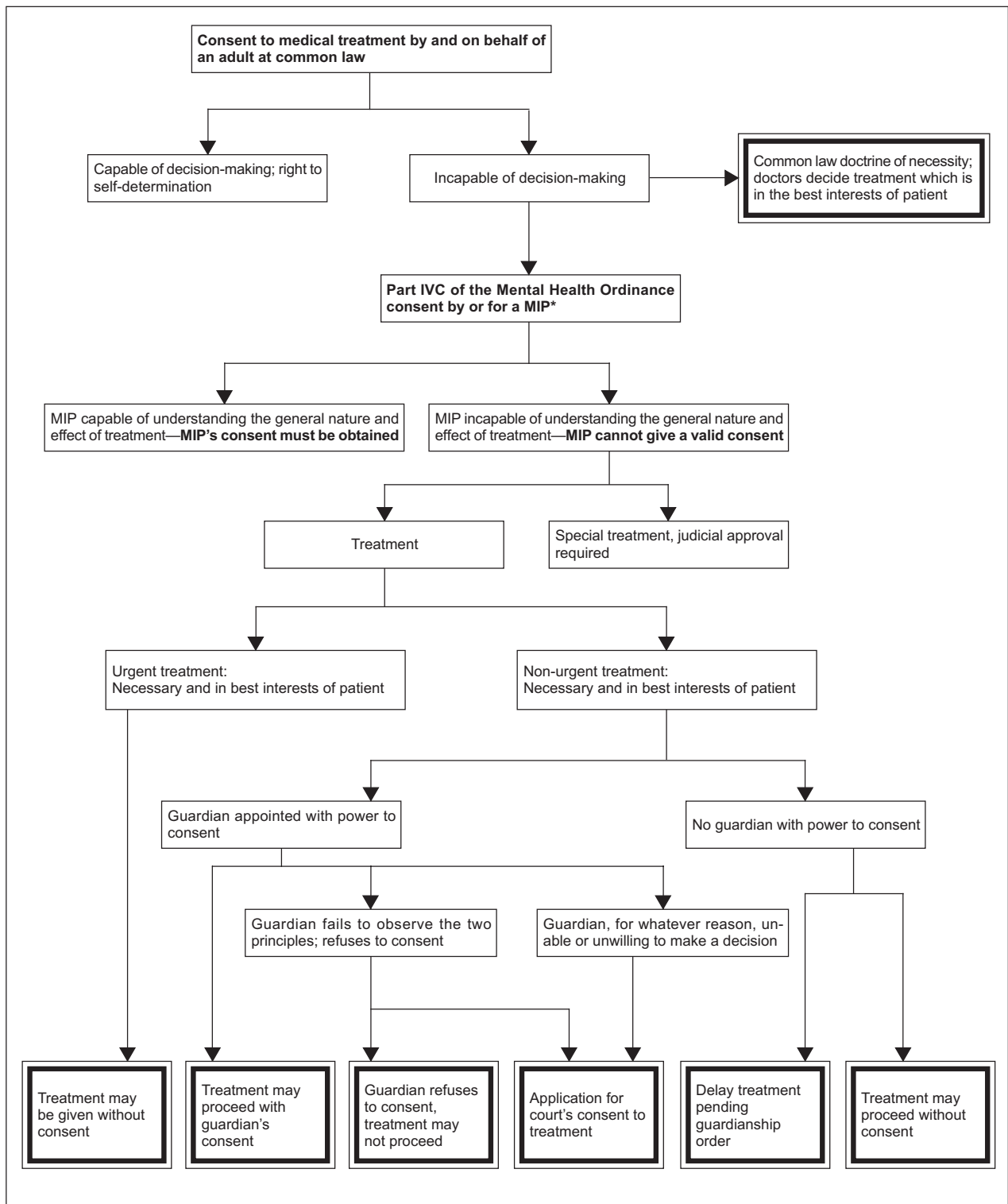


FIGURE. The consent scheme

* MIP denotes mentally incapacitated person

under Part IVC is hereafter referred to as the ‘consent scheme’ and the key aspects are outlined in the FIGURE. In this section, the focus is on examining the consent scheme and the new elements introduced into the law.

Proxy consent: effect and two principles

Unlike the common law which does not recognise proxy consent, the consent scheme envisages two types of proxy consent. These are proxy consent given

by a guardian, and that given by the court, on behalf of a MIP. Proxy consent, unlike a judicial declaration of the best interests of a patient, operates as if the MIP had been capable of giving such consent and that treatment had been carried out with that person's consent. s59ZK thus provides:

“Consent given under this Part for the carrying out of treatment or special treatment, as the case may be, in respect of a mentally incapacitated person to whom this Part applies has the effect for all purposes as if

- (a) that person had been capable of giving such consent to the carrying out of that treatment or that special treatment; and
- (b) that treatment or that special treatment has been carried out with the consent of that person.”

Under the consent scheme, a proxy (guardian or the court) exercising his power must apply and observe two principles ('two principles'): firstly, to ensure that the MIP is not deprived of the treatment because he lacks the capacity to consent, and secondly, to ensure that the treatment is provided in the best interests of that person. According to s59ZA, in the 'best interests of the person' means treatment that

- (a) saves the life of the MIP;
- (b) prevents damage or deterioration of the physical or mental health and well-being of that person; or
- (c) brings about an improvement in the physical or mental health and well-being of the person.

It is interesting to note that the two principles are worded more or less the same way as the common law doctrine of necessity. As will be argued below, this effectively means that it is unlikely that a guardian's refusal to consent will be overturned by the court.

Urgent treatment: doctrine of necessity preserved

As can be seen from the FIGURE, the consent scheme envisages two types of treatment: urgent and non-urgent. In the case of urgent treatment (that is, where 'treatment is necessary and is in the best interests of the patient'), s59ZF(1) authorises treatment without consent. The doctrine of necessity in *Re F (Mental Patient: Sterilisation)* is effectively

preserved, even though the MHO has not expressly mentioned the doctrine of necessity. To that extent, Part IVC puts *Re F (Mental Patient: Sterilisation)* on a statutory footing.⁸

Non-urgent treatment protected

Under the common law, as explained in *Re F (Mental Patient: Sterilisation)*, there is no justification for providing non-urgent treatment to an incapacitated person. Now, under the consent scheme, the legality of non-urgent treatment is protected in two ways.

Doctors' obligations and guardians' empowerment

Where treatment is not urgently needed, a doctor must take 'all reasonably practicable steps' to ascertain whether there is a guardian. These practicable steps refer, in the case of Hospital Authority doctors, to checking with the Legal Services Section of the Hospital Authority headquarters, and to ascertain if the patient has a guardian.⁸ Interestingly, there are no procedures for a private hospital or doctor (not practising within the Hospital Authority setting) to discharge his obligation under Part IVC. The Guardianship Board recommends that "If the mentally incapacitated adult is unable to consent, the private hospital or private doctor can check with the Guardianship Board, family or service provider, whether a guardian has been appointed and whether he or she has the power to consent to medical treatment."⁹ If there is a guardian with the power to consent to treatment, s59ZD(1) renders treatment with the guardian's consent lawful.

A doctor who treats a MIP without checking, and is hence unaware that there is a guardian with the power to consent, is arguably in breach of s59ZF(2). Such behaviour may or may not be a deliberate act of ignoring the authority of a guardian. Ignorance of the law, however, is no defence. Nonetheless, no penalty is imposed for such a breach. The common law arguably still applies, thus rendering the treatment unlawful.

The consent scheme envisages the situation where a guardian's consent is not forthcoming. Where a guardian refuses to consent, there are two possible avenues for judicial intervention, seeking judicial consent under s59ZG(2), namely, where a guardian:

- (i) is for 'whatever reason unable or unwilling' to make a decision, or
- (ii) has 'failed properly to observe and apply' one of the two principles (discussed above).

As a guardian's consent operates in the context of non-urgent treatment, the guardian's refusal deprives a MIP of a proposed treatment. However, such deprivation could rarely be against the best interests of the patient. Otherwise there is no distinction between non-urgent and urgent treatment. In the light of this, it seems that a guardian is permitted, in many cases, to refuse to consent to non-urgent treatment without having such a decision overturned by the court. This, however, is not the same as a guardian who is for 'whatever reason unable or unwilling' to make a decision.

No consent required

When 'after all reasonably practicable steps have been taken' to ascertain whether a guardian has been appointed and there is, or there appears to be, no guardian so appointed, or the guardian appointed does not have the power to consent to treatment, s59ZF(2) provides that treatment may be given without consent.

However, the consent scheme recognises an alternative, and a more desirable outcome. Where a MIP's family member or carer has no knowledge of the consent scheme, a doctor's explanation to a family carer of the need to seek a guardianship order may allow such a carer to apply for one, thus empowering the family carer to give proxy consent for a proposed treatment. It would be interesting to study the extent to which this option is used as opposed to doctors simply treating without consent.

CONCLUSION

In this paper, the author has outlined both the common law and the consent scheme under the MHO. The practical implications of the interplay between the common law and the consent scheme

can be summarised as follows. In the case of urgent treatment, the common law continues to apply, and a doctor may lawfully treat a patient without the patient's consent. In the case of non-urgent treatment, first, the consent scheme introduces a new concept of proxy consent (and refusal) for a mentally incapacitated adult, empowering a guardian to decide on medical treatment on behalf of such a patient. Failure to seek a guardian's consent may render the treatment unlawful. If a guardian refuses to consent, the doctor may need to consider whether such refusal ought to be overturned by the court. As has been argued, such a judicial challenge is only likely to be successful if the lack of treatment is shown to be detrimental to the best interests of the patient. Second, where there is no guardian, a doctor may lawfully treat without consent. Provided that this possibility is not abused, the protection of an incapacitated adult may not necessarily be undermined. Third, certain treatments are 'controversial or irreversible' in nature, e.g. non-therapeutic sterilisation, and doctors are required to seek judicial approval prior to treatment. This has been explored by the author elsewhere.¹⁰ Finally, how the consent scheme operates in practice requires further study.

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