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Court authorises hospital to perform an elective caesarean where the patient lacked capacity — a consideration of what is in the best interests of the patient

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On 28 January 2014, in *Great Western Hospitals NHS Foundation Trust v AA, BB, CC, DD*,[1] the English High Court granted declaratory relief to the Great Western Hospitals NHS Foundation Trust (the Hospital), allowing the Hospital to perform an elective caesarean on a mentally ill pregnant woman (AA) who lacked capacity to consent. The Hospital brought the application in circumstances where AA's membranes had ruptured and AA was noncompliant with attempts at medical assistance and was unable to understand the seriousness of her condition. At the time of the application, a caesarean was clinically indicated, but there was no suggestion that the caesarean was proposed as emergency treatment.

The court concluded that the treatment was in AA's best interests and, if she were able to understand her condition, she would have followed the advice of her doctors to have the caesarean.

Although this case concerns the application of UK case law, it is nevertheless instructive as a demonstration of a court's decision-making process in determining whether an elective caesarean was in a patient's best interests.

Background

On the evening of 26 January 2014, AA presented to the Hospital "in a confused and disoriented state".[2] AA had a history of affective borderline disorder, in addition to substance and alcohol abuse.[3]

At the time of presentation, AA was 38 weeks pregnant and her membranes had ruptured (possibly just before presentation, although the court noted that the exact timing was not certain). However, AA was not in labour.[4] AA was admitted to the labour ward, and the following morning she was detained under the Mental Health Act 1983 (UK) (MHA).

The court heard evidence that AA and her partner (BB) were devoted to being parents, and AA's parents (CC and DD) supported the pregnancy.[5] However, in the lead-up to AA's admission, AA had ceased taking her medication, causing a serious deterioration in her mental condition.

Following admission, attempts were made to treat AA; however, because she was pregnant, she could not be given antipsychotic medication. In addition, AA was "largely uncooperative with almost every aspect of her obstetric care", with AA's father noting that AA had removed an intravenous line from her arm. Psychiatric assessment of AA revealed that AA could not "comprehend the concerns … being expressed to her by the variety of health care professionals or by her family" and that she was under a "strong and fixated" delusion that her baby could not be born before its due date (the due date also coinciding with AA's own birthday).[6] The psychiatric opinion was that "AA simply does not believe that she has in fact begun the labour process".[7]

Given AA's inability to cooperate with management of a normal birth, the Hospital made an emergency application to the out-of-hours judge seeking permission to undertake the caesarean. However, the out-of-hours judge was of the view that, because AA had not entered labour, the emergency orders were unnecessary, although authority was given to perform the caesarean in the event that AA went into labour. The matter was fixed for hearing the following morning.

The Hospital's position

On the morning of the hearing, AA was assessed by a psychiatrist, who confirmed her inability to comprehend her situation and that she was thus unable to consent to treatment. Evidence was provided to the court that there were two options for AA's management. One option was for labour to be induced. However, given AA's condition, there was a 25–33% chance that an emergency caesarean would be required, which could result in the death of the foetus and an increased risk of life-threatening shock and haemorrhage to AA. The court concluded that this was "plainly an unsuitable course".[8]

The second option presented to the court was for AA to have an "elective" caesarean under general anaesthetic. The clinical team considered that this approach was in

AA's best interests, particularly because AA had demonstrated noncompliance with intravenous regimes and, as articulated by the court, appeared "unable to comprehend any aspect of her treatment".[9]

The issue for the court was whether it should make orders permitting the Hospital to undertake the elective caesarean procedure.

Power to make declarations

The court had to determine whether it had a statutory power to make the orders sought, or whether the orders should be made under its inherent jurisdiction as a superior court. The court noted that because AA was detained under the MHA, that Act took precedence over the operation of the Mental Capacity Act 2005 (UK) (MCA). The MCA contains provisions allowing courts to authorise treatment where an individual is unable to consent.

The court referred to English case law for authority that, where a patient is detained in a hospital under the MHA, the MHA prevailed over the MCA, and the MCA could not be used to allow treatment "for any purpose".[10] In addition, the court noted authority that in the case of patients detained under the MHA, treatment that is not for a patient's mental disorder cannot be ordered under the MHA or the MCA. Thus, the court concluded that "the inherent jurisdiction [of the court] provided the route by which treatment in the patients [sic] best interest should be authorised".[11]

The court noted that:

> … the decision to restrain and compel medical procedures on those who do not have the capacity to take them themselves is an onerous one. The declaratory relief is sought for two purposes: firstly, the legal purpose, which is to cloak the Trust with the legal authority to carry out the procedure and to provide them with a defence to any allegation of criminal or tortious liability for trespass to the person … secondly, the clinical purpose, which stems from the fact that in many instances the co-operation of a patient, or at least a patient's confidence in the efficacy of a treatment, is a major factor contributing to the treatment's success. Failure to obtain the consent of a patient not only deprives the patient but the medical staff of this advantage. The court has the jurisdiction over the legal purpose; it does not have jurisdiction over the clinical one, and its approval helps to ameliorate that disadvantage.[12]

Was the proposed medical treatment in AA's best interests?

In considering whether the proposed caesarean was in AA's best interests, the court stated:

> I have addressed here the disadvantages to the mother in this process conducting a balance of the positives and negatives in the competing alternatives. I do so because I am not in this application concerned with the welfare of the foetus. It must be said however that the alternative to the elective cesarean [sic] plainly carries significant risks to the foetus or to the baby and the real clinical prospect of foetal distress.
>
> When I consider the best interests of AA here, I do so by evaluating the clinical alternatives keeping her medical interests in focus. But a best interests decision requires a broader survey of the available material. I am perfectly satisfied that this is a wanted baby in a supportive family unit. I have listened carefully to what the family has said, particularly what AA's partner, BB, has said. He was not always consistent or indeed logical. If I may say so, at such a stage in his life in these difficult circumstances I would hardly expect him to be so. He communicates to me that AA is extremely anxious, extremely distressed, but he also says she is tired and he believes in some way she now wants to get on with the delivery. I believe that he was telling me that if AA were not florid, if she were not suffering this profound psychotic episode, and if she were in a position to reason her situation objectively, she would follow the recommendation of the doctors.[13]

The court concluded that if AA were competent, she would consent to the caesarean and that it was within this "wider context" that the court weighed the "compelling medical evidence", noting that "[b]est interests declarations are never grounded exclusively in medical issues: the wider context is frequently just as illuminating".[14]

Orders

The court granted the Hospital declaratory authority to perform the elective caesarean section under general anaesthetic, finding the proposed treatment to be in AA's best interests. Given that AA was uncooperative, the Hospital was also authorised to use reasonable and proportional physical force to restrain AA from leaving the Hospital, to permit treatment, and to allow the administration of anaesthesia and sedation.[15] However, the court directed that:

> Any restraint used shall be the minimum deemed necessary by those applying that restraint (having consulted with the treating clinical team) in order to facilitate the assessment and treatment of AA and shall be used in a manner to ensure she suffers the least distress and retains the greatest dignity possible in the circumstances.[16]

Conclusion

This case illustrates how an English court answered the question of whether an elective caesarean was in the best interests of the patient. The case is instructive because it demonstrates that a "best interests" consideration under common law principles focuses on the best interests of the mother — not necessarily the foetus. However, the case does demonstrate that in determining whether a proposed treatment is in a patient's best interests, in addition to considering the patient's medical

interests, courts may also consider the "wider context" — such as the attitude of the patient's partner and parents, and whether there is evidence to suggest that the patient would have consented to the procedure if competent.

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Footnotes

1. *Great Western Hospitals NHS Foundation Trust v AA, BB, CC, DD* [2014] EWHC 132 (Fam).
2. Above, n 1, at [6].
3. Above, n 1, at [4].
4. Above, n 1, at [6].
5. Above, n 1, at [2].
6. Above, n 1, at [19].
7. Above, n 1, at [19].
8. Above, n 1, at [10].
9. Above, n 1, at [11].
10. Above, n 1, at [21].
11. Above, n 1, at [21].
12. Above, n 1, at [23].
13. Above, n 1, at [15]–[16].
14. Above, n 1, at [17].
15. Above, n 1, at Appendix [3(ii)].
16. Above, n 1, at Appendix [4].