Shield bearers

Where does the Court of Protection stand on the concept of a 'good death'? **Andrew Parsons** investigates

The courts have regularly been called on to decide life or death issues, be it under their inherent jurisdiction or now under the Mental Capacity Act 2005. Where the court has to be involved, treatment decisions are often difficult cases. Despite the statutory framework provided by the Mental Capacity Act, such cases are still not always straightforward.

The Mental Capacity Act had sought to codify the approach to such cases, providing a definition of incapacity, a test for incapacity and a set of principles to apply in approaching capacity issues. However, a recent Court of Protection case (unrecorded but known as *DO*) has demonstrated that it can still be difficult to determine such issues.

The patient (DO) suffered from treatment-resistant schizophrenia. She had previously been detained under the Mental Health Act, and was currently a voluntary patient in a psychiatric unit. She was a chronic smoker and also suffered from either peripheral vascular disease or trench foot. Definitive diagnosis was difficult as the patient suffered from delusions and would not allow anyone to see or touch her feet, nor to discuss her problems. A number of her toes had auto-amputated but she believed that these would either re-grow or could be reattached.

The clinical team caring for the patient were concerned that the patient's condition could progress to gangrene of the leg, septicaemia or uncontrollable pain, all of which could give rise to the need for amputation on an elective or life-saving basis.

However, the patient lacked capacity to make decisions about her healthcare, and the difficult clinical decision that therefore arose was whether, if needed, she should undergo amputation on a life-saving basis or whether she should receive palliative care, thereby allowing her life to come to an end. There was no doubt that she had no understanding of the clinical issues that confronted her nor would she be able to understand the reasons for treatment if that became necessary.

Best interests

The court was asked to decide whether it was in the patient's best interests to have an amputation (should the need for this arise) or not. The case for amputation was that it would be a life-saving treatment. However, the alternative view was that, in this particular case, such treatment would not be in the patient's best interest. She would not understand or cooperate with the treatment and thus everything would have to be done under sedation and compulsion. The prospects of a successful procedure and post-operative care were therefore low.

The court received competing views from different experts and thus had to resolve the issue as to whether treatment would or would not be in the patient's best interests. In addressing this issue the court clearly took account of the concept of a 'good death'. The judge said: "We must accept that all life comes to an end, and how it ends is important in terms of quality."

Although the court will normally take decisions on the basis of maintaining life, in *DO* the judge held that, if the need for a life-saving amputation arose, it would be lawful to reject the option of treatment by amputation and instead to effect palliative care. The court felt it would not be in the patient's best interests to proceed with an amputation where she was unable and unwilling to cooperate with the various clinical processes inherent in this. It also took account of the fact there may be an unwillingness in the treating team to see through the processes, particularly if

sustained sedation and compulsion were required which put the patient under great stress.

However, the outcome in this case is to be contrasted with another recent case where the court did authorise surgery despite the patient's resistance.

In *DH NHS Foundation Trust v PS* [2010] EWHC 1217, the patient lacked capacity to make treatment decisions as a consequence of a learning disability. She had cancer of the uterus and needed to undergo a hysterectomy, removal of the fallopian tubes and ovaries. Without such surgical intervention, the cancer would spread and lead ultimately to her death.

Medical opinion confirmed that surgery was the best available treatment; however, the patient had refused to attend hospital. She would therefore need to be sedated to convey her to hospital and detain her there during the post-operative period.

The court held that it was in the patient's best interest to undergo the surgery. There were the usual risks inherent in all such surgery, but they did not render the operation inappropriate. While the surgery might involve the use of force and sedation, this would ensure the patient received the treatment which she plainly needed and was in her best interests.

In *Re D* [2010] (Court of Protection Decision), the court ordered that a 69-year-old woman who had been in the care of mental health services for 25 years and held the delusional belief that her condition was normal should receive sedation for seven days before surgery for a prolapsed womb.

The medical evidence before the court was that the patient had strong antipathy to medical staff and would not attend hospital voluntarily or cooperate in any way. Untreated her condition would result in bladder infections, kidney failure and possibly ultimately death.

The judge ordered that the operation should go ahead and authorised a general anaesthetic six days before surgery so that she would have no way of preventing this. The judge commented that such restraint was to be used only if "absolutely necessary" and that all reasonable steps should be taken to minimise the distress and to preserve the patient's "greatest dignity possible in the circumstances". The judge felt the risks associated with anaesthesia and surgery were proportionate when balanced with the likely greater good of the procedure.

Final judgment

Although in all these cases the patient would have to be forced to undergo surgery, the cases and thus the outcomes were very different. This seems to have been driven by the presenting clinical condition of the patients and the practicality of pursuing the surgery, but also, importantly, the likely effectiveness of aftercare without their cooperation. While in all cases the patient would require compulsion and sedation even to be brought to hospital, in *PS*, once the surgery was complete, the need for continued understanding and cooperation from the patient was much less.

In contrast, in *DO*, the post-operative care regime, particularly in terms of physiotherapy and wound care, would require a much higher level of involvement and cooperation from the patient which, without understanding of the process and why radical surgery had been undertaken, would be difficult to effect.

The judge in *DO* was particularly concerned that the practicalities of undertaking the post-operative aftercare would be very difficult to implement and traumatic both for the patient and the treating clinical team. The judge was concerned in particular that the clinical team might reach the point at which they were ethically unwilling to continue to impose treatment on the patient, or it became impossible to do so effectively. She would thus suffer radical surgery with an unsatisfactory outcome. Accordingly, he concluded that to compel surgery in those circumstances would ultimately not be in her best interests, as contrasted with palliative care.

Some may find the *DO* decision surprising. However, the judge had the benefit of evidence from the treating clinicians and two independent experts. The clinical team believed that forcing the patient to undergo an operation that she would not understand, and that would probably leave her completely dependent on her carers, was not right.

Applying the principles of the Mental Capacity Act, the judge was clear that a decision had to be taken that reflected the patient's best interests. However, the judge also acknowledged that it is an important function of the Court of Protection to provide professional clinical teams, who often feel vulnerable, with a shield in the form of a court declaration when they make controversial decisions.

Andrew Parsons is a partner at RadcliffesLeBrasseur