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Common Law and the 'Code of Practice' – a commentary

MATTHEW JELLEY, Senior Registrar in Psychiatry, Glenside Hospital, Stapleton, Bristol BS16 1DD

The decision of the Law Lords in May 1989 that allowed the sterilisation of a woman with serious mental handicap (F. v. W. Berkshire H.A., 1989) is arguably the single most important legal development in relation to psychiatry in the last 30 years. It has far-reaching implications beyond the field of mental handicap and will affect the practice of all psychiatrists. The Law Lords used the appeal to consider "the startling fact that there is no English Authority on the question whether as a matter of common law (and if so in what circumstances) medical treatment can lawfully be given to a person who is disabled by mental incapacity from consenting to it" (Lord Goff). Quite clearly this encompasses a large part of psychiatric practice and promised to clarify much of the controversy surrounding consent and the incompetent patient. The decision that they reached has now been incorporated into the Code of Practice of the Mental Health Act 1983 which was approved by Parliament in December 1989. The effects of this are of huge importance, and it has extensive consequences for all psychiatrists and their patients by simplifying the legal aspects of treatment. The most surprising aspect of this whole issue, therefore, is the silence that has surrounded both the original decision by the Law Lords and the subsequent publication of the Code of Practice. The only reference to these in *The British Journal of Psychiatry*, or its sister journal, *Psychiatric Bulletin*, has been a brief letter outlining some implications of the Lords' decision (Lovett, 1989). This is doubly surprising as the Royal College of Psychiatrists has shown considerable interest in this debate, not least by publishing a book about it! (Hirsch & Harris, 1988). The purpose of this paper is to provide a background to the Code of Practice and to clarify certain issues surrounding the Common Law.

What is the Common Law?

The Common Law has a central place in any discussion on treatment in the absence of consent. Generally speaking it has less relevance to patients liable to be detained under the Mental Health Act, as Part IV of this Act specifically deals with consent to treatment for mental disorder for virtually all detained patients (notable exceptions being patients on Sections 5(2) or (4). Gostin states "where the statute applies, its provisions override the Common Law; but where the Act does not apply the Common Law remains in force" (1986). So for all informal patients and for the treatment of physical illness in both informal and detained patients the Common Law applies. It is a term that is often invoked in a talisman-like fashion by staff in the treatment of patients not covered by the Act, and yet it is one that is often poorly understood. One confusion arises from the fact that the term describes not one concept, but four. In its broadest sense it describes the whole of English Law: that is one can describe the English Legal System as a Common Law system. This is in contrast to other countries which have a Civil Law System (e.g. France).

The second sense in which it is used is in an historical sense – prior to the Norman Conquest of 1066 there were local laws, rules and customs without any uniformity. The Normans collected these practices into one system common to the whole country – therefore called the Common Law.

The third usage further subdivides the Common Law into common law and law of equity, and has little relevance here.

The final sense, however, is the most pertinent to psychiatry as it describes that part of English Law which has evolved piecemeal over the centuries and is not derived from statutes. To clarify this one may state that the law has reached its present state by two broad routes. The first is by the passing of laws or statutes by which specific rules on one topic are collected together and debated by Parliament. This allows large numbers of related policies to be introduced at one time, or for the law to be changed after discussion in public. This is Statute Law, and the Mental Health Act is an example of such a statute. The other route concerns a vast body of law that has bypassed the procedure of being processed by Parliament and that has been handed down by the Courts themselves through the rulings of the judges. These decisions (the "ratio decidendi") are then applied in similar cases and have a hierarchical nature: i.e. if the decision emanates from a court with superior authority then that decision must be applied in other cases, and it can only be modified by a court of similar or higher standing (the highest court being the Law Lords).

The benefit of this system is that judges can reflect contemporary attitudes and common sense in a flexible response to a given problem presented to them.

The drawback is that nobody can confidently predict exactly what any given judge will rule in a given case, and it has been this vagueness that has caused the most concern to mental health professionals. Kennedy summarised this by saying: "Doctors, it seems must comply with their legal duty, which, on consulting a lawyer, they will be told consists in setting a standard which is right. When they ask what rightness consists in, they will be further advised that it involves setting a standard which conforms with their legal duty and which a judge does not subsequently think is wrong" (1984).

How does the Common Law relate to psychiatry?

The Common Law has long recognised that there are circumstances when mental illness requires special provisions: "Anyone is entitled at Common Law to apprehend a person who is mentally disordered and who is a danger to himself or others, the purpose of apprehension, of course, being to get him to a doctor" (Williams, 1983). It has also conferred certain powers on doctors to treat patients without their consent ("doctor" and "patient" being the terms I shall use, in line with the Code of Practice, to exemplify the disciplines involved in treatment and the people they see as needing treatment, respectively). The Common Law, however, is also the body of law that contains the two major actions that are open to a patient for legal recourse in the event of wrongful treatment – battery and negligence. Much of the fruitless debate surrounding this area has been to do with which of these is of most importance when treating without consent.

In Common Law, battery and assault are forms of trespass against the person; the most confusing aspect of which (especially for doctors) has been that the trespass has not had to have been malevolent to be defined as battery. The concepts arise from the "fundamental principle, plain and incontestable . . . that every person's body is inviolate" (Collins v. Wilcock, 1984) and that any infringement of that should be judged under the law of battery. In 1962 Devlin was able to write that the Common Law "does not consider an act done without a person's consent but for his benefit is deserving of reward or even of immunity from the action of trespass. The Good Samaritan is a character unesteemed by the English Law" (1962). On the other hand, the law of negligence provides that in a situation where there is a duty of care owed by one party (in this case a doctor) to another (a patient), if that duty is breached and harm results from the breach, then the doctor is negligent. In the Law Lords decision in re F, Lord Bridge summarised the problem: "It would be intolerable for members of the medical, nursing and other professions devoted to the care of the sick that, in caring for those lacking the capacity to consent to treatment, they should be put in the dilemma that, if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but if they withhold that treatment, they may be in breach of a duty of care owed to the patient."

The Code of Practice

That there was a need for guidelines for doctors and other professions in the legal aspects of treatment was recognised by the 1983 Act and written into it (Section 118). After two years of consultation and deliberation, the Mental Health Act Commission produced the Draft Code of Practice (1985). This was severely criticised, most notably by the Royal College of Psychiatrists, for overstepping its remit and was subsequently shelved. The DHSS then produced its own Draft Code in 1987 and avoided giving practical guidance with regard to consent to treatment, which resulted in further criticism, this time notably from the Mental Health Act Commission. A third Draft (which was approved by Parliament in 1989) was drawn up by a separate working party and was able to include the decisions reached by the Law Lords in May 1989. Those decisions are best summarised by Lord Brandon: "In my opinion . . . a doctor can lawfully operate on, or give treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health."

Quite clearly this is a seminal statement and has, at a stroke, settled much of the controversy surrounding the issue of consent and the incompetent patient. In many ways it supports the stand taken by the medical profession over the years that Hoggett has described as an "invincible belief that they have a 'common law' duty to treat their patients" (1984) and in fact in the Law Lords' decision Lord Brandon goes on to say "in many cases . . . it will not only be lawful for doctors, on the ground of necessity, to operate on or give other medical treatment to adult patients disabled from giving their consent: it will also be their common law duty to do so." In drawing together, therefore, those powers already commonly accepted that a doctor possesses and those newly allowed by the Law Lords, the Code of Practice has given a list of indications for when treatment can be given without consent. The first three indications it lists are

unremarkable as they summarise already accepted practice. These are that treatment may be given when the patient is incapable for giving consent by reason of the fact that he is (a) an immature child; (b) unconscious, and in urgent need of treatment; and (c) suffering from a mental disorder which is leading to immediately serious danger.

The final indication is the one that is the new departure, the patient being "otherwise incapable and in need of medical care in circumstances in which he has not declared his unwillingness to be treated prior to the onset of the incapacitating condition". This gives doctors a very wide field in which to work – the caveat being that the treatment must be "in the patient's best interest".

In practical terms this means that treatments for physical illness may be given to patients without the capacity to consent before the problem reaches a "point of no return". This will apply to people with chronic problems such as severe mental handicap or dementia, and will also apply to acutely mentally ill patients who refuse such treatment, provided that the patient is "incapable" of giving (or in this case withholding) consent; because, as the Code of Practice points out, "the fact that a person is suffering from a mental disorder does not mean that he is thereby incapable of giving consent".

The other main issue arising from the Law Lords' decision is the question of good practice. The Draft Code of Practice of 1985 dwelt at length on the people with whom it was recommended one should consult before embarking on a course of action. This does not appear in the definitive Code, but Lord Goff states: "it must surely be good practice to consult relatives and others who are concerned with the care of the patient. Sometimes, of course, consultation with a specialist or specialists will be required; and in others ... an inter-disciplinary team will in practice participate in the decision". Although recognising that relatives have no legal rights with regard to the patient's consent, and that ultimately the decision rests with the clinician, one can acknowledge the common sense in consultation.

Finally, the major issue that the Law Lords' decision failed to resolve is that of non-therapeutic research. The ruling applies only to procedures that affect the health of that individual patient and so the debate as to whether the law of battery pertains to patients involved in non-therapeutic research will continue.

Comment

The Code of Practice has reflected in a fortuitous fashion the most recent developments in the Common Law affecting consent and the incompetent patient. It will be seen by some as a reestablishment of paternalism or a backlash against patients' rights; others will be relieved of anxieties surrounding their own practice. Whichever way, it remains a priority to disseminate the guidelines in the Code to all mental health professionals as quickly as possible to redress the existing lack of knowledge.

References

COLLINS v. WILCOCK (1984) 3 All E.R., P.374.

DEVLIN, P. (1962) *Samples of Law Making*. Oxford: University Press.

F v. WEST BERKSHIRE HEALTH AUTHORITY AND ANOTHER (Mental Health Act Commission intervening) (1989) 2 All E.R., P. 545.

GOSTIN, L. (1986) *Mental Health Services – Law and Practice*. London: Shaw & Sons.

HIRSCH, S. R. & HARRIS, J. (eds) (1988) *Consent and the Incompetent Patient: Ethics, Law and Medicine*. London: Gaskell (Royal College of Psychiatrists).

HOGGETT, B. (1984) *Mental Health Law*. Second Edition. London: Sweet & Maxwell.

KENNEDY, I. (1984) The patient on the Clapham omnibus. *The Modern Law Review*, **47**, 454–471.

LOVETT, L. M. (1989) Treatment for patients unable to consent. *Psychiatric Bulletin*, **13**, 510–511.

WILLIAMS, G. (1983) *Textbook of Criminal Law*. London: Stevens.

A full list of references is available on request from the author.