Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

Ethics Committee Guideline No. 1
September 2006

LAW AND ETHICS IN RELATION TO COURT-AUTHORISED OBSTETRIC INTERVENTION

This is the second edition of this guideline. It updates and replaces the first edition published in 1994 and the supplement that was added in 1996.

1 Purpose and scope

The purpose of this guideline is to:

- clarify the position of the current law on Court-authorised obstetric intervention in competent and incompetent patients (or those with and without capacity) (sections 3 and 4)
- identify the ethical principles involved (section 5)
- provide guidance on best practice in how to prevent such conflicts and deal with them when they arise (section 6).

2. Background

This guideline intentionally focuses on Court-authorised caesarean section because that is the dominant issue to have been brought to the Courts in the UK thus far.

Law and ethics are not synonymous. Although laws often consolidate ethical positions, it is quite possible to have unethical practice that is legal (and *vice versa*).

The legal and ethical principles that apply to caesarean section also apply to other possible interventions, such as intrauterine transfusion, cervical cerclage or medication in pregnancy.

This guideline is based on the fundamental premise in English law that the competent adult has the right to refuse treatment. Surgery without consent is, therefore, illegal.[1,2]

The major experience of Court-ordered intervention has so far been in the USA and Canada. The law of England and Wales relating to the fetus has been described as 'both unclear and confused'.[3] However, as far as the right of the fetus to live and its protection is concerned, an unborn child is not distinct from its mother. The question of whether a fetus is a separate person under European Human Rights Legislation has been reviewed.[4] The majority view of the Court was that Article 2 'Right to Life' did not apply to the fetus.

Although Court-authorised intervention in the UK remains an extremely rare event, it has occasionally occurred since the first case in 1992.[5] Details of relevant cases are summarised in Appendix 1 (Cases 4, 5 and 7).

Helpful guidelines were given by the Court of Appeal in 1998 as to suggested practice when declarations permitting intervention are sought.[6] The Court made it clear that it is unlikely to entertain an application for a declaration unless the capacity of the patient to consent to or to refuse the medical intervention is in issue.

The main ethical issues are maternal autonomy, bodily integrity, the interests of the fetus and the obligations of the mother and other caregivers.

3 The legal position

The competent adult has the right to refuse treatment and surgery without consent is an assault in English law.[1,2] This has recently been confirmed: 'Where a competent patient makes it clear that he does not wish to receive treatment which is, objectively, in his best interests, it is unlawful for doctors to administer treatment. Personal autonomy or the right to self determination prevails'.[7] While concerned primarily with the law in the UK, relevant decisions from other jurisdictions are considered.

3.1 Consent and the capacity to make decisions

The usual rules relating to consent apply to pregnant women in the same way as to other patients. The NHS Management Executive's document, *A Guide to Consent for Examination or Treatment* (1990), states: 'Principles of consent are the same in maternity services as in other areas of medicine. It is important that the proposed care is discussed with the woman, preferably in the early antenatal period when any wishes she expresses should be recorded in the notes, but of course the patient may change her mind about these issues at any stage, including during labour'.[8]

The Department of Health defines capacity (or competence) to make decisions as the abilities 'to comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question' and ' to use and weigh this information in the decision making process'.[9] The guide emphasises:[9]

- The presumption is 'that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way.'
- 'Capacity should not be confused with a health professional's assessment of the reasonableness of the patient's decision'. As long as she understands what it entails, the woman is entitled to make a decision based on her own religious belief or value system even if it seems to others to be irrational.'
- 'If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment this decision must be respected even where this may result in the death of the patient and/or the death of an unborn child, whatever the stage of the pregnancy'.

Under the new Mental Capacity Act 2005 (see section 3.5) 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.' And '… a person is unable to make decisions for himself if he is unable: to understand the information relevant to the decision; to retain that information; to use or weigh that information as part of the process of making the decision; or to communicate his decision (whether by talking, using sign language or other means)'.

3.2. Refusal of consent

Axiomatic to the patient's right to consent to treatment is the right to refuse treatment.[10] The Court of Appeal in the case of *Re T* (Appendix 1, Case 3)[11] affirmed that right whatever the rationality of the decision. However, for such refusal to be effective, doctors had to be satisfied that at the time of the refusal:

- the patient's capacity to decide had not been diminished by illness or medication or given on the basis of false assumptions or misinformation
- the patient's will had not been unduly influenced by another person
- any refusal had been directed to the relevant situation.

Only where a patient's refusal was ineffective could doctors treat in accordance with their clinical judgment of the patient's best interests.

This case affirms a patient's absolute right, properly exercised, to refuse medical treatment. The issue was reviewed again in 2002 in the case of *Ms B v an NHS Hospital Trust* (Appendix 1, Case 6) and the Court confirmed that 'if mental capacity is not in issue and the patient, having been given the relevant information and offered the available options, chooses to refuse the treatment, that decision has to be respected by the doctors.[12] Considerations that the best interests of the patient would indicate that the decision should be to consent to treatment are irrelevant'. In the case of *R (Burke) v GMC* the Court said, 'The relationship between doctor and patient usually begins with diagnosis and advice. The doctor will describe the treatment that he recommends or, if there are a number of alternative treatments that he would be prepared to administer in the interests of the patient, the choices available, their implications and his recommended option. In such circumstances the right to refuse a proposed treatment gives the patient what appears to be a positive option to choose an alternative. In truth, the right to choose is no more than a reflection of the fact that it is the doctor's duty to provide a treatment that he considers to be in the interests of the patient and that the patient is prepared to accept'.[7]

Usually children will be considered competent to make decisions on their own behalf when they are capable of understanding fully the nature of what is proposed[13] and, in general, a competent child's refusal should not be overridden, save in exceptional circumstances.[14] There is a distinction between consent to and refusal of treatment (covered by *Re R [1991]* and *Re W [1992]*).[15,16] Young people under the age of 18 years may not refuse treatment where someone with parental authority consents.

3.3. Possible exception to right to refuse consent

In *Re T [1992]*,[11] Lord Donaldson made one hypothetical exception in relation to pregnancy to the right of a competent patient to refuse medical treatment. He said: 'The only possible qualification is a case in which the choice may lead to the death of a viable fetus'. He stressed, however, that this was not the case and that when the situation arose the Court would be faced with a novel problem of considerable legal and ethical complexity. Despite this being an incidental remark tangential to the judicial opinion being given, it formed the basis of a decision in *Re S [1992]* to authorise a nonconsensual caesarean section.[5]

While the direct point has not been tested, there is considerable judicial authority to the effect that the interests of the fetus are necessarily subordinated to the rights of the pregnant woman. In *Paton v BPAS*,[17] Sir George Baker, President, said: 'The fetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country'.

More significant are the comments made in *Re F [1988]*,[18] when the Court considered whether it had the jurisdiction to make an unborn child a ward of Court. Details of the case and judicial statements regarding the decision not to allow wardship are presented in Case 2 in Appendix 1. Their lordships considered that allowing wardship would have meant unacceptable control over the mother's actions. Lord Justice Balcombe said: 'If the law is to be extended in this manner, so as to impose control over the mother of an unborn child, where such control may be necessary for the benefit of that child, then under our system of parliamentary democracy, it is for Parliament to decide whether such controls can be imposed and, if so, subject to what limitations or conditions'.

3.4 Court-authorised caesarean section, UK

In light of the above, concern has been expressed about the decision in *Re S [1992]* in which a declaration was given that 'a caesarean section and any necessary consequential treatment which the hospital and its staff proposed to perform on the patient could be lawfully performed despite the patient's refusal to give her consent being vital in the interests of the patient and her unborn child' (Appendix 1, Case 4).[5] This case differs from others in respect of the threat to life of both the mother (in obstructed labour) and the baby.

Re S [1992][5] was not appealed. Can it be legally justified that a competent patient's wishes are overridden purportedly in her best interests? The justification provided by the case of *Re F [1988]* applies only in the case of incompetent adults,[19] and should certainly not be applied in the case of competent female patients. Indeed, even if the woman were unconscious, *Re F [1990]*[19] would only justify treating her if such treatment were in her best interests, either to save her life or to ensure improvement or prevent deterioration in her physical (or mental) health. This would not necessarily justify a caesarean section unless it fulfilled these criteria.

Re S [1992][5] is also out of step in elevating the status of the fetus in law to such an extent that its supposed rights become more important than its mother's. To do so is out of line with both previous case law and with the Congenital Disabilities (Civil Liabilities) Act 1976, which gives a child a right of action for damage caused *in utero* against everyone except its mother (with the exception of motor accidents, for which the mother is insured). Indeed, as Grubb points out,[20] the Law Commission, in its report on injuries to unborn children,[21] explicitly stated that a woman should not be liable for 'rash conduct during pregnancy' which causes harm to the unborn child. Rather, the intent of Parliament was to leave it up to the individual mother to decide how to act in the 'best interests' of her unborn child.

Moreover, there is no other precedent in law for forcing one person to use his or her body to save the life of another. In the American case of *McFall v Shimp* (Appendix 1, Case 1)[22] it was determined that a person could not be forced to give a potentially life saving bone marrow donation for his cousin even though his moral stance was heavily criticised. Thus, by extension, although a pregnant woman may well have an extremely strong ethical responsibility towards her unborn child, this does not mean that it is correct to use the law to enforce these responsibilities.

Two further cases have subsequently arisen; *Re MB [1997]* and *St George's Healthcare NHS Trust v S* (Appendix 1, Cases 5 and 7).[6,23] There were a number of cases in which clinicians used the Mental Health Act to section women as mentally disordered, in order to perform a physical procedure as supposed treatment for a mental disorder. Following the *Re MB [1997]* and *St George's Healthcare NHS Trust v S* decisions, it would be incorrect for clinicians to have the impression that the Mental Health Act is allowed to be used for this purpose.

In *Re MB [1997]*,[23] the appeal judgement gave guidance as to what should be done in cases where such emergency applications were made. It stated:

- It is a criminal and civil wrong to perform an operation of any sort without a patient's consent.
- All competent patients (including women in labour) have the right to refuse medical treatment for good, bad or even no reasons. The unborn child has no rights in law that complicate this fundamental proposition.
- Every person is presumed to have capacity to consent to or refuse medical treatment until the contrary is shown.
- Competent patients are those who have the capacity to take a decision to consent to operations. The test is whether they are able to:
    - comprehend and retain information material to the decision
    - weigh the information so as to reach a decision.

- Medical treatment can be undertaken in an emergency even where a patient lacks capacity to consent. The attendants then have a duty to act in the best interests of the patient, although the treatment given must be limited to that which is a necessity in the best interests of the patient.
- It would be inappropriate to ask the Courts to overrule an informed and competent woman's refusal of treatment.
- In cases of doubt the Court can be asked to give guidance.

Such emergency incidents by their very nature require urgent resolution and leave little time for deliberation or for seeking advice. Their rarity usually means that no one directly involved has previous experience of what to do in such circumstances. Conventional legal processes do not fit easily with the acuteness of the clinical situation in most of these cases and this has led to some criticism.[24] For example, applications were made without any representation of the patient or formal evidence being tendered. The Court was prepared to act on information relayed by telephone with no opportunity for cross-examination of the witness.

In *St George's Healthcare NHS Trust v S [1998]*,[6] the Court suggested the practice to be followed when declarations from the Courts were being sought. These are summarised below (and given more fully in Box 1). It should, however, be noted that the guidelines have no application where the patient is competent to accept or refuse treatment. In principle, a patient may remain competent notwithstanding detention under the Mental Health Act 1983. It will be seen that the Court is unlikely to entertain an application for a declaration unless the capacity of the patient to consent to or refuse the medical intervention is an issue. Best practice includes:

- Any problem about mental capacity to consent to treatment should be identified as early as possible so that both the hospital and the patient can obtain legal advice and allow time for proper instructions from the patient.
- If the capacity of the patient is seriously in doubt it should be assessed as a matter of priority. In many such cases the patient's general practitioner or other responsible doctor may be sufficiently qualified to make the necessary assessment, but in serious or complex cases involving difficult issues about the future health and wellbeing or even the life of the patient, the issue of capacity should be examined by an independent psychiatrist.
- If, following this assessment, there remains a serious doubt as to the patient's competence, an application to the Court may need to be made. The trust should seek legal advice as quickly as possible and, if a declaration from the Court is to be sought, the patient's solicitors should be informed immediately.
- The hearing of the application should be held in the presence of both parties and representation of the woman in all cases (unless she does not wish to be). If she is unconscious an advocate for her best interests should be appointed.

3.5 The Mental Capacity Act 2005

The Mental Capacity Act 2005 was passed by Parliament after the cases relating to Court-authorised obstetric intervention were determined. As with all new legislation, it may be that during the early days of the Act more cases will come before the Court until there is some clarity as to interpretation of the Act's provisions.

The Mental Capacity Act states: 'A person must be assumed to have capacity unless it is established that he lacks capacity … A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success … A person is not to be treated as unable to make a decision merely because he makes an unwise decision … a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

So far as the inability to make decisions is concerned, the Mental Act states:

'(1) a person is unable to make decisions for himself if he is unable:
- to understand the information relevant to the decision
- to retain that information
- to use or weigh that information as part of the process of making the decision, or
- to communicate his decision (whether by talking, using sign language or other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of:
(a) deciding one way or another, or
(b) failing to make the decision.'

Any act performed or decision made for or on behalf of a person who lacks capacity must be done or made in his best interests. In determining what is in the person's best interests and where it relates to life-sustaining treatment, the person making the determination 'must consider so far as is reasonably ascertainable:

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so'.

Section 37 of the Mental Capacity Act 2005 seeks to address the issue of what should happen if an NHS body is 'proposing to provide, or secure the provision of, a serious medical treatment for a person … who lacks capacity to consent to the treatment'. In such circumstances, the NHS body must instruct an independent mental capacity advocate to represent the patient. It remains to be seen how this section of the Act will operate in practice. It appears that the advocate will be able to challenge or assist in challenging a decision. It also appears that if the treatment needs to be given urgently the body can give the treatment without the advocate being appointed. Until the Act has come into force and there is greater clarity about the role of advocates clinicians would be advised to follow the St George's Guidelines.

4. The patient who does not have capacity to make decisions

In the event of an adult patient being incompetent and in the absence of specific statutory authority under the 1983 Mental Health Act (see below), no one else, not even the next of kin, is in a position to give consent to treatment. The doctor's duty is to act in the best interests of the patient.[25] Not only is he or she justified in taking such steps as good medical practice demands, the doctor may even have a duty (*per* Lord Brandon) to administer treatment in such circumstances. Under the provisions of the Mental Health Act 1983 Section 63, 'The consent of the patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering if the treatment is given by or under the direction of the responsible medical officer'. It should be noted, however, that the medical treatment concerned must be for the mental disorder from which the patient is suffering as opposed to treatment for any other condition. As Section 63 of the Act only authorises nonconsensual treatment for a mental condition, not for a physical condition, it should not be used for enforced caesarean sections. Lord Donaldson said in *Re T [1992]*,[11] 'If an adult patient did not have capacity to decide at the time of the

purported refusal and still does not have that capacity, it is the duty of the doctors to treat him in whatever way they consider, in the exercise of their clinical judgement, to be in his best interests'.

The underlying moral presumptions are first in favour of life and second in favour of a mother's normal will to do what is best for the fetus. For example, in the absence of an advance directive and with neurological evidence of brain death in the mother, it would be appropriate to act on behalf of the fetus.

4.1. Advance Directives (or 'living wills')

The Mental Capacity Act 2005 (Section 26) addresses the issue of Advance Directives. In summary, if the patient who does not have capacity at the time of proposed treatment has made an advance decision in writing in respect of treatment at a time when she had capacity, has not withdrawn it at a time when she had capacity to do so, and the decision specifies the treatment concerned, the decision has the effect as if she had made it and had capacity to make it at the time when the question about the treatment being carried out arises. However, an advance decision will not be applicable to the treatment in question if the treatment is not the treatment specified in the advance decision, any circumstances specified in the advance decision are absent or there are reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of the decision and which would have affected the decision.

The Court has power under the Act to make a declaration as to the validity and applicability of an advance decision. In the case of *R (Burke) v GMC*,[7] the Court said of the Mental Capacity Act: 'While Section 26 of that Act requires compliance with a valid advance directive to refuse treatment, Section 4 does no more than require this to be taken into consideration when considering what is in the best interests of a patient'.

In general, doctors are under duty to respect, in an advance directive, refusal of any procedure debarred to them by a patient's refusal of consent.[26,27] They are however, not obliged to honour a request for specific treatment in advance directives that they would hold to be contrary to professional judgement or personal conscience.

What then is the status of an advance directive in pregnancy? The BMA Code of Practice states: 'Women of childbearing age should be advised to consider the possibility of their advance statement or directive being invoked at a time when they are pregnant. A waiver covering pregnancy might be written into the statement' and: 'If an incapacitated pregnant woman presents with an apparently valid advance directive refusing treatment, legal advice should be sought to clarify the position'.[26]

The Law Commission reports: 'the majority of the US states with living will legislation set statutory limits to the effectiveness of any declarations during the maker's pregnancy'[28] and quotes a similar opinion from King's College London Centre of Medical Law and Ethics.[29]

The Law Commission continues: 'We do not, however, accept that a woman's right to determine the sorts of bodily interference which she will tolerate somehow evaporates as soon as she becomes pregnant. There can, on the other hand, be no objection to acknowledging that many women do in fact alter their views as to the interventions they find acceptable as a direct result of the fact that they are carrying a child. By analogy with cases where life might be needlessly shortened or lost it appears that a refusal, which did not mention the possibility that the life of a fetus might be endangered, would be likely to be found not to apply in circumstances where a treatment intended to save the life of the fetus was proposed. Women of child-bearing age should therefore be aware that they should address their minds to this possibility if they wish to make advance refusals of treatment'.

They suggest, 'The best way of balancing the continuing right of the patient to refuse such treatment with the public interest in preserving life is to create a statutory presumption in favour of the preservation of

life.'They recommend,'In the absence of any indication to the contrary,it shall be presumed that an advance refusal of treatment does not apply in circumstances where those having the care of the person who made it consider that the refusal (a) endangers that person's life;or (b) if that person is a woman who is pregnant, the life of the fetus.' The Law Commission's recommendations are not legally binding. No statutory presumption in favour of society's interest in preserving life has been created by act of Parliament.

4.2 The patient who lacks capacity at the time of the proposed treatment but with whom the treatment has previously been discussed during the pregnancy and who at a time when she did have capacity, was fully informed, has refused it in advance

In such a case, Section 4(4) of the Mental Capacity Act 2005 will apply.Thus,'Any act done or decision made for or on behalf of a person who lacks capacity must be done or made in his best interests'. In determining what is in the person's best interests and where it relates to life-sustaining treatment the person making the determination 'must consider so far as is reasonably ascertainable:

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)
(b) the beliefs and values that would be likely to influence his decision if he had capacity, and
(c) the other factors that he would be likely to consider if he were able to do so'.

The mother's wishes should be respected in the same way as if she were conscious and competent.This may be at the expense of the fetus.

4.3 The patient who does not have capacity at the time of the proposed treatment but who made a valid advance directive relating to some form of treatment but with whom there has been no opportunity for discussion during the pregnancy

Section 26 of the Mental Capacity Act 2005 will apply (see above).Thus, it will be necessary to look at whether the treatment is the treatment that was specified, whether circumstances specified are or are not present and whether there are reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of making the directive which would have affected the decision if they had been anticipated.

Where there is no mention of pregnancy in the directive, the timing and content of the advance directive are relevant. If the document was drawn up before the pregnancy was known, and made no reference to pregnancy, the directive could be declared invalid because the circumstances at the critical time of decision were not clearly envisaged when the directive was made.The obstetrician, being uncertain of the intentions of the mother, would be free to allow more weight to the interest of the fetus. If the directive referred to pregnancy, or had been made after the pregnancy was known, that freedom would be denied. Whether a particular directive will be found invalid or not will depend on the facts of the case.To avoid ambiguity, women of childbearing age drawing up advance directives are advised to clarify their views regarding pregnancy.

4.4 The patient who does not have capacity where there is only a presumption of her refusal

One possible example would be if she belongs to a religious sect with relevant scruples. In such circumstances, the obstetrician may be advised to act in the patient's 'best interests' as stated in for example *T v T [1988]*[30] and *Re F [1990]*[19] and as now provided for by Section 4 of the Mental Capacity Act 2005.The previous wishes and feelings of the patient must be taken into account as well as the views of those who know her.

The condition for which the patient is on life support is relevant to any decision. If the condition were one of a trauma from which the patient might reasonably be expected to emerge, her own interest would

be higher than if she were brainstem dead. In the latter case, the interests of the fetus would predominate. It would, thus, be appropriate to defer any decision to withdraw life support until intact independent survival was likely.

4.5 Refusal of intervention resulting in adverse outcome

As well as a common law duty of care towards an unborn child (confirmed by the Court of Appeal in *Burton v Islington HA: de Martell v Merton and Sutton HA [1992]*),[31] since July 1976, a third party has a statutory duty of care towards an unborn child who is subsequently born disabled, under the Congenital Disabilities (Civil Liability) Act of that year. However, a person is only liable towards a child, if he or she would, if sued in time, be liable in civil law to one or both of the child's parents.

This raises the question of a child damaged *in utero* or in the course of delivery as a result of maternal noncompliance. An obstetrician has a duty of care to a mother to exercise reasonable care for her wellbeing. Consider the following scenario: A woman who has capacity to consent to or refuse treatment, being fully informed about the potential risks and benefits of the proposed intervention, refuses to permit the obstetrician to act in such a way as to secure the interests of herself and of her unborn child. As a direct result, the child suffers damage. In this case, no unlawful act has been committed, because the obstetrician's duty is to respect the mother's wishes. To do otherwise would be to commit a battery. An obstetrician who complied with a mother's refusal of consent to a caesarean section would not incur legal liability towards the child, even if it suffered harm.

A crucial test is how well informed the woman was. It may be that, in the event of an adverse outcome, the woman or her family will claim in retrospect that, 'if she had truly understood the risks she would, of course, have consented to the procedure'. The best prospective defences against this are good communication, inter-professional team working and, most of all, meticulous record keeping (see the guidelines in *St George's Healthcare NHS Trust v S [1998]*).[6]

4.6 The Adults with Incapacity (Scotland) Act 2000

The position in Scotland is distinguished by The Adults with Incapacity (Scotland) Act 2000, which defines incapacity, provides a legal framework for decision making on behalf of incapable adults (in relation to medical treatment and research in Part 5 but also financial and property issues), clarifies the law for the carers of adults with incapacity and covers the power to appoint an attorney to look after finances and welfare. The definition of an adult in Scotland is 16 years. Incapacity is defined as being incapable of acting, making or communicating decisions, understanding decisions, or retaining memory of decision by reason of mental disorder or an inability to communicate by reason of physical disability (but not if the deficiency can be made good by the use of an aid e.g. hearing aid, computer screen).

In general, no intervention should be undertaken unless it will benefit the adult and the proposed benefit cannot readily be achieved without the intervention. The least restrictive option in terms of personal freedom consistent with the purpose of the intervention should be chosen. Account should be taken of the present and past wishes and feelings of the adult in so far as they may be ascertained; any personal welfare attorney; primary care giver; nearest relatives. The Act has been in place for several years but with no challenges in an obstetric situation as yet. Further information can be found at www.scotland.gov.uk/justice/incapacity.

5 Ethical principles

5.1 Unique relationship

The maternal–fetal relationship is unique. The doctor can benefit or harm the mother and the fetus but

there is only access to one through the other. For the duration of pregnancy, the woman is the only person who can directly control what is done to her fetus. The fetus is totally reliant on the mother so long as it remains *in utero*. The protection of the fetus stands on her performance of her moral obligations, not on any legal right of its own.

5.2 Maternal obligations

The unique relationship between a mother and her embryo or fetus places on her a responsibility that increases as the pregnancy advances. The welfare of the child may well be dependent on her commitment to this unique obligation. The concern of parents for their offspring *in utero* is normally deep and genuine and many pregnant women more than fulfil their obligations, even to the extent of putting their own lives and health at risk.

The pregnant woman's actions and lifestyle may enhance or damage her fetus. There are many ways in which a mother can influence her fetus. Indirectly, she can accept or reject advice regarding drugs, alcohol, smoking, diet and also maternal examination and investigation. More directly related to the fetus, she alone decides whether to accept prenatal diagnosis and treatment, such as ultrasound scans, chorionic villus sampling, amniocentesis, fetal monitoring and caesarean section.

There are different views of the moral status of the fetus, which are contested and might lead to different views as to the extent of maternal obligations. The concept of 'the fetus as a patient' is confusing; it might be a description of a fetus inside its mother undergoing tests and treatment or it may refer to a person under the care of a doctor. The latter contains a moral assumption, but a fetus is not a person.

It has been argued that Court-authorised interventions are still not ethically justified even if we consider that fetuses have the same full moral status as their mothers and there were maternal duties to look after them.[32] A legal system of 'hands-off' pregnant women encourages altruism, attendance for care and better outcomes, whereas Court-authorised intervention relies on coercion and will inevitably drive women from care, causing worse outcomes.

The pregnant woman may have a different perspective from that of her professional adviser towards a recognised problem.[33] Some may have religious or other convictions that prevent them from accepting a particular course of action.

While doctors cannot force treatments on women, they can build trusting relationships, give advice and use the power of communication and persuasion (but not coercion). So long as a doctor does everything within his or her ability and professional limits, and the mother fully understands, then, if things go wrong, she alone shoulders the burdens of responsibility and guilt. Clearly, this is not to diminish the distress caused to obstetricians, and midwives, of being prevented from using their skills to act as usual to preserve life and health, and from witnessing avoidable tragedy.

5.3 Relationship between caregiver and patient

The aim of those who care for pregnant women must be to foster the greatest benefit to both the mother and fetus with the least risk to both.

Obstetricians must recognise the dual claims of the mother and her fetus. The mother may have separate interests from her future child. Obstetricians must inform and advise the family, using their training and experience in the best interests of both parties. When medical information and the possible options are communicated sensitively and effectively, the mother and her obstetrician can share both the decision and the responsibility for it.

There are limits to the accuracy and effectiveness of many diagnostic and therapeutic procedures during pregnancy and confinement and this should be discussed with the mother. For example, the methods for detecting fetal compromise antenatally and during labour are not always reliable indicators of a poor outcome. The fine indices that determine whether the dynamic process of labour will culminate in a normal outcome are difficult to measure.

In caring for the pregnant woman, an obstetrician must respect the woman's autonomy and her legal right to refuse any recommended course of action. He or she must also fulfil the professional obligation to promote the wellbeing of mother and child. In addition, the caring doctor will be attentive to the woman's reports and concerns about their experiences during pregnancy.[34]

In considering so-called 'non-compliance' in pregnancy,[34,35] a number of reasons for the rejection of a doctor's advice by the pregnant woman have been proposed as factors:

- The attitude of the doctor involved.
- The advice runs contrary to the woman's values.
- The doctor and patient fundamentally disagree about the grounds on which medical knowledge is based.
- The woman may question the specific knowledge on which the advice is based: this can arise as a result of the intrinsic lack of certainty of medical knowledge, very different advice being given on the same clinical issue by different doctors, past tragic failures (such as the use of thalidomide in pregnancy, or past personal or family experience).
- The patient may distrust doctors, fail to understand the issues or be afraid.
- There may be just too much advice 'and it is simply not practical for anyone to follow it all'.
- There may be other concerns and constraints on her life (such as demands of work, children or social circumstances such as poverty, being a single parent or having an uncaring or abusive partner).
- Sometimes the reasons for rejecting the advice may not be fully understood even by the woman herself.

Other ethics committees have reached similar conclusions.[36,37] The Ethics Committee of the American College of Obstetricians and Gynecologists advises that caregivers should refrain from performing procedures that are unwanted by a pregnant woman.[37] The use of judicial authority to implement treatment regimens in order to protect the fetus violates the pregnant woman's autonomy and should be avoided unless stringent criteria are met.

6 What should the obstetrician do?

The first question is whether the patient has capacity to consent to, or to refuse, treatment and is refusing recommended treatment. If the patient has capacity there is no action to be taken save for the making of meticulous notes. These must record:

- the unequivocal assurance from the patient that the refusal represents an informed decision
- that she understands the nature and reasons for the proposed treatment, and the risks and the likely outcome involved in the decision to refuse or accept it.

If the patient is unwilling to sign, an indication of this refusal too must be noted in writing.

If the patient's capacity is seriously in doubt, it should be assessed as a matter of priority by a medical practitioner experienced in such assessments (such as a consultant psychiatrist). If, following that assessment, there remains a serious doubt about the patient's competence, legal advice should be sought.

All NHS trusts should have an 'out of hours' contact number to enable legal advice to be obtained and to deal with this sort of situation. Those who may need to make use of the service must know the particular system that applies in each trust.

The number of times that it is necessary to apply to the Court is small; the law is relatively settled and in most, if not all, cases the Court would not need to be involved.

In the event that an Application to the Court has to be made, other issues need to be considered. Commonly, the Official Solicitor will need to be involved to ensure that the interests of anyone lacking mental capacity are represented. There are also questions as to what evidence needs to be put before the Judge and what precisely is being sought from the Court.

The Courts recognise that there is a need for an urgent response at any time and there is therefore at all times a duty Judge in the High Court who is available to hear such cases. In appropriate and urgent cases the Application will generally be dealt with by telephone rather than by way of a Court hearing.

The guidance from the Court in the case of *St Georges Healthcare NHS Trust v S [1998]* is set out in Box 1.[6]

Box 1. Suggested practice when declarations are sought from the Courts

1. The guidelines have no application where the patient is competent to accept or refuse treatment.
2. The Court is unlikely to entertain an application for a declaration unless the capacity of the patient to consent to or refuse the medical intervention is in issue.
3. Refusals should be recorded and authenticated in writing wherever possible. The hospital authorities should seek unequivocal assurances from the patient (to be recorded in writing) that the refusal represents an informed decision; that is, that she understands the nature of and reasons for the proposed treatment and the risks and likely prognosis involved in the decision to refuse or accept it. If the patient is unwilling to sign a written indication of this refusal, this too should be noted in writing.
4. For the time being, at least, the doctors ought to seek a ruling from the High Court on the issue of competence.
5. Those in charge should identify a potential problem as early as possible so that both the hospital and the patient can obtain legal advice. In this case, for instance, the problem was identified at the antenatal clinic.
6. It is highly desirable that, in any case where it is not an emergency, steps are taken to bring it before the Court, before it becomes an emergency, to remove the extra pressure from the parties and the Court and to enable proper instructions to be taken, particularly from the patient and where possible give the opportunity for the Court to hear oral evidence, if appropriate.
7. Both parties should be present at the hearing(s).
8. The mother should be represented in all cases, unless, exceptionally, she does not wish to be. If she is unconscious, she should have an advocate appointed by the Court to act in her best interests (known as '*guardian ad litem*').
9. The Official Solicitor should be notified of all applications to the High Court. It would be helpful if, at least for the time being, in cases where he is not asked to be *guardian ad litem*, the Official Solicitor were prepared to continue to act as an adviser to the Court who is not a party to the case (*amicus curiae*).
10. If competence is in issue there should in general be some evidence, preferably but not necessarily from a psychiatrist, as to the competence of the patient.
11. Where time permits, the person identified to give the evidence as to capacity to consent to or refuse treatment should be made aware of the observations made in this judgement.
12. In order to be in a position to assess a patient's best interests, the judge should be provided, where possible and if time allows, with information about the circumstances of and relevant background material about the patient.

7 Summary

- The management of pregnancy rests upon dual responsibilities of mothers and other caregivers. While the clear professional obligation of the obstetrician is under the sanction of law, the moral obligation of the mother is not. Normally both responsibilities are exercised in concert.
- The aim of those who care for pregnant women is to foster the greatest benefit to both mother and fetus with the least risk.
- The competent adult has the right to refuse treatment and surgery without consent is an assault.
- Doctors must recognise that medical advice is based on evidence that is seldom, if ever, infallible. It is the doctor's duty to provide appropriate information so that the pregnant woman can make an informed and thoughtful decision.
- Occasionally, problems arise when a pregnant woman and her doctor fundamentally disagree over action believed to be in the best interest of mother or fetus or when advice is in conflict with her religious scruples.
- Such circumstances are usually unexpected and the requirement of haste leaves little time for the case to be properly prepared and decided.
- The presumption is that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way.
- Capacity should not be confused with a health professional's assessment of the reasonableness of the patient's decision.
- Although obligations to the fetus increase as it develops *in utero*, UK law does not grant it personal legal status. This comes from the time of birth.
- The law provides no restriction on a woman's freedom on account of her pregnancy. Any medical action requires her informed consent.
- Where conflict arises the doctor should seek help and advice from other professional colleagues and, with the patient's agreement, it may be appropriate to involve other members or friends of her family.
- A doctor must respect the competent pregnant woman's right to choose or refuse any particular recommended course of action while optimising care for both mother and fetus to the best of his or her ability. A doctor would not then be culpable if these endeavours were unsuccessful.
- The best defences against any retrospective claim that the woman did not fully understand the risks are good communication, interprofessional teamworking and, most of all, meticulous record keeping.
- It is inappropriate to invoke judicial intervention to overrule an informed and competent woman's refusal of a proposed medical treatment, even if it seems to others to be irrational.
- If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment this decision must be respected, even where this may result in the death of the patient and/or the death of an unborn child, whatever the stage of the pregnancy.
- In an emergency (and in the absence of an advance directive) the obstetrician should act in what he or she considers to be the best interests of the woman.
- If the treatment had previously been fully discussed with the now incompetent woman when she was competent and she had refused it, her wishes should be respected, even at the expense of the fetus.
- When an advance directive specifies refusal of treatment during pregnancy this, too, should be honoured.
- If the advance directive does not mention pregnancy, the obstetrician should act in what he or she considers to be the best interests of the woman (and the fetus).
- Legal advice should be sought when the obstetrician has doubt or reservations.
- In all cases, consultation with senior colleagues is advisable and grounds for decisions and actions must be clearly set down.
- Any Court application must be supported by accurate and relevant information about the reasons for the proposed treatment, the risks involved, any alternatives, and the patient's reasons for refusal.
- The patient or her representative must have notice of the proceedings and an opportunity to put her case. The terms of any declaration must be communicated quickly and accurately to the woman.

APPENDIX 1. Legal precedents (in chronological order)

Case 1 1978 *McFall v Shimp*[22]

A man was found to be the only person with compatible bone marrow to save his cousin's life. After some reflection, the first cousin declined to have the tissue removed, even in the knowledge that his cousin would probably die as a result. The issue went to Court. The Court, unsurprisingly, was unwilling to order the removal of the tissue, even though the cousin's moral culpability was criticised heavily. This is a critical distinction. Although a pregnant woman may well have an extremely strong ethical responsibility towards her unborn child, this does not mean that it is correct to use the law to enforce these responsibilities.

Case 2 1988 *Re F (in utero)*[18]

The case concerned a 36-year-old pregnant woman who suffered from severe mental disturbance, accompanied by occasional drug use. Her first son had been the subject of a care order and was being adopted by foster parents. The woman had a nomadic life style and the local authority became concerned when she disappeared from her flat and could not be located. Expressing concern for the welfare of her unborn child, the local authority sought to extend the wardship jurisdiction to the child *in utero*. The Court of Appeal was entirely opposed to this course of action.

Lord Justice Balcombe said, 'Since an unborn child has, *ex hypothesi*, no existence independent of its mother, the only purpose of extending the jurisdiction to include a fetus is to enable the mother's actions to be controlled. ... indeed, that is the purpose of the present application.'

He cited *Lowe*,[38] who gave examples of how such control might operate in practice: 'It would mean, for example, that the mother would be unable to leave the jurisdiction without the Court's consent, the Court being charged to protect the fetus' welfare would surely have to order the mother to stop smoking, imbibing alcohol and indeed any activity which might be hazardous to the child. Taking it to the extreme, were the Court to be faced with saving the baby's life or the mother's, it would surely have to protect the baby's.'

Lord Justice Balcombe went on to consider that another possibility would be that the Court might be asked to order that the baby be delivered by caesarean section. He said: 'it would be intolerable to place a judge in the position of having to make such a decision without any guidance as to the principles on which his decision should be based. If the law is to be extended in this manner, so as to impose control over the mother of an unborn child, where such control may be necessary for the benefit of that child, then under our system of parliamentary democracy, it is for Parliament to decide whether such controls can be imposed and, if so, subject to what limitations or conditions'.

He went on to observe that, in such a sensitive field, affecting as it does the liberty of the individual, it was not for the judiciary to extend the law.

Additionally, Lord Justice May pointed to the 'insuperable difficulties' that would be caused if one sought to enforce any order in respect of an unborn child against its mother, if that mother failed to comply with the order. He said 'I cannot contemplate the Court ordering that this should be done by force, nor indeed is it possible to consider with any equanimity that the Court should seek to enforce an order by committal'. All three of their Lordships stressed that such a drastic extension of wardship jurisdiction to protect the fetus at the expense of the liberty of the mother would be a matter for Parliament. While this statement was not at the heart of the decision in the case, it is fairly persuasive.

Case 3 1992 *Re T (Adult: refusal of treatment)*[11]

T was a 20-year-old woman who was injured in a road traffic accident when she was 34 weeks pregnant. On admission to hospital, her condition deteriorated. T, who had been brought up by her mother as a Jehovah's Witness, stated spontaneously to a nurse that she did not want a blood transfusion, having spent a period of time alone with her mother. T gave birth to a stillborn child. She reiterated her opposition to a blood transfusion. Her condition became critical and she was sedated and placed on a ventilator. Her father, supported by her boyfriend, applied to the Court for a declaration that it would not be unlawful for the hospital to administer a transfusion to her in the absence of her consent.

The Court of Appeal held that an adult patient was entitled to refuse consent to treatment, irrespective of the wisdom of the decision. However, for such refusal to be effective, doctors had to be satisfied that at the time of the refusal the patient's capacity to decide had not been diminished by illness or medication or given on the basis of false assumptions or misinformation, or that the patient's will had not been overborne by another's influence, and that any refusal had been directed to the situation which had become relevant. Only where a patient's refusal was ineffective could doctors treat in accordance with their clinical judgment of the patient's best interests. In T's situation, it was held that the effect of her condition, together with misinformation, rendered her refusal of consent ineffective.

Notwithstanding the outcome for the individual patient, this case affirms a patient's absolute right, properly exercised, to refuse medical treatment.

Lord Donaldson said 'An adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered'.

Lord Justice Butler Sloss said: 'A man or woman of full age and sound understanding may choose to reject medical advice and medical or surgical treatment either partially or in its entirety. A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered'.

Agreeing with the reasoning of the Court of Appeal in Ontario *[T v T 1990]* in which a blood transfusion was given to an unconscious card-carrying Jehovah's Witness, she cited Robbins,[40] who said: 'At issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults ... are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one's body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority'.

Likewise, Lord Justice Staughton said: 'An adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment'.

Case 4 1992 *Re S (Adult: refusal of medical treatment)*[5]

'Mrs S is 30 years of age, she is in labour with her third pregnancy. She was admitted to a hospital last Saturday with ruptured membranes and in spontaneous labour. She has continued in labour since. She is already 6 days overdue beyond the expected date of birth and she has now refused, on religious grounds, to submit herself to a caesarean section operation. She is supported in this by her husband. They are described as 'born again Christians' and are clearly quite sincere in their belief. I have heard the evidence of P, a Fellow of the Royal College of Surgeons, who is in charge of the patient at the hospital. He has

given, succinctly and graphically, a description of the condition of this patient. Her situation is desperately serious, as is also the situation of the as yet unborn child. The child is in what is described as a position of "transverse lie" with the elbow projecting through the cervix and the head being on the right side. There is the gravest risk of a rupture of the uterus if the section is not carried out and the natural labour process is permitted to continue. The evidence of P is that we are concerned with "minutes rather than hours" and that this is a "life and death" situation. He has done his best, as have other surgeons and doctors at the hospital, to persuade the mother that the only means of saving her life, and also I emphasise the life of her unborn child, is to carry out a caesarean section operation. P is emphatic. He says it is absolutely the case that the baby cannot be born alive if a caesarean operation is not carried out. He has described the medical condition. I am not going to go into it in detail because of the pressure of time.'

After proceedings conducted in the absence of legal representation for Mrs S, lasting for under 2 hours, the President granted a declaration authorising treatment. He gave only two justifications for granting the declaration, namely: 'The fundamental question appears to have been left open by Lord Donaldson in *Re T (Adult: refusal of medical treatment)[1992]*[5] and ... there is no English authority which is directly in point'.

He also referred to: 'Some American authority, which suggests that, if this case were being heard in the American Courts, the answer would be likely to be in favour of granting a declaration in these circumstances' and cited *Re AC [1987]*[41] and *[1990]*.[42]

The reliance on the case of *Re AC [1987]*[41] and *[1990]*[42] was both extraordinary and, it has been submitted by a number of legal commentators, wrong. In the Columbia Court of Appeal's decision in *Re AC*, the majority departed from the Court's earlier decision in the case, and ruled that a caesarean section should not have been authorised on AC by the trial Court to save her unborn child. It was held that a full hearing was required involving legal representation of both parties before a Court could contemplate authorising a procedure upon a pregnant woman who was refusing treatment. Rather, the correct approach was for the Court to determine whether the woman was competent, and if so what were her wishes. If she was not competent, the Court should apply a substituted judgment test to decide what she would have wanted in the circumstances. Judge Terry stated in *Re AC* that the woman's wishes would be determinative in virtually all cases. The Court left open whether there might be 'truly extraordinary or compelling reasons' to override the woman's wishes. The only possible justification for Sir Stephen Brown's decision could be an assumption by him that the facts of *Re S [1992]*[5] involved the truly exceptional case.

This seems unlikely, since even in *Re AC*, where the carrying out of a caesarean section was likely to affect the mother's health adversely (the pregnant woman had cancer and died 2 days after the caesarean), Judge Terry stated: 'Some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against the person's will'.

Martha Swartz[43] points out that the decision of the District of Columbia Court of Appeals which overturned the decision in *Re AC* only applied to Washington DC and elsewhere the overwhelming trend has, worryingly, been to override the pregnant woman's objections to treatment. Certainly, Sir Stephen Brown's reliance on *Re AC* has made the *Re S* judgement be regarded with considerable scepticism by legal commentators.

The *Re S* case has not been appealed. There is no legal justification for overriding a competent patient's wishes purportedly in her best interests. Thus, to the extent the declaration in Re S purports to be in the mother's vital interest, this must surely be wrong. The justification provided by the case of *Re F [1990]*[19] applies only in the case of incompetent adults and should certainly not be applied in the case of competent female patients. Indeed, even if the woman were unconscious, *Re F* would only justify treating her if such treatment were in her best interests, either to save her life or to ensure improvement or prevent deterioration in her physical (or mental) health. This would not necessarily justify a caesarean unless it fulfilled the above criteria.

Case 5 1997 *Re MB*[22]

A caesarean section was planned for a footling breech presentation but the appellant withdrew consent in the anaesthetic room because of a fear of needles. The defendant health authority sought a decision from the Courts that it would be lawful to perform the caesarean section. A psychiatrist examined the patient and gave his opinion by telephone jointly to the solicitors for the hospital and the patient. In a telephone hearing that lasted from 9.25pm until 9.55pm, the judge decided that it would be lawful because the patient lacked capacity to decide. By this time, the emergency had abated because she went out of the incipient labour. An appeal was initiated by MB via her solicitors and in a hearing that lasted from 11.30pm until after 1am, the Court of Appeal upheld the decision, albeit reserving judgement. The following day she agreed to the induction of anaesthesia and a healthy male infant was born by operative delivery on that day.

As far as MB herself was concerned the Court of Appeal held:

1. The judge was right to hold that the appellant lacked capacity to consent; although generally she was perfectly competent, at the moment when confronted with the needle in the anaesthetic room, she panicked and for that moment she lacked capacity to take a decision whether or not to consent to the operation;
2. He had to make a finding as to what were the appellant's best interests and on the evidence he had reached a correct finding.

The Court then gave the guidance that was subsequently approved in *Re S* (see Case 6). *Re MB* remains a puzzling decision because it illustrates clearly both the legal principles and the way in which they are likely to be interpreted. At the time when the Court of Appeal decided that MB lacked capacity as a result of a temporary panic brought on by the sight of a needle, she was in fact on an antenatal ward out of sight of any needle. Her refusal was being presented by a QC to whom she was competent to give clear instructions that she did not want to have an operation if it involved a needle.

The Court's analysis of this issue was that she wanted the caesarean section; what she refused was not the surgical incision but only the prick of the anaesthetist's needle; she could not bring herself to undergo the section she desired because her fear of the needle at the moment of panic dominated all her thinking, rendering her incapable of taking any decision at all The Court pointed out that fear of an operation may be a rational reason for refusal; here, it paralysed the will, destroying the capacity to make a decision.

Furthermore, the guidance that in future cases this problem should be detected in the antenatal clinic and brought before the Court before any emergency has arisen implied that this was not an expedient devised for the facts of this case but the way in which such problems should be tackled in the future.

Case 6 1997 *Re Ms B v an NHS Trust*[12]

This was a case in which the main issue was whether Ms B had the capacity to make her own decision about her treatment in hospital. Underlying this important issue was the tragic story of an able and talented woman of 43 years of age who had suffered a devastating illness which had caused her to be tetraplegic and whose expressed wish was not to be kept artificially alive by use of a ventilator. The Court found that she did have capacity. In giving judgement, the Court restated the basic principles and offered additional guidelines in case a similar situation arose. These included the following: 'if there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental incapacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to

cloud their judgement in answering the primary question whether the patient has mental capacity to make the decision'.

Case 7 1998 *St George's Healthcare NHS Trust v S*[6]

Guidelines were given by the Court of Appeal in July 1998, in relation to an appeal in the case of *St George's Healthcare NHS Trust v S*, *R v Collins* and others, *ex parte* S. The case of S had centred on the question of S's competence to decide on treatment, in this case whether or not to undergo the recommended caesarean section to control a case of severe pre-eclampsia. Incorrect submissions to the judge at the time had resulted in a decision to proceed to caesarean section against S's wishes. This decision was subsequently appealed against, being heard approximately 2 years later. The appeal against the decision allowing the caesarean section was allowed.

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These guidelines were produced under the direction of the Ethics Committee of the Royal College of Obstetricians and Gynaecologists, as an educational aid to obstetricians and gynaecologists. These guidelines do not define a standard of care, nor is it intended to dictate an exclusive course of management. Variations of practice taking into account the needs of the individual patient, resources and limitations unique to the institution or type of practice may be appropriate.

Valid until September 2009
unless otherwise indicated