

JERSEY / JUDGMENT

AG v X [2004] JRC 010 (14 January 2004)

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judgment

the DEPUTY bailiff:

Introduction

1. This case raises the issue of whether the prison or hospital authorities may force feed a prisoner who is on hunger strike. The Court heard the application as a matter of urgency on Friday and gave its decision at the conclusion of the hearing. The hearing was in private on the grounds that it involved evidence from medical practitioners as to the mental state of an individual and was therefore similar to applications for the appointment of a curator, which are always held in private. Furthermore similar cases in England appear generally to have protected the identity of the individual concerned. We now give our reasons publicly in view of the general importance of the issues raised. 2. X is aged 53. He is on remand at the prison. He states that he has decided to starve himself to death. He ceased to eat on 18 th December 2003. On 27 th December he ceased to drink. On 31 st December he was admitted to the General Hospital for a period of observation under Article 13 of the Mental Health (Jersey) Law 1969. During his period of admission he agreed to be re-hydrated by way of intravenous saline drip and oral fluids. He said that his reason for doing this was to allow for an assessment of his mental state which, he believed, would confirm that his decision to starve himself to death was not due to any mental illness. He further stated that he would resume his hunger strike once he returned to prison. 3. Following detailed assessment at the hospital X was discharged on 5 th January 2004 and returned to the prison. He immediately recommenced his hunger strike and has taken no fluid or food since then. It is clear that, if he continues with his course of conduct, he will in due course die. 4. On 8 th January, in the presence of his advocate, X signed an Advance Directive in the following terms:- "I, (X) state that if I require treatment either medical or nutritional in the future as a result of my food/ fluid refusal at HM Prison, La Moye, I state that I do not give my consent for any emergency intervention which may be deemed necessary. I accept that as a result of my food and fluid refusal this may cause permanent damage to my health and I understand fully the implications of this Directive. I also understand that if I carry on this action I will die." The last sentence was added in manuscript and his signature was witnessed by his advocate. 5. Faced with this situation the Attorney General brings these proceedings seeking

declarations as to how the prison and hospital authorities should proceed in the event of X continuing with his expressed intention of starving himself to death. In particular they wish for guidance on whether they should force-feed him either now or following the inevitable loss of capacity and consciousness which will occur should he continue. The Law 6. A decision by a person to starve himself to death brings into stark relief two competing principles of the highest order. On the one hand there is the sanctity of life (specifically recognised in Article 2 of the European Convention on Human Rights). The obligation under Article 2 in certain circumstances calls for positive action to safeguard life on the part of the State. On the other hand there is the recognition of the autonomy of the human spirit and the consequent right to self-determination. 7. It would seem from the authorities to which we have been referred that not all jurisdictions have struck the same balance when considering these two competing principles. However in England it would seem that the courts have given greater weight to the need to respect the right of self-determination. 8. In *Re T (adult; refusal of medical treatment)* (1992) 3 All ER 649 the Court of Appeal was faced with an adult woman who refused a blood transfusion but who was feared to be under the undue influence of her mother, a Jehovah's Witness. The case was therefore primarily concerned with whether she had the necessary capacity to decide for herself what treatment she should receive. But the Court of Appeal outlined the general position in clear terms:- "The law requires that an adult patient who is mentally and physically capable of exercising a choice must consent if medical treatment is to be lawful, although the consent need not be in writing and may sometimes be inferred from the patient's conduct in the context of the surrounding circumstances. Treating him without his consent or despite a refusal of consent will constitute the civil wrong of trespass to the person and may constitute a crime. If, however, the patient has made no choice and, when the need for treatment arises, is in no position to make one, e.g. the classic emergency situation with an unconscious patient, the practitioner can lawfully treat the patient in accordance with his clinical judgment of what is in the patient's best interest." (original emphasis). per Lord Donaldson MR at 653.: "This situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient's interest consists of his right to self-determination - his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount." per Lord Donaldson MR at 661.: "Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so notwithstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable." per Lord Donaldson MR at 664. "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 I agree with the reasoning of the Court of Appeal in Ontario in their decision in Mallette -v- Shulman (1990) 72 OR (2d) 417 (a blood transfusion given to an unconscious card-carrying Jehovah's Witness). Robins J A said

- (432) "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, as I have sought to demonstrate, 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 own 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 anatomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority." per Butler-Sloss L J at 664. 9. Re MB (Medical Treatment)
- (1997) 2 FLR 426 was concerned with an adult woman who, although she wanted her baby born, panicked at the last moment because of her needle phobia and refused to consent to the necessary Caesarean section. The Court of Appeal summarised the general position as follows at 432:- (1) "Subject to (3) below, in general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patient's consent..... (2) A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death (3) Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent has been competently given, provided the treatment was a necessity and did no more than was reasonably required in the interests of the patient". 10. Home Secretary-v-Robb
- (1995) 1 All ER 678 was concerned with a prisoner on hunger strike. The prisoner was suffering from a personality disorder indicated not only by repeated criminal offending, addiction to drugs and ambivalence as to his sexual orientation but also by violent tendencies and ill-sustained personal relationships. However all the medical experts were agreed that he was of sound mind and understanding and understood the clinical consequences of his decision. The Home Secretary sought declarations to the effect that the prison authorities could lawfully respect his wishes and abstain from providing him with hydration and nutrition whether by artificial means or otherwise. The court granted the declarations holding that, in England, the principle of the sanctity of human life was seen to yield to the principle of self-determination. Thorpe J said at 680:- "The first principle is that every person's body is inviolate and proof against any form of physical molestation..... Secondly, the principle of self-determination requires that respect must be given to the wishes of the patient. So if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so". At 682 having considered the cases of Thor -v- Superior Court

- (1993) 5 Cal 4th 725 in the Supreme Court of California and *Re Caulk*
- (1984) 125 NH 226 in the Supreme Court of New Hampshire, Thorpe J went on to say:- "It seems to me that within this jurisdiction there is perhaps a stronger emphasis on the right of the individual's self-determination when balance comes to be struck between that right and any countervailing interests of the state. So this decision is not a borderline one: this is a plain case for declaratory relief. The right of the defendant to determine his future is plain. That right is not diminished by his status as a detained prisoner..... Against the specific right of self-determination held by the defendant throughout his sentence there seems to me in this case to be no countervailing state interest to be set in the balance. I have no hesitation in making the declarations in the form ultimately agreed between counsel." 11. Finally in *Re AK (Medical Treatment: Consent)* (2001) 1 FLR 129 the court was faced with the question of how to deal with the express wishes of an adult patient suffering from the advanced stages of motor neurone disease, that his ventilator should be removed at a specific time following the loss of his ability to communicate, with the inevitable consequence that he would die. Hughes J set out the position as follows at 133:- "The law in relation to such a person, an adult of full capacity, is clear. In the case of an adult who has no mental disability and is of sound mind and has the capacity to make his own decision the court has no power to make decisions for him. The relevant principles have many times been set out by the court. They are expressed in the clearest possible terms in the well-known case of *Airedale NHS Trust -v- Bland*
- (1993) AC 789 ,
- (1993) 1 FLR 1026 and in the speeches of all their Lordships in the House of Lords. It is enough to set out Lord Goff's observations at 864C and 1035-1036: 'First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so! A little later: 'To this extent, the principle of the sanctity of human life must yield to the principle of self-determination and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued: see *Nancy B -v- Hotel-Dieu de Quebec* (1992) 86 D. L. R. (4) 385. Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred! I respectfully endorse what is there said, and refer also to the clearest possible expressions of opinion to the same effect in *St George's Health Care Trust -v- S; R -v*

- Collins and Others ex parte S

(1999) Fam 26, (1998) 2 FLR 728, at 40 and 741, a case which demonstrates the vital nature of the principle of autonomy and the manner in which it extends to the case of a pregnant woman who by exercising her right of self-determination puts at grave risk the unborn child she is carrying. Accordingly, the first principle of law which I am satisfied is completely clear, is that in the case of an adult patient of full capacity his refusal to consent to treatment or care must in law be observed. It is clear that in an emergency a doctor is entitled in law to treat by invasive means if necessary a patient who by reason of the emergency is unable to consent, on the grounds that the consent can in those circumstances be assumed. It is, however, also clearly the law that the doctors are not entitled so to act if it is known that the patient, provided he was of sound mind and full capacity, let it be known that he does not consent and that such treatment is against his wishes. To this extent an advance indication of the wishes of a patient of full capacity and sound mind are effective. Care will of course have to be taken to ensure that such anticipatory declarations of wishes still represent the wishes of the patient. Care must be taken to investigate how long ago the expression of wishes was made. All the circumstances in which the expression of wishes was given will of course have to be investigated. In the present case the expressions of AK's decision are recent and are made not on any hypothetical basis but in the fullest possible knowledge of impending reality. I am satisfied that they genuinely represent his considered wishes and should be treated as such." 12. Despite some reservation expressed by Maurice Kay J in *R -v- Collins and Ashworth Hospital Authorities ex p Brady*

(2000) Lloyds L. R. 355 at 367 (para 71-79), the position under English law would seem to be clear. In the case of an adult of full mental capacity, his or her decision to refuse treatment or food and drink must be respected. It is a tortious assault to perform any invasive act by way of treatment or force feeding where such a person has refused consent to such action. 13. We were informed by the Solicitor General that this is the first occasion upon which this issue has fallen for decision in Jersey and accordingly we have quoted at some length from the English cases in order fully to describe the position in that jurisdiction. The Solicitor General submitted that we were not bound to follow those decisions. That is clearly right. It is open to Jersey law to follow a different path. We are a separate jurisdiction. It would appear that some jurisdictions have adopted a different approach and given more weight to the preservation of life as compared with the right of self-determination (see for example the American cases referred to by Thorpe J in *Robb* and the report of Applicant No 10565/83 -v- Germany 7 EHRR 135, an application to the European Commission of Human Rights, from which it appears that, under German law, there is provision for the force feeding of prisoners on hunger strike). 14. However, in matters of this nature, Jersey law has tended to be similar to English law. Furthermore our doctors are usually trained in England and the hospital contains many doctors on short term contract from the United Kingdom. The medical profession in Jersey looks to the British medical professional bodies for guidance in such difficult matters. It would seem

highly undesirable in principle that the duties and obligations of doctors in Jersey should be different from those in England, particularly given that these difficult matters can arise as a matter of emergency. 15. We are in no doubt that we should adopt the principles described in the cases to which we have referred as accurately reflecting the law of Jersey. Accordingly a mentally competent adult with full capacity has an absolute right to refuse to consent to medical treatment or to take food and drink for any reason, or for no reason at all, even where the decision may lead to his or her death. Capacity 16. As the extracts to which we have referred make clear, this principle is only applicable in the case of an adult of full mental capacity. A decision to refuse food and drink or medical treatment such as to be likely to lead to death is clearly a decision of the very first importance. The law therefore requires that the person must have the requisite capacity to take such an important decision. If the person does not have the requisite capacity (by reason of permanent or temporary impairment) doctors are free to treat the person in what they believe to be his best interests. 17. We were referred to three English cases which are helpful in clarifying what is required in order for a person to have the necessary capacity to decide such matters. In *Re T*, Lord Donaldson MR said at 661:- "The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned. However a small minority of the population lack the necessary mental capacity due to mental illness or retarded development..... This is a permanent or a long-term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment. Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. It may not be the simple case of the patient having no capacity because, for example, at that time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the person has the requisite capacity, they are bound by his decision. If not, they are free to treat him in what they believe to be his best interests." 18. The test for establishing the necessary capacity was elaborated by Thorpe J in *Re C* (Adult: refusal of medical treatment) (1994) 1 All ER 819 at 824:- "However, submissions divide over the definition of the capacity which enables an individual to refuse treatment. Mr Gordon argues for what he calls the minimal competence test, which he defines as the capacity to understand in broad terms the nature and effect of the proposed treatment. It is common ground that C has the legal capacity to initiate these proceedings without a next friend within the terms of RSC Ord 80. Mr Gordon contends that the capacity to refuse treatment is no higher and is equally no higher than the capacity to contract. I reject that submission. I think that the question to be decided is whether it has been established that C's capacity is so reduced by his

chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation. I consider helpful Dr Eastman's analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, secondly, believing it and, third, weighing it in the balance to arrive at choice." 19. Finally the Court of Appeal in *Re MB*, having referred with approval to the comments of Thorpe J in *Re C* and to the recommendation of the Law Commission in Law Com No 231 on Mental Incapacity, formulated the position as follows at 436:- "(1) Every person is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted. (2) A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise. (3) Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it. As Kennedy and Grubb *Medical Law* (Butterworths, 2nd edn, 1994) point out, it might be otherwise if a decision is based on a misperception of reality (e.g. the blood is poisoned because it is red). Such a misperception will be more readily accepted to be a disorder of the mind. Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision: (4) A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when: (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. If, as Thorpe J observed in *Re C* (above), a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one. As Lord Cockburn put it in *Banks -v- Goodfellow*

- (1870) LR 5 QB 549, 569: '..... one object may be so forced upon the attention of the invalid as to shut out all others that might require consideration.' (5) The 'temporary factors' mentioned by Lord Donaldson MR in *Re T* (above) (confusion, shock, fatigue, pain or drugs) may completely erode capacity but those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent. (6) Another such influence may be panic induced by fear. Again, careful scrutiny of the evidence is necessary because fear of an operation may be a rational reason for refusal to undergo it.

Fear may also, however, paralyse the will and thus destroy the capacity to make a decision." 20. We adopt the guidance given in these cases as part of Jersey law and the psychiatrists in this case have applied the test set out in *Re C* and *Re MB*. Application to the facts 21. The Court has received reports from Dr G W Blackwood and Dr J Sharkey, consultant psychiatrists to the States of Jersey. Both have also given oral evidence. Both are agreed that X has the necessary mental capacity to decide to refuse food, drink or medical treatment. We can therefore summarise the position briefly, particularly bearing in mind our intention to make this judgment publicly available. 22. X's background is set out in some detail in Dr Blackwood's report. He is described as probably having a dissocial personality disorder as shown by his repeated anti-social acts, social isolation, and inability to learn from experience, difficulty with friendships and close social relationships. It is not uncommon for such patients to find life generally without pleasure and for them to have a general dysphoric unhappy mood state and to move sometimes from general unhappiness into episodes of depressive illness during which their sadness and unhappiness merits a diagnosis of clinical depression. X has previously suffered from periods of amnesia and states that he has no recollection of the incident for which he is on remand at the prison. X was first referred to Dr Blackwood in May 2000 and was diagnosed as suffering from a major depressive illness. Antidepressants were prescribed but they did not have any material impact. Dr Blackwood interviewed X on 8 th January for the purposes of this hearing. X told Dr Blackwood that he wanted to die in a passive way by not eating or drinking. He wanted to do this because, although he was content in prison, he did not want to go out of prison and once again have to face the problems in his life that he had had to face before. They gave him no pleasure, only distress. At the meeting X presented himself as bright with good concentration. Dr Blackwood was of the clear opinion that X was mentally competent to reach his decision to refuse food and drink. Applying the criteria laid down in *Re C* and *Re MB* as described above, X was able to comprehend the information relevant to his decision, he was able to retain that information and believe it and he understood the consequences of his action. He was able to weigh the information which he had received in the balance in reaching his decision. His personality disorder and depression did not impact on his capacity to make that decision. 23. Dr Sharkey saw X on 9 th January. He agreed that X did not suffer from a major mental illness but he had a number of symptoms of mental disorder which fitted within the diagnostic classification of antisocial personality disorder. This explained his long term unhappiness and poor fit within society. He was nevertheless of the clear opinion that X had the necessary capacity to sign an Advance Directive saying that he should be allowed to die by reason of starvation and fluid refusal. In his judgment X was able to retain the necessary information and believed it. He understood the consequences of refusing food and fluid, namely that he would die in a slow fashion with kidney damage and loss of vision. Dr Sharkey was not convinced that X in fact intended to pursue matters to the end and he thought that he would change his mind before he died. However he was clear that X's capacity to decide whether to refuse treatment was not impaired. 24. X also gave evidence before us. Of course we are not qualified psychiatrists, but our assessment

of X was not inconsistent with their clinical judgment and we formed the clear opinion that he knew exactly what he was doing. His explanation as to why he wanted to die was consistent with that which he had given to the psychiatrists. He was aware of the manner in which he would die if he continued with his course of action (i.e. kidney failure etc) and emphasised that he wished to die in this particular manner. 25. However much we might wish that X's decision were different and how ever little we might understand his decision to end his life at this time and in this manner, we are in no doubt, having regard to the evidence of the two psychiatrists, that X has the necessary capacity to reach the decision which he has and to sign the Advance Directive saying that he wishes to be allowed to die by reason of his starvation and fluid refusal and does not consent to emergency treatment in the future. 26. It follows that, applying the law as we have held it to be, we have no alternative but to make the declaration in the form as set out in paragraph 2 of the Representation:- "(i) that the hospital authority and/or the prison authority may lawfully observe and abide by the respondent's refusal to receive nutrition and/or hydration and/or medical treatment; (ii) that the hospital authority and/or the prison authority may lawfully abstain from providing him with nutrition and/or hydration whether by artificial means or otherwise, and/or medical treatment, unless and until he wishes to be provided with the same." It is of course abundantly clear that, should X change his mind at any time and wish to receive food or drink or medical treatment, he may be provided with it forthwith. We all earnestly hope that that will be the case. Nevertheless, if he does not change his mind before he loses the capacity to decide such matters

- and we were told of the likely course of events including confusion and possible hallucinations before he eventually slips into a coma - the Advance Directive will continue to operate even after he has lost the capacity to change his mind. 27. At one stage in the proceedings the Solicitor General sought to confine the declaration to such period as X retained the necessary mental capacity to refuse food, drink or treatment. The making of a declaration in such a form would have enabled the medical authorities to force feed or medically treat the defendant the moment he lost his mental capacity. However, on reflection, she did not maintain this submission and agreed that, if we found that X currently had the necessary capacity, the Court should make a declaration in the form referred to above. We think she was right to do so. It is clear from the observations of Lord Goff cited by Hughes J in *Re AK* (referred to at paragraph 11 above) as well as the observations of Hughes J himself, that an advance refusal of a patient of full capacity and sound mind is effective provided that it is still properly to be regarded as applicable in the circumstances which have subsequently occurred. A classic example would be the Jehovah's Witness who is undergoing an operation and who makes it clear in advance that, no matter what emergency may occur during the course of the operation, no blood transfusion is to be given even if this will result in death. Although, at the time the emergency arises, the patient will be unable to give or refuse consent because he will be unconscious, the previous refusal continues to operate and it would therefore be unlawful for the surgeons to give a blood transfusion, even if necessary to save the patient's life. The Advance Directive in this case is

to similar effect and makes it clear that X wishes his refusal to accept food, drink or medical treatment to continue until he dies. Accordingly, to make a declaration which only covered the position for as long as X retained capacity would in effect be to refuse to give effect to the Advance Directive. This would be inconsistent with the law as we have held it to be. Furthermore it would in theory allow the development of the 'revolving door' referred to by the Solicitor General. X could refuse food and drink until he lost his mental capacity. Thereafter his life could be saved by force feeding or other medical treatment. Once he recovered his mental capacity he could then again insist on his hunger strike, but treatment could again take place once he lost his mental capacity the next time; and so an 'ad infinitum'. 28. For all these reasons, albeit with a heavy heart, the Court declared that X was on 8th and 9th January mentally competent to decide to refuse food, drink and medical treatment and made the further declaration set out at paragraph 27 above. The Court earnestly hopes that X will change his mind and was pleased to note, following enquiries at the conclusion of the case, that all those concerned are making every effort to persuade X not to proceed with his stated course of action. 29. The Court would like to express its appreciation of the preparation and submissions by the Solicitor General and Advocate Juste, carried out at very short notice, as well as its gratitude to Dr Blackwood and Dr Sharkey for their reports, again prepared at very short notice. Postscript 30. The Court was pleased to learn, after preparation of this judgment, that X has now begun to take fluids and we hope that he will continue to do so. Should X again go on hunger strike, it would, at the very least, be highly questionable whether, at that stage, the wishes expressed in the Advance Directive should continue to be regarded as applicable, bearing in mind the cautionary words of Lord Goff and Hughes J referred to in paragraph 27 above. Authorities. Mental Health (Jersey) Law 1969: Article 13. European Convention on Human Rights: Article 2. *Re T* (adult; refusal of medical treatment) (1992) 3 All ER 649. *Re MB* (Medical Treatment)

(1997) 2 FLR 426 . *Home Secretary-v- Robb* (1995) 1 All ER 678. *Thor -v- Superior Court* (1993) 5 Cal 4th 725 (Supreme Court of California). *Re Caulk* (1984) 125 NH 226. *Re AK* (Medical Treatment: Consent)

(2001) 1 FLR 129. *Airedale NHS Trust -v- Bland*

(1993) AC 789 ,

(1993) 1 FLR 1026 . *Nancy B -v- Hotel-Dieu de Quebec* (1992) 86 D. L. R. (4) 385. *St George's Health Care Trust-v-S; R-v-Collins and Others ex parte S*

(1999) Fam 26 , (1998) 2 FLR 728, at 40 and 741. *R -v-Collins and Ashworth Hospital Authorities ex p Brady* (2000) Lloyds L. R. 355 at 367 (para 71-79). *Applicant No 10565/83 -v- Germany* 7 EHRR 135. *Re C* (Adult: refusal of medical treatment) (1994) 1 All ER 819 at 824. *Banks-v- Goodfellow*

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