

# Benevolent Paternalism or a Clash of Values: Motherhood and Refusal of Medical Treatment in Ireland

*Fitzpatrick v. K* [2008] IEHC 104 (25 April 2008)  
(H.Ct) (Ir.)<sup>1</sup>

*Kay Wilson*<sup>2</sup> and *Penelope Weller*<sup>3 4</sup>

## Introduction

The recent decision of the Irish High Court in *Fitzpatrick* is both a typical and an extraordinary case. It is typical in that it reflects a long line of refusal of treatment cases in England that illustrate the reluctance of the courts to respect a patient's choice where the outcome of the decision is unpalatable.<sup>5</sup> It is extraordinary because (i) it arises from unique facts where the outcome of the patient's decision was particularly emotive; (ii) the failure of the patient to take into account the interests of a third party was deemed a critical factor in the judicial finding of a lack of capacity;<sup>6</sup> and (iii) it displays a willingness by the Court to require that 'capacity' is demonstrated by a high level of understanding.

Notably, there were two contradictory approaches in *Fitzpatrick* on the issue of the patient's capacity. At the initial ex parte hearing Mr Justice Abbott granted an order to authorise the hospital to override the

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1. Available at <http://www.bailii.org/ie/cases/IEHC/2008/H104.html> (last visited March 2010)

2. Barrister and Solicitor of Supreme Court of Victoria, Research Assistant, Rethinking Mental Health Laws, Faculty of Law, Monash University, Australia.

3. Postdoctoral Research Fellow, Rethinking Mental Health Laws, Faculty of Law, Monash University, Australia.

4. The authors would like to thank Professor Bernadette McSherry and an anonymous referee for their comments on earlier drafts of this paper.

5. See Alasdair R. Maclean, *Advance Directives and the Rocky Waters of Anticipatory Decision-Making*, 16, *Med. L. Rev* 1 (2008).

6. Mary Donnelly, *The Right of Autonomy in Irish Law*, 14(2) *M.L.J.* 34, 37 (2008).

patient's refusal of a blood transfusion on religious grounds, because the constitutional rights of the patient's baby to be cared for and nurtured by his mother outweighed the rights of the patient to refuse medical treatment. The actual content of the ex parte hearing in relation to the issue of the patient's capacity is controversial. It was not formally reported, the only record being the order itself, a solicitor's note and press coverage. At the subsequent plenary hearing, Ms Justice Laffoy found that Mr Justice Abbott, in making the ex parte order on constitutional grounds, had accepted by implication that the patient was a competent adult. At the plenary hearing, however, Ms Justice Laffoy found that the patient was not a competent adult and upheld the ex parte order based on the patient's lack of capacity. The incapacity finding meant that Her Honour did not consider it necessary to rule on the rights of the patient's baby under the Irish constitution as to do so would "in effect, amount to an advisory judgment on an issue which has been rendered moot by the decision on the capacity question."<sup>7</sup>

The ex parte order "sparked heated debate"<sup>8</sup> in Ireland. Irish commentators were quick to point out that it may have gone too far in departing from *In Re A Ward of Court (Withholding Medical Treatment) (No.2)*<sup>9</sup> which involved the withdrawal of treatment from a near permanent vegetative state (P.V.S) patient (and which is almost identical to the English authority of *Airedale N.H.S Trust v. Bland*).<sup>10</sup> *In Re A Ward of Court* the Irish Supreme Court affirmed the rights of a competent adult to refuse life sustaining treatment. Irish commentators noted that the ex parte order in Fitzpatrick "would find little supporting jurisprudence in modern jurisprudence in other jurisdictions."<sup>11</sup> They also argued that the decision could not be justified by the constitutional obligation of the State to defend the rights of the unborn (Article 40.3.3), because the patient's baby was born so that her decision to refuse blood threatened her own life but not her baby's.<sup>12</sup>

At the plenary hearing the High Court affirmed that patient autonomy is a right protected by Irish law, but validated the ex parte order to administer a blood transfusion on the basis that the patient lacked capacity. The High Court decision was welcomed by Irish commentators as "another aspect of judicial guidance in the on-going discussion of the doctrine of consent".<sup>13</sup> Unlike the ex parte order, however, it has received little critical comment or analysis. This paper will provide an overview of the *Fitzpatrick* case, critically analyse the formulation and application of the capacity test, and compare *Fitzpatrick* with English jurisprudence. The paper concludes with a consideration of the implications of the decision.

## Facts and Judgment

As Ms Justice Laffoy commented near the beginning of the judgment:

"Apparently, this is the first case in which an Irish court has been asked to decide the core issue which underlies these proceedings. It is whether and if so, in what circumstances, a court may intervene in

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7. *Fitzpatrick*, [2008] IEHC at page 34 of that transcript.  
8. *Law Reform Commission, Consultation Paper, bioethics: Advance Care Directives (LRC CP 51-2008) (Ir.)*, para 2.51.  
9. [1996] 2 I.R. 79; Asim A. Sheikh, *Medico-Legal Issues and Patient Autonomy – Here today, Gone tomorrow?* 12(2) M.L.J.I, 54 (2006).  
10. [1993] AC 789 (H.L)

11. *Donnelly*, *supra*, note 6 ,37; Asim. A. Sheikh, *The Right to Life and the Right to Bodily Integrity in Human Rights Law (Brind Moriarty & Eva Massa eds., Oxford University Press 2nd Ed 2008)* 218 -220.  
12. *Donnelly*, *supra* note 6, 37. Sheikh, *supra* note 11 at 219. *Paradoxically, a child may have greater rights in Ireland before it is born than after it is born.*  
13. Asim A. Sheikh, *Issues of Capacity and Consent* 14(2) M.L.J.I, 33 (2008).

the case of a patient, who is an adult and is not *non compos mentis*, who has refused medical treatment.”<sup>14</sup>

The plenary hearing went for 37 days, with the resulting judgment being lengthy and complex.

### Facts

Ms K was a 23 year old asylum-seeker from the Democratic Republic of Congo (DRC). She spoke only French. On 21 September 2006 at around 9.40 am, after a long labour and difficult delivery, Ms K suffered a post-partum haemorrhage, losing 50% to 70% of her blood. When blood was being prepared for immediate transfusion, Ms K told the medical staff for the first time, through her “birth partner” and interpreter Ms F, that she would not take blood because she was a Jehovah’s Witness. Ms K had previously advised the hospital when booking that she was a Roman Catholic. This is because she had indicated on her visa application that she was Roman Catholic and did not want to officially record an inconsistent statement. At the trial, Ms K professed to have, but was unable to produce, an advance directive card refusing a blood transfusion.

After the initial blood loss, Ms K was stabilised without using blood products. The doctors feared that if Ms K bled again she would die if a blood transfusion was not administered. At trial, medical expert evidence differed as to the risk of death attributable to a re-bleeding without a transfusion, with the estimates varying between “better than 50%”<sup>15</sup> and “less than 5%”.<sup>16</sup> Between 9.52 am and 11.30 am, on the morning following the birth, the medical team advised Ms K on at least four occasions that she needed a blood transfusion and without one she would die. Each time she refused. The Hospital Liaison Committee for Jehovah’s Witnesses was contacted by Ms F at about 10.30 am and the hospital received a faxed document entitled “Care plan for women in labour refusing a blood transfusion.” Most of the care plan was implemented, but the medical team considered that the need for a blood transfusion remained urgent. Ms K was then asked by the hospital about her family and the whereabouts of her husband. In what Ms Justice Laffoy subsequently concluded was “the most crucial part of the evidence”<sup>17</sup> Ms K told the hospital that she had no family other than the baby, and that her husband was uncontactable in the DRC. This information was untrue. Ms K’s husband was in Ireland and had in fact been visiting her in the hospital. He was, however, an illegal immigrant and did not wish his whereabouts to be disclosed. Furthermore, Ms K’s birth partner and interpreter Ms F, who was related to her by marriage, was party to the secrecy.

At 11.30am, the most senior obstetrician at the hospital, the Master, was summoned. He again told Ms K that because of the amount of blood she had lost she needed a transfusion or she would die. Ms K again responded “No” (in English), and suggested instead that she be given common remedies to strengthen the body, such as “coke” (referring to the drink Coca Cola), tomatoes, eggs and milk. This response was taken to indicate that she misunderstood the gravity of her condition, prompting the Master to seek advice from the hospital’s solicitors.

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14. Fitzpatrick, [2008] IEHC at page 2 of that transcript. In stating that the patient was “not non compos mentis” it appears that Ms Justice Laffoy simply meant that the patient was fully conscious and stabilised, rather than that she had capacity to refuse treatment as a matter of law: *Id.* page 5 of that transcript.

15. *Id.* at page 28 of that transcript.

16. *Id.* at page 30 of that transcript.

17. *Id.* at page 22 of that transcript.

### **Ex parte application**

At around 12.30pm that day the hospital made an ex parte application to the High Court, brought before Mr Justice Abbott, to give a blood transfusion to Ms K. Ms K was not advised of the application. The application was made on two grounds:

- (i) that the Hospital “while not suggesting that she was incompetent to make the decision...[submitted that]... the question was open to the court as to what extent her refusal was made on the basis of an informed decision”<sup>18</sup> (“the capacity issue”); and
- (ii) whether the rights of Ms K's baby to his mother's care under the Irish Constitution overrode her right to refuse the transfusion (“balancing of rights issue”).

Mr Justice Abbott authorized the hospital to administer the transfusion and take all appropriate steps, including any necessary restraint, based on the balancing of rights issue. That is, His Honour held the constitutional rights of the child to be nurtured and reared by his mother ‘trumped’ the mother's rights to refuse the transfusion. His Honour's findings on the capacity issue are unclear, but he appears to have accepted that Ms. K was competent. Ms Justice Laffoy stated that His Honour's findings were that he “expressed no view on the capacity issue”<sup>19</sup>, but

“on an objective appraisal of the basis which he advanced for making the order, as set out in the attendance note, the only reasonable inference is that Abbott J. was not basing his decision on any concern as to the capacity of Ms K. to make a valid refusal. On the contrary, it is implicit in his statement that he was overriding her decision that he considered her decision [sic] to be legally valid.”<sup>20</sup>

### **Outcome**

At around 2.35 pm, the hospital administered the transfusion and a sedative to Ms K who resisted being transfused against her will. Ms K did not re-bleed as was feared. She made a full recovery and was discharged from hospital with her baby on 28 September 2006.

The ex parte order provided that the matter be returned to the High Court for a plenary hearing.

### **Plenary Hearing**

At the plenary hearing, before Ms Justice Laffoy, the hospital sought declarations that the transfusion was valid. Ms K pleaded that in providing her with the transfusion against her will the hospital had either (1) exceeded the authority of the ex parte order, assuming it was valid, or (2) the ex parte order was a nullity and of no effect and should be set aside. In the event that Ms K successfully challenged the ex parte order, the hospital may have acted unlawfully, and she sought damages for assault, trespass, breach of her constitutional rights and her rights under the *European Convention on Human Rights Act 2003* (“ECHR Act”).

The Attorney-General was named as a co-defendant in the plenary proceeding, but his role was limited to pleading by way of preliminary objection that the balancing of rights issue was moot and ought not be determined.

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18. *Id.* at page 16 of that transcript.

19. *Id.* at page 17 of that transcript.

20. *Id.*

## Decision at the Plenary Hearing

The Court found that Ms K lacked capacity to refuse treatment.

Ms Justice Laffoy accepted that patient autonomy is recognized by the Irish constitutional right to protect the person (Article 40.3.2) and the “unenumerated” right to bodily integrity.<sup>21</sup> Her Honour also accepted that the right of a competent adult to refuse medical treatment was established by the Irish Supreme Court *In re A Ward of Court*.<sup>22</sup> Her Honour was satisfied that Ms K’s refusal was voluntary and that the hospital had provided Ms K with sufficient information to make a valid decision. She concluded that the matter before her turned on the question of capacity.

As there were no Irish authorities on the mental capacity test, Ms Justice Laffoy considered the English authorities.<sup>23</sup> She adopted the following principles:

- that there is a rebuttable presumption of capacity;
- that a patient lacks capacity if by permanent cognitive impairment or temporary factors the patient does not sufficiently understand the nature, purpose and effect of treatment and consequences of accepting or rejecting it;
- that the three-step test in *Re C*<sup>24</sup> is helpful. The patient must:
  - (1) comprehend and retain the treatment information;
  - (2) believe the treatment information and that refusal may lead to death; and
  - (3) weigh the treatment information, alternatives and outcomes;
- treatment information is that which the clinician has a duty to impart;
- there is a need to identify if an irrational decision is made due to misunderstanding or misperception of the treatment information. Irrationality may be evidence of incapacity;
- the capacity assessment must have regard to the gravity of decision and clear evidence is required.

Ms Justice Laffoy applied *Re C* and concluded that in light of all of the evidence available including the consequence that she might die, Ms K failed each limb of the capacity test. That is:

- (a) Ms K did not sufficiently understand and retain the information given to her by the Hospital personnel as to the necessity of the blood transfusion to save her life;
- (b) Ms K did not believe that information and, in particular, that she did not believe that she was likely to die without a blood transfusion being administered; and
- (c) in making her decision to refuse a blood transfusion, Ms K had not properly balanced the risk of death inherent in her decision to refuse the transfusion and its consequences, including its

21. Unenumerated rights are rights that have been recognized by Irish case law as being implicit in the text of the Irish constitution, even though they are not expressed in the Irish Constitution. In *Ryan v. Attorney General* [1965] I.R. 294 different judges derived these implied rights from a natural law theme and Justice Kenny in the High Court considered that they “arise from the Christian and democratic nature of the State.”: Hugh O’Donoghue, *Human Rights and the Irish Constitution*, *Human Rights Law*, *supra* note 11 at 32 (Table 2.4.2).

22. [1996] 2 I.R. 79. (27 July 1995) (Ir.)

23. Ms Justice Laffoy did not consider the Mental Capacity Act 2005 (Eng. & Wales) or its Code of Practice, presumably because it is not binding in Ireland. As stated in note 33 *infra*, however, it is still a significant development in English law that codifies and has influenced the development of the capacity test.

24. *Re C (adult: refusal of medical treatment)* [1994] 2 FCR 151.

consequences for her new-born baby, against the availability of a blood transfusion that would save her life.<sup>25</sup>

It is unclear from the judgment what specific findings of fact lead to these conclusions in the application of each limb of *Re C*. While Her Honour recounts the evidence of each witness in great detail it is difficult to pin-point which factors were critical in making the incapacity finding. However, Her Honour, explicitly states in applying the third limb of the test that she was concerned that Ms K had not properly weighed the consequences for her new-born baby. It seems that Her Honour:

- preferred the evidence of the medical personnel that they were concerned that Ms. K had not properly understood that she needed a blood transfusion or she might die. Essentially, even though the medical team never made a formal capacity assessment, they were not happy with the responses they were getting from Ms. K. (e.g. she was not upset enough at the news she might die) to make them feel comfortable that Ms K understood the gravity of her situation;<sup>26</sup>
- rejected Ms K's own evidence that she knew she was in danger of dying without a transfusion, essentially because she did not "believe" that a transfusion was "necessary" to save her life (e.g. she had some doubts about the after-effects of a transfusion and made the "coke and tomatoes" suggestion as an alternative); and
- Ms K's misrepresentation about her husband's whereabouts raised questions about her credibility and ability to understand the consequences of her decision to refuse blood for her baby's future care.<sup>27</sup>

Ms Justice Laffoy found that the hospital personnel should have doubted and genuinely did doubt Ms K's capacity to give a valid refusal. Her Honour found it instructive to reiterate the factors that were outlined to the court on that day, being:<sup>28</sup>

- Ms K's seriously compromised medical status following a difficult delivery and massive haemorrhage;<sup>29</sup>
- Communications difficulties as Ms K's first language was French;<sup>30</sup>
- The hospital's belief that Ms K had no family in Ireland from whom it could gain assurance of her religion and her understanding of her need for a transfusion;
- The hospital's belief her baby had no traceable kin, including his father; and
- The inconsistency between her disclosure, after the haemorrhage, that she was a Jehovah's Witness with the hospital's understanding that she was a Roman Catholic.

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25. Fitzpatrick, [2008] IEHC at page 34 of that transcript.

26. The doctors were also generally frustrated that Ms. K was refusing their advice. As the Master indicated, Ms K. was not thinking rationally because a rational person would not refuse a transfusion, a sentiment that Ms Justice Laffoy carefully pointed out was not evidence of incapacity: *Id.* at page 31 of that transcript.

27. *Id.* at page 23 of that transcript.

28. *Id.* at page 33 of that transcript.

29. This is the only factor that suggested that Ms K might

have lacked capacity to process the treatment information, although there is no evidence or judicial finding that it actually interfered with her cognitive functioning on the day to the extent that she could not make a decision. The other factors all relate to matters external to Ms. K.

30. This is hard to reconcile with the finding that Ms. F properly communicated the treatment information and that had the hospital obtained a professional interpreter, it probably would not have helped "because obviously the communication difficulties were not limited to linguistic difficulties." *Id.* at page 34 of that transcript.

On the basis of the finding that Ms K lacked capacity, Ms Justice Laffoy found that the transfusion was “necessary” to save Ms K’s life and fell within the scope of what was authorized by the ex parte order because it was appropriate treatment that was medically indicated. Her Honour declined to consider the balancing of rights question.

## Discussion

*Fitzpatrick* illustrates the unresolved tension in the law in distinguishing between an incapacity finding where there is “a misunderstanding or misperception of the treatment information in the decision-making process” (legitimate evidence of incapacity) or “an irrational decision or a decision made for irrational reasons” (irrelevant to capacity).<sup>31</sup>

### (a) Capacity and the test in *Re C*

The test in *Re C* was central to Her Honour’s incapacity finding. While *Re C* is undoubtedly a seminal English case, it is relatively old. Accordingly, Ms Justice Laffoy missed two factors that narrowed the *Re C* test in *Re MB*<sup>32</sup> and the *Mental Capacity Act 2005* (Eng & Wales) (“MCA”).<sup>33</sup> These are that (i) incapacity is limited to cases where there is some impairment or disturbance of in the functioning of the mind or brain; and (ii) the requirement to “believe” the treatment information is omitted from those inabilities listed in *Re MB* and section 3(1) of the MCA as indicative of incapacity.

While Ms K had a difficult delivery with substantial blood loss, there is no evidence that Ms K was medically compromised to such a degree that she had no capacity to decide or that she was suffering from any impairment or disturbance in mental functioning, other than revealing that she was a Jehovah’s Witness at the eleventh hour. By contrast, in England where patients have been found incompetent there is some identifiable factor such as, a needle phobia,<sup>34</sup> belief that their blood is evil,<sup>35</sup> or personality disorder<sup>36</sup> that interfered with their decision-making ability. Even in the adult Jehovah’s Witness cases, the courts have found some basis to show that there were temporary factors that interfered with the adult’s decision-making process, or have overridden the patient’s decision on a basis other than their capacity. For example, *In Re T (Adult: Refusal of Treatment)*<sup>37</sup> Ms T was found to lack capacity due to her accident, illness, being in pain, treatment with drugs and generally being “drowsy, detached and not fully compos mentis.”<sup>38</sup> This together with the undue influence of her mother, misleading information from the hospital about her need for a transfusion and the effectiveness of alternatives to transfusion, was enough to override Ms T’s refusal. In *HE v A Hospital NHS Trust*<sup>39</sup> and *JM v The Board of Management of Saint Vincent’s Hospital*<sup>40</sup> the patient’s refusal was overridden as there was evidence that they were either no longer a Jehovah’s Witness or had only become one on marriage for cultural reasons. Although the hospital was uneasy about Ms K’s lie about her religion, none of these factors were present in

31. *Id.* at page 15 of that transcript.

32. *Re MB (An Adult: Medical Treatment)* [1997] 2 F.C.R. 541, 553 (C.A.).

33. Although the MCA is not binding in Ireland it is an important development in the English Law. As set out in the REPORT OF JOINT COMMITTEE ON THE DRAFT MENTAL CAPACITY BILL, SESSION 2002-03, H.L.189-1, H.C. 1083-1,16, “the draft Bill is designed to codify existing Common Law practice in statute.”

34. *Re MB*, [1997] 2 F.C.R. 541.

35. *NHS Trust v. T (adult patient: refusal of medical treatment)* [2004] EWHC 1279 (Fam); [2004] 3 F.C.R. 297.

36. *R v. Collins, ex parte Brady* 58 BMLR 173.

37. [1993] Fam 95.

38. *Id.* 111.

39. [2003] EWHC 1017 (Fam); [2003] 2 FLR 408.

40. [2003] 1 I.R. 321 (24 October 2002) (Ir.).

*Fitzpatrick*. Indeed, if simply undergoing a traumatic experience were enough to make an incapacity finding, the rights of individuals could be eroded.

As Ms K failed all limbs of the test, the disappearance of the “belief” limb is less significant to the overall incapacity finding. It is, however, the most troublesome aspect of the test. *In Re MM (an adult)*<sup>41</sup> Munby J found the “belief” limb had not so much “dropped off” as been “subsumed” in the more general requirements to understand and use the treatment information. Bartlett, however, argues that an “inability to believe had been part of the common law test for many years prior to the passage of that Act, in cases expressly considered by the Law Commission. Its absence from the MCA cannot be thus viewed as accidental.”<sup>42</sup>

*Fitzpatrick* demonstrates many difficulties with the “belief” limb. First, it is subjective. Ms Justice Laffoy found that Ms K lacked belief in the treatment information, despite her own evidence that “when a doctor tells you that you are going to die, it is not a joke.”<sup>43</sup> Secondly, the strength of the “belief” limb depends on the reasons for non-belief.<sup>44</sup> *Fitzpatrick* was not a case where the patient was suffering from a “compulsive disorder or phobia”<sup>45</sup> preventing her from assessing the treatment information because it did not apply to her. Rather, Ms K assessed the treatment information within an alternative framework – namely that of her religion. Thirdly, the “belief” limb prevents patients from challenging the treatment information or suggesting alternatives. As Bartlett suggests, a lack of belief can become “a euphemism for decay of trust between an individual and his or her carers.”<sup>46</sup> This is evident in *Fitzpatrick*. The doctors had doubts about Ms K’s capacity because she was not reacting to the news that she would die without a transfusion. Ms K’s “coke and tomatoes” suggestion was treated as evidence of incapacity because, it was thought that if she believed that “coke and tomatoes” would save her life, she misunderstood her predicament. However, Ms K’s suggestion did not necessarily mean she did not believe she might die, but rather, not being able to accept a transfusion she simply “proposed what she knew.”<sup>47</sup> As many treatment decisions are uncertain,<sup>48</sup> it is important that patients can question medical advice without impugning their capacity by demonstrating a lack of belief. It was far from certain that Ms. K would die without a transfusion, although her recovery would clearly be much slower without one. The ability to choose between competing medical alternatives is implicit in the principle of free and informed consent.

### **(b) Capacity and Informed Refusal**

At the ex parte hearing the hospital submitted to the court that it was not suggesting that Ms K was incompetent but that “the question was open to the court as to what extent her refusal was made on the basis of an informed decision.”<sup>49</sup> Ms K argued that as the hospital did not suggest that she was incompetent, it did not raise the capacity issue at the ex parte hearing and that the hospital could not raise it in the plenary hearing.<sup>50</sup> Ms Justice Laffoy rejected Ms K’s submission by relying on the hospital’s doubts at the ex parte hearing about the “quality of the refusal” and Mr Justice Abbott’s implied finding that Ms K had capacity.<sup>51</sup> In doing so, Ms Justice Laffoy equates the concept of “capacity” with making

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41. *A Local Authority v. MM* [2007] EWHC 2003 (Fam); [2008] 3 F.C.R. 788.

42. Peter Bartlett, *Capacity, Best Interests and Sex*, *J. Mental Health L. May* 2008 at 85. *The capacity test in the MCA is closely related to the test in Re MB.*

43. *Fitzpatrick*, [2008] IEHC at page 26 of that transcript.

44. Bartlett, *supra*, note 42, 85.

45. *Re MB*, [1997] 2 F.C.R. at 554.

46. Bartlett, *supra* note 42, 85.

47. *Fitzpatrick*, [2008] IEHC at page 27 of that transcript.

48. Shaun O’Keefe, *A Clinician’s Perspective: Issues of Capacity in Care*, 14(2) *M.L.J.I.* 41, 47 (2008).

49. *Fitzpatrick*, [2008] IEHC at page 16 of that transcript.

50. *Id.* page 17 of that transcript.

51. *Id.* page 33 of that transcript.



an “informed” and “valid refusal” and uses those terms interchangeably throughout the judgment. This may be more than mere semantics. It captures the tension between the doctrine of informed consent (a negligence issue) and capacity to consent or refuse treatment (a trespass issue). The difficulty is that while misinforming and withholding information from a patient can vitiate consent,<sup>52</sup> the requirement that a patient give an informed refusal is new. It adds a gloss to the test in *Re C* that undermines the principle that treatment can be refused for reasons that are “rational, irrational, unknown or even non-existent.”

### (c) Capacity, the Irish Constitution and Human Rights

Even though Ms K asserted her rights under the Irish Constitution and ECHR Act, Ms Justice Laffoy only gave those rights scant consideration. In part, this is because those rights arise in relation to the “balancing of rights issue” where Ms K’s rights are balanced against her baby’s, which was deliberately not decided by the judgment. But there is also the issue of how Ms K’s rights are balanced against each other, which is not addressed. While the Attorney-General submitted that the test in *Re C* should be applied taking into account “the panoply of constitutional rights and duties which form the backdrop against which the test must be applied: the rights to life, bodily integrity, privacy, self-determination and freedom to practice religion”<sup>54</sup> it is unclear whether Ms Justice Laffoy accepted that submission.

The only right Ms Justice Laffoy took into account in formulating the capacity test was the right to life. Her Honour held that where the decision to refuse life-saving treatment amounts to a waiver of a person’s constitutional right to life, there should be “clear and convincing proof having regard to the gravity of the decision.”<sup>55</sup> The right to life is the paramount right in Irish law, although it is not absolute. While this could be argued to be merely a reflection of the principle in *Re T*,<sup>56</sup> that doubt should be resolved in favour of preservation of life, if the bar is too high, it may amount to a reversal of the presumption of capacity.

The balancing of Ms K’s other rights seem to have been subsumed into the capacity assessment. Ms Justice Laffoy rejected submissions that “the capacity issue was, in essence, a contrivance which had been created by the Hospital personnel and the reality was that there was no assessment of capacity because it was accepted that Ms K was a Jehovah’s witness who would not take blood, the issue being one of religious belief, not of capacity.”<sup>57</sup> Interestingly, the avoidance of this issue indicates that freedom of religion can only be exercised by patients whose capacity cannot be challenged.

### (d) Capacity and the rights of Ms K’s baby

Ms Justice Laffoy concluded that Ms K had failed the third limb of the test in *Re C* because she had not properly weighed the treatment information “including its consequences for her new-born baby.”<sup>58</sup> While it could be argued that the rights of her baby was only part of the treatment information that Ms K failed to properly weigh, it is the only factor expressly referred to by the court in reaching that conclusion. It is unclear what other factors the court considered that she failed to properly weigh or how she failed to properly weigh them. This suggests that while the legal basis for ordering a transfusion changed from the balancing of rights issue in the ex parte application, to the capacity issue at the plenary hearing, the rights

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52. *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 115.

53. *Id.* 113.

54. Fitzpatrick, [2008] IEHC at page 11 of that transcript.

55. *Id.* at page 13 of that transcript.

56. *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112.

57. Fitzpatrick, [2008] IEHC at page 32 of that transcript.

58. *Id.* at page 33 of that transcript.

of Ms K's baby were still a significant, if not overriding, factor.

However, the incapacity finding may not reflect Ms K's inability to weigh the treatment information, but a failure to weigh it in the way the court thought she should have. That is, Ms K put her spiritual salvation above motherhood. As Dame Butler-Sloss warned in *Re B (adult: refusal of medical treatment)* "the view of the patient may reflect a difference in values rather than an absence of competence."<sup>59</sup>

### **(e) Capacity, Lack of Communication and Cultural factors**

It is likely that the hospital's concerns that Ms K had not properly considered her baby's welfare were more a result of poor communication than incapacity. The hospital never actually asked Ms K what she wanted to happen to her baby if she died. This is a very different question from "tell us about your family." We can only speculate about Ms K's understanding of the operation of social services in Ireland and whether her response would have been different if the hospital had spelt out to her what the consequences would be for her baby if she died without anyone in Ireland to take responsibility for him. We do know that Ms K was concerned that her husband should not be arrested because she considered him to be "the only person who could stay with her baby."<sup>60</sup>

Ms Justice Laffoy is particularly unsympathetic to Ms K regarding her misrepresentations about her religion and the whereabouts of her husband. Her Honour stated that "the situation in which Ms K was transfused against her wishes unfortunately was of her own making."<sup>61</sup> While there is no doubt that these misrepresentations caused inconvenience to the hospital, Ms Justice Laffoy's attitude is surprising. Ms K explained that her misrepresentations were motivated by her fears that if she told the truth it would damage her asylum application and that her husband would be arrested, deported and unable to take care of the baby. Yet, Ms Justice Laffoy dismissed these fears as an irrational response that raised questions about Ms K's credibility and capacity in relation to her understanding of the consequences of her decision to refuse treatment for her baby's future care.

## **Future Implications**

Despite rejecting submissions from Ms K that the ex parte order should be set aside because of defects in the order itself, a lack of full and frank disclosure, and the failure to inform Ms K of the ex parte application, Ms Justice Laffoy recommended that:

- the information required of women when booking into maternity care be improved;
- guidelines be developed for women in labour who refuse transfusions;
- General Medical Council guidelines be developed for assessing capacity and the use of advance directives;
- a legal officer be appointed to perform similar functions to the Official Solicitor in England and Wales; and
- a High Court practice direction be developed for similar cases.<sup>62</sup>

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59. [2002] EWHC 429 (Fam), Para 100 (v).

60. Fitzpatrick, [2008] IEHC at page 23 of that transcript.

61. *Id.* at page 34 of that transcript.

62. *Id.* at page 43 of that transcript.

Innovations such as these will improve maternity care in Ireland. Nevertheless, *Fitzpatrick* is a step back for patients' rights in Ireland. As authority for the principle that a patient can be found incapable for failing to take into account the needs of a third party, it is a significant limitation on patient autonomy. The closest parallel is the English case of *Re E (a minor)*,<sup>63</sup> where a 15 year old Jehovah's Witness refusing a transfusion was held to lack competence as he had not taken into account the horrible manner of his death (of which he had not been informed by his doctors) and his parents' distress in watching him die (even though his parents supported his decision). In that case, E refused treatment when he turned 18 and subsequently died.

Ms Justice Laffoy excused the failure of the hospital to make a formal capacity assessment and to inform Ms K of the ex parte application, based on the "exigencies of the emergency." This indicates that after *Fitzpatrick*, a patient's rights to be informed of proceedings and be properly assessed, even though he or she is fully conscious and stabilised, may be diminished in situations that are time pressured but fall short of an immediate emergency.

The issue of advance directives did not arise on the facts as Ms K never produced one. However, given that the case turns on Ms K's capacity on the morning she gave birth, one can only speculate whether the result may have been different had Ms K produced an advance directive card refusing the transfusion and specifying that it was applicable following the birth of a child. Patients would be well advised to put in place an anticipatory refusal, as a contemporaneous refusal may be overridden if a hospital doubts or a court finds that the patient lacks capacity on the day.

*Fitzpatrick* comes at a time of continuing law reform in Ireland related to bioethical issues in the *Law Reform Commissions Third Programme of Law Reform 2008-2014*. The recent Law Reform Commission Consultation Paper *Bioethics: Advance Care Directives* (LRC CP 51-2008) refers to *Fitzpatrick*, noting that guidance on the issue of capacity is warranted for healthcare decisions. It recommends that "statutory codes of practice be formulated to guide healthcare professionals when assessing the capacity of the individual."<sup>64</sup>

This, in conjunction with the suggestions for the future made by Ms Justice Laffoy in *Fitzpatrick* itself, while falling short of the detailed procedural guidelines the English Courts have developed in *Re MB*<sup>65</sup> and *St George's Healthcare NHS Trust v S*,<sup>66</sup> may be a starting point for law reform based on the lessons learned from *Fitzpatrick*.

## Conclusion

While a patient's right to refuse medical treatment is well established in England and Ireland as a legal principle, *Fitzpatrick* provides an example of how "brittle"<sup>67</sup> this right can be in practice, especially where a patient makes what seems like a morally repugnant decision to people who do not share the patient's religious beliefs. The incapacity finding in *Fitzpatrick* helped to avoid: (i) the embarrassment (and liability to the hospital) of setting aside an ex parte order of the court to transfuse the patient without her consent; and (ii) creating a precedent on whether the baby's rights to the care of his mother outweighed

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63. [1993] 1 FLR 386.

64. See pages 80-81, para 3.33.

65. [1997] 2 F.C.R 541, 561.

66. [1999] Fam 26, 63 (C.A.).

67. Maclean, *supra* note 5, 3.

her rights to autonomy, bodily integrity and religious freedom. In doing so, the Court did not consider the broader social context or the possibility of injustice to the patient. While it could be argued that *Fitzpatrick* is an extreme case, the boundaries of the law are set by extreme cases. Time will tell whether *Fitzpatrick* is confined to its extraordinary facts and the extent to which it will shape law reform in Ireland and elsewhere in striking a balance between benevolent paternalism, clashing values and maternal autonomy.