***St George's Health Care NHS Trust v SR v Collins and others ex parte S***

Although the case of *St George's Health Care NHS Trust v S, R v Collins and others ex parte S*[1] reiterates general principles of patient autonomy and self-determination, it is of special significance for women because of its unequivocal affirmation that a competent pregnant woman can refuse medical treatment even if that refusal may result in harm to her or the foetus.[2] It also establishes that mental health legislation cannot be used to prevent a competent pregnant woman from exercising this right. In confirming that the right of an adult of sound mind to refuse any or all medical treatment 'reflects the autonomy of each individual and the right of self-determination',[3] the Court of Appeal held that

> while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment…an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights.[4]

*St George's Health Care Trust v S, R v Collins and others ex parte S* thus addresses three important issues: first, a pregnant woman's right to decline medical treatment even where this may harm her unborn child; second, that this right is not diminished because her decision to exercise it contravenes societal expectations of pregnant women or appears morally repugnant; and third, mental health legislation cannot be deployed to detain and treat an individual against her will merely because her thinking process is unusual or even bizarre, irrational, and contrary to the views of most people. In the case of a pregnant woman, the fact that her thinking may result in harm to her unborn baby does not mean that she must therefore be mentally disordered.

**Context**

Historically, women have existed in the domain of the 'private', especially in relation to pregnancy and motherhood. Often this meant that the voices and experiences of pregnant women were silenced or minimised. There is a long association of female reproduction with weakness or 'hysteria', which was said to show that women were unfit to participate in the

---

[1] [1999] Fam 26.
[2] Ibid, 43.
[3] Ibid.
[4] Ibid, 50.

'public', masculine world.[5] The view that pregnant women should surrender decision-making to doctors and that women's own experiences and preferences were less important than the opinions of the medical profession persisted into the twentieth century, as expressed in particularly extreme form in a 1980s handbook on pregnancy:

> why do women have to recount such stories to one another, especially when the majority of them are so blatantly untrue … Probably more is done by wicked women with their malicious lying tongues to harm the confidence and happiness of pregnant woman than by another other single factor.[6]

Hostility to the notion that women may wish to have some control over their experience of pregnancy and childbirth is reflected in attitudes to the capacity of pregnant women to make decisions about their own bodies. The law presumes that every adult is competent provided she is able to understand and retain information and weigh it as part of the process of arriving at the decision.[7] The presumption is not displaced simply because a decision is not one of which most people would approve, nor is it rebutted simply because a person has a mental illness. Nevertheless, pregnant women often find themselves absorbed into a medical process in which it is assumed that they will defer to the expertise of those treating them. This expectation of deference is bolstered by prevailing expectations of how pregnant women should behave – as captured in Anne Morris' discussion of the Victorian poem 'Angel in the House', which praises the 'sublime altruism of one whose desires are subordinated to the happiness of others'.[8] A pregnant woman is expected to do all she can to promote the welfare of the foetus. Those women who fail to do this have been labelled 'bizarre,'[9] 'not very bright',[10] 'difficult',[11], 'angry … and uncooperative[12] or simply mad or bad mothers.[13] In other words, a woman's refusal to follow medical advice is taken not just as an indication of a

---

[5] Anne Oakley, *Women Confined: Towards a Sociology of Childbirth* (Martin Robertson, 1980); Jo Murphy-Lawless, "The Silencing of Women in Childbirth: Or Let's Hear It for Bartholomew and the Boys," (1988) 11 (4) *Women's Studies International Forum,* 293.
[6] Gordon Bourne, *Pregnancy* (Cassell, 1984), 15.
[7] *Re C (Adult, refusal of treatment)* [1994] 1 All ER 819 and see now Mental Capacity Act 2005, s. 1(2).
[8] Anne Morris, 'The Angel in the House: Altruism, Competence and the Pregnant Woman,' in *Well Women: The Gendered Nature of Health Care Provision*, (eds A Morris and S Nott Ashgate, 2002).
[9] *St George's Healthcare Trust v S* [1999] Fam 26*,* 51.
[10] *Re MB (An adult: medical treatment)* [1997] 2 FCR 541, 546.
[11] *Whitehouse v Jordan* [1981] 1 WLR 246, 250.
[12] Julia Burrows, 'The Parturient Woman: Can There Be Room for More Than 'One Person with Full and Equal Rights inside a Single Human Skin?' (2001) 33 (5) *Journal of Advanced Nursing*, 693.
[13] See eg Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Hart, 2001), 135.

lack of proper femininity, but also as a lack of competence.[14] In 1996, in *Rochdale Healthcare NHS Trust v C*, Johnson J held that the 'acute emotional stress and physical strain' of labour rendered C incapable of making a decision even of the most trivial kind.[15] This was despite the fact that C had refused a caesarean based on her previous bad experience of such intervention, and that her obstetrician was of the opinion that she was competent to refuse.

A further challenge to women's control over their bodies and their pregnancies has been the increasing medicalisation of pregnancy and childbirth, which has accompanied a shift from childbirth at home to delivery in hospital, and from midwifery to obstetrics.[16] While the increased availability of free ante-natal care and hospital delivery following the creation of the NHS in 1948 was an important factor in reducing maternal mortality rates, Anne Oakley suggests that that the move from midwife-managed home delivery to delivery by obstetricians in hospitals was not simply due to social and medical advancement but was part of a power struggle over the language, control and cultural construction of childbirth. Oakley argues that assumption of control of pregnancy and childbirth by doctors in the second half of the twentieth century was accompanied by a side-lining and denigration of midwives who were represented as 'half taught' or 'totally ignorant'.[17] Increased medical control of pregnancy has been accompanied by its 'pathologisation': treating pregnancy as illness with imminent complications.[18] Pregnant women undergo (usually very willingly) tests, scans and screenings which can enhance the experience of pregnancy and be life-saving, but which may also lead to an increased number of interventions. Deliveries by caesarean section, for example, have risen from four per cent of births in 1970 to 26.5 per cent in 2014-15 in England.[19]

**The Landmark**

The socio-historical context sheds light on why the question of pregnant women's autonomy became so highly contested in *St George's Healthcare NHS Trust v S;* and why S's refusal to

---

[14] Sheena Meredith, *Policing Pregnancy: The Law and Ethics of Obstetric Conflict* (Ashgate, 2005).

[15] *Rochdale Healthcare (N.H.S.) Trust v. C.* [1997] 1 F.C.R. 274, 275.

[16] Oakley, n 5, 12; Jackson, n 13, 119-136. In 1955, 33 percent of births were in the home. In 2006, the rate was 2.7 per cent: Home Births in the UK, 1955 – 2006, Andrea Nove et al, Population Trends No. 133, Office for National Statistics. The rate is fairly stable.

[17] Oakley, n 5.

[18] Jackson, n 13, 120.

[19] NHS Maternity Statistics – England: http://content.digital.nhs.uk/catalogue/PUB19127/nhs-mate-eng-2014-15-summ-repo-rep.pdf, accessed 21/01/17.

have a caesarean section presented such a strong challenge to the dominant assumptions that regulate pregnancy and labour.

S was 29 years old and 36 weeks pregnant when on 25 April 1996 she sought to register at a doctor's surgery having not received any previous ante-natal care. She was diagnosed with pre-eclampsia, a condition that can endanger the life of the woman and foetus. S declined the recommended treatment, which included an early induced delivery. Her refusal led to her immediate compulsory detention in hospital under section 2 of the Mental Health Act 1983 for assessment because it was feared that her mental state 'may be compromising her ability to make decisions' and that she was 'probably depressed'. In the face of her continuing refusal to consent to treatment, an application was made to the High Court by the hospital for a declaration that it would be lawful to proceed with a caesarean section without her consent.

The Court did not hear from S even though she had instructed solicitors and had expressed very clearly in writing that she understood the risks of pre-eclampsia, but that she had always held 'very strong views' with respect to medical and surgical treatment and opposed medical intervention in her pregnancy. She emphasised her own strong belief that 'natural events', including death, should not be interfered with.

At the hearing, however, the fact that S had instructed solicitors was not made clear, nor were S's solicitors made aware of the proceedings. The judge was informed that S was suffering from severe pre-eclampsia, that she had been admitted to hospital under section 2 of the Mental Health Act 1983, that an assessment of her mental and psychiatric condition was 'ongoing', that 'moderate depression' had been diagnosed, and that she was refusing any intervention. Beyond that, the question of her capacity to consent was not addressed. It was also – mistakenly – claimed that S had been in labour for 24 hours, when in fact labour had not yet begun.

Permission to perform a caesarean section was granted and S was delivered of a baby girl by emergency caesarean section. While not resisting sedation or anesthetisation, S refused to sign the operation consent form and so it proceeded on the basis of the court order.
Several months after these events, S applied for judicial review of the High Court order, arguing that her admission, detention and treatment were unlawful. She also appealed against

the declaration authorising the caesarean section. The Court of Appeal found in her favour in all aspects. In relation to her detention under the Mental Health Act 1983, it was held that

> The [Mental Health] Act cannot be deployed to achieve the detention of an individual against her will merely because her thinking process is unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large.[20]

The Court noted that the approach taken to S by those around her had been that it was so bizarre for a pregnant woman to refuse treatment for herself and the foetus that she had to be mentally ill. Under the Mental Health Act, however, compulsory detention for assessment is lawful only where certain conditions are met and, in particular, the mental disorder must be serious enough to warrant detention. Here, it was clear that detention had occurred not because of S's supposed mental disorder, but because of her physical condition (pre-eclampsia). If she had not been pregnant and physically unwell, there would have been no question of detaining her under the Act. Her detention was therefore unlawful. As far as the non-consensual treatment was concerned, the Court upheld the right of a competent adult to refuse even life-saving treatment. This extends to pregnant women even though 'pregnancy increased the personal responsibilities of a woman'.[21] The needs of the unborn child do not 'prevail over her right not to be forced to submit to an invasion of her body against her will' and that right 'was not reduced or diminished merely because her decision to exercise it might appear morally repugnant'.[22] In the absence of lawful justification, removal of the baby from within S's body under physical compulsion was an infringement of her autonomy and a trespass to her person.

**What Happened Next**

Five days after the emergency caesarean, S discharged herself from hospital. Initially, she rejected her baby and considered having her adopted or fostered. However, she later reconsidered, fought for, and won custody of her daughter.[23] In part, it was this battle for custody, which led to the lengthy delay between S's detention and the Appeal Court hearing.

---

[20] [1999] Fam 26, 38.
[21] Ibid, 50.
[22] Ibid.
[23] The Independent, 15 March 1997; http://www.independent.co.uk/news/appeal-on-forced-birth-is-refused-1272883.html

The Appeal Court's judgment itself was generally well-received, with a leader in the *Independent* newspaper proclaiming it a 'loud clear blast on the trumpet of liberty from the Court of Appeal.'[24] The paper went on to say that 'women have been bullied and coerced into Caesareans and hysterectomies to an extent which is an affront to the liberal values of a civilised society.' Of course, one judicial decision is not going to bring about a sudden transformation of attitudes to pregnant women. Indeed, *St George's Heathcare NHS Trust* v S had been foreshadowed by an earlier Court of Appeal decision in *Re MB*[25] in which the Court had again asserted the right of a pregnant woman to refuse treatment but then went on to find that MB was lacking in capacity because of her phobia of needles. The Courts have continued to authorise caesarean sections on non-consenting women, including those who are compulsorily detained under the Mental Health Act 1983.[26] Moreover, despite policies which aim to put the woman at the heart of maternity care, and national guidance which states that 'women's decisions should be respected, even when this is contrary to the views of the healthcare professional',[27] women are not always listened to. One survey suggested that only 50 per cent of women questioned felt they had experienced the birth they wanted.[28] It is undeniable that pregnancy and childbirth remains a contested sphere.

**Significance**

What then is the significance of St George's *Health Care NHS Trust v S*? First, it should be noted that the case is not primarily about the rights and wrongs of medical intervention in pregnancy. Nobody would suggest that women would be better off without the life-saving technologies and procedures to which women in the developed world have access. Nor would it be fair to overlook the fact that those involved in this case were motivated by what they saw as the interests of the woman and her foetus. Rather, the legacy of *St George's Healthcare NHS Trust v S* is the clear statement that a pregnant woman is not be treated as incapable of making a decision *simply* because she chooses something that many would judge to be misguided, or even immoral. Equally important is the finding that competent pregnant

---

[24] The Independent, 7 May 1998;http://www.independent.co.uk/voices/leading-article-judges-strike-a-blow-for-freedom-1160736.html
[25] [1997] 2 FCR 541.
[26] See e.g. *Re AA (Mental Capacity: Enforced Caesarean)* [2012 EWHC 4378, [2014] 2 FLR 237.
[27] National Institute for Health and Care Excellence: Antenatal care for uncomplicated pregnancies, Clinical Guideline [CG62] (2008), 1.1.1.7. See also NICE Clinical Guidelines [CG132] (2011), 1.2.9.5 on choosing a planned C-Section.
[28] Dignity in Childbirth: The Dignity Survey 2013, (Birthrights), 7; http://www.birthrights.org.uk/wordpress/wp-content/uploads/2013/10/Birthrights-Dignity-Survey.pdf

women may not be detained under mental health legislation in order to be compulsorily treated for a physical rather than a mental condition.

The case sets out clear markers against which court-authorised caesareans must be tested and affirms the autonomy of the pregnant women in medical decision-making. It also highlights the importance of listening to women and involving them in the decision-making processes during pregnancy and childbirth. The ongoing influence of the case can be seen in *Montgomery v Lanarkshire Health Board (General Medical Council intervening)*. Here, an obstetrician took the view that it was not 'in the maternal interests for women to have caesarean sections', and failed to offer a women with a high-risk pregnancy a caesarean section, despite the risks of vaginal delivery.[29] In her judgment Lady Hale commented that the doctor seemed to have judged that vaginal delivery was 'morally preferable' to caesarean section. Referring to *St George's* she held:

> A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the "natural" and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide … There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby. She cannot force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.[30]

This shows the positive impact of the landmark decision, but it should not be overlooked that the Court of Appeal in *St George's Healthcare Trust NHS Trust v S* did not suggest that S's refusal of treatment was to be condoned or approved. This is important because the historical context of pregnancy, maternity and motherhood continues to influence views and attitudes going far beyond the issue of non-consensual caesarean sections. Campaigns concerned with

[29] [2015] UKSC 11, [2015] AC 1430.
[30] Ibid, [114]-[116]

foetal rights, abortion, new technologies, IVF and surrogacy have all raised issues of decision-making, autonomy and capacity. Lady Hale noted in *Montgomery*:

> Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.[31]

The decision in *St George's Trust v S* remains a landmark because it insists that we are vigilant in ensuring that women are not silenced or side-lined within their own experiences of pregnancy and childbirth.


**Further Reading**

Jackson, Emily *Regulating Reproduction: Law, Technology and Autonomy*. Oxford: Hart, 2001.

Morris, Anne. "The Angel in the House: Altruism, Competence and the Pregnant Woman." In *Well Women: The Gendered Nature of Health Care Provision*, edited by A Morris and S Nott.

Oakley, Ann. *Essays on Women, Medicine and Health*. Edinburgh: Edinburgh University Press, 1993.

**Statues**

Mental Capacity Act 2005

**Cases**

*Montgomery v Lanarkshire Health Board (General Medical Council intervening)* [2015] UKSC 11, [2015] AC 1430.

*Re AA (Mental Capacity: Enforced Caesarean)* [2012] EWHC 4378, [2014] 2 FLR 237.

*Re C (Adult, refusal of treatment)* [1994] 1 All ER 819

*Re MB* [1997] 2 FCR 541.

*Rochdale Healthcare (N.H.S.) Trust v. C.* [1997] 1 F.C.R. 274

*St George's Health Care NHS Trust v SR v Collins and others ex parte* S [1999] Fam 26.


[31] Ibid [116]