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Transfer to hospital under the Mental Capacity Act 2005

SUMMARY

This paper presents the case of an elderly gentleman who sustained a fractured neck of femur following a fall at home but refused to go to hospital. His general practitioner determined that he lacked capacity but ambulance and police crews refused to escort him due to

concerns regarding deprivation of liberty.

The legal grounds for treating people who lack capacity in emergencies are discussed and the development of the common law into the Mental Capacity Act 2005 is demonstrated. The Mental Health Act 1983 is inappropriate to treat

primarily physical conditions, whereas deprivation of liberty cannot be authorised by the Mental Capacity Act 2005 without a means of challenging the lawfulness of the detention. In response, the government has produced Deprivation of Liberty Safeguards, which came into force in April 2009.

We (C.H. and C.S.) were involved in the transfer of an acutely confused elderly gentleman who lived alone, had become acutely immobile secondary to a fractured neck of femur and was refusing to go to hospital. The man lacked capacity but attempts to transfer him to hospital under the Mental Capacity Act 2005 failed when ambulance and police crews refused to take him, due to concerns regarding an unlawful deprivation of liberty in the absence of detention under the Mental Health Act 1983. This paper proposes to outline the historical and current legal frameworks for treating incapacitated patients without consent in emergencies.

Common law

Prior to the Mental Capacity Act 2005, health and social care could be provided to non-consensual incapacitated patients with the authority of the common law doctrine of necessity.

Remarkably, before 1987 the legality of treating incapacitated patients had not been questioned. However, with the rise of litigation and criminal proceedings, doctors felt increasingly vulnerable in regard to treating or not treating patients without consent and sought declarations from the judiciary regarding the lawfulness of proposed actions.¹

In 1989, Lord Brandon in *F v. West Berkshire Health Authority*² declared that a doctor 'can lawfully operate on, or give other treatment to, adult patients who are incapable for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of the patient.' Lord Goff elaborated the doctrine of necessity, saying that 'to fall within the principle, not only, (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.'²

Best interests

There are difficulties with regard to the interpretation of 'best interests'. In *F v. West Berkshire Health Authority*,

the Lords applied the Bolam test,³ which states that the proposed action is lawful if it conforms to a reasonable and competent body of professional opinion. The test proves inadequate, however, where professional opinion is divided. The concept of best interests has subsequently been defined in terms of intolerability,⁴ practicability,⁵ a balance of pros and cons,⁶ whether the proposed action is therapeutic rather than prophylactic,¹ the inclusion of the interests of third parties,⁷ and more widely to include emotional and other issues.⁶

The objectivity of best interests⁴ has therefore not gone unchallenged. The idea of providing a precise definition of the meaning of best interests has been rejected on the basis that it would be impossible for a single definition to capture all the relevant factors in an individual case.⁸

Nonetheless, a duty to preserve life is enshrined in both the common law⁴ and Article 2 of the European Convention on Human Rights. In the case of an incapacitated patient who resists being taken to hospital for a physical disorder, where the treatment of the physical disorder cannot be delivered at home, the common law doctrine of necessity provided authority for an appropriate degree of force to be used to take the patient to hospital.⁹

The problem with common law arises in regard to interpretation and the application of common law declarations in similar situations.¹⁰ This problem is particularly highlighted in the case of *Re L* where the Law Lords could not agree whether L was detained or not and if so, whether it was lawful.¹¹ The Law Commission proposed that best interests need to be determined using verifiable criteria.¹

Mental Capacity Act

The Mental Capacity Act has sought to codify in statute the principles of common law and thereby it supersedes the common law.¹² Common law does not remain an alternative to statutory powers, other than where statute has not provided the necessary powers.¹¹ It will be necessary, however, to look at the old common law 'not only in order to understand the legislative provisions, but also – as the Act does not expressly overrule any



common law principles – in order to provide guidance as to future decision-making carried out under the provisions contained in the Act.⁸

Section 1(2) of the Mental Capacity Act emphasises that attempts to maximise the decision-making capacity of a person must be made. If it is reasonably believed a person lacks capacity in making a decision about going to hospital, however, Sections 5 and 6 of the Mental Capacity Act allow for patients to be restrained and escorted to hospital^{13,14} and provided with medical treatment if it is in their best interests and is a proportionate response to the risk of harm. This applies even if it involves a restriction of the person's liberty.¹⁴

Best interests as defined by the Act

The concept of best interests has been modified to accommodate the deficiencies of the common law. Not only does the Mental Capacity Act require the past and present wishes, feelings, beliefs and values to be taken into consideration, following consultation from individuals best placed to advise regarding the views of the patient and make judgements about their welfare, legal authority has also been conferred onto valid advance decisions and proxy decision makers. In order for an advance decision to refuse life sustaining treatment to be valid, however, there must be a statement in writing (signed and witnessed) to the effect that it applies to specific treatment even if the person's life is at risk.

Restraint and deprivation of liberty

The Mental Capacity Act Section 6(5) does not allow for restraint, or other care or treatment, which would involve a deprivation of liberty under Article 5 of the European Convention on Human Rights, although a temporary deprivation for a short period in order to respond to an emergency would not constitute a violation of Article 5.¹⁴

Restraint is defined as the use or the threat of the use of force to secure an act which the patient resists, or which restricts the patient's liberty of movement whether or not the patient resists.¹⁴ According to Section 6(7) of the Mental Capacity Act, 'nothing stops a person' from 'providing life sustaining treatment' which involves 'doing any act which he reasonably believes to be necessary to prevent a serious deterioration in the patient's condition'. Indeed, within best interest principles, there is a duty of care to prolong life.

There is no clear definition of what constitutes a deprivation of liberty. The Mental Capacity Act Code of Practice (6.52) sets out the view of the European Court of Human Rights, stating that the difference between restriction and deprivation is 'one of degree or intensity, not one of nature or substance.' Necessity and deprivation are not mutually exclusive. Whether an act amounts to deprivation will depend on the particular circumstances of the case and will consider the type of care being given, how long it lasts, the effects of treatment and the way a particular situation came about.

In the absence of a statutory legal test, relevant European and domestic case law has sought to establish what may or may not constitute a deprivation. Benign force used to take a confused patient to hospital would not, by itself, constitute a deprivation of liberty, although it may contribute.¹⁴ Furthermore, given that the provision of any medical treatment to an incapacitated patient necessarily involves the clinician assuming complete control of that treatment, it is further argued, there would be no deprivation of liberty unless the control extended to the patient's movements.¹⁴

The *Mental Capacity Act 2005 Code of Practice Deprivation of Liberty Safeguards Draft Addendum to the MCA 2005 Code of Practice*¹⁵ acknowledges that 'there will be occasions when people who lack capacity to consent to admission are taken to hospital for treatment of physical illnesses or injuries and may be cared for in circumstances that amount to deprivation of liberty.' The Mental Capacity Act Code of Practice (13.12, 13.14) advises that the Mental Health Act should be considered if a patient needs to be restrained in a way that is not allowed under the Mental Capacity Act, but the Mental Health Act is not an option if the patient's mental disorder does not justify detention in hospital or the patient needs treatment only for a physical illness or disability.¹³

It was appropriate to transfer our confused immobile patient under the Mental Capacity Act. The level of restraint required was proportionate to his injury and risk of deterioration if he was left at home. In the event that his care and treatment in hospital amounted to a deprivation of liberty, the government had issued interim advice¹⁶ until the Deprivation of Liberty Safeguards¹⁷ were made available in April 2009.

The Safeguards (paragraph 1.9) make no distinction between depriving an incapacitated person of their liberty for the purpose of treating them for a physical or mental disorder. Transportation to hospital in an emergency will not amount to a deprivation of liberty, although a particularly long journey or the requirement of more than restraint may (2.14, 2.15). There will be times when people who lack capacity to consent to admission for treatment of physical illnesses and injuries will be cared for in circumstances that amount to a deprivation of liberty. The Deprivation of Liberty Safeguards will therefore apply to acute hospital settings as well as social care homes and mental health units.

Where a deprivation of liberty does occur, it will be the responsibility of the hospital or care home to apply to the supervisory body, which will be the commissioners of care and in most circumstances the primary care trust or local health board. In emergencies, the hospital or care home has the authority to issue an urgent authorisation, pending a standard authorisation from the supervisory body which must be obtained within the next 7 days (paragraphs 3.1–3.3).

The assessment for an authorisation of deprivation of liberty is rigorous. A minimum of two assessors are required to establish the patient's age, mental capacity, mental health, best interests and that a valid advance directive or decision by a deputy or donee and the Mental



Health Act do not apply. The assessors must have no conflict of interest. In the event that an authorisation is not provided, the provision of life-sustaining treatment can be continued pending a decision by the Court of Protection. Furthermore, although an independent mental capacity advocate can be invoked to assist where there is doubt regarding certain healthcare decisions, this is not required in emergencies.¹

An urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed (6.3). Such a situation might be expected where a person who lacks capacity to make a decision about their care and treatment has developed a mental disorder as a result of physical illness, and the physical illness requires treatment in hospital in circumstances that amount to a deprivation of liberty, but the treatment is expected to lead to rapid resolution of the mental disorder. Furthermore, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency department and it is anticipated that within a few days they will no longer be in that environment (6.4).

It is likely that our patient was suffering a delirium secondary to his chest infection and fractured neck of femur. Assuming that he did not succumb to his physical illness, it would be anticipated that his delirium would improve within days with appropriate treatment. The necessary course of action would be to reassess his capacity. In the event that his capacity did not return as expected and there remained concerns regarding his deprivation of liberty, an authorisation could then be sought from the supervisory body.

Conclusion

It might be envisaged that there will be instances whereby health professionals, and particularly police and ambulance personnel who actively participate in the restraint and transportation of patients to hospital, feel vulnerable to the perceived relative lack of protection afforded by the Mental Capacity Act, until more experience of the Act and a body of case law helps to clarify individual situations. Mental Health Act assessments may

be requested but pressure to make applications should be resisted when the Mental Capacity Act is clearly appropriate.

Declaration of interest

None.

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