Managing patients without their consent: a guide to recent legislation

Patients who do not consent to treatment are frequently encountered in the general hospital setting. Issues of personal autonomy, best interests, mental health and capacity need to be carefully considered in these cases. This article summarizes recent changes in the law governing the management of patients who do not, or cannot, consent.

Clinicians often encounter patients who do not consent to be treated. In a psychiatric setting this is most commonly because they explicitly refuse treatment, often because they do not consider themselves to be ill. In the general hospital patients may be unable to consent because they lack capacity, the most common reasons being unconsciousness, delirium, severe intoxication and fear, among countless others.

Until 2008 the doctrine of common law allowed staff to manage patients lacking capacity. Interventions considered to be in a patient's best interests, which a majority of doctors would provide in similar circumstances, could be undertaken without consent [Bolam v Friern Hospital Management Committee 1957]. The Mental Capacity Act 2005 (implemented in 2008) replaces common law in these cases. It defines capacity and how to determine whether it is present or not, and it provides a framework for providing care when capacity is absent. In addition the Act defines a greater role for the next of kin, and sets out how advance directives can be drawn up by a patient who may lack capacity in the future.

Many clinicians remain uncertain, however, about the difference between capacity legislation and the Mental Health Act 2007 which also came into force in 2008. On-call psychiatrists are frequently asked to assess capacity, often based on the misunderstanding that only the Mental Health Act can prevent a patient without capacity from leaving hospital or refusing urgent care. Similarly, should a patient require physical restraint, staff may believe that only the Mental Health Act permits this.

Even as clinicians become familiar with the new legislation, an amendment to the Mental Capacity Act 2005 became law in April 2009: the Deprivation of Liberty Safeguards. These define how to manage a group of highly vulnerable patients whose treatment has previously risked breaching human rights legislation.

In this brief review of the legislation, the important features will be highlighted in a practical guide for use in common clinical scenarios.

What is capacity?

Capacity is always presumed to be present, unless it has been specifically assessed as absent. A patient's age, general state of health, psychiatric history and level of intellectual functioning should not indicate a lack of capacity, nor should decisions which seem imprudent to clinicians. The only way to determine if capacity is absent is to assess it specifically (Church and Watts, 2007). All doctors should be able to assess capacity, and indeed knowledge of specific risks and benefits of proposed management is required in order to do this, along with an understanding of the likely outcomes without treatment.

To have capacity, a patient must be able to:

1. Understand the information relevant to making the decision
2. Retain that information for long enough to weigh up the options
3. Use the information in a process of weighing up the options
4. Communicate the decision he or she has reached.

In practice this means the patient must demonstrate that he/she understands the risks and benefits both of receiving and declining treatment. All efforts must be made to facilitate the four processes listed above: information must be given in a form appropriate to the patient's language and intellectual level.

Capacity must only be assessed in relation to a particular decision at a particular point in time; lacking capacity in relation to one decision does not imply it is lacking in relation to another. The disturbance to mental function that reduces capacity may be permanent or temporary, global or highly specific.

There is no dedicated paperwork associated with the Mental Capacity Act; clear documentation in the patient's notes is needed, explaining how the clinicians decided that the patient lacks capacity.

What if the patient lacks capacity?

Absence of capacity does not necessarily require further action; it becomes important only where treatment decisions are necessary. Then the treating team must decide whether to delay treatment, hoping the patient will regain capacity, or provide treatment without consent. Clinicians must do what they can to allow the patient to participate in the decision, and this might require spe-

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cific interventions to improve capacity. However, the patient's best interests remain paramount; if delaying the decision could harm the patient, then a decision on the patient's behalf may be necessary (*Case example 1*).

In making this decision, clinicians must consider several factors:

- What the patient may chose if he/she did have capacity
- Any wishes or preferences stated by the patient in the past
- The wishes and opinions of the patient's relatives and carers.

'Consideration' of the above does not mean that decisions should be dictated by these factors, but they should be borne in mind when the complex issues of a patient's 'best interests' are decided.

Restraining a patient under the Mental Capacity Act 2005

The Act does not define how treatment can be delivered if management proceeds in a patient's best interests without consent. This means patients can be prevented from leaving hospital and even physically restrained if this is necessary for providing care. This is probably the part of the Act most unfamiliar to clinicians and security staff; there is understandable anxiety about being accused of assault, and misconceptions that restraint is only permissible under the Mental Health Act.

The Mental Capacity Act defines restraint as being a situation when a doctor 'uses, or threatens to use, force to secure the doing of an act which P [the patient] resists, or restricts P's liberty of movement, whether or not P resists'. Restraint is permitted if the doctor 'reasonably believes that it is necessary to do the act in order to prevent harm' to the patient. The mechanism of restraint needs to be proportionate both to the likelihood and the seriousness of harm coming to the patient.

With care to ensure the criteria above are fulfilled, restraint is allowed when unavoidable and in the patient's best interests. National Institute for Health and Clinical Excellence (NICE) has published guidelines on the use of rapid tranquillization which may be relevant in these cases (National Institute for Health and Clinical Excellence, 2005). The circumstances of restraint should be documented in the patient's notes, and consideration should be given as to whether the patient's ongoing management requires Deprivation of Liberty Safeguards.

Case Example 1

A 72-year-old man with a 40-year history of paranoid schizophrenia is admitted to a medical ward with confusion and disorientation. Investigations show a left lower lobe pneumonia, and he requires intravenous antibiotics. However, he becomes agitated on the ward, trying to leave his bed area and head for the exit. The nursing staff manage to calm him down and he returns to his bed, but he appears profoundly confused, thinking he is in his parents' home, and asking to speak to his mother who died many years ago. The doctors try at length to explain his situation and obtain consent for his treatment in hospital, but he is unable to understand the nature of his illness or the consequences of refusing treatment. The patient does not appear to be psychotic, and the GP confirms that the patient is compliant with medication and has been free from psychotic symptoms for a long time.

The most appropriate next step in this patient's management is to treat the patient in hospital without consent under the Mental Capacity Act 2005. He has an acute delirium caused by his pneumonia, and this is a disturbance in the functioning of the mind as set out in the Mental Capacity Act. As he cannot retain and process the information relating to his illness, he lacks capacity to consent and is therefore liable to treatment under the Mental Capacity Act. The seriousness of his condition indicates it is in his best interests to receive treatment without his consent. In the case outlined above, the patient would not come under the Deprivation of Liberty Safeguards as it can be argued that his liberty is being restricted rather than deprived. The patient is not liable to be sectioned under the Mental Health Act as his schizophrenia is in remission: this is not the illness for which he requires treatment in hospital.

Deprivation of Liberty Safeguards

In 1997 a man with autism and severe learning disability was an inpatient in Bournewood Hospital; he was assessed as lacking capacity and was accommodated at the unit under common law, without use of the Mental Health Act. The European Court of Human Rights ruled in 2004 that this breached Article 5 of the Human Rights Act (the right to liberty). There has subsequently been uncertainty on how to manage a patient who lacks capacity to consent to treatment, but does not actively refuse it or attempt to leave hospital. Deprivation of Liberty Safeguards have been introduced to close the so-called 'Bournewood gap' (Department of Health, 2007).

The Safeguards apply to a particular group of patients: those who suffer from a disorder or disability of mind, and who lack capacity to consent to treatment, and who need to be deprived of their right to liberty to protect them from harm, for example by accommodating them in a hospital or care home. The majority have severe dementia or learning disability. In circumstances when the Mental Health Act would apply, it should be used over and above the Mental Capacity Act for these patients.

An important distinction exists between the terms deprivation and restriction of liberty. Deprivation of Liberty Safeguards only apply to cases where deprivation occurs, and this is extremely hard to define, differing from restriction only by degree (Ministry of Justice, 2008). An example would be where a patient is accommodated permanently in a care home, with restrictions on his or her movement and contact with others. Therefore in most cases of short-term hospital-based treatment, Deprivation of Liberty Safeguards will not apply as liberty is restricted rather than deprived, but each case can be discussed with the local Trust legal advisors for guidance where necessary.

If circumstances arise where Deprivation of Liberty Safeguards should apply to a patient in hospital, the

Trust must make an application to the local primary care trust, which will undertake a formal Deprivation of Liberty Safeguards assessment, as set out in the Department of Health (2007) briefing paper.

Lasting powers of attorney and advance decisions

Lasting powers of attorney form part of the Mental Capacity Act 2005. These allow people, when they do have capacity, to appoint someone (who becomes their attorney) to take decisions should they lose capacity in the future. A 'personal welfare lasting power of attorney' allows the attorney to make decisions about health and personal welfare, and a 'property and affairs lasting power of attorney' relates to financial dealings. This means that all treatment decisions for an incapacitated patient with a personal welfare lasting power of attorney need to be taken on the patient's behalf by the attorney. A decision by the attorney is like a decision taken by the patient him-/herself, meaning the attorney can refuse treatment on the patient's behalf. The exception is 'life-sustaining treatment', unless this has been expressly specified in the patient's lasting power of attorney document. The Court of Protection can arbitrate in situations when the attorney and clinicians disagree.

The Mental Capacity Act 2005 also allows patients to make advance decisions about treatment they wish to refuse in a future situation when they lack capacity. Except for treatment which is life sustaining, the advance directive does not need to be in writing, and it is for the clinician to decide whether or not the advance directive is valid. This means it must have been made when capacity was present, and it must relate to the treatment now being considered. Where an advance directive is in place, it has the same force as if the patient explicitly refused the treatment.

For decisions concerning life-sustaining treatment, the same conditions apply except the directive must be recorded in writing with a witness present. Examples include a wish not to receive a blood transfusion in the case of haemorrhage, or cardiopulmonary resuscitation in the case of cardiac arrest.

The Mental Health Act 2007

The Mental Health Act 2007 differs significantly from the legislation above. The Act defines circumstances in which patients may be admitted to hospital, detained in hospital, and treated for a mental illness without their consent. The two crucial differences from the Mental Capacity Act are that only mental illnesses are covered, and it is usually not necessary to take capacity into account. The most important sections of the Act for hospital doctors are sections 2, 3 and 5.

Section 2 permits admission to hospital for assessment of a mental illness (*Case example 2*). It lasts up to 28 days, after which the patient can be discharged or placed on a longer-lasting section. To implement a section 2, two doctors must assess the patient and make recommendations for detention. The grounds are that:

- The patient suffers from a mental illness
- There is a risk to the patient's health, to his/her safety or to the safety of others if the patient is not the subject of specialist assessment
- This assessment cannot safely take place outside of a hospital
- The patient refuses to consent to be in hospital voluntarily.

One of these doctors must be certified as 'section 12 approved', usually a senior psychiatrist. The doctors submit their recommendations to an Approved Mental Health Act Practitioner (the majority are specialist social workers) and if the Approved Mental Health Act Practitioner agrees with the doctors, the patient is then sectioned. Special forms exist for all three practitioners to record their recommendations.

Section 3 is similar, but is used for treating patients who do not need a period of assessment before a diagnosis and treatment plan are determined. It lasts up to 6 months, and may be renewed after this time. The process of applying for section 3 is largely the same as for section 2.

Section 5(2) is the part of the Act most relevant to general hospital doctors. It is an emergency 'holding order' which allows an inpatient on any hospital ward

Case Example 2

A 20-year-old woman has jumped from a second floor window, sustaining multiple fractures to her legs. In the accident and emergency department she is extremely agitated, singing loudly, swearing irritably at staff and speaking very rapidly. She also appears to be responding to hallucinations. The psychiatrist on call reviews the patient's mental state and diagnoses an acute manic episode; the orthopaedic surgeons determine she requires admission for surgical management of her fractures. When they try to explain her fractures and the need for surgery, she replies that she can not have broken legs because she is indestructible and feels no pain. She says she jumped out of the window because she can fly. She refuses all offers of treatment for her fractures or her mental state.

The most appropriate next step in this patient's management is to section her under the Mental Health Act to manage her mania, and treat her fractures under the Mental Capacity Act. In this more complex case, the patient requires treatment for two separate conditions: her mental illness, which has caused a serious act of self harm, and the physical injuries following this. Under the Mental Health Act, she fulfils criteria for a section 2, as she has a mental illness, and its degree is such that she poses a grave danger to herself. As she refuses treatment, she should be sectioned so that assessment and treatment can take place. The section will not, however, give any authority to treat her fractures: although these were caused by her mental illness, they are not considered a part of it, and they require their own management. The issue then is whether she has the capacity to refuse or consent to this treatment. Since she demonstrates delusional ideas about being indestructible, she can be considered unable to process the information she is told about her injuries, and as such she lacks capacity. Any management of the fractures will therefore need to proceed under the Mental Capacity Act. She is therefore liable to treatment under both pieces of legislation.

(including medical and surgical wards) to be detained there so an assessment for section 2 or section 3 can take place. The criteria are that a patient who appears to be suffering from a mental illness ought to be detained for the safety of him-/herself or others.

Section 5(2) lasts up to 72 hours, and can be applied to a patient by any doctor who is treating the patient – it does not require input from a psychiatrist. Special forms need to be filled out in order to place a patient under section 5(2), and doctors are advised to know where these are kept. Section 5(2) only applies to inpatients: a patient seen in the community, in clinic or in accident and emergency cannot be placed under section 5(2).

The issue of capacity is not considered in the Mental Health Act 2007 – only consent is assessed. There is considerable debate over this, with some arguing that the principles of autonomy applied to medically unwell patients should not be denied those with mental illnesses (Richardson, 2007). A study suggested that a majority of patients sectioned under the Mental Health Act do lack capacity (Owen et al, 2008), but nevertheless in most circumstances the Mental Health Act 'trumps' the Mental Capacity Act, including any advance decisions to refuse treatment.

The Mental Health Act 2007 applies only to the assessment and treatment of mental illness. Coexisting physical illnesses are not covered by the Act: assessment or treatment of these can proceed only with the patient's consent, or under the conditions of the Mental Capacity Act 2005.

KEY POINTS

- Patients in general hospitals who refuse consent to treatment are common.
- Where a patient lacks capacity to consent, there are circumstances where the Mental Capacity Act provides a framework for treatment without consent.
- Lasting powers of attorney and advance decisions can be made by patients at a time when they have capacity, and clinicians must take these into account when determining if treatment is lawful.
- The Mental Health Act may be applicable to patients with a mental illness who refuse treatment and whose illness places themselves or others at risk, but cannot be used to treat physical health problems.

Conclusions

This article has provided a brief review of the newly introduced Mental Capacity Act 2005 and the recently revised Mental Health Act 2007, which in clinical practice may be confused. In both cases they provide a framework for treating a patient who does not give consent for the treatment proposed for them. The Mental Capacity Act permits treatment against the patient's will only if the patient lacks capacity to consent. The Mental Health Act does not require an assessment of capacity, only that a patient suffering from a mental illness is likely to suffer harm or harm someone else if he/she is not detained in hospital. As such their distinctions are clear in most circumstances of common clinical practice within a general hospital. **BJHM**

Conflict of interest: none.

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