Safeguarding the rights of patients who lack capacity in general hospitals. Do the Bournewood proposals for England and Wales help or hinder?

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The UK government has now published its intentions for England and Wales regarding the Bournewood judgement. This concerns the many people who lack the capacity to consent to admission to hospitals or care homes, and who are, in effect, prevented from leaving, even when they do not object to remaining. In 2005, the European Court of Human Rights held that this could constitute deprivation of liberty under Article 5 of the European Convention on Human Rights. Detention of ‘persons of unsound mind’ is permitted, but only when appropriate standards and right of appeal are in place.

The government has not yet published draft legislation, but has indicated its intention to amend the Mental Capacity Act, 2005 [1]. This will require hospital and care home staff to identify, at the time of admission (or later if circumstances change), whether an individual lacks capacity, and assess if their liberty might be defined as deprived. The Mental Health Act (MHA), 1983, should be used if its criteria apply (suffering from treatable mental disorder, and a danger to him- or herself, or others) and the person objects to admission (or staying) [1]. Otherwise, the hospital must apply to a ‘supervisory body’ (Primary Care Trust or Local Authority in England or the National Assembly for Wales) for authorisation to accommodate the individual (arrangements for Scotland and Northern Ireland are not yet published). The supervisory body will obtain assessments of the person’s capacity and best interests, and will determine if detention is required to prevent harm, and is a proportionate response to the harm prevented. The hospital must reapply if circumstances change, and patients or relatives can appeal. In an emergency, the hospital can admit with immediate effect, but must apply for authorisation within 7 days.

The impact of the Bournewood amendments on general hospitals is potentially substantial. Many people with delirium, dementia, severe aphasia, or in coma are admitted to hospital, but lack the capacity to consent to admission. Clinicians will understandably wish to ensure that patients do not leave hospital in advance of recovery or the setting up of appropriate community support. Currently, clinicians rely on lack of objection to allow implementation of sensible and pragmatic solutions to a patient’s problems. All may now require ‘authorisation’ to remain in hospital. Moreover, the provisions may apply in unexpected places. For example, all people sedated in an intensive care unit lack capacity and are not free to leave by definition. Applications for authorisation would be legally required for such patients, despite clear ‘common sense’ arguments to the contrary.

The new provisions will increase the use of the MHA. The current MHA Code of Practice recommends avoiding it if an individual lacking capacity does not object to informal admission. The proposals require the use of the MHA when individuals ‘object or would object, if they were in a position to do so’ [1]. Managing patients detained under the MHA will be a new departure for general hospitals, and something previous judgements in the Bournewood case were at pains to avoid. It is far from obvious that this is desirable. The most significant safeguard of the MHA is the Review Tribunal, which is instigated by the patient. Ill in-patients lacking capacity are unlikely to do so. These people may end up with fewer protections than similar patients who did not object.

The process itself will be demanding. Staff will have to assess the capacity, assess deprivation of liberty, document decisions, apply for authorisation, prepare documentation for the various assessments commissioned by the supervisory body, monitor patients’ status, and constantly reassess...
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for changes requiring reapplication or rescinding of authorisation. In addition, the MHA imposes duties on the responsible medical officers, in this case the general hospital consultants, for detained people under their care.

For people with cognitive impairment, or those who are acutely medically ill, assessment of capacity is fraught with difficulty. To have the capacity to consent to an intervention, a person must, in broad terms, be able to understand its nature, purpose and consequences, including adverse effects and the consequences of refusal. They must be able to retain this information, weigh it up and use it to make a decision, and then communicate this decision. In the context of acute illness, challenges will include gaining attention and interest, judging the quantity of information to be imparted, and assessing how much has been understood or retained. Furthermore, capacity assessments will be complicated by fluctuations in the level of consciousness and cognitive function characteristic of delirium. What is clear is that physicians will have to assess and document the capacity much more thoroughly and systematically than ever before. Structured assessment tools may have to be developed to aid the process.

Deprivation of liberty is also difficult to assess. The proposals set out a series of factors to be taken into account in deciding on potential deprivation of liberty. These include freedom to move around or leave the facility, participation in the decision to admit, consultation with family or friends, the influence a person or family and friends have in the arrangements made for care and treatment and whether there is freedom to choose whether to receive different treatments, limitations on visits or contacts, and the timescale of imposed limitations and reviews.

A distinction is made between ‘deprivation’ and ‘restriction’ of liberty. However, under the proposed guidelines, anyone whom we might hesitate to allow to leave may be classified as potentially deprived of their liberty. The guidance suggests that physical incapacity, such that the individual ‘could not effect egress under their own volition’ (the case for many seriously ill medical and trauma patients) will fall within the definition of deprivation of liberty. Where doubt exists, the amendments require that an application to the supervisory body be made. Clinicians familiar with today’s in-patient populations will find it hard to agree with the Department of Health that the provisions will only apply infrequently.

The proposals raise some awkward questions about service provision. Many people with dementia are admitted because of breakdowns in social care, or remain in hospital after a treated illness while awaiting arrangements to be put in place for community or institutional care. In-patient services may feel that there is no compelling reason to deprive those persons of their liberty, and that this no longer represents their best interests (although it may be a better option than an unsafe discharge home without support). It is unclear what procedures will be followed if an application for authorisation is not made, is withdrawn, or is refused in these circumstances. A duty of care to make satisfactory alternative arrangements still exists.

On the positive side, the proposals may prompt doctors to define more carefully what in-patient care is for, what good it does, and what cannot be done elsewhere, framing it more as a service than a reluctant last resort. The reason for many admissions is that someone outside the hospital (relative, general practitioner or care worker) thinks that the hospital is a safe and suitable place to be in. The new procedures will sharpen thinking as to what purpose is served by admission. Furthermore, there will now, in effect, be a legal process to ensure that care home placement is the best option. Pressure from relatives, or failure to explore less restrictive home care possibilities, will no longer be sufficient.

Health care law has a long tradition of recognising actions in ‘good faith’ and has placed considerable emphasis on ‘common sense’. It is to be hoped that the Mental Capacity Act Code of Practice will facilitate sensible, consensual procedures for most cases. However, the implications of the current proposals are potentially substantial and, at a time when resources in hospitals are more under pressure than ever before, may represent a considerable unanticipated burden.

Reference