

## THE COSHE REPORT ON THE MANAGEMENT OF VIOLENT PATIENTS

### Counsel's Opinion

*Note by the Registrar:* In September 1977 the Confederation of Health Service Employees (COHSE) published a Report on *The Management of Violent or Potentially Violent Patients*. This publication was welcomed by the College and comments were prepared and published in the *Bulletin* for July 1978 (p 123). In the Report reference was made to 'compulsory treatment without consent', and COHSE stated that it had received legal advice to the effect that such treatment may be unlawful. Because of our concern that such a view might render it impossible to treat certain patients the College decided to obtain further legal advice and arranged for C. S. C. S. Clarke, Esq., Q.C., to prepare the Opinion which is published below. The first part refers to patients detained under Sections 25, 26, 29 and 30 of the Mental Health Act 1959, and the second to patients who are dealt with under Section 60 of the same Act, where similar considerations apply.

Counsel's Opinion does not deal with the treatment of those informal patients who may not be able to give informed consent. Such patients are, of course, to be found not only in psychiatric hospitals but in geriatric and ordinary medical and surgical wards, and the College intends to pursue consideration of this question in conjunction with other Colleges and professional organisations.

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*Registrar*

1. I am asked to advise the Royal College of Psychiatrists whether or not it is lawful to administer treatment to patients compulsorily, i.e. without their consent, and, if so, in what circumstances. The question arises in the light of the Report of the Confederation of Health Service Employees which states that compulsory treatment is probably unlawful and recommends that the Confederation's members should under no circumstances participate in it.

2. There are two types of patient in question. Firstly there are those who are admitted to hospital of their own volition—the so-called informal patients. Their rights must be determined by the common law, for there are no relevant statutory provisions other than Section 5 of the Mental Health Act, 1959 which itself confers no powers which bear upon the question as to whether they may be compulsorily treated. Secondly, there are those who are admitted pursuant to Sections 25, 26, 29 and 30 of the Mental Health Act, 1959 in respect of whom different considerations may, and in my opinion do, apply.

#### 3. *Informal patients*

The English decided cases are singularly sparse and inconclusive. What follows must, therefore, necessarily represent a view as to how the Courts are likely to deal with questions that arise in the light of existing legal principles. That for the most part they have not so far had to do so is a measure of how in practice the good sense of the profession has prevented contentious disputation on the legal right to treat or be treated.

4. Medical treatment may give rise to civil or criminal consequences. In the civil law such treatment is *prima facie* a trespass to the person constituting an assault followed by battery, i.e. the direct application of physical force or constraint to the person. No wrong is committed unless the act in question was done intentionally or negligently: *Letang v. Cooper* [1965] 1 Q.B. 232. But this is of no matter since inadvertent non-negligent treatment is a virtual impossibility. In the criminal law medical treatment may amount to any one of the offences against the person from common assault to manslaughter. Further, an agreement to effect unlawful treatment may amount to a conspiracy.

Whether medical treatment can successfully be made the subject of criminal or civil proceedings must, therefore, depend upon the defences open to the person who gives it. That, in 1978, the principle should be formulated in this way (i.e. by holding something *prima facie* unlawful subject to defences) may seem curious; but it is so because historically trespass to the person is the form of action by which the Courts have enforced the vital common law right to bodily integrity, just as trespass to goods enforces the right of ownership.

The following defences may arise:

- (i) necessity;
- (ii) self-defence or the defence of others or the defence of someone from himself;
- (iii) consent;
  - (a) express;
  - (b) implied;
  - (c) by third parties duly authorized.

### 5. *Necessity*

No relevant English case assists except by analogy. But, in my view, the Court is likely to hold, in line with the Canadian cases, that a doctor or psychiatrist is justified in an emergency in performing an operation or giving treatment without consent when that is necessary for the purpose of saving life or preserving the health of the patient and when it would be unreasonable to postpone the treatment in order to seek to obtain the consent of the patient. This principle would not apply if it was merely more convenient to perform the treatment on the occasion in question rather than to postpone. The principle derives from *Marshall v. Curry* [1933] 3 D.L.R. 260 and *Murray v. McMurchy* [1949] 2 D.L.R. 442. I agree with the opinion expressed by P. D. G. Skegg in an article in the *Modern Law Review* of October 1974 entitled 'A Justification for Medical Procedures Performed Without Consent' that the English Courts may be expected to provide a justification at least as broad as the principle set out about.

The circumstances in which this defence may arise must necessarily be limited. The obvious type of example is the discovery in the course of a routine surgical operation of a malignant growth which requires instant operation. I forbear from any further discussion of the principle because it can, it seems to me, have little application in the case of an informal psychiatric patient. Cases where it may be necessary as a matter of emergency to restrain a patient from harming others may be dealt with under the heading referred to below. Other cases more appropriately fall within the purview of Sections 25 and 26 of the Mental Health Act, 1959. Residual cases not covered by either classification may exist, but they must, I think, be limited in number.

### 6. *Self-defence or the defence of others*

It is lawful to use reasonable force (including, for instance, sedation) to prevent injury reasonably anticipated to oneself from a patient or to prevent a patient harming other staff or patients. It is also, in my view, lawful to use reasonable force to prevent a patient from committing suicide. Indeed, a hospital will owe a general duty of care to all its patients (a duty the fulfilment of which may be the more onerous in proportion to the diminution of the patient's mental capacity: *Glasgow Corporation v. Taylor* [1922] 1 A.C. 44). The fulfilment of that duty may require that reasonable steps are taken to supervise a patient to ensure that he does no injury to himself or to others, even if that means forcible restraint.

However, I am of opinion that where an informal patient displays symptoms which make it difficult for the hospital to fulfil their duty of care to him without forcibly treating or detaining him, then, in the absence of an effective consent, an application should be made under Section 30 of the Act.

### 7. *Express consent*

That a doctor commits no crime or tort if without negligence he performs an ordinary surgical operation or gives ordinary treatment to a person of sound mind who consents thereto is clear. The proposition that consent discharges from liability is not, however, limitless. In *R. v. Cone* [1882] 8 Q.B.D. 534 Stephen J. said:

'When one person is indicted for inflicting personal injury upon another, the consent of the person who sustains the injury is no defence to the person who inflicts the injury if the injury is of such a nature or is inflicted under such circumstances that its infliction is injurious to the public as well as to the person injured.'

It may, therefore, be that there is a class of treatment which is of such a nature that consent is not a defence to any criminal charge that may be made. It is difficult to think of a form of treatment which any conscientious practitioner might use which would fall into that category, but there may be a residual class of treatment so suspect or so lacking in benefit to the patient that, even with his consent, it would be a crime to effect it. But provided the treatment is of a type which is reasonable in relation to the disorder of the patient and is consented to by a patient who is properly capable of consent no action or charge will properly lie. But this principle is of only limited assistance in the case of patients who are mentally ill, since the very unsoundness of mind from which they suffer may prevent them from giving an effective consent.

### 8. *Implied consent*

The notion of 'implied consent' is a legal fiction upon which it is, in my opinion, unsafe to rely. It is also a confusing phrase. It is sometimes put forward as the theoretical basis for rendering lawful an emergency operation upon a patient who cannot consent (e.g. because he is unconscious). But the notion that a man who is unconscious impliedly consents to anything is artificial and such an operation can be better justified on other grounds. The alternative way in which implied consent may be said to arise is where a patient so conducts himself as to make it clear to the person who is treating him, even though without express words of consent, that he does consent to the

treatment. If, for example, a patient presents himself a second time for the treatment of a particular disorder it may be that he can be said by his conduct to consent to the repetition of any previous treatment that he may have had for the same disorder. But that is, if anything, an express consent to be inferred from his conduct. For practical purposes it seems to me that the notion of 'implied consent' is dangerous to use and should not be relied upon.

#### 9 *The consent of others*

In some circumstances the power to consent may have been lawfully delegated to others. There may be some cases where the patient has authorized someone else to consent on his behalf. They would be rare and would need particular scrutiny, but there is nothing in theory to prevent a man or woman from authorizing someone else to consent or dissent on his behalf. In other circumstances third parties may be authorized by law to give consent. Thus, the local authority to whom care of a child has been committed by a Juvenile Court may give such consent, and it may be, although I entertain some doubt about the matter, that the Court of Protection would be entitled so to do. Difficult problems, which lie outside the scope of this Advice arise in relation to parents who purport to give consent to treatment of their children. Authority is sparse. Skegg, in an article entitled 'Consent to Medical Procedures on Minors' in the *Modern Law Review* in 1973, suggested that the parent of a child could consent to medical procedures where (a) it was in the best interests of the child, and (b) the child was incapable of consenting, but that if the child was capable of consenting and refused the parent could override that refusal so long as he reasonably believed the medical procedures to be in the child's best interests or not against them or that a reasonable parent would consent. Whilst those propositions seem to me to merit acceptance, the law is unclear. That lack of clarity affects also the question as to the extent to which a guardian appointed under the Mental Health Act, 1959 may lawfully consent to treatment, since by Section 34(1) of the Act the guardian is given:

'to the exclusion of any other person all such powers as would be exercisable by [the guardian] in relation to the patient if [the guardian] were the father of the patient and the patient was under the age of 14 years.'

#### 10. *Summary*

The limits of the right to treat an informal patient without his consent are unclear. For practical

purposes it would be unwise to give treatment compulsorily to an informal patient, save in cases of self-defence, the immediate protection of others, or extreme emergency satisfying the test of necessity suggested above. Additionally, however, it is almost certainly lawful to take reasonable steps to prevent a patient from killing or injuring himself even if forcible restraint or medication is required.

#### 11. *The Mental Health Act 1959*

The Act is not wholly clear, for the relevant sections are so drafted as to leave uncertain whether any right to carry out treatment without the consent of the patient is thereby granted. Two views compete:

##### (i) *The conventional view:*

'That in the case of a patient detained for treatment under the Mental Health Act any recognized form of treatment which is considered necessary for such disorder may lawfully be administered without the consent of the patient. Where, however, the patient is capable of understanding what is proposed it is normal practice to explain this to him and, if possible, to obtain his agreement.'

[Sir Keith Joseph, then Secretary of State for Social Services]

##### (ii) *The alternative view:*

'The fact that the patient should be detained in a hospital seems to carry with it no more of a meaning than that medical treatment (including here treatment from doctors) should be readily available to the patient should he and the doctors wish it. Given this undistorted view of the meaning of the word "warrant" the sections convey no more than compulsory powers of detention: they say nothing of the powers of treatment.'

12. In my view the conventional view is right and the alternative is wrong. Take, for instance, Section 26. It provides, so far as relevant, as follows:

'(1) A patient may be admitted to a hospital, and there detained for the period allowed by the following provisions of this Act, in pursuance of an application (in this Act referred to as an application for admission for treatment) made in accordance with the following provisions of this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds:

(a) that he is suffering from mental disorder being:

(i) in the case of a patient of any age, mental illness or severe subnormality;

(ii) in the case of a patient under the age of 21

- years psychopathic disorder or subnormality;  
and that the said disorder is of a nature or degree which warrants the detention of the patient in a hospital for medical treatment under this section; and
- (b) that it is necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should be so detained.'

Whilst there is an ambiguity in the drafting of the section, in my view the Court will hold that Section 26 authorises compulsory treatment. I take that view for the following reasons:

- (i) The application to be made under Section 26 is an application for admission for treatment. It is not an application for admission for the mere availability of treatment.
- (ii) The alternative view amounts to this: A psychopath urgently in need of treatment may be detained for treatment. But although detained on the basis of such urgent need he cannot be given the treatment unless he gives a consent which his condition almost certainly precludes him from doing. If so, the section is curiously emasculated.
- (iii) The application is necessarily on the grounds that the patient's disorder warrants his detention for medical treatment. The authority given by Section 26(1) is to detain the patient in pursuance of that application. Detention for the availability of treatment rather than for actual treatment seems to me neither to carry out nor to fulfil the terms of the application.
- (iv) Despite what Mr Jacob argues in his article in the *Modern Law Review* it seems to me clear that it was the view of both of the Davies Committee and, more importantly, the Percy Commission that the section should and does confer a power of compulsory treatment.
- (v) Although it may not be strictly admissible in legal proceedings, that view appears to have been shared by those who spoke on the second and third readings of the Bill in the House of Commons: see Hansard 1958-9 Vol. 605 at page 276 and Vol. 598 at page 780.

13. I have read with interest Mr Joseph Jacob's article. I see its force but I do not agree with it. It seems to me that it gives insufficient weight to the fact that the patient's disorder warrants 'the detention of the patient in a hospital for medical treatment under this section' and reads the section as if it said 'which warrants the detention of the patient in a hospital for

what may or may not be medical treatment depending on whether he consents'. I also consider that he has misconstrued for the purposes of his argument what the Percy Commission said, and I find the arguments that appear at pages 22-30 of his article either neutral or unconvincing. Lastly, his argument proves too much. Since medical treatment 'includes nursing, and also includes care and training under medical supervision' (see Section 147(1)) it would be a logical consequence of his argument that the patient need submit only to be detained and may refuse all nursing and care.

In short, I am of opinion that a patient admitted to Section 26 or treated as so admitted by Section 30 of the Mental Health Act, 1959 may be given treatment provided that is recognized treatment which is considered necessary for the disorder for which he was admitted even if he has not consented.

14. A further question arises as to what extent a patient admitted, not under Section 26 but under Section 25, may be compulsorily treated. The obscurity arises because the section refers to a disorder which 'warrants the detention of the patient in a hospital under observation (with or without other medical treatment) for at least a limited period'. Does that mean that if he is admitted he may be treated compulsorily, or does it not? Not without some hesitation I think that it does permit of treatment. It seems to me that the matter was expressed in that way because Section 25 is to be used when the patient is admitted for observation which may or may not require other treatment. But, on any view, the section is unhappily drafted and it seems to me that, as a matter of practice, whenever it is decided that a patient requires treatment other than observation, tests and medication, application should be made under Section 26 before that treatment is initiated in the absence of an effective consent. And it should only be in exceptional circumstances of urgent necessity that treatment other than observation, including tests and medication, should be given pursuant to a Section 25 detention.

15. I am further asked to confirm whether or not my comments on Section 26 of the Mental Health Act, 1959 also apply to patients who are dealt with under Section 60 of the same Act.

16. The answer is that, in my opinion, they do. Section 60(1) of the Act gives the relevant Courts, if satisfied that the offender's mental disorder is of a nature or degree which warrants the detention of the

patient in a hospital for medical treatment, power to authorise the offender's admission to and detention in such hospital as may be specified in the order. By Section 63(3) of the Act:

'A patient who is admitted to a hospital in pursuance of a hospital order . . . shall be treated for the purposes of Part IV of this Act . . . as if he had been so admitted . . . on the date of the order in pursuance of an application for admission for treatment . . . duly made under the said Part IV.'

with certain exceptions not presently relevant. It is true that the latter half of Section 63(3) provides that 'the provisions of the said Part IV specified in the first column of the Third Schedule to this Act shall apply in relation to him subject to the exceptions and modifications set out in the second column of that Schedule and the remaining provisions of the said Part IV shall not apply'; and that Section 26 is not in the first column of the Third Schedule. But that is immaterial since Section 60, the operative Section, enacts in the case of offenders the material provisions, *mutatis mutandis*, of Section 26.

17. If anything, I find support for my views on the proper construction of Section 26 in the existence of Section 60. It would be palpably absurd for an order under Section 60 not to authorise treatment. In my view it does authorise treatment as does Section 26 by

using the same wording. Similar wording ('which warrants the detention of the patient in a hospital for medical treatment') is also used in Section 72 which gives the Secretary of State power to remove to hospital persons already serving sentences of imprisonment, and, by reference back to Section 72, in Section 73 which gives similar powers in respect of persons on remand.

18. Nothing that I have said in this Advice must be interpreted as detracting from the practical advisability of securing consent in every case where it can be obtained.

19. That the law should appear unclear on so important a topic as this is wholly undesirable. It is plain from the circumstances in which I am asked to give this Advice that there are two different views that can validly be held as to whether compulsory treatment is authorized by the Act, and that until a Court is called upon to pronounce which view is the 'correct' one the differences cannot be authoritatively resolved. In those circumstances any pressure that the Royal College can bring to bear upon the Administration to clarify the law is much to be welcomed.

C. S. C. S. CLARKE

## PSYCHIATRIC NURSING

The Nursing Sub-Committee of the Education Committee would like to thank all those who have completed the questionnaire, sent out with the programme for the Autumn Quarterly Meeting in November 1978, on the information available to psychiatrists about GNC inspectors' visits and about the nurse-training in psychiatry in the hospitals or units in which they work. In particular, the Sub-Committee is grateful to those who took the trouble to

supply additional information in covering letters. This was most helpful, and when the replies have been evaluated it is hoped to publish the information. In the meantime the Sub-Committee would be glad to hear from those who have not yet replied—as soon as possible, please.

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*Chairman, Nursing Sub-Committee*