

Capacity choice and compulsion

*Lucy Scott-Moncrieff**

Harold C, originally from Jamaica, was admitted to Broadmoor Hospital in the 1960's. In 1993, at the age of 68, he developed gangrene in his foot and was transferred to Heatherwood Hospital for treatment.

Mr Rutter, the orthopaedic surgeon treating Mr C, considered that he only had a 15% chance of survival if he did not have his foot amputated. However Mr C refused to agree to the amputation, and as Mr Rutter said that he would not amputate without Mr C's unequivocal consent, the wound was simply cleaned up, although Mr Rutter considered that there was a high likelihood of infection spreading from the wound to other organs, causing them to fail. He therefore continued to believe that amputation was in Harold C's best interests. Mr C wanted to get a guarantee that the hospital would not amputate his foot without his consent, whatever might change in the future, so I wrote to the hospital, asking for an undertaking to this effect. The hospital refused to give the undertaking, and pointed out that if the infection spread there was a real likelihood that Mr C would become delirious, would thereby lose the capacity to make decisions about his treatment, and the hospital could then, acting in his best interests, amputate his foot. Mr C went to court, to seek a declaration that the hospital could not operate on him without his written consent.

The judge, Mr Justice Thorpe, had to decide first whether Mr C had the mental capacity to refuse the amputation. If he did have capacity, the judge then had to decide whether he had the right to make a decision about his future treatment that would be binding on the hospital even if he subsequently lost the mental capacity to make treatment decisions.

The judge used a three part test to assess Mr C's mental capacity:

- a) Could Mr C take in and retain information about the treatment being offered, including the consequences of not accepting the treatment?
- b) Did he believe what he was told?
- c) Could he weigh the information, balancing risks and needs?

Mr C's position was that he was an internationally famous doctor, who had never lost a patient, and who was capable of treating himself successfully. He believed that God would help him, and he did not believe that his gangrenous foot would cause his death, although he acknowledged that he could be wrong about this. He was also very clear that even if lack of treatment lead to his death,

** Partner, Scott-Moncrieff Harbour & Sinclair, Solicitors*

he would rather die with two feet than live with only one. At first glance, therefore, it would appear that he lacked capacity, as he had delusional beliefs about his own ability to cure himself. However the judge was impressed with his acceptance of the possibility that he might be wrong (not commonplace in people with delusions) and that he might die if he did not have the operation; particularly after he heard from the surgeon, who said that it was not at all uncommon for elderly people to refuse life-saving amputation, and Mr C was no different from many others of his patients in this respect.

Mr C won his case. The judge decided that he did have capacity to refuse the operation and that he should be allowed to make an advance directive about his future treatment, which would be binding on the hospital. (This was the first time an advance directive was endorsed by a UK court) In the course of the judgment the judge quoted from the case of *re T (An Adult: Medical Treatment)* [1992] 2 FCR 861.

- “(a) Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so, notwithstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide which stems from the fact that the patient is an adult is rebuttable.
- (b) An adult patient may be deprived of his capacity to decide by long-term mental incapacity.
- (c) If an adult patient did not have the capacity to decide at the time of the reported refusal and still does not have that capacity, it is the duty of the doctors to treat him in what ever way they consider in the exercise of clinical judgment to be in his best interests.
- (c) Doctors faced with a refusal of consent have to give very careful and detailed consideration to what was the patient’s capacity to decide at a time when the decision was made. It may not be a case of capacity or no capacity; it may be a case of reduced capacity. What matters is whether at that time the patient’s capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health; others may not”.

Delightfully, not only did Harold C win his case, he also survived. The gangrene did not recur; the infection did not spread; he was transferred to a nursing home on the South Coast and he lived out his days with both legs, and a crutch.

Subsequent events caused me to doubt whether Mr C had actually had the capacity to make this decision about his treatment. He was quite a wealthy man; he did not smoke and he wore hospital-issue clothes, so he had accumulated thousands of pounds in unspent benefits. He had lost touch with his family, and after the court case I suggested to him that he might like to write a will if he did not want all his money to go to the State when he died. He agreed that this was a good idea, and asked me to draw up a will in which he would be the sole beneficiary. He explained that he wanted to take his money with him.

I did not need the help of a doctor to work out that he lacked the capacity to make a will, as he did not appear to accept the finality of death or, at least, the inevitable loss of the ability to spend money that accompanies death.

It is clear that what tipped the balance with Mr Justice Thorpe was Harold C’s assertion that he knew

that he might die if he did not have the operation, but he that would prefer to die with two feet than live with one. Harold C's instructions in relation to his will suggested that his ideas about death and dying were so unusual that his assertion that he was not afraid to die probably reflected a conviction that death did not involve any loss of identity or autonomy, but merely a change of scene.

If Mr C had flatly said to the judge that he did not believe what the doctors were saying about the risk to his life, and that he refused the operation for this reason, I think it likely that the judge would have decided that he lacked capacity. The fact that Mr C turned out to be right would not have invalidated the correctness of the judge's decision – it is possible to be right for the wrong reasons, just as it is possible to be wrong for the right reasons.

Not everyone is as lucky as Harold C.

David Bennett, also originally from Jamaica, was first admitted to a psychiatric hospital in the early 1980's. He was then in and out of hospital for many years until his final admission to the Norvic Clinic in October 1995.

The Norvic Clinic is a medium secure unit: less secure than a high security hospital such as Broadmoor, but completely secure for all ordinary purposes. It has a high perimeter fence; all the doors are very solid and lockable; and the glazing bars on the windows are a fine example of form following function where the function is containment rather than illumination.

All the patients at the Norvic Clinic are detained under the Mental Health Act 1983. Some of them will be there because they are too ill to be managed in local, open, psychiatric hospitals; some of them will be prisoners who are too ill to be treated in prison; and some of them will be people who have been in a special hospital such as Broadmoor and who are on their way out to the community via medium security.

The different pathways into the Norvic Clinic are likely to be reflected in the different attitudes of the patients. For some, the Norvic Clinic will be a blessed refuge from the inadequacies of the prison psychiatric services. For others it will be an irksome, restrictive but bearable step on the way to freedom. Those who have come in from their homes or from open hospitals are most likely to be unhappy about their stay there, as they are likely to perceive that the alternatives for them would be less restrictive.

It is not only the pathways and the attitudes that will vary considerably. Some of the people coming in will be acutely psychotic, unstable, and unpredictable. Others will be very well, very stable, and hoping for the opportunity to continue with their Open University degrees as they move towards discharge into the community. What they all have in common is their subjection to the provisions of the Mental Health Act 1983 and, therefore, their exclusion from the general principle that adults with mental capacity cannot be given medical treatment without their consent.

David Bennett died at the Norvic Clinic shortly before midnight on the 30th October 1998.

The independent inquiry set up to investigate his death reported in February 2004. It records that: "At about 22.00 hours in Drayton Ward, a patient (DW) was making a telephone call to his mother. There was one telephone in Drayton Ward for patients to use. Occasionally two or more patients wanted to use this telephone at the same time but normally there were no problems. That evening, DW had been on the telephone for about 45 to 60 seconds when David Bennett asked him how long he was going to be. DW described how David Bennett then left and a little later returned. He appeared quite angry and said, "give me the fucking phone". DW told him to go away and

David Bennett grabbed the phone out of DW's hand, who grabbed it back again. Then David Bennett threw a punch at DW's face; his hand hit the phone which itself hit DW's face. It was quite a hard blow. DW put his hand to his mouth and saw blood on his hand.

DW's mother made a statement in which she confirmed the words used by David Bennett to her son. She also heard a thud and then heard DW say, "that was my fucking face". As soon as that call had ended, DW's mother telephoned the Norvic Clinic and was told that DW was being examined by a doctor.

Shortly after being hit, DW went to David Bennett's bedroom, kicked on his door and shouted at him. He was extremely offensive and racist in his remarks. The evidence is that he called him, "a black bastard" and, said, "you niggers are all the same". David Bennett opened his bedroom door suddenly and DW punched him on his chin. This too was quite a hard blow. David Bennett took a step back and said, "please don't do that".

Nursing assistant Bartlett was the first member of staff on the scene. He saw David Bennett come out of his bedroom and he saw the two men start to fight. He saw DW using his fists and David Bennett trying to kick DW in karate style. He then saw DW hit David Bennett with a powerful punch to his jaw. By this time two other nurses had arrived. They took hold of DW and took him away from David Bennett. DW was still uttering obscenities and racists remarks".

The nursing staff decided that the two men should be apart for a while, and it was decided that David Bennett should move to Thorpe Ward, which was a smaller ward than Drayton, with a higher ratio of staff to patients; a higher dependency ward.

The patient culture perceives transfer from a lower dependency ward to a higher dependency ward as a retrograde step and, particularly after a violent incident, a form of punishment. A patient is likely to have a strong sense of grievance if he feels that he is the innocent (or, at least, less guilty) party in a violent incident, and yet he is moved to a higher dependency ward and the other patient is allowed to remain "unpunished" on the lower dependency ward.

Although David Bennett had apparently initiated the incident between the two men, and although he had certainly struck the first blow, he would have good reason to consider himself the less guilty party. Many patients in secure hospitals have what are rather primly called impulse control and anger management problems. The standard advice is that the person on the receiving end of such problems should not retaliate, should walk away, and should report the matter to staff. This, of course, reflects the standards of behaviour in society at large; if someone comes up to you and punches you in the face, and then walks away, you are meant to report the matter to the police. If you run after him and beat him up you are likely to find yourself in the dock, possibly facing a more serious charge than your assailant.

When David Bennett was told that he needed to move to Thorpe Ward, he was in an agitated state, but said, "I won't mind a little while on Thorpe Ward". Having arrived on Thorpe Ward he appeared calmer, but the staff then decided that he would need to spend a night on the ward, and a nurse who knew him well went over to him to tell him this.

"She bent down, putting her hand on his arm and said, "I am going back to Eaton Ward and I just want to tell you that you are going to stay the night here on Thorpe Ward". David Bennett said, "Yep, yep, ok", then he said, "What about DW?" She said, "No, he will be staying...". That is as far as she got because David Bennett then punched her on the left side of her face at least three times. The blows were very hard. The first punch knocked her backwards and she tried to block

the other punches. She put her arm up to shield her face. SN Hadley considered that in hindsight the trigger factor was probably the fact that DW was staying on Drayton Ward.”

Nursing staff restricted David Bennett, and he ended up on the floor with five, and subsequently four, nurses pinning him down. He was restrained in this way for about 25 minutes, at the end of which time he was dying or dead. Less than 90 minutes had elapsed since he first approached DW.

The inquiry in to the death of David Bennett found that “the possibility of moving David Bennett to Thorpe Ward should have been discussed with him carefully and gently before a final decision was made. He should not have been presented with the decision already made. When he arrived in Thorpe Ward the evidence indicated that he had calmed down further and was capable of having a rational conversation.

Some witnesses have told us that, with the benefit of hindsight, their view is that David Bennett should never have been transferred to Thorpe Ward. We recognise that when a situation of violence occurs, it is difficult for the staff to deal with. Immediate decisions have to be made and its possible to get them wrong. But we have formed the strong impression that on that evening David Bennett was not treated by the nurses as if he were capable of being talked to like a rational human being, but was treated as if he was “a lesser being” to use his sister’s phrase, who should be ordered about and not be given a chance to put his own views about the situation before a decision was made”.

The inquiry report quotes Dr. Ball, the clinical director of the Norvic Clinic. In a letter to the Chief Executive of the NHS Trust, referring to David Bennett’s transfer to Thorpe Ward, he said “his sense of injustice together with the singularly grievous sense of insult generated by a racist taunt should not be underestimated”.

The inquiry also found that:

“Even if it was a correct clinical decision to take David Bennett to Thorpe Ward temporarily, further consideration should have been given to the problem before deciding to keep him there for the night. This decision too was not dealt with in a sensitive way. He was simply informed of the decision. We consider that this must have seemed to him to be the last straw. But we wish to make it clear that despite the criticisms we have made, we do not condone his actions in hitting out at SN Hadley.”

Why were Harold C and David Bennett treated so differently? Why was Mr C given the opportunity to go to court to establish his right to refuse treatment, whereas David Bennett was not even consulted about the decision to move him to a higher dependency ward?

It is very likely that the heart of the problem lies in the deeply discriminatory compulsory treatment powers of the Mental Health Act 1983.

Under the Mental Health Act, nearly all forms of treatment can be given to patients without their consent, regardless of their mental capacity. Some treatments, such as medication and ECT, can only be given if a capacitous patient consents or if a second opinion doctor confirms the treatment should be given.

All other forms of treatment for mental disorder, such as restraint, seclusion, transfer to another ward, withdrawal of privileges (“treatment for mental disorder” is defined very widely), require neither consent nor a second opinion, regardless of whether the patient has capacity to make his own decision on the issue. The Mental Health Act contains no explanation or justification for this state of affairs: the only explanations that I can come up with are expediency and the unexamined prejudice that people with mental health problems are, by definition, not entitled to autonomy.

Harold C got lucky and David Bennett got so very unlucky because, although they were both black men with schizophrenia detained under the Mental Health Act 1983, the compulsory treatment provisions did not apply in Harold C's case. It is clear that Mr C's consultant psychiatrist would have authorised the amputation if she had had the power to do so, because she believed that the operation was very much in his best interests. However, as treatment for gangrene cannot be seen as treatment for mental disorder, the provisions that would have allowed his refusal to be overruled did not apply. In David Bennett's case, it appears that the staff felt that the violence and abuse that he had suffered had rendered his mental state fragile, and he therefore needed to be moved to a higher dependency ward. This amounted to treatment for mental disorder, and decisions could be made (and were made) without consulting him or considering his wishes.

Remarkably, when assessing a patient to see if he should be detained under the Mental Health Act, those carrying out the assessment do not even have to consider whether or not the person being sectioned has the capacity to make his own treatment decisions. It is sufficient for them to decide that he has a mental disorder, and it is necessary, in his own interests or to protect others, that he should receive treatment for it. It is true, of course, that people with mental disorders are more likely than the general population to lack capacity to make decisions, at least some of the time. However the Mental Health Act does not say that decisions can be made without the agreement of the patient because the patient lacks capacity; it specifically provides for the decisions of detained patients to be overruled, even when they have capacity.

Imagine what it would be like if all medical treatment could be imposed in this way – we would have to build many vast new hospitals to cater for all the alcoholics, heavy drinkers, smokers, drug addicts, body-building steroid abusers and morbidly obese people who did not accept their doctor's advice about their harmful and life-threatening habits, and who would therefore need to be admitted for some compulsory treatment in their own best interests.

It is easy to be scared in hospital. However big and brave and clever and successful you are in your ordinary life, when you go in to hospital you are in another world. You are on the receiving end of other people's knowledge and competence and efficiency and systems. And you are ill, so you really hope that the doctors and nurses know what they are doing, and if you get a feeling that they do not know what they are doing, you may not feel strong enough or assertive enough to do much about it. If your sense of reality is also adrift, if you are depressed or hallucinating or dementing or delusional, it may be even harder to believe in the validity of your own opinion about what is best for you. What must it be like to have hung on to your decision-making ability throughout the vicissitudes of mental illness, removal from home, and enforced hospitalisation, only to be told that you have no right to refuse the medical treatment that your doctor has decided on? This treatment, of course, can include medication with commonplace side-effects such as impotence, huge weight gain, unbearable feelings of restlessness, uncontrollable dribbling, lethargy, slurred speech, jerky movements (and sometimes all of these).

And what's it like from the other side? How easy is it to go on relating to the other as an equal in human terms when the law has endorsed society's view that people with mental disorders are not equal? One of the nurses who restrained David Bennett referred to him, quite unselfconsciously, as a boy: "I wanted the boy to be as calm as can be before I am prepared to let him up" and "regardless of what the boy has done, that's still someone who has died in my arms and that is a hard thing to live with". David Bennett was 38 when he died.

I do not think anyone would describe a 38 year old white man as a boy, whether he was detained in a hospital, a police station or a prison, but I also do not think that David Bennett would have been described as a boy if he had been detained in a prison or police station. There is no sense that the nurse intended to be derogatory; he gave evidence that he had a good relationship with David Bennett, and he spoke fondly of him. However, in describing David Bennett as a boy, he reveals, with utmost clarity, the status given to patients at the Norvic Clinic. David Bennett's sister, Dr. Joanne Bennett, said in her evidence "when you are mentally ill and isolated from your family in a predominately white area, when you feel oppressed and are experiencing racial abuse, you think that you are a lesser being". The words of the nurse make clear that this was a perception shared by the staff.

The law used to distinguish between men, who had legal autonomy, and women, children and lunatics, who had little or no autonomy. Women now have legal equality with men, and in most circumstances children's views are also taken into account when legal decisions are made about their lives. However in the case of people with mental disorders, there has been remarkably little change. The underlying assumption is still that people with serious mental disorders should have fewer rights, even though there is no inevitable correlation between such disorders and mental incapacity.

Psychiatry is the Cinderella service of the National Health Service. There are many reasons for this; it is not glamorous; the work is difficult; dramatic cures are infrequent, people in mental distress are often not easy to work with, or even to be with; the status of health care staff who work with psychiatric patients reflects the status that mentally ill people have in our society. Psychiatric wards, particularly acute admission wards, are often grubby, noisy, crowded and frightening places, to the extent that someone would have to be very desperate to chose to be there. But of course many of the patients on such wards have not chosen to be there. They are there under compulsion, having been detained under the Mental Health Act.

There are a number of initiatives within the NHS to try and raise standards by increasing patients' choice: patients do not have to accept treatment at their nearest hospital, and if they cannot find a hospital that will offer them satisfactory treatment within a reasonable period of time, they can go to the private sector, even abroad, and have their treatment paid for by the NHS. None of this is available to people with mental health problems.

Dr. Stephen Amiel and Dr. Iona Heath have been GP's in North London for many years. I met them to discuss my theory that the compulsory treatment powers in the Mental Health Act are implicated in the lower levels of service that people with psychiatric problems receive as against people with other medical problems. They did not altogether agree with my proposition, but did agree that people with psychiatric problems (and elderly people) get a worse deal from the NHS than everyone else. GP's frequently need to refer patients to specialists or for inpatient treatment. Generally speaking, they have the right to refer their patients to the specialist or hospital that they consider most appropriate. Strong moral and bureaucratic pressure is brought to bear to try and get them to refer to services with which the patient's Primary Care Trust already has a contract, but if they are persistent enough in referring their patients to an "out-of-area" specialist or hospital, they will eventually prevail and the Primary Care Trust will pick up the tab. It is quite different for patients in the medical specialities of psychiatry and geriatrics, where they have been told that the referrals have to be made to the catchment area services, regardless of the greater suitability of "out-of-area" services.

They believe that the inequality is compounded in that NHS psychiatrists are only able to treat within their individual catchment areas. These catchment areas are geographical areas within the larger catchment area of the NHS Trust for whom the psychiatrist works. If a patient moves from the catchment area of one psychiatrist into the catchment area of another psychiatrist, all within the larger catchment area of the Trust, the care of that individual will pass from one psychiatrist to another, regardless of the need for continuity of care.

There is a rather perverse exception to this – if a patient moves from the catchment area of one NHS Trust to that of another, the staff from the original Trust will continue to be responsible for the patient for 6 months, whether or not this is appropriate, and at the end of 6 months the patient's care will transfer to the new NHS Trust, whether this is clinically appropriate or not. This system appears to be purely driven by the bottom line.

I asked the doctors if they knew the legal rationale behind any of this, and they said that the limitations on referrals for psychiatric patients have been in existence for many years, throughout all the changes in the NHS, and they believe that the restrictions can be put down to custom and practice rather than law or regulation.

The doctors agreed that if GPs have choices in making referrals, standards are raised. Dr. Heath pointed out that if Dr. Amiel had a heart attack and needed an emergency admission, it would be perfectly acceptable to admit him to the local cardiac unit, where he would receive a satisfactory level of care. However if he had a psychotic breakdown, it is very unlikely that it would be thought acceptable for him to be admitted to the local mental health unit, because his professional colleagues in the unit would be embarrassed at the level of care that is available on such a unit. They would try and arrange for him to go out-of-area, so that his treatment was provided by people who did not know him.

It occurred to me afterwards that another reason for referring Dr. Amiel elsewhere in such circumstances might be to protect the local staff from having to engage with the discomfort of experiencing a blurring of the boundary between “them” and “us”. The same blurring, of course, applies when the doctor/patient is receiving treatment for a physical illness, but the very much greater difference in status between staff and mentally ill patient would make the discomfort unbearable for the treating staff.

The lack of choice in psychiatry is pervasive. Dr. Amiel and Dr. Heath told me that if they refer a patient with back-pain to a back-pain specialist, the patient will be seen by that specialist. However if they refer a patient with a psychiatric difficulty to a particular psychiatrist or psychologist, the referral will go to the mental health team rather than to the individual specialist, and the case might then be dealt with by another member of the team, such as a nurse. Equally, a GP can decide with his mentally ill patient that the patient needs to be referred for an emergency admission. However he cannot simply call for an ambulance and arrange for the patient to be taken up to the hospital. He has to make the referral to the crisis intervention team, and a member of the team, quite possibly a nurse, will assess the patient, with the express view of trying to keep the patient out of hospital if possible. The knowledge and experience of the GP is not sufficient to effect an admission, although it would be in a medical emergency within another specialism.

The David Bennett inquiry was specifically asked to look at the issue of racism within NHS mental health services. It took evidence from a large number of people on this issue, and reported that they were unanimous in saying that institutional and individual racism existed within the NHS.

One witness was reported as saying that, “using the word “racism” was not very helpful. It was necessary to deconstruct what racism was about. It was about human relationships and was based on power, namely the power of one person over another. Just using the word “racism” did not communicate to people what it was that was discriminatory about what they did. To make things better it was necessary to explain that something was wrong with the relationship and to try and put it right.

He therefore had some hesitation about the use of the term “institutional racism” which he considered had its own complexities and its own history. But he told us that the sum total of his view was that the mental health services and the NHS were racist within the meaning of the McPherson definition of instructional racism. He emphasised that black patients were particularly sensitive to any hint of regulation, control or disrespect, because they had been primed by their experiences to expect to be treated badly in society.

The inquiry adopted the definition of “institutional racism” set out by Sir William McPherson in the Stephen Lawrence inquiry: “institutional racism is the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people”.

David Bennett’s sister, Dr. Joanne Bennett, told the inquiry that, “people sometimes fail to understand that there was a huge variation in defining blackness. Individual experiences by different black people may be totally different. Just putting two black people together did not necessarily mean that the first black person understood the second black person. Nor by putting two black people together as patient and practitioner did that mean that a patient was getting the appropriate cultural care.

There were huge differences between different people who are called black, or who come from the ethnic minorities. We should pay more attention to what the person has to say about their own experiences, namely, what were the things that were significant and important for them. If doctors and nurses were prepared to spend more time talking with families that would help.

Rather than mental health services focusing on cultural matching, whatever that was supposed to mean, we should be focusing more on how we enable practitioners to deal with the people as people, with some humanity, because that was how you were going to find out what really matters to that person. If we took time to respect an individual and say to him, “what is it that is troubling you, what are your needs?” we are more likely to get it right than if we started to talk about culture, ethnicity and cultural competence. We also need to understand about the ideology of racism and how that creates stereotypes, assumptions and values. That had nothing to do with culture”.

Everything said here about racism also describes the experience of people with mental disorders; particularly detained patients. It only takes a moment’s thought to realise that not only common humanity but also good psychiatric practice must require that people are listened to properly, treated as individuals, shown respect and have their wishes and anxieties taken into account when decisions about treatment are being made. The fact of the matter is, however, that this is not how things work.

How ever well-intentioned the health-care staff are, they are likely to be rushed and busy, to have limited time to spend with any individual patient, and limited options to offer that patient. Also,

if the doctor has the power to impose medical treatment, he may feel an obligation to do so if he considers it to be in the patient's best interests. There is little necessity for the sort of discussion that I have when I go to my GP; she offers me her best advice based on her medical knowledge, her experience, and her awareness of the available options, and I make a decision based on her advice, and my experience and knowledge about myself. Where society's lack of respect for people with mental health problems is combined with the institutional racism of the NHS and the official paternalism authorised by the Mental Health Act, it is not surprising that the opportunities for such discussions appear to be very limited.

The David Bennett inquiry makes a number of recommendations, many of them, quite appropriately, dealing with ways of combating institutional and individual racism within the NHS. However, they also recommend that:

“All patients in the mental health services should be entitled to an independent NHS opinion from a second doctor of their choice, in order to review their diagnosis and/or care plan. If the patient, by reason of mental incapacity, is unable to make an informed decision, their family should be entitled to make it for them”

and

“All psychiatric patients and their families should be made aware that patients can apply to move from one hospital to another for good reason, which would include such matters as easier access by their family, a greater ethnic mix, or a reasoned application to be treated by other doctors. All such applications should be recorded. They should not be refused without providing the applicant and their family with written reasons”.

If these recommendations were implemented, the NHS psychiatric services would, over time, be transformed. Patients would have real choice, and this would affect the culture within NHS psychiatric services. The provisions of the Human Rights Act 1998 would almost certainly ensure that the real choices available to patients with physical health needs would be extended to patients with mental health needs.

After reading the David Bennett inquiry report I spoke to Professor Sashidharan, one of the authors of the report. He has worked as an NHS consultant psychiatrist in Birmingham for many years, so his opinions and knowledge are based on great experience.

I asked Professor Sashidharan whether he thought that a culture of greater patient choice and autonomy could have prevented the tragedy at the Norvic Clinic. I was expecting a fairly non-committal reply, because the inquiry report is very careful to acknowledge that David Bennett's death occurred in the context of a difficult and emergency situation, and I knew that he would not take advantage of the luxury of hindsight. So I was surprised by his answer.

He told me that when he was working in the NHS in Birmingham, he instigated a system whereby any patient who was likely to be subject to an emergency intervention (for instance being put in seclusion, or being moved from one ward to another, or having privileges removed), had the right to request a phone call to him before the intervention was implemented. If Professor Sashidharan was not on the unit, he could be phoned at home or on his mobile. A surprisingly large number of patients availed themselves of this opportunity and, very frequently, a conversation with Professor Sashidharan resulted in the emergency intervention being proved unnecessary.

There were no doctors on duty at the Norvic Clinic on the night that David Bennett died. If David

Bennett had had the right to phone his doctor, or the Medical Director, Dr. Ball, before being moved from Drayton Ward, or before a decision was made that he had to spend the night on Thorpe Ward, perhaps a different decision would have been made. Even if the same decision had been made in the end, Mr Bennett would have had the opportunity to discuss the matter with his doctor, and he would have known that his doctor would have discussed the matter with the nursing staff before making a final decision. Perhaps he would have understood that the decision had been made in the interests of his mental health, rather than because he was being treated unfairly.

Professor Sashidharan also told me about his prescribing habits. Many psychiatrists will not only prescribe medication to be taken at stated intervals, but will also prescribe "p.r.n." medication. This is medication to be given as required, and once it has been prescribed, nurses can administer it without further reference to a doctor. It is not unusual for psychiatrists to prescribe quite high doses of injectable anti-psychotic or sedative medication to be given p.r.n.

Professor Sashidharan never prescribed p.r.n. medication. If an emergency arose when he was not on duty, and the nurses felt that sedative or anti-psychotic medication needed to be given, the nurses would have to contact Professor Sashidharan, and he would have to come in to the clinic to write up the prescription. This practise ensured that there was always a pause for thought between the beginning of an emergency and the administration of medication.

The treatment of people with mental health problems is bound to change, because everything always does. In NHS mental health services the pressures for change are coming from two different directions, and it is not at all clear which will prevail. The Government has made it plain that it intends to introduce new mental health legislation that will empower doctors and other health-care professionals to impose treatment on those living in the community, including compulsory medical treatment such as injections of anti-psychotic medication. The Government has said that it is only trying to ensure that people who are currently subject to compulsory powers will be subject to compulsory powers in the community as well as in hospital. However to try and achieve this result it has defined mental disorder and the scope of compulsory powers so widely that, for instance, a psychiatrist will probably have the power to require a hyperactive child to take Ritalin (a central nervous system stimulant similar to amphetamine), even if the child's parents do not consent. Luckily, the opposition to many of the Government's proposals has been solid, and has united groups who frequently do not feel that they have interests in common, such as the Royal College of Psychiatrists and mental health user charities. Probably as a result of the strength of the opposition, the new proposals have still not been introduced in Parliament.¹

Another promising sign is the acknowledgement by various individuals that the NHS is institutionally racist. Disappointingly, the Government has still not accepted the three key recommendations of the Bennett report – that the Health Minister, John Reid, should acknowledge the presence of institutional racism in the mental health services; that the Health Minister should appoint an ethnicity tsar to spearhead reform; and that there should be a three minute time-limit on staff restraining patients by pinning them face down on the floor.

A decisive factor, one way or the other, may turn out to be the case of John Wilkinson. John Wilkinson is an elderly, white, patient in Broadmoor who has been there since the 1960's. For many years he had been diagnosed as suffering with a personality disorder (which would not usually be treated with medication), but a few years ago he came under the care of a doctor who felt that he

¹ A new Mental Health Bill 2004 was published on 8th September 2004, as this issue of the Journal went to print. (Editor)

may have had an underlying and untreated mental illness, which was preventing him from making the progress necessary to move on from Broadmoor. His doctor wanted to give him anti-psychotic medication, but Mr Wilkinson was vehemently opposed to this. The doctor decided to prescribe the medication in any event, and, following the rules laid down in the Mental Health Act 1983, obtained a second opinion from a doctor appointed by the Mental Health Act Commission who endorsed the compulsory imposition of medication. Mr Wilkinson said that he would strenuously resist any attempt to medicate him against his will, and, unlike many patients in such a situation, he followed through. He refused to accept the medication, and had to be pinned down on the floor by nurses and forcibly injected. He suffers from angina, and had an angina attack following the struggle. An injunction was obtained to prevent further compulsory medication until the court had had an opportunity to consider whether it was lawful to impose it in these circumstances. The injections were given in early 2000, before the Human Rights Act 1998 came into effect on the 2nd October of that year. However, because the court had to decide whether future treatment would be lawful, the case was considered in the light of the Human Rights Act when it was finally dealt with by the Court of Appeal in 2002.

The judgment contained the following remarks:

“It seems to me that the court must inevitably now reach its own view both as to whether this claimant is indeed incapable of consenting (or refusing consent) to the treatment programme planned for him by the first defendant as his RMO and, depending upon the court’s conclusion on that issue, as to whether the proposed forcible administration of such treatment (a) would threaten the claimant’s life and so be impermissible under article 2 (b) would be degrading and so impermissible under article 3 and (c) would not be justifiable as both necessary and proportionate under article 8 (2) given the extent to which it would invade the claimant’s right to privacy.”

and

“Forcible measures inflicted upon an incapacitated patient which are not a medical necessity may indeed be inhuman or degrading. The same must apply to forcible measures inflicted upon a capacitated patient. I would hesitate to say which was worse; the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done. The European Court of Human Rights understood how vulnerable such patients can be and how much in need of the protection of the world outside the closed world of the psychiatric institution however well meaning”.

As yet, the domestic courts have not considered the issue, as Mr Wilkinson’s doctor has not renewed his attempts to medicate him against his will. Mr Wilkinson has taken his challenge to the European Court of Human Rights, on the basis that the provisions of the Mental Health Act which allowed his doctor to inject him forcibly in February and March 2000 are incompatible with the European Convention on Human Rights.

The case is inching its way through the ECHR. If John Wilkinson wins, the current compulsory powers will have to go, and the extension of those powers will not take place (unless the government declares a national emergency again and derogates from the European Convention on Human Rights). If he loses, look to see compulsory psychiatric treatment coming to a street near you very soon.