

A summary of the law in England and Wales

Treatment first - emergency treatment and clinical care should be the first priority.

Consent / capacity – for each relevant decision about medical treatment, an assessment of the patient’s capacity (per the MCA) will determine whether it is something to which they can consent / refuse, or whether it is a best interests decision. Even lifesaving treatment will be unlawful if it is given to a patient who has capacity to consent and refuses it (or where there is a valid and effective Advance Decision to Refuse Treatment that has the same effect).

Best interests decision making – where a patient lacks capacity for a particular medical treatment decision (and there is no effective ADRT to pre-determine this) then a best interests decision must be made. The lead clinician responsible for the treatment is likely to be the decision maker (unless there is a relevant Lasting Power of Attorney or deputy), but in any case decision making should be collaborative, and aim to determine the patient’s best interests in the round (including social and emotional, as well as purely medical aspects). It should be informed by the patient’s own wishes, feelings, beliefs and values, and consultation as much as practicable with those engaged in caring for the patient or interested in their welfare, especially to enhance an understanding of the patient as an individual. [Note that there is no particular special role or status in this for those designated in lay terms as “next of kin”]. In some cases an Independent Mental Capacity Advocate (IMCA) can assist.

Documentation - it is good practice, of course, to document assessments of capacity and best interests decisions, as appropriate.

Disputes - where there are disputes about capacity or best interests which cannot be resolved locally by discussion, or for example obtaining independent second opinions, they may need to be referred to the Court of Protection. Case-law and a Practice Direction suggests that some types of medical treatment decisions (notably proposed withdrawal of ANH from a patient in PVS / MCS) should go to Court for proper approval in every case, whether or not there is any dispute.

Restraint – it is possible that a patient’s best interests can be served by the use of restraint to administer medical treatment. This is best interpreted widely, as including both physical restraint and pharmacological restraint by sedation, as the law doesn’t distinguish. Where restraint is used, in addition to being in the patient’s best interests it must be necessary to prevent harm and proportionate to the likelihood and seriousness of that harm. Any decision about the patient’s best interests should always be tested with the question – is there a less restrictive way to meet their best interests?

Delirium etc – capacity for any particular decision is time specific, ie at the time that the decision has to be made. Clinicians should consider whether a decision can reasonably be deferred until a patient has recovered the capacity to make it for themselves. Lack of capacity can either be temporary or permanent.

Deprivation of Liberty – The Court of Appeal (in *Ferreira v Coroner of Inner South London*, 26 January 2017, per Lady Justice Arden) is clear that “...**any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1)** [the right to liberty] ... so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose”. (para 89, our emphasis)

“The treatment must be given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness” (para 93).

This means that the procedural safeguards of Article 5 are not triggered in those circumstances – ie there is no need for a Deprivation of Liberty Safeguards referral.

In another context, the test for objective deprivation of liberty was set out as being “under continuous supervision and control and not free to leave” (the Supreme Court in *Cheshire West*). Arden LJ also said that the “not free to leave” element of the test requires that the patient themselves wants to leave but is being prevented by the state. This means that it is not met where the true reason for the patient not being able to leave is their underlying medical condition, or the essential treatment of it.

Here, “...the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital” (para 10)

There may still be cases where procedural safeguards are appropriate to protect a patient’s right to liberty. The Court gave an example of an earlier case (*An NHS Trust v FG*) in which an obstetric care plan was approved providing for care to a woman of unsound mind against her wishes, and anticipating preventing her leaving and compulsion of invasive treatment including a caesarean section. The treatment would have been materially different from that offered to a patient of sound mind.

In cases where significant coercion may be required to provide treatment, it may be prudent to seek legal advice and wider support within the Trust in any event.

In saying that the rules that apply about deprivation of liberty elsewhere do not apply to delivery of “life saving treatment”, the obvious question is what exactly amounts to “life saving treatment”? Where should the line be drawn between that context, where the Court of Appeal has held that Article 5 is simply not engaged, and the provision of longer term care packages, involving decisions about where a patient should live, where the protection of Article 5 is essential?

These questions will be more challenging in other clinical contexts than in ICU and it is reasonable to say that the Court of Appeal clearly considered that treatment in ICU should not raise issues of deprivation of liberty, save in exceptional circumstances. The further the situation goes down the continuum towards being “living arrangements”, potentially including a prolonged in patient stay while awaiting a suitable transfer or discharge, the more obviously the *Cheshire West* test should be reconsidered, and Article 5 procedural safeguards applied.

It is inevitable that there will be further tests of the scope and interpretation of this law. The case is likely to go to the Supreme Court later in 2017, but the Court of Appeal judgment in *Ferreira*, set out above, is the leading case in the meantime.

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