PART II

PERSONNEL IN THE MENTAL HEALTH SERVICES

Chapter 6

MANAGEMENT, MEDICAL AND NURSING STAFF

A. MANAGEMENT

6.01 Definition of "the Managers"

The definition of the term "the managers" varies according to whether the establishment is a hospital,[1] a special hospital[2] or a mental nursing home.[3] "The managers" means (s. 145(1)):

(*i*) in relation to a Health Service hospital and to any accommodation provided by a local authority and used as a Health Service hospital, the district health authority (See para. **2.11** *ante*) or special health

[1] Defined at para. **3.02** *ante*.
[2] Defined at para. **3.04** *ante*.
[3] Defined at para. **5.02** *ante*.

authority (see para. **2.17** *ante*) responsible for the administration of that hospital;[1] As to managers of special hospitals, see para. **3.05** *ante*).

(*ii*) in relation to a mental nursing home registered in pursuance of the Registered Homes Act 1984, the person(s) registered in respect of the home. (See paras. **5.02–5.09** *ante*)

(*iii*) in relation to a hospital vested in a National Health Service Trust, the trust.

The health authority should appoint a committee to undertake the duties of managers comprising persons who are well informed members of the health authority and outside persons. The managers may properly authorize competent officers to act on their behalf. However, they cannot delegate the function of deciding whether to discharge detained patients. The discharge decision is personal, and must be exercised by three or more hospital managers. In an N.H.S. trust the duties of managers have to be carried out by "the trust", thus permitting delegation by the directors to a committee (Code of Practice, para. 24.4, Mental Health (Amendment) Act 1994, s. 1.).

6.02 Concept of Management

The concept of management presumes overall responsibility for the reception to, and detention in, hospital of patients, and the quality of services provided. Managers have the legal control over beds, they employ most staff and are ultimately accountable for the operation of the hospital. Management functions can be divided into three broad areas of responsibility. First, the managers are the **formal detaining authority** with ultimate responsiblity for compulsory admission, transfer, and renewal of the authority to detain; they also have an independent power to discharge unrestricted patients. Second, the managers are responsible for ensuring the **rights and welfare** of patients. They must inform patients of their rights under the Act; provide information to relatives; refer certain cases to tribunals; investigate complaints; and take decisions about withholding correspondence sent by, or to, certain detained patients. Third, the managers have a **record keeping** function to ensure that appropriate documentation and information about patients within the hospital are kept in an accurate and current form. In pursuance of this function they are to receive various reports and notices; the managers are also required to make certain records and report themselves.

6.03 Admission and Transfer

In practice consultants make beds available in hospitals. However legal control over admissions rests with the hospital managers.

[1] In the definition of the managers "hospital" means a hospital within the meaning of Part II of the Act. See para. **3.02.1**.

(See para. **3.03** *ante*). (As to the managers of special hospitals, see para **3.05** *ante*). Every application under Part II of the Act must be addressed to the managers of the hospital to which admission is sought (s. 11(2); see reg. 4(1)). Where a patient is admitted to the hospital within the specified period (s. 6(1)), (see Appendix E *post*) in pursuance of a duly completed application, the application is sufficient authority for the managers to detain the patient (s. 6(2)).

Where a patient has been admitted to hospital in pursuance of an application under section 2, 3 or 4, or detained pursuant to a report under section 5(2), a record of the admission must be made by the managers (reg. 4(3), form 14).

The managers have a duty to ensure that the grounds for admission are valid and reasonable and that all documents are in order. The managers should request a social circumstances report from the local authority (s. 14) where the nearest relative applied for admission. (Code of Practice, para. 24.7)

The managers also have control over transfers to hospital (see para. **11.18** *post*). Transfers between hospitals under the same managers (s. 19(3)), or transfers of special hospital patients by direction of the Secretary of State (s. 123), can be effected by the managers without regard to the regulations. (See further para. **3.08** *ante*). In other cases transfer requires an authority in the prescribed form (reg. 7(2)(*a*); form 24, Pt. 1) given by the managers of the hospital in which the patient is liable to be detained; and those managers must be satisifed that arrangements have been made for the patient's admission to hospital within 28 days of the authority for transfer (reg. 7(2)(*b*)).[1] The functions of the managers relating to transfer in pursuance of regulation 7 may be performed by an officer authorised by them (reg. 7(5)).

The delegated officer(s) must be able to justify a transfer and ensure that it is not for punitive reasons. (Code of Practice, para. 24.8)

A hospital order, and other orders under Part III of the Act, also cannot be made unless the court is satisfied on evidence of the medical practitioner who would be in charge of treatment or another representative of the managers, that arrangements have been made for the person's admission to hospital. (For these purposes the court can request the Regional Health Authority to furnish information with respect to hospitals at which such arrangements could be made (s. 39).) (See further para. **15.09** *post*)

6.04 Scrutiny of Documents

The foregoing requirements indicate that the managers are ultimately accountable for the lawfulness of compulsory admission. The

[1] This requires the agreement of the managers of the hospital to which the person is to be transferred; and, on the transfer, those managers must record the admission in the prescribed form (reg. 7(2), form 24, Pt. II).

managers who act on the authority of documents (*e.g.* the application and medical recommendations) must ensure that they are in the proper form as an incorrectly completed document may not constitute sufficient authority for the patient's detention. In scrutinising the documents the managers may assume the authenticity of the signature or qualifications of the person by whom the document is made (s. 6(3); reg. 3(4)). The managers are not specifically required to go beyond the face of the documents, for example, by questioning the facts or opinions stated in them; but they must ensure that the documents are legally sufficient—*i.e.*, the procedures and time limits laid down in the Act and Regulations are complied with; where reasons are given (*e.g.*, in a medical recommendation supporting an application for admission for treatment) they must be sufficient. Research at the time of the 1959 Act suggested that a significant number of applications did not fulfil the statutory requirements and were not noticed by the managers.[1]

The managers should formally designate a limited number of officers with adequate knowledge of the Act to receive and scrutinise documents. A general manager is advised to take overall responsibility for the receipt and scrutiny of documents. Managers may delegate the task of receiving documents to the nurse in charge of the ward, preferably a first level nurse. To minimise errors the "receiving officer" should use a standard list and check accuracy with the ASW making the application. The receiving officer should have access to a manager at all times. Documents must be scrutinised by a person authorised by the managers to rectify a defective application immediately after the patient's admission (see para. **6.05.1** below). The managers must also arrange for medical recommendations to be scrutinised to ensure they are sufficient (see para. **6.05.2** below).

6.04.1 *Access by patient to his admission forms*

The Act is silent as to the power or duty of the managers to allow the documents to be examined by the patient or his representative for the purpose of establishing their legal sufficiency.[2] The definition of health records in section 1 of the Access to Health Records Act 1990 is sufficiently broad to include medical reports supporting an application for compulsory admission. The patient, his authorised representative or, if he is unrepresented, his receiver, may apply for access to these records under section 3 of the 1990 Act. Certainly if the documentation

[1] See P. Bean (1980) *Compulsory Admissions to Mental Hospitals*, Wiley, Chichester.

[2] But there is a power given to a registered medical practitioner to inspect documentation relating to detention or treatment either when authorised by the nearest relative for the purpose of advising as to his power of discharge (s. 24(1), (2)), or when authorised by the patient for the purpose of furnishing information for a manager's reference to a tribunal (s. 68(3)).

is not in order, and cannot be rectified under the Act, the legal remedy of *habeas corpus* (see para. **17.07** *post*) would lie and a court could require the relevant documents to be released.

6.04.2 *Mental Health Act Commission*

There is no longer any central body such as the Board of Control with responsibility systematically to scrutinise all documents. (See paras. **1.06.2** *ante* and **22.02** *post*). However the Secretary of State for Health has the responsibility (exercised through the Mental Health Act Commission) to review the exercise of the powers and duties relating to the detention of patients (s. 120(1)). Any person authorised on behalf of the Secretary of State may require the production of and inspect any records relating to the detention or treatment of the patient (s. 120(4)). Thus the responsibility for regularly reviewing the documentation relating to detention rests with the managers, and the Commission may endeavour to ensure that they exercise this and other responsibilities (*e.g.* investigation of complaints) efficiently; further the Commission can itself examine the lawfulness of compulsory admission (but it cannot itself discharge a patient). (see further paras. **22.02–22.14** *post*).

6.05 Rectification of Documents

Section 15 provides for the rectification of documents after they have been acted upon; patients may continue to be detained for a limited period while an error capable of rectification is corrected. Documents cannot be rectified under section 15 unless they can properly be regarded as applications or recommendations under the Act. A document cannot be regarded as an application or recommendation if it is not signed or if it is signed by a person not empowered to do so, for example, an application signed by a social worker who is not approved or a recommendation by a practitioner who is not registered. Another fault which would invalidate the application completely would be if the two medical recommendations did not specify at least one form of mental disorder in common (s. 11(6)). If any fault of this kind is discovered there is no authority for detention; authority can be obtained only through a new application.[1]

6.05.1 *"Incorrect or defective" documents*

Faults which are capable of rectification may be amended within fourteen days of the date of admission to hospital in pursuance of an

[1] See DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, paras. 52–53. If a patient were to lose his liberty by virtue of an insufficient application, the person who completed the faulty document and the managers (as the detaining authority) could be the subject of an action for false imprisonment unless they acted in good faith and with reasonable care. See further para. **21.02.2** *post*.

application for assessment or treatment.[1] If any such application, or any recommendation upon which it is founded, is discovered to be incorrect or defective, it may, within this period and with the consent of the managers, be amended by the person by whom it is signed. Upon such amendment the document is deemed to have had effect as though originally made as amended (s. 15(1)). Consent to the amendment should be given by a senior officer of the hospital who has been authorised on behalf of the managers (reg. 4(2)). The consent should be recorded in writing and could take the form of an endorsement on the document itself.[2]

"Incorrect or defective" appears to refer to an inaccurate or incomplete document—*i.e.*, a genuine mistake or omission relating, for example, to names, dates, places or qualifications. A document mistakenly completed could be rectified by correcting the error or omission. However, if the document accurately represents the facts, it could not be rectified in order to appear to conform with the procedural requirements—for example, if the recommendation was, in fact, signed **after** the application. Similarly if a document is incomplete (*i.e.*, all of the information required by statute and regulation has not been given) it can be rectified if, with the amendment, it complies with the procedural requirements. It could not, however, be rectified if, with the amendment, it is still defective—for example, if a doctor who is **not** qualified to make a recommendation omits his qualification (see *e.g.* s. 12(13)–(6)) or if a date which does **not** conform with the statutory time limits[3] is omitted. The distinction to be drawn by the managers is between a genuine mistake in the documentation and a failure to comply with a procedural requirement[4]; the former can be rectified while the latter cannot.[5]

6.05.2 *Insufficient Medical Recommendation*

If the managers consider that one of the two medical recommendations is insufficient to warrant the patient's detention, they may, within the fourteen day period, give notice in writing to that effect to the applicant. (Note that written notice goes to the applicant not to the

[1] This would, of course, provide no justification for the detention of a patient admitted under an emergency application (s. 4) beyond 72 hours, unless the second recommendation were received complying with s. 4(4)(*a*), (*b*) (or which would have complied with that section apart from any defect which could be rectified under s. 15 (s. 15(4)).

[2] DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, para. 55.

[3] As to the various time limits see Appendix E *post*.

[4] It should be observed that under s. 15(2), (3) there are certain limited circumstances where the Act permits the remedying of a genuine deficiency in the medical recommendations which would otherwise invalidate the compulsory admission. See para. **6.05.2** below.

[5] In *R. v Managers of South Western Hospital, ex parte Mulcahy* (1992) 12 BMLR 151, at 166 Laws J said that s. 15(1) cannot cure a defect which arises because a necessary event in the procedural chain leading to the detention has not taken place at all. It is essentially concerned with correction of errors on the face of the document.

person who signed the form as under s. 15(1)). Where such a notice is given the recommendation is disregarded, but the application will be deemed always to have been sufficient if, within the fourteen day period, a fresh recommendation in the proper form is furnished to the managers; and both recommendations together comply with the provisions of the Act (s. 15(2)). The medical recommendation should provide a description of the patient's symptoms and behaviour, not merely a diagnostic classification. (Code of Practice, para. 12.4)

The term "insufficient to warrant the detention" can be taken to mean something more than "incorrect or defective". It suggests that the recommendation does not disclose adequate grounds (whether substantive or procedural) to justify the compulsory admission. For example, the officer scrutinising the recommendation for the managers (who may be a doctor) may not consider the reasons given sufficient to warrant the patient's admission for treatment as there is no reasonable discussion of alternative methods of care or treatment or whether informal admission is appropriate (see reg. 4(1)(*f*)(*ii*); form 11).

The provisions allowing the managers to give notice to the applicant of insufficient medical recommendations apply in two circumstances: where one of the two recommendations is found to be insufficient (s. 15(2)) as discussed above; or where both recommendations are valid in themselves but, taken together, are insufficient (s. 15(3))—for example, where neither doctor is approved under section 12, or where the medical examinations were more than five days apart. The fresh medical recommendation must comply with the provision of Part IV of the Act (see s. 12), but need **not** comply with the provisions relating to the time of signature (*e.g.* which must under s. 12(1) be **before** the application is made) and the interval between examinations (s. 12(2)). Thus an initial failure to comply with section 12(1) or (2) can be remedied. However, an insufficiency that can never be remedied is if the application itself is not valid because the recommendations did not specify at least one form of mental disorder in common as required by s. 11(6) (s. 15(3)).

The hospital managers may authorise in writing an officer or class of officers on their behalf to consent to the amendment of a document (s. 15(1)), or to consider the sufficiency of a medical recommendation and to give written notice if the recommendation is insufficient (s. 15(2)). This should be done by a resolution of the health authority.[1] The managers of a mental nursing home, if two or more in number, may similarly authorise one of their number to exercise these functions (reg. 4(2)).

[1] DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, paras. 51, 64.

6.06 Continuing Detention, Discharge and the Managers Hearing

The managers are authorised to detain any patient compulsorily admitted in accordance with the provisions of the Act (*e.g.*, ss. 6(2), 40(1)(*b*)). The managers are also to receive the report completed by the RMO in the prescribed form (reg. 10(1); form 30, Pt. 1) renewing the authority for detention (reg. 10(3); form 30, Pt. ii).

The managers have a power to discharge unrestricted patients (s. 23(2)(*b*)). The power to discharge can be exercised by any three or more members of the authority or body authorised by them, or by three or more members of a committee or sub-committee of the authority or body they constitute (s. 23(4)). This power cannot be exercised by **officers**. A health authority can also discharge a patient maintained under a contract by that authority in a mental nursing home (s. 20(3)).

The managers right to discharge unrestricted patients is an independent safeguard, and is quite separate from the power of the tribunal or RMO to order a discharge. The managers will have full regard to medical advice, but they can override the opinion of the RMO if they feel it is appropriate. Although the managers have the power of discharge, the Act does not specify any particular steps they must take to fulfil their responsibilities. The managers should regard themselves as under a personal obligation to visit the hospitals under their management and be generally familiar with patients and staff. When a request for discharge is made by the patient or a near relative the managers should read the RMO's report and any other relevant documentation available and discuss the matter with those concerned. Having considered these reports and discussions they must decide whether there is reasonable justification for the patient's continued detention. They may find it helpful to hold a "managers' hearing" to give the patient and relative the opportunity to speak with them in person and to present relevant evidence. There is no legal requirement to allow the patient or relative to be accompanied by a representative or spokesperson, but in appropriate cases this may assist the managers in making a fully informed decision and instill confidence in the decision-making process. There is a particularly strong case for a managers' hearing when the patient has missed an opportunity to apply for a tribunal. Such "hearings" or "interviews" should be arranged with as little delay as possible.[1]

Managers should also keep themselves informed of general trends in each hospital, and should be able to monitor the use of compulsory powers—for example, if there is an apparent disproportionate use of emergency admissions. The managers should be prepared to investigate any apparent abnormalities in the patterns of admission in order to

[1] *Ibid.*, para. 62. See also L. Gostin and P. Fennell (1992) *Mental Health: Tribunal Procedure*, Longman, London.

assure themselves that the powers under the Act have been properly exercised.

6.06.1 *Criteria for exercising a decision to admit or continue to detain*

The managers possess a general discretion not to admit, or to discharge, patients that is largely unfettered. Nevertheless, managers' decisions must be based on relevant considerations. First, the managers must have regard to the statutory criteria for admission or continuing detention. In determining the appropriateness for detention for assessment or treatment they must consider the statutory criteria, respectively, under s. 2 or s. 3. Second, the managers must carefully review medical and other evidence before them and the probative value of that evidence. Finally, if a nearest relative has exercised a power to discharge that is "barred" by the RMO, the managers must take into account the cogency of the reasons offered by the nearest relative and the RMO, together with the statutory criterion for issuing a "barring" report—i.e., the patient, if discharged, would be likely to act in a dangerous manner.

The court in *R. v. Riverside Mental Health Trust ex parte Huzzey*[1] quashed the managers' decision to detain a patient for treatment pursuant to s. 3 of the act. The nearest relative had asked for his discharge and the RMO issued a "barring" report. For the purposes of their review, the managers received a joint report from two doctors. The court held that the managers could not reasonably have authorized the patient's detention under s. 3: (i) the statutory criteria for s. 3 states that the patient must be in need of treatment, but the joint medical report merely stated that he required further assessment to determine the need for treatment; and (ii) the managers did not consider whether the patient would be likely to act in a dangerous manner as required when an RMO issues a barring report. Consequently, in exercising their discretion, the managers must apply their minds to the appropriate statutory criteria in light of all the relevant evidence.

6.06.2 *Managers' review: practice pointers*

Patients must be clearly informed that a managers' review is not a condition precedent to a tribunal hearing, nor does a managers' review negate any right to apply to a tribunal.

The Code of Practice (paras. **22.1–22.6**) states that, in addition to the discretionary right to conduct a review at any time, the managers have a duty to do so: (*a*) when requested by the patient (unless there has been a recent review and nothing has changed); (*b*) when the RMO

[1] QBD. The Times 18 May 1998, CO/3773/96 (Transcript: Smith Bernal), 43 BMLR 167.

issues a report seeking to renew the period of detention (s. 20);[1] and when the RMO issues a report barring a nearest relative's discharge (s. 25(1)).

The managers should have full information about the patient's medical and social situation prior to the review. This includes reports from, and consultation with, all relevant disciplines. The nearest relative should be consulted, provided the patient consents.

No specific form of managers' review is recommended in the Code of Practice. The managers' review should not be very formal, but should be complete, serious, and impartial. The patient should be able to express his point of view and present evidence; be accompanied by a representative of his choosing; be able to question, and have the managers' question, the RMO and other relevant professionals; and be present while opinions and evidence are being provided by relevant parties and professionals.

The managers must give reasoned decisions, orally and in writing, to the patient, relatives, and professionals involved in the review. Copies of relevant reports and reasons should be placed in the patient's records.

6.07 Duty to Inform Detained Patients

The managers must take such steps as are practicable to ensure that every detained patient understands:

(*i*) the section of the Act under which he is for the time being detained and the effect of that section; and

(*ii*) the right (if any) he has to apply to a Mental Health Review Tribunal.[2]

The information must be given as soon as practicable[3] after the commencement of the patient's detention under the provision in question (s. 132(1)). This means that the information must be given when the original detention begins and, again, after a different section is used to authorise his detention.

The managers have a further duty to take such steps as are practicable to ensure that the patient understands the effect, so far as relevant to his case, of the following provisions:

(*i*) the power of the RMO, the managers and the nearest relative to discharge the patient (s. 23) (see para. **17.02** *post*);

(*ii*) the power of the RMO to issue a report barring a discharge by

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[1] It is recommended that such reports be submitted no less than two weeks prior to the expiration of the period of detention to enable the review to take place.

[2] As to periods of eligibility to apply to tribunals see paras. **18.03–18.04** *post*.

[3] In practice this will mean the patient must be given the information immediately if he is detained for 72 hours or less. DHSS, *op. cit.*, para. 274.

the nearest relative (s. 25), and the right of the nearest relative to apply to a tribunal within 28 days beginning with the day the relative is informed of such a report (s. 66(1)(*g*), (2)(*d*) (see para. **17.02.3** *post*);

(*iii*) consent to treatment (Part IV) (see paras. **20.07–20.28** *post*);

(*iv*) the code of practice prepared by the Secretary of State (s. 118) (see para. **22.14** *post*); the Secretary of State's duty (exercised on his behalf by the Mental Health Act Commission) to keep under review the exercise of powers and duties relating to detention of patients, including the function of visiting and interviewing detained patients and investigating complaints (s. 120) (see paras. **22.10–22.11** *post*); the withholding of correspondence of certain patients (s. 134) (see paras. **24.30–24.36** *post*).

The foregoing information must be given to the patient as soon as practicable after the commencement of the patient's detention (s. 132(2)). This wording is slightly different from s. 132(1) insofar as it appears that the patient must be told after the commencement of his detention, but need not necessarily be told again if placed under a subsequent section. However, if the detention is broken by a period, however short, of informal admission or discharge into the community, and the patient is again placed under detention, there is a requirement to give the information afresh. The intention of s. 132 is that the patient should understand the means by which his detention can be ended and the various safeguards available to him while he is in hospital. This should be regarded as the minimal amount of information required by law. The patient should also be informed about any other right which could benefit him—for example, the availability of legal advice or assistance for a court of appeal; entitlement to welfare benefits; transferred patients should be told of any particular rights to apply to a tribunal.[1] Further, it would be beneficial if the patient's rights were discussed with the patient at reasonable intervals. When the patient is discharged from detention, or the authority for detention expires, this fact should be made clear to him. Arrangements should be made for his after-care. Finally, his rights in the community (*e.g.*, under the Housing Act 1985) should be discussed and assistance given to secure those rights.[2]

The words in s. 132 "shall take such steps as are practicable to ensure the patient understands" are important. "To take such steps" indicates the managers can, and arguably should, delegate their function to be carried out by a person familiar with the patient—*e.g.*, the RMO, nurse or social worker. Further, the duty is not simply to give information but to do whatever is possible to help the patient understand the information. This could involve the assistance of an interpreter if there

[1] See DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, para. 275.

[2] *Ibid.*, para. 277. As to rights to services in the community, see chap. 4 *ante*.

are linguistic or hearing difficulties; the professional who provides the information should explain in an appropriate and sympathetic manner at a level suitable for the patient's maximum comprehension; and he should discuss problems, answer questions and provide assistance to the patient in securing his rights.

The managers are under a duty to provide the information both orally and in writing (s. 132(3)). They are under a further duty, except where the patient otherwise requests, to take such steps as are practicable to furnish to the person (if any) appearing to be the nearest relative with a copy of any information given to the patient in writing. This information must be provided within a reasonable time after it is given to the patient (s. 132(4)).[1]

6.08 Duty to Inform Nearest Relative of Discharge

Where a patient liable to be detained is to be discharged other than by an order by the nearest relative, the managers must take such steps as are practicable to inform the person (if any) appearing to be the nearest relative. Such information must, if practicable, be given at least seven days before the date of discharge (s. 133(1)). However, the foregoing information should not be given if the patient **or** the nearest relative has requested that it should not be given (s. 133(2)).

6.08A Managers' Information Policy

The managers should devise a policy for ensuring that all patients (detained and informal) receive full and accurate information about their rights throughout their stay in hospital. Information should be provided in a clear and comprehensible manner; requests for information should be answered completely and honestly; and patients should have the opportunity for frank and open discussions with hospital staff. (Code of Practice, para. 14.1).

Managers should ensure that information required by statute (see paras. **6.07–6.08** above) is provided by well trained professionals and that records are kept to ensure that the appropriate information is given in a timely manner. The person giving the information should record details on the patient's case notes, together with his assessment of the patient's comprehension.

Patients should be provided with information about their rights beyond those required under the Act. Particular information includes: (*a*) the right of informal patients to know that they are free to leave the hospital at any time; (*b*) an explanation of the nature, purpose, and likely effects of treatment for the purposes of consent, withdrawing

[1] Leaflets are available from the DHSS Publications Unit for the purposes of the written information required to be given to the patient and his nearest relative. Information leaflets are also available from MIND.

consent, and second opinions provided by the Mental Health Act Commission; (*c*) the section under which the patient is detained, as well as renewal of detention and transfer to informal status, so that the patient is aware of all of his rights of review by the managers, the Commission, and the tribunal. (Code of Practice, para. 14.13).

6.09 Reference to Tribunal

The managers have responsibilities for referring cases to Mental Health Review Tribunals in the following circumstances:

(*i*) if an application,[1] or a reference by the Secretary of State, has not been made to a tribunal in respect of a patient admitted to hospital for treatment (s. 3), or transferred from guardianship to hospital (s. 19), within the first six months of the admission or transfer (s. 68(1));

(*ii*) if the authority for the detention of a patient in hospital is renewed (s. 20), and a period of three years (or one year in the case of a patient under the age of sixteen)[2] has elapsed since the case was last considered by a tribunal (s. 68(2)). (See further para. **18.05** *post*)

6.10 Correspondence

The managers may, under certain circumstances, withhold the post sent by, or to, a patient detained in a special hospital (s. 134(1), (2)) (see further paras. **24.30–24.36** *post*). Further, the managers may inspect and open post for the purposes of determining whether it can be withheld (s. 134(4)). Where post is inspected (whether or not it is withheld) the managers must make a written record of the information specified in regulation 17 (s. 134(5)). Where post is withheld the managers must, within seven days, give written notice of the fact to the patient and, if applicable, to the person who sent the post. The notice must include an explanation of the power of the Mental Health Act Commission to review the decision to withhold post (s. 134(6); reg. 18). The functions of the managers **must** be discharged on their behalf by a person on the staff of the hospital appointed by them for that purpose, and different persons may be appointed to discharge different functions. This does not obviate the fact that the responsibility for decisions rests with the managers who should carefully monitor the exercise of these powers which affect a person's ordinary rights.

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[1] For the purposes of determining if a patient's case must be referred to a tribunal, any application made but subsequently withdrawn is treated as if there had been no application (s. 68(5)). See para. **18.04.8** *post*.

[2] The Secretary of State for Social Services may by order vary the length of the periods mentioned (s. 68(4)).

6.11 Record Keeping and Reports

The managers have to keep a number of records under the Regulations. These include making a record of admission under Part II (reg. 4(3), form 14); receipt of a medical recommendation (reg. 4(4), form 15); receipt of a report reclassifying a patient (reg. 6(*a*), form 22); admission of a transferred patient (reg. 7(2), form 24, Pt. II); receipt of a report renewing detention (reg. 10(1), form 30, Pt. II); reception of a patient removed to England and Wales (reg. 11(3), (4), form 33); and receipt of a report barring discharge by the nearest relative (reg. 15(3), form 36). The managers also have to make certain reports under the Regulations, including a report giving authority for transfer from one hospital to another (reg. 7(2), form 24) or from hospital to guardianship (reg. 7(3), form 25, Pt. I). The hospital managers are entitled to delegate to individual officers or a class of officers their function of making records or reports under the Regulations (reg. 3(6)). This should be done by a resolution of the health authority.

6.12 General Management Functions

There is a whole range of functions undertaken by responsible managers which are not specified in the Mental Health Act, but are implied by the general management responsibility of ensuring the efficient operation of the hospital—*i.e.*, service development, administration and patient care. The requirement of managers to investigate complaints independently and thoroughly is already contemplated in section 120(1)(*b*)(*i*) of the Act. General principles to strive for, already referred to in international declarations, are the rights to dignity, privacy and humane care within as normal environment as possible.[1] This should include the right to communicate (by visiting, correspondence and telephone), to keep personal possessions and money, to have the opportunity of exercise and recreation, to have individually locked storage space for private use, to exercise the franchise and other rights of citizenship. Many of the statutory and implied responsibilities of management can be delegated. However, the managers must ensure that the responsibilities for which they are accountable are discharged lawfully, efficiently and caringly.

6.13 Service of Documents

Except in the case of an application for admission and a nearest relative's discharge order (see below) any document required or authorised to be served upon the managers under Part II of the Act or the Regulations may be served:

(*i*) either by delivering it personally to the managers or to any person authorised by them to receive documents on their behalf; or

[1] See L. Gostin (vol. 1; 1975) *A Human Condition*, MIND, London, Appendix IV.

(*ii*) by sending it prepaid post addressed to the managers at their registered or principal office (reg. 3(1)).[1]

These documents include: a report furnished to the managers authorising the detention of an informal patient for up to 72 hours (doctor's holding power) (s. 5(2)) (see para. **10.04** *post*); the written record of the nurse's six hour holding power (s. 5(4), (5)) (see para. **10.05** *post*); a report by the RMO which renews the authority for detention (s. 20) (see para. **11.06.5** *post*).

An **application for admission** under Part II of the Act must be served by delivering the application personally to an officer of the managers (of the hospital to which the patient is to be admitted) authorised by them to receive it (s. 11(2); reg. 3(2)). Any **order by the nearest relative** for the discharge of a patient (s. 23) and the 72 hours notice of such an order (s. 25(1)), must be served either by delivering it at the hospital to an officer of the managers authorised by them to receive it or by sending it by post to the managers at the hospital (reg. 3(3)).

None of the documents discussed in this paragraph takes effect until delivered to the managers or the person authorised to receive them on their behalf. The only exception is where a nurse has exercised a holding power, in which case the authority to detain commences from the time when the nurse makes the recording, and not when it is delivered to the managers (s. 5(4), (5)). Some of the documents discussed (particularly the doctor's report under s. 5(2), an emergency application under s. 4, or the nearest relative's notice of intention to discharge the patient (s. 25)) may need to be received out of office hours. It follows that there should always be someone in the hospital who is authorised to receive documents on behalf of the managers.[2]

[1] Note that any document required to be sent to the managers is deemed to be properly addressed if addressed to the administrator of that hospital (reg. 3(5)).

[2] See DHSS, *op. cit.*, para. 65.

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B. MEDICAL PRACTITIONERS

6.14 The General Medical Council

The General Medical Council was first established by the Medical Act 1858. Its contemporary functions include keeping and publishing the Register of qualified doctors, fixing the standards of education and experience required for entry to the Register and taking action against registered doctors if it appears that they have become unfit to practice.[1] Control over professional conduct and fitness to practice on grounds of physical or mental health are entrusted to three committees of the Council:[2] preliminary proceedings,[3] professional conduct[4] and health.[5] Provision is made for appeals to the Judicial Committee of the Privy Council.[6]

6.14.1 *Procedures of General Medical Council Committees*

Rules promulgated in 1980 govern the conduct of proceedings of General Medical Council committees.[7] In *Gee v. General Medical Council*[8] a charge of serious professional misconduct contained a number of separate allegations relating to eight different patients. The medical practitioner claimed the charge was bad for duplicity (*i.e.* a charge should not allege more than one offence). The House of Lords held that the rule against duplicity did not apply to a charge alleging a course of conduct amounting to serious professional misconduct. A course of conduct might amount to serious professional misconduct even though the particular instances making up that course did not.

6.15 Registration of Medical Practitioners

Any person who possesses the following two qualifications is entitled to be **provisionally** registered:

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[1] The Council is established by s. 1(1) and Sch. 1 of the Medical Act 1983. Unless otherwise specified, any reference in paras. **6.14–6.15** is to the Medical Act 1983.

[2] See Medical Act 1983, ss. 1, 43, Sch. 4.

[3] The preliminary proceedings committee decides whether a case ought to be referred for inquiry to the professional conduct or health committee; it can make interim orders for suspension or conditional registration (s. 42).

[4] The professional conduct committee holds inquiries into charges that practitioners have been convicted of criminal offences or guilty of serious professional misconduct; it can make directions for erasure, suspension or conditional registration (ss. 36, 38).

[5] The health committee holds inquiries into charges that the fitness to practice of a practitioner is seriously impaired by reason of his physical or mental condition; it can make directions for suspension or conditional discharge (ss. 37, 38). There is also established an Education Committee (ss. 5–9) which promotes high standards of medical education.

[6] The Medical Act 1983, s. 40.

[7] General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1980, S.I. 1980, No. 858.

[8] [1987] 2 All E.R. 193.

(*i*) a primary U.K. qualification[1] such as a degree of bachelor of medicine or surgery granted by a university in the United Kingdom;[2] and

(*ii*) successful completion of a qualifying examination.[3]

A practitioner must spend one year in a resident medical capacity in an approved hospital or institution before he can proceed to full registration.[4]

A person who is not fully registered cannot use any title or designation implying he is registered or legally recognised as a physician or surgeon;[5] he is not entitled to recover his charges in a court of law;[6] he may not hold certain appointments such as in the NHS;[7] and he cannot possess or supply controlled drugs. An unregistered person is specifically prohibited from any medical appointment in any hospital or other place for the reception of persons of unsound mind.[8] A certificate required by any enactment from a medical practitioner is not valid unless the person signing it is fully registered.[9] This would include recommendations for the purposes of compulsory admission to hospital or guardianship under Part II of the Mental Health Act and certificates for the purposes of consent to treatment under Part IV of that Act.

6.16 Royal College of Psychiatrists

The Royal College of Psychiatrists was formed from the Royal Medico-Psychological Association and was granted a Supplemental Charter in 1971. Its objects include the advancement of the science and practice of psychiatry, to further publication therein, and to promote study and research work. Membership may be granted to practitioners registered for not less than three years if they have undergone the requisite training in psychiatry and have passed the qualifying examination; the practitioner is then awarded the diploma MRCPsych. Fellows

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[1] *Ibid.* s. 53.

[2] Section 3 also requires recognition of medical qualifications granted in EEC countries (see also ss. 17, 18). The registration of overseas qualified doctors is provided for in certain circumstances. Medical Act 1983, Pt. III. At least 60% of registrars and senior officers in psychiatry were born outside the U.K. Since psychiatry is the most language-bound branch of medicine, such psychiatrists may have special difficulties. See Mahapatra (1980) Problems of Language in Examinations for Foreign Psychiatrists in *Handbook for Inceptors and Trainees in Psychiatry* (T. Bewley and S. Mahapatra, eds.) Royal College of Psychiatrists, London, pp. 78–80; A. Clare (2nd ed., 1980) *Psychiatry in Dissent*, Tavistock, London, pp. 401–13.

[3] Medical Act 1983, s. 4.

[4] Medical Act 1983, s. 10.

[5] *Ibid.*, s. 49.

[6] *Ibid.*, s. 46.

[7] Medical Act 1983, s. 47. If a doctor's registration is suspended his contract of employment as a medical officer at a hospital is frustrated and is at an end. *Tarnesby v. Kensington, Chelsea and Westminster Area Health Authority (Teaching)* (1978) 123 Sol. Jo. 49.

[8] Medical Act 1983, s. 47(1)(*b*)).

[9] *Ibid.*, s. 48.

are elected and hold the title FRCPsych. Both are registrable qualifications.[1]

6.17 Statutory Definitions and Functions

6.17.1 *Responsible Medical Officer*

In relation to a patient liable to be detained under an application for assessment (s. 2 or s. 4) or for treatment (s. 3) or under Part III of the Act, the responsible medical officer (RMO) is the registered medical practitioner in charge of the treatment of the patient (ss. 34(1), 55(1)).[2] Responsible medical officer takes on the same meaning in respect of the consent to treatment provisions under Part IV of the Act (s. 64(1)). The person who is RMO is a question of fact; it is the consultant who has clinical responsibility for the patient. The term RMO is reserved for the registered medical practitioner who has responsibility for certain patients who are liable to be detained; with one minor exception[3] the term is not employed in the Act in relation to informal patients.

In relation to a patient subject to guardianship the RMO is the medical officer authorised by the social services authority to act as the RMO (s. 34(1)). A registered medical practitioner can be authorised by the social services authority to act as RMO generally, or in any particular case, or for any particular purpose. Further, the Act does not specifically state that the RMO is "in charge of the treatment" of a guardianship patient.

The RMO has specific powers and duties under Parts II and III of the Mental Health Act including the power to grant and revoke leave of absence in respect of certain patients detained in hospital;[4] make statutory reports for the renewal of the authority for detention or guardianship of certain patients;[5] bar the discharge of certain patients by the nearest relative;[6] and discharge certain patients.[7]

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[1] See T. Bewley and S. Mahapatra, eds. (1980) *Handbook for Inceptors and Trainees in Psychiatry*. Royal College of Psychiatrists, London.

[2] The patient's usual consultant is the person to exercise most statutory powers of the RMO such as a report renewing detention. However, functions requiring swift action, such as a report barring the nearest relative's discharge order, may be undertaken by the doctor for the time being in charge of the patient's treatment. See DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, para. 66.

[3] The exception is the RMO in relation to an informal patient for whom it is proposed should be given a serious treatment referred to in s. 57(1).

[4] That is, patients liable to be detained under Part II (s. 17); non-restricted patients under Part III (s. 40(4), Sch. 1, Pt. I, para. 1); and, with the consent of the Home Secretary, restricted patients (s. 40(4), Sch. 1, Pt. II, paras. 2, 3).

[5] That is, patients admitted for treatment or subject to guardianship under Part II (s. 20); and non-restricted patients under Part III (s. 40(4), Sch. 1, Pt. I, paras. 2, 6).

[6] That is, patients liable to be detained in hospital for assessment or for treatment (s. 25).

[7] That is, non-restricted patients liable to detention or subject to guardianship under Part II (s. 23(1), (2)) or Part III (s. 40(4), Sch. 1, Pt. 1, paras. 2, 8); and, with the consent of the Home Secretary, restricted patients (s. 40(4), Sch. 1, Pt. II, paras. 2, 7).

The functions of the RMO in relation to the patient's treatment and care are not specified in the Act. He is, however, described as the doctor "in charge of the treatment of the patient", and "medical treatment" includes care, habilitation and rehabilitation "under medical supervision" (s. 145(1)). It is probable that the term RMO would be regarded by a court as primarily a descriptive term in which Parliament did not intend to confer any specific powers and accountability in the consultant, other than those expressly provided for in the Act. As such the term has no substantive meaning outside the context of the specific functions given to the RMO in the Act. There is, for example, nothing in the Act which specifies where responsibility for the patient primarily resides or in whom overall accountability for every treatment is vested. The court would not be concerned with accountability in the managerial sense. If the consultant were to refer the patient for treatment, he would have to exercise reasonable care in choosing a professional. (The consultant would usually be entitled to assume that the health authority, in appointing a particular individual to a post, has satisfied itself that he is adequately trained and possesses the necessary qualifications for the satisfactory discharge of his duties.) A separate duty of care is owed by each individual providing care or services whether he is a consultant, a non-medical professional or a member of the auxiliary staff of the hospital; the required standard of care varies according to the skills and qualifications of the professional group.

6.17.2 *Nominated Medical Attendant*

The term RMO is used where the patient is subject to the guardianship of a local social services authority. In the case of a patient subject to the guardianship of a person other than a social services authority, a registered medical practitioner must be appointed to act as the nominated medical attendant of the patient (s. 9(2)). The nominated medical attendant is the registered medical practitioner appointed as the medical attendant of the patient under reg. 12(*a*), (*b*).[1]

6.17.3 *Appropriate Medical Officer*

In section 16 of the Act (reclassification of patients) the appropriate medical officer means, in the case of a patient subject to guardianship of a person other than a local social services authority, the nominated medical attendant; and, in any other case, the responsible medical officer (s. 16(5); reg. 2(1)).

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[1] Unless the context otherwise requires all references to regulations are to the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983 No. 893.

6.17.4 *Registered Medical Practitioner In Charge of Treatment*

The phrase "registered medical practitioner in charge of treatment" is used in s. 5(2), (3) of the Act (application in respect of a patient already in hospital). The phrase is used instead of RMO because it relates to patients for whom there is, for the time being, no authority for their detention. By virtue of s. 5(2), the medical practitioner in charge of treatment (or his nominated practitioner) can furnish a report to the managers authorising the detention of an informal patient for 72 hours. (See further para. **10.04** *post*). It would appear that "the medical practitioner in charge of the treatment of the patient" becomes the RMO once he has furnished this report.

6.17.5 *Approved Medical Practitioner*

Medical recommendations are required for the purposes of an application for compulsory admission to hospital or reception into guardianship under Part II of the Act. Where two medical recommendations are required, one must be by a practitioner approved for the purposes of s. 12 by the Secretary of State for Health[1] as having special experience in the diagnosis **or** treatment of mental disorder (s. 12(2)). Each doctor is required to state in the medical recommendation whether or not he is approved.[2] If neither recommendation states that the doctor is approved, the managers must make enquiries. If one of the doctors is approved the statement or recommendation can be amended (s. 15); if neither doctor is approved, a new recommendation must be sought (s. 15(3)). (see para. **6.05.2** above). Similar approval under s. 12 is required for one of the two practitioners whose evidence is taken into account by a court before ordering admission to hospital or reception into guardianship under Part III; or for one of the practitioners whose reports are considered by the Home Secretary before directing the transfer to hospital or guardianship of prisoners and certain other persons (s. 54(1)).[3]

Approval of medical practitioners for the purposes of section 12(2) is carried out by Health Authorities.[4] Advice and directions on the approval of doctors is given in HSG(96)3. Regional offices of the National Health Service Executive are directed to form consortia of Health Authorities with one or more member authorities chosen to

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[1] Responsibility for approving practitioners is delegated to regional health authorities (in England) and district health authorities (in Wales). See para. **2.19** *ante*.

[2] Reg. 4(1)(*b*), (*e*), forms 3, 4, 8, 9.

[3] The detailed requirements for medical recommendations and medical evidence or reports given to the court are described, respectively, at paras. **11.10** and **15.23** *post*. Doctors are sometimes entitled to special fees for conducting an examination with a view to making a recommendation. See DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, para. 27.

[4] National Health Service (Functions of Health Authorities and Administrative Arrangements) Regulations 1996, S.I. 1996, No. 708, reg. 4(6) and Sch. 1.

commission or manage arrangements for appointing "section 12 doctors." The lead authority or authorities should: (i) establish a suitably experienced panel of medical practitioners expert in the diagnosis of mental illness, mental impairment, severe mental impairment and psychopathic disorder from across the authorities to approve doctors under section 12; (ii) report annually to the Regional office as part of the performance management process on the arrangements adopted; (iii) take steps to encourage suitably qualified medical practitioners, including general practitioners and doctors working in the prison medical service, to apply for approval; (iv) ensure that there are sufficient approved doctors to provide 24-hour cover, and that all concerned parties, including GPs, mental health centres and social services know how to find out about the local on-call rota. The aim should be to ensure that each purchasing authority is satisfied that all individual provider units have sufficient section 12(2) approved doctors to meet service requirements, including "out of hours" requirements; (v) maintain a list of approved doctors and ensure that all relevant agencies, including Directors of Social Services, Health Authorities, police authorities, police surgeons and courts, have copies; (vi) take responsibility for ensuring the provision of training for doctors on the operation of the Mental Health Act 1983.

Approval is for a maximum of five years renewable, and approved doctors will be able to make medical recommendations under Part II of the Act (or give evidence under Part III) in any part of England and Wales.

HSG(96)3 gives guidance on the criteria for approval. The guidance states that appropriately qualified doctors must have attended a Mental Health Act (section 12 approval) Training Course which has been accredited for Continuing Professional Development purposes by the Royal College of Psychiatrists, for specialist registrar training by the Joint Committee on Hospital Practitioner Training by the Royal College of General Practitioners and at local level for Post-Graduate Education Allowance by the Regional Adviser in General Practice.

Approval panels should accept on to a training course leading to approval only those doctors who fulfil the following criteria relevant to career grade psychiatrists, senior registrars, GPs, prison doctors and others. General Practitioners should have at least three years experience as a principal, with six months full-time or equivalent supervised experience in psychiatry involving use of the Mental Health Act 1983. New applicants would be expected to be members of the Royal College of general practitioners. Psychiatrists will be expected to be members of the Royal College of Psychiatry or have an equivalent qualification. As soon as practicable it is intended that members of the Royal College will be expected to be up to date with Continuing Professional Development. The Guidance says that "other doctors could be considered, but they should provide evidence of special experience or qualifications

such as a Diploma in Psychological Medicine or a Diploma in Medical Jurisprudence."

In *R. v. Trent Regional Health Authority, ex parte Somaratne*[1] the Court of Appeal construed the requirements in section 12(2) for approval of medical practitioners: the practitioner must have "special experience in the diagnosis or treatment of mental disorder." The facts of the case suggested that the Regional Health Authority's decision not to approve Dr. Somaratne may have been influenced by a report of a committee of inquiry into the death of patients at St. Johns Hospital, Lincoln. The committee report was critical of Dr. Somaratne's clinical judgment and record-keeping. Potts J held that the words "special experience" in section 12(2) do no more than provide a minimum requirement for approval. Given the purpose of the legislation, the health authority is entitled to have regard to the fitness of a practitioner for the task at hand.[2]

The Court of Appeal in a divided opinion allowed Dr. Somaratne's appeal. The Court of Appeal ruled that "special experience" is the sole criterion for approval of a medical practitioner. Having "special experience" requires examination of the practitioner's current knowledge and skills in the diagnosis and treatment of mental disorder. However, the health authority is not entitled to have regard for "the fitness of a practitioner for the task at hand" as a separate and additional criterion. The trial judge's conclusion was wrong as a matter of law; the Authority's refusal of the doctor's application and its reconsideration were both flawed because they took as a primary focus a past event and not his present qualifications.[3]

The Court of Appeal provided a limited view of the "special experience" required of medical practitioners, particularly in light of the purposes of approval. The approval process is to be taken seriously for it is intended to assure sound and appropriate decision-making regarding compulsory admission to hospital. "Special experience" requires consideration of all the positive qualifications and practice experiences of a doctor. Surely, it ought also to include evidence of poor judgment and behaviour that reflect on the doctor's ability to assure adequate diagnosis and treatment in the present and future. The evidence provided a reasonable basis for the health authority to conclude that Dr. Somaratne had exercised poor clinical judgment, did not communicate clear instructions to staff, and had engaged in inaccurate record-keeping. These all appear to be relevant to the judgment as to whether the practitioner has sufficient experience to make sound decisions about

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[1] Court of Appeal, Civil Division, (Transcript: John Larking) 29 March 1994.

[2] R. v. Trent Regional Health Authority, ex parte Somaratne, C.O. 2224/93. Judgment of 9 November 1993.

[3] R. v. Trent Regional Health Authority, ex parte Somaratne, Court of Appeal, Civil Division, (Transcript: John Larking) 29 March 1994.

the diagnosis, detention, and treatment of persons with mental disorder.[1]

6.17A Medical Recommendations under the Mental Health Act

Approved medical practitioners (see para. **6.17.5** above) and other doctors have responsibilities for medical recommendations under the Act. (See further, paras. **11.04.2, 11.05.3, 11.06.3, 11.07.4, 11.10**). The Code of Practice (paras. 2.18–2.25) provides the following guidance on the doctor's professional responsibility and the conduct of medical examinations.

6.17A.1 *The doctor's professional responsibility*

The doctor has an individual professional responsibility to: (*a*) decide whether the patient is suffering from mental disorder within the meaning of the Act, and assess its seriousness and the need for further assessment and/or medical treatment in hospital;[2] (*b*) specifically address the legal criteria for admission, setting out those aspects of the patient's symptoms and behaviour which fulfil those criteria; (*c*) ensure that, where there is to be an application for admission, a hospital bed will be available.

6.17A.2 *Medical examination*

A proper medical examination requires the doctor to: (*a*) conduct a direct personal examination of the patient's mental state, taking into account the social/cultural/ethnic context; (*b*) consider all available relevant medical information including that in the possession of others, professional and non-professional; and (*c*) have recourse to a professional interpreter who understands the terminology and conduct

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[1] Ultimately, Dr. Somaratne was unsuccessful in his bid for approval. On reconsideration, the Regional Health Authority again refused his application. Dr Somaratne again applied for judicial review. Latham J dismissed the application, holding that the authority was entitled to consider all the evidence that resulted in the refusal of Dr. Somaratne's application. His Lordship held that: (1) the Health Authority was entitled to take into account the doctor's age because this issue was only considered in the context of the length of approval which might be given; and (2) the authority was entitled to issue guidance to members of its Mental Health Approval Panel which took into account the number of psychiatrists in a given area and adjusting the standard to be applied in considering special experience provided this was applied generally and that the adjustment was directed to consideration of experience only. There was no shortage of approved doctors in the relevant areas which would have justified departing from this standard of experience. *R. v. Trent Regional Health Authority ex parte Somaratne*, 20 July 1995, CO/258/95 (Transcript: John Larking) [1996] C.O.D. 138.

[2] The doctor should consider the factors set out at para. **7.14.3A** *post*, discussing his views with the applicant and the other doctor involved.

of a psychiatric interview whenever there are difficulties in communication.[1]

It is desirable for both doctors to discuss the patient with the applicant. It is essential for at least one of them to do so. (Code of Practice, para. 2.22).

[1] Health authorities should ensure that doctors receive sufficient guidance on the use of interpreters, and should make arrangements for an easily accessible pool of professional interpreters. (Code of Practice, para. 2.35).

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C. NURSING STAFF

6.18 The United Kingdom Central Council and the National Boards

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), together with four national boards, came into operation on July 1, 1983;[1] the General Nursing Council for England and Wales, the Central Midwives Board and the Council for Education and Training of Health Visitors ceased to exist.[2] The principal functions of the UKCC are to establish and improve standards of professional training and conduct; to determine the conditions of admission to training, and the kind and standard of training with a view to registration; and to give advice on standards of professional conduct (s. 2). The principal functions of the National Boards are to approve institutions for the training of nurses, and to monitor their standards. Whilst under the 1979 Act the National Boards had direct responsibility for arranging training, this function now falls to regional health authorities with the role of the Boards being to approve courses (see the Nurses, Midwives

[1] Nurses, Midwives and Health Visitors Act 1979, ss. 1, 5. As to rules relating to registration and training see S.I. 1983, No. 873. The 1979 Act has been substantially amended by the Nurses, Midwives and Health Visitors Act 1992, which is largely based on the recommendations of the *Review of the United Kingdom Central Council and the Four National Boards for Nursing, Midwifery and Health Visiting (1989)* carried out by Peat Marwick-McLintock on behalf of the Department of Health, the Scottish Home and Health Department, the Welsh Office and the Northern Ireland Office.

[2] The 1979 Act implements a major proposal of the *Report of the Committee on Nursing* (Briggs, 1972) Cmnd. 5115, HMSO, London, to bring together, for the first time, the different professions, and each of the four countries, under one central authority. Two-thirds of the members of the UKCC are elected by members of the nursing profession. The remaining one-third are appointed by the Secretary of State for Health (Nurses, Midwives and Health Visitors Act 1992, s. 1).

and Health Visitors Act 1992, s. 5(2)). The 1992 Act also removed the disciplinary functions of the National Boards. The UKCC now has responsibility for all stages of disciplinary procedure.[1]

6.19 Registration of Nurses

The UKCC must prepare and maintain a register of qualified nurses, midwives and health visitors, divided into such parts as the Secretary of State may by order determine (s. 10(1), (2)). Parts 3–6 concern nursing of mentally ill or mentally handicapped people; the parts comprise, respectively, registered mental nurses, enrolled nurses (mental), registered nurses for the mentally handicapped and enrolled nurses for the mentally handicapped.[2] On payment of the required fee, a person must be placed on the professional register if he satisfies the UKCC that he is of good character and has the appropriate professional qualifications (s. 11(2)).[3] The UKCC has stated that there should be a clear separation between the award of the qualification (the responsibility of the National Boards) and registration (the responsibility of the Council).[4] A person commits an offence if, with intent to deceive, (whether by words, writing, conduct or by wearing of any uniform or badge) he represents himself to possess qualifications or to be registered (s. 14).

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[1] The Nurses, Midwives and Health Visitors Act 1992, ss. 5(4) and 8, and the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order, S.I. 1993, No. 893.

[2] For the parts of the register see S.I. 1983, No. 667 as amended by S.I. 1989, No. 1455.

[3] A person is regarded as having the appropriate qualifications for registration if he has (*i*) in the U.K. undergone the training and passed the examinations set by the Council; or (*ii*) in a country of the EEC received special professional qualifications; or (*iii*) elsewhere than the U.K. undergone training recognised by the Council as being of a sufficient standard (s. 11(3)).

[4] UKCC (1983) *Review: Handover Special.*

6.19.1 *Removal from and restoration to the Register*

The UKCC must determine the circumstances and means by which a person may for misconduct be removed from the register (s. 12). The National Boards are to carry out investigations of cases of alleged misconduct with a view to proceedings before the Council for a person to be removed from the register (s. 6(1)(*e*)). The Council must set up committees to hear and determine proceedings for a person's removal or restoration to the register (s. 12(2)). The Professional Conduct Committee and the Health Committee of the Council conduct enquiries to determine, respectively, whether by reason of professional misconduct[1] or unfitness to practice, the person should be removed from (or restored to) the register.

6.20 Statutory Functions

The nursing profession has a vital professional function in respect of the care of mentally disordered people. "Medical treatment" under s. 145(1) of the Act "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision". This language suggests that nursing (unlike other forms of treatment) need not necessarily be under medical supervision. Nurses may have to be consulted under the Act in the following circumstances. A nurse may be the person professionally concerned with the patient's medical treatment with whom the RMO must consult before furnishing a report under s. 20(3) for the purpose of renewing the authority for detention (s. 20(5)) or before reclassifying a patent (s. 16(3)).Further, before a registered medical practitioner can give a certificate that treatment should be given under Part IV of the Act, he must consult two persons who have been professionally concerned with the patient's medical treatment, one (but only one) of whom **must** be a nurse (ss. 57(3), 58(4)). The only specific statutory power given under the Act to nurses is a holding power under s. 5(4) of the Act, which is discussed later. (See para. **10.05** *post*) Nurses, however, have certain common law powers to restrain or search dangerous patients; and they also have protection against civil or criminal proceedings for acts done in pursuance of the Mental Health Act. (See further Chapter 21)

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[1] See UKCC (1983) *Code of Professional Conduct*. (To be used by the Investigating Committees of the National Boards and the Professional Conduct Committee of the Council in carrying out their functions.) As to rules relating to removal from the register, see S.I. 1983, No. 887.

6.21 Responsibility to Carry Out "Reasonable" Nursing Instructions

Nurses are not merely agents for the responsible medical officer. They are professionals in their own right and must contribute to clinical judgments made as part of a multi-disciplinary team. The issue arises whether a nurse can refuse to participate in treatment decisions to which he or she has an objection on grounds of clinical judgment or conscience.[1]

In *Owen v. Coventry Health Authority*[2] a registered mental health nurse refused to participate in electro-convulsive therapy (ECT) in relation to a particular patient, and any other patient. The objection was based upon a professional and personal objection to the treatment. The Court of Appeal had little doubt that the applicant had a duty to carry out "reasonable nursing instructions." The Court accepted that a nurse is professionally bound to express his concern in the interests of the patient if he thought treatment was inappropriate. But a nurse could not refuse to participate in administering a whole class of treatment such as ECT. (The Court had no need to decide whether a nurse reasonably could refuse to cooperate with treatment where he felt it was not in the patient's best interests.)

The *Owen* Judgment still leaves open the scope of the right or duty of a nurse in respect of any particular case where he or she has good grounds for disagreeing with a decision. It also leaves open the scope of the right or duty of a nurse to object to treatments as a class which are hazardous, unestablished or irreverisble.

[1] There already exists statutory authority for a nurse to refuse to participate where she has a conscientious objection to abortion.

[2] Unpublished judgment of the Court of Appeal from the Employment Appeal Tribunal, 19th December 1986 (Parker LJ, Stocker LJ, and Bingham LJ).