SECTION 47

THE COMPULSORY REMOVAL OF OLD PEOPLE FROM THEIR HOMES

by

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SUMMARY

The objective of the research presented in the thesis was to review the use of the powers of compulsory removal contained in Section 47 of the National Assistance Act of 1948. These powers do not require the person to be mentally ill, as the Mental Health Act does. All that is required is that he or she is either suffering from "grave chronic disease" or is "aged, infirm, or physically incapacitated", and that they are living in insanitary conditions. Such persons can be removed by a community physician acting for the local authority if "they are not devoting to themselves or receiving from other persons proper care and attention" provided that he applies to a magistrate or a court.

The Department of Health no longer collects information about the use of Section 47 so it was necessary to write to all the responsible community physicians in England. From the 90 per cent response, the frequency of use of these powers was calculated. In most cases elderly people in crisis were removed. Most of them went to hospitals rather than to old people's homes. There is a considerable variation in the frequency with which the powers are used and 25 per cent of the community physicians did not use them at all during the four years under consideration, which were 1974-78. The possible reasons for this are analysed and the effects of compulsory removal on the elderly people are discussed.

Two disturbing themes emerged from the research. First, there is considerable evidence to suggest that the powers are not used often enough; that many elderly people are coerced, deceived, or "persuaded" from their homes without Section 47 powers of compulsory removal being invoked. There are many admissions which can in no way be considered to be voluntary admissions although they are not covered by Mental Health Act or Section 47 orders. The implications for professional training and practice are outlined and the need for greater legal protection for elderly people is considered.

The second disturbing theme is that the manner in which the Act has been drafted and is currently interpreted defines the "need"

only in terms of personal incapacity. Criteria are laid down with respect to the degree of the person's disability but nothing is said about the degree of community support he should be entitled to expect before he is deemed to need institutional care. Where the need is for treatment which can only be obtained in hospital, for example operative repair of a fractured neck of femur, such definition is unnecessary. However, where the person's requirement is for more care of the type he could receive in his own home if more resources were available, such a definition of "need" evades the basic issue of resource shortage. The implications of this particular definition of need for professionals who meet elderly people and for those who plan services are discussed, using examples from other areas of health care, for example, renal transplantation.

The research summarised in the thesis had two broad aims. One was to determine whether the law was still relevant or whether it should be repealed and the conclusion reached is that it should not be repealed. It is argued that the existence of these powers of compulsory removal is, paradoxically, a means of safeguarding liberty, although their use does infringe the liberty of those individuals who are compulsorily removed. If it were repealed those who would at present be removed using Section 47 would not all be left in liberty at home: many would be coerced, persuaded, drugged, or deceived into an institution without any legal control over the professionals and without any means of appeal.

The second of these more general aims was to analyse paternalistic attitudes towards old people. This relates closely to the former aim because the law, as a whole, is more than a collection of legal instruments. It is an expression of certain attitudes and values and a reflection of certain beliefs, and the function of a law is as important as the manner in which it is used. The methods used in studying this aspect of the subject were drawn from the closely related methodologies of history and anthropology. It is this aspect of the thesis which is, in my opinion, the most significant for the practice of medicine and other professions because it is an appreciation of the attitudes

towards old people which prevail in society which is of fundamental importance in understanding public pressure on professionals and the manner in which professionals themselves analyse, classify and attempt to solve the problems of elderly people.

PART I: SECTION 47

Chapter 1

THE SCOPE OF THE STUDY

THE CONTEXT

Health and social services face two types of problems with elderly people. The most obvious are the problems which result from a shortage of resources, where it is clearly indicated and unanimously agreed what should be done for the elderly person, but there are insufficient resources to do it: examples of this abound in the health service, for example the shortage of facilities for hip replacement, pacemaker insertion or chiropody. The other type of problem is more disruptive to the service, as opposed to being deleterious to the old person concerned, although it also has this effect: it is that which arises at the interfaces - the interface between the health service and other services, and the interfaces within the health service itself.

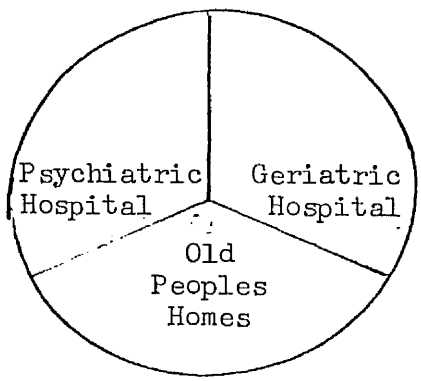
The paradigm of this type of problem is the old person who is deemed not to need hospital care by the health service because she is too fit, but is also assessed by social services as being unfit for an old people's home. If the person has become disabled at home she remains at home, depending on the help of a spouse, who is often disabled also, or a daughter, who is sometimes elderly herself, or a warden who is not employed to provide personal care. Alternatively, she may have to continue living alone with only visits from the domiciliary services to sustain her. If, on the other hand, an elderly person is in hospital and is stated to be ready for discharge by hospital staff but is unacceptable to an old people's home because she is too disabled, she may either have to be discharged to the unsatisfactory home conditions described above, or have to remain in an acute medical, geriatric, or

orthopaedic bed, or in a psychiatric ward, although she does not need hospital care and is occupying a place which cannot therefore be used for the benefit of anyone else. This type of problem - "the blocked bed" - is becoming a major health service problem, and old people who are "at risk" at home but who are ineligible for either a psychiatric hospital or a geriatric hospital or an old people's home, are a major problem for all the statutory and voluntary services, and a common problem for relatives, neighbours, and friends.

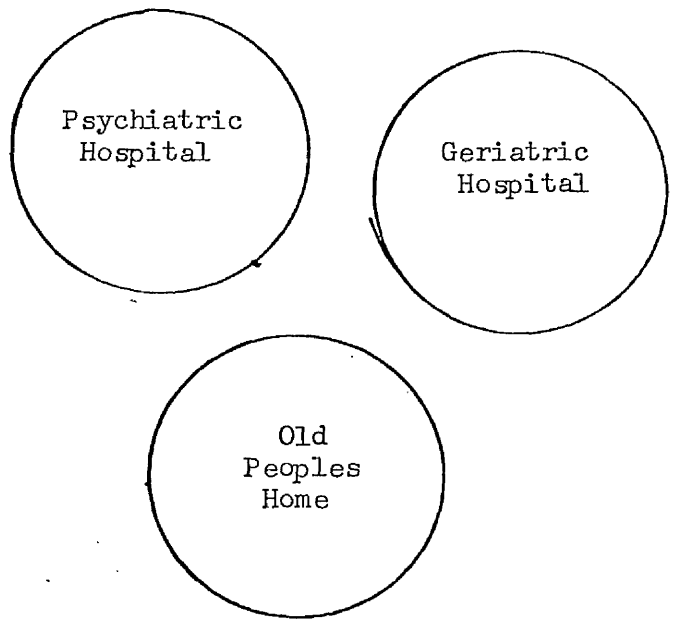
An old person at the interface is not just "a problem": she is an individual with her own expectations, hopes, fears, and wishes, but her wishes may be different from those of her relatives, friends, and neighbours, and the professional may also have to deal with problems which arise at this interface. Often the professionals find themselves aligned with the elder, supporting her against the pressure applied by relatives, friends, and neighbours. On other occasions the professional may disagree with the elder's analysis of her situation and her opinion as to what is best for her. When this disagreement is so profound that compulsory removal of the old person is considered, using the powers which were given to the Medical Officer of Health by Section 47 of the 1948 National Assistance Act, a particular problem is created for the community physician. It is this type of case which forms the focus of my research. (I dislike the term "the elderly" and will use the word elderly only as an adjective throughout this thesis, and will also use the noun "elder"[1], [2]).

It is, however, important that the community physician does not see this type of case in isolation. It is certainly essential to concentrate on the individual's problem while involved in the case referred as requiring compulsory removal, but he should also be using the case to test his hypothesis about the social policies and attitudes which have deemed the old person as being "at risk" and have defined institutional admission as the appropriate solution to the problem. Furthermore, the old person who does not fit neatly

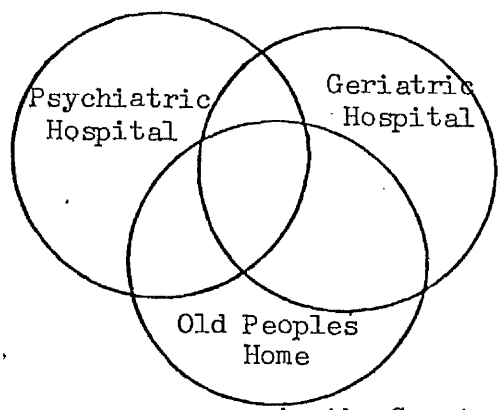
into one of the three main categories of problem - physical illness, mental illness and social incapacity - in the opinion of those who provide each of the three relevant services, offers the community physician the means of plotting the boundaries of each service, as defined by the providers. This type of information is very useful to the community physician trying to encourage the development of an integrated service, one in which the margins of each of the services merge harmoniously with all the others, as in Diagram A, instead of having gaps and overlaps.



A. An Integrated Service



B. Gaps in the Service



C. Overlaps in the Service

There are of course overlaps between the services, as well as gaps between them - that is, there are some people in hospital who are fitter than some in old people's homes and there are some in homes

who are more disabled than some patients in hospital - and they are also of interest to the community physician, particularly if it is impossible to effect the appropriate exchange. (This population is indicated by the overlapping areas in diagram C). It could be argued that the community physician could obtain the necessary information by the use of standardised criteria, such as the Clifton Assessment Procedures for the Elderly[3], but I do not believe this to be the case for the result of an assessment is a function not only of an old person's abilities but of the attitudes and beliefs of the assessor[4]. To understand why there are gaps and overlaps it is necessary to appreciate the attitudes of those who provide each service; their aspirations for their own service and their expectations of the others. Data collection by questionnaire cannot obtain this type of information; involvement in individual cases can, especially if the case is one which is the source of anger and conflict[5]. An old person who is the cause of an interface problem not only helps define the boundaries of the services. She is also a reminder that all such boundaries are arbitrary and artificial.

No illness is without its social implications, especially in old age, and it cannot be assumed that a social problem in this age group is not the result of disease, unless and until a careful medical examination has been conducted[6]. The fact that we have health policies and services and social policies and services does not reflect the existence of two separate classes of problem, two distinct nosological entities. It is the consequence of a political decision. To the community physician, and to all other policy makers, the individual who does not fit in with the existing policies is a useful reminder that the classification of problems into different categories is artificial, although necessary, and that the categories in use and the policies and services in operation have to be continually modified by changing social, economic and technological circumstances.

The fundamental cause of all interface problems is the lack of a unanimously accepted view of the nature of problems which occur in old age. On the basis of terms like "the elderly mentally infirm" or "the elderly" or "the at risk population" attempts are made to draw up criteria, publish guidelines, develop services and implement policies, but insufficient effort has been given to analysing the nature of the problems. Those attempts which have been made appear to have considered the problems as originating principally within old people, and have largely ignored both the manner in which the attitudes of other people cause, aggravate, or precipitate the problems of older people and shape the policies and services intended to solve them. The ageing process is obviously important, as are the pathological processes which occur more commonly in the older age groups, but these physical and mental changes have to be set in their social context - the attitudes towards old people, the beliefs about them, the value placed on them, and the attitudes of old people themselves.

Each professional group, each academic discipline and each individual tries to fit the elderly person into his model, but the use of the metaphor model, as in "medical model", or "models of madness" actually creates problems although it has been helpful. There is no single model which fits all cases, and the attempts of different people to force elderly people and their problems into their own particular model, to the exclusion of other models, creates conflicts. A more appropriate metaphor is the lens[7]. Each profession, discipline and individual has its own view, its own Weltanschauung, which focuses usefully on one aspect of the elder's problem, and it is always necessary to take more than one view of the population.

This thesis summarises its author's attempt to develop a conceptual framework, a theoretical view which brings together all these different views. The emphasis of the work is on paternalistic attitudes towards older people - their origin, influence and implications. The focus

of the work is on a piece of paternalistic legislation - Section 47 of the National Assistance Act 1948 - which gives local authorities the power of "removal to suitable premises of persons in need of care and attention".

AIMS AND OBJECTIVES

The first objective of the research presented in the thesis was to review the use of the powers of compulsory removal which were delegated to the medical profession in Section 47 of the National Assistance Act of 1948, amended in 1951 by the National Assistance (Amendment) Act. These powers do not require the person to be mentally incapable, as the Mental Health Act does, only that he or she be either suffering from "grave chronic disease" or be "aged, infirm or physically incapacitated", and living in "insanitary conditions". Such persons can be removed if "they are not devoting to themselves or receiving from other persons proper care and attention" to a "suitable hospital or other place". I have been responsible for the execution of these powers in the City of Oxford since 1972 and was disturbed not only by the fact that I was frequently called on to implement them, but by the lack of interest in their use. In a decade during which the powers of compulsory removal vested in the Mental Health Act were, quite rightly, the subject of searching review, very little mention was made of Section 47 in the literature and that which did appear was more descriptive than critical or analytical.

The second objective of the research was to publicise the issues involved, through such media as articles in the relevant professional journals, to stimulate debate on the ethical issues involved, to challenge certain aspects of professional practice and to suggest an approach to the problems of elderly people which would make better use of the resources available. The third objective - the parliamentary review of Section 47 - was closely related to the second. Many doctors are unaware of Section 47 powers as are many magistrates and Members of Parliament - and it was my objective to draw attention to this particular piece of legislation and this increased interest,

together with the support of one or two Members of both Houses, would, I hoped, lead to the debate and reform of a statute first passed in 1925.

These were the specific objectives. The work also had three more general aims.

The first was to review the values, beliefs, and the attitudes which allowed society to justify the compulsory removal from their homes of people who were not mentally ill and to consider, more specifically, the relevant attitudes towards, and beliefs about, old people, because Section 47 powers and the antecedent laws were introduced primarily to deal with old people although Section 47 permits the removal of people who are not aged. Related to this was an attempt to explain why there had hitherto been so little interest in the ethical implications of Section 47 powers. In short, the first aim was to consider the legislation not merely as an instrument by which compulsory removal could be effected but as an expression or symbol of certain attitudes and values; a view of law promoted by anthropologists, such as Evans-Pritchard, and popularised in recent years by the debates about the relationship between the law and morality. The second aim was to analyse the concept of need. The need for certain types of treatment, for example, operative repair of a fractured neck of femur or the rewarming of someone who is hypothermic, is assessed with respect to criteria based on objective standards. However, the need for "care", for example the need for admission to an old people's home or psychiatric hospital or a long stay geriatric ward is measured not only against certain conventional criteria relating to the disability of the person in need but is determined also by shortage of resources. This was examined in some detail as this has been a subject which has not received much consideration until the concept of "need for institutional care" has been challenged by the "hospital-at-home" schemes. They have demonstrated clearly that the need for institutional care is not only a function of the person's disability but that it is also a function of the amount

of services available to the person in her own home, providing that the individual does not require procedures available only in hospital, for example, an operation under general anaesthetic. The third aim was to consider the policy implications of paternalism, in particular to review the place of the institution in the spectrum of services and the present pattern of institutional services concentrating on the interface between hospitals and old people's homes, that is, between treatment and care, and argue the case for a new approach to institutional provision for elderly people.

THE STRUCTURE OF THE STUDY

The material is arranged in four parts. The first part of the thesis concerns the use of Section 47 powers. One chapter summarises the legislation, considers the community physician's role in detail, and describes the cases in which I have used the powers of compulsory removal. The second chapter reports the findings of the survey necessary to ascertain the number of times the powers are used in England, and the first part closes with a chapter in which I discuss whether the powers have been abused or underused.

The second part of the thesis sets out the social context in which Section 47 should be considered. It consists of two chapters, one summarising the main steps in the evolution of the legislation, the other analysing the attitudes towards elderly people which I believe to be relevant to an understanding of Section 47.

The third part of the thesis is an examination of the ethical justifiability of those legal powers of compulsory removal. A chapter is devoted to each of the three principal arguments which can be advanced to justify Section 47.

The final part of the thesis attempts to draw together all the themes developed in the first three parts. In this part I discuss the advantages and disadvantages of repealing or amending the legislation and summarise the implications of my evidence for health and social policies and for professional practice.

Chapter 2

THE COMPULSORY REMOVAL OF OLD PEOPLE WHO ARE IN NEED OF PROPER CARE AND ATTENTION

Section 47 of the 1948 National Assistance Act gave the Medical Officer of Health the power to remove a person in need of "proper care and attention" to "a suitable hospital or other place" for a period "not exceeding three months", provided that he has given seven clear days' notice to a Court. The main points of the Section, which is in Part IV, the Miscellaneous part of the Act, are contained in its first few paragraphs.

National Assistance Act 1948, 11 and 12, Geo. VI, Chapter 29:

Removal to suitable premises of persons in need of care and attention.

Section 47.-(1) The following provisions of this section shall have effect for the purposes of securing the necessary care and attention for persons who-

(a) are suffering from grave chronic disease, or, being aged, infirm or physically incapacitated, are living in insanitary conditions, and

(b) are unable to devote to themselves, and are not receiving from other persons, proper care and attention.

(2) If the medical officer of health certifies in writing to the appropriate authority that he is satisfied after thorough inquiry and consideration that in the interests of any such person as aforesaid residing in the area of the authority, or for preventing injury to the health of, or serious nuisance to, other persons, it is necessary to remove any such person as aforesaid from the premises in which he is residing, the appropriate authority may apply to a court of summary jurisdiction having jurisdiction in the place where the premises are situated for an order under the next following subsection.

(3) On any such application the court may, if satisfied on oral evidence of the allegations in the certificate, and that it is expedient so to do, order the removal of the person to whom the application relates, by such officer of the appropriate authority as may be specified in the order, to a suitable hospital or other place in, or within convenient distance of, the area of the appropriate authority, and his detention and maintenance therein:

Provided that the court shall not order the removal of a person to any premises, unless either the person managing the premises has been heard in the proceedings or seven clear days' notice has been given to him of the intended application and of the time and place at which it is proposed to be made.

(4) An order under the last foregoing subsection may be made so as to authorise a person's detention for any period not exceeding three months, and the court may from time to time by order extend that period for such further period, not exceeding three months, as the court may determine.

The Section is reproduced in full in Appendix I.

In 1951 this legislation was amended to permit the immediate removal of a person satisfying these criteria for a period not exceeding three weeks, provided that the Medical Officer of Health had obtained a second medical opinion. This Act is reproduced in Appendix II.

In 1974 these powers were transferred from the sanitary authorities stipulated in paragraph 12 of Section 47, to the new district councils, together with the other environmental health responsibilities. (In London, the boroughs continued to have responsibility for Section 47 powers). The reorganisation of local government, which brought about these changes, was accompanied by the reorganisation of the National Health Service and the Medical Officer of Health vanished in this bureaucratic upheaval. No longer were doctors employed by local authorities; public health doctors such as the Medical Officer of Health were renamed community physicians and the advice on the medical aspects of environmental health matters which was formerly given by the Medical Officer of Health was now to be given to district councils by a community physician bearing the title Medical Officer for Environmental Health. Among his duties were included the execution of Section 47 removals.

In the six metropolitan centres the newly created area health authorities shared the same boundaries with the metropolitan district councils, as they did with the London boroughs. Outside these metropolitan areas the area health authorities had the same boundaries as the county councils and therefore health authority boundaries have no relationship to district council boundaries except on their county council perimeter. The majority of area health authorities were subdivided into health districts, the number of health districts being determined by the number of major general hospitals in the area, the boundaries of the health districts being the limits of the catchment areas of these hospitals.

The District Community Physician for each health district was nominated as the medical officer for environmental health, responsible not only for the management of health services within the health district but for environmental health advice to any local authority districts wholly, or largely, in that district. In health authorities in which there was only one major general hospital there was no subdivision into districts and therefore there were no District Community Physicians. A post named Specialist in Community Medicine for Environmental Health was created, the holder of which was to be the medical officer for environmental health for all local authority districts within the boundaries of the area, including the responsibility for Section 47 powers.

This type of information which has been called inter-personal information by the ethnomethodologists, consists of data released by one person to another with the releaser being uncertain about the purposes for which the enquirer wishes it. If a health visitor, social worker, or community physician asks an old person a question about her ability to cope, such as "can you prepare food for yourself?" the elder may be uncertain how to answer. If she admits that she is unable to cope, will she be given home help or will she be told that she needs to go into a home? Similarly, if she admits she is in pain will she be offered relief from her pain or will she be told that the fact that she is in pain makes it essential that she should enter hospital? She imparts a bias to the information she releases to achieve a certain objective. People often bias the information they release, according to their supposition about the reaction which different types of revelation will produce - almost everyone does this at job interviews - and the community physician has to be aware of the biases which not only the elder who is the focus of attention but also other people may be imparting to the information they are releasing to him for they may exaggerate the elder's disabilities.

If the community physician is of the opinion that admission to an institution is the most appropriate form of help he will try to persuade the person to change his decision by emphasising the gravity of the situation. He will explain the burdens which are being borne by others as a result of the person's refusal and try to correct any misconceptions which the person may have, such as the belief that he is going to be incarcerated in a workhouse.

In addition to his interaction with the old person the community physician also has to try to analyse the nature of the problem and to decide on the most appropriate response to it.

Firstly, he has to decide if he is the most appropriate professional to deal with the problem. If, as is usual, the main problem is that the old person is refusing help, it is only he or a consultant

THE ROLE OF THE COMMUNITY PHYSICIAN

The active role

The first and most important role of the community physician is to try to understand the old person's view of his condition and circumstances.

Firstly he has to listen to all the evidence. This is often very difficult. Not only may communication be impaired by deafness or speech disorders, or by the person's refusal to communicate, as in the case of Mrs. P (see page 33), but the person who is the subject of the enquiry may have already been seen by many people, all of whom have urged him to go to a home or hospital and some of whom may have threatened him with the powers of compulsory removal "by the local authority doctor" should he not agree. The community physician therefore may meet a person who has been living in fear of his arrival and who assumes that he has come to take him away by force. This makes the analysis of the information offered by the person he has been asked to visit very difficult.

Some of the information is objective, that is, it can be tested by the community physician and invalidated if wrong; for instance, if the person says that he has plenty of food in the larder this statement can be tested by going and looking in the larder. However, many of the important aspects of the information revealed by the person cannot be tested in this manner and cannot therefore be considered as objective information. Statements such as "I have no pain", "I can get to the lavatory without help", or "I can make myself some food if I want it" cannot be tested objectively. Even if the person is asked to demonstrate the abilities he claims he can merely reply "I don't feel like doing it just now".

Such information cannot be tested objectively; it is impossible to falsify it empirically and it has to be evaluated in the context of the social situation in which it has been revealed by the old person.

psychiatrist who can proceed with the compulsory removal and he has to decide if it is more appropriate for the case to be considered under the Mental Health Act. In many cases a psychiatrist's opinion will have been obtained before the community physician was consulted, indeed the community physician may only be called in because the general practitioner's expectation that the elderly person would be removed using Mental Health Act powers was thwarted by a psychiatrist's or a social worker's refusal.

If the Mental Health Act is inappropriate the community physician has then to consider if the criteria stipulated in Section 47 are fulfilled. In many cases they are not, because those who were requesting compulsory removal were mistaken in their conception of Section 47. The community physician has to explain why the power cannot be invoked.

If the individual's condition and circumstances come within the scope of the Section the community physician has to investigate the possibility that she could be kept at home if sufficient resources were available. If he suspects that the person has a fractured neck of femur or some other problem which can only be treated in hospital his problem is relatively simple. Much more difficult is the situation in which the old person is willing to have more services in her own home but the community physician is told that no more services are available. In many parts of the country it is impossible to mobilise home help if an emergency crops up at the weekend.

The need for the community physician to give advice on the clinical management of the case is rare. Not only is the present day community physician much less in touch with the main stream of medicine than the general practitioner but the latter has often obtained the opinion of a consultant in geriatric medicine by a domiciliary consultation before the community physician was consulted. He may make an examination of the elderly person, and it has always been my practice to take the person's pulse employing this simple technique as do many doctors, as much to establish

physical contact as to learn about the heart's rate and rhythm. If the general practitioner has not requested a domiciliary consultation by either a psychiatrist or consultant in geriatric medicine the community physician may suggest this. His medical training gives him the status which allows him to suggest to the general practitioner that the possibility exists that the medical management of this case is not as good as it could be, although it may be wiser to state that the reason for requesting a domiciliary consultant is more to try to obtain the agreement of "the manager" of a hospital bed that admission is appropriate than to say that it is to review the general practitioner's management of the case.

Particular difficulties arise if the person refuses to be examined as in the case of Miss N (see page 32) and Mrs. P (see page 33). Examination without consent is an assault, and Section 47 does not permit this principle to be breached so the community physician may have to weigh up the medical factors from a distance, although such an investigation cannot be the "thorough enquiry and consideration" required in paragraph 2(8). His assessment may even have to be made from outside the house because although forcible entry is justified after an order has been obtained(9) there are no powers of entry if the need is only suspected.

Finally, if neither persuasion - itself an ethically worrying process (see page 78) - nor alternative means of support are successful, the community physician may have to explain to the elder that she can be removed against her will if he obtains a magistrate's order. How frequently this step is taken is not clear. I am very reluctant to take it as it may so frighten the elder that she retreats into a defensive position so strongly entrenched that it is no longer possible to negotiate a settlement: to mention that compulsory removal is possible takes the relationship between the elder and the community physician across a Rubicon.

Having decided that compulsory removal is immediately necessary the community physician and another registered medical practitioner, usually the person's general practitioner, complete a "certificate for removal of Person to hospital or other place without delay" (Shaw's form NA 53). This the community physician takes to a Magistrate's Court or, more usually, a magistrate in his or her own home with his form of "Application and Complaint" (Shaw's form NA 54), and a statement by the manager of the institution that he is willing to accept the person. The magistrate signs this form, if satisfied, and completes the removal order (Shaw's form NA 55).

Information about the manner in which the magistrate arrived at the decision was provided by 74 community physicians who were asked whether or not they took the magistrate to visit the person to whom the application referred. 48 remarked that they did not, 15 that they would if requested, and it could be inferred from the replies from a number who provided more information than they had been asked for that the common practice is for the community physician to ask the magistrate if he wishes to visit the person. Ten of the 74 made a practice of taking the magistrate to see the person, sometimes at the insistence of the Clerk to the Justices, and 21 took the magistrates on some occasions, presumably when there was doubt in the magistrate's mind. One community physician stated that he had been so upset by the sign of maggot infested wounds that magistrates had subsequently preferred to reach their decision solely on the report of the community physician.

In only three cases was the request for an order refused by the magistrate and in two of these the refusal was for an extension of an order; in only one case was an order refused and this was on a point of law, not because the magistrate disagreed with the community physician's opinion.

The passive role

In addition to the active role the community physician has another equally valuable but passive role in which who he is is as important as

what he does. Just by being the person who is seen as having ultimate responsibility for the decision as to whether the elder is allowed to remain at home or is to be compulsorily removed, he acts as the receptacle for some or all of the anxiety and anger of relatives, neighbours and other professionals.

Anxiety may be generated by a fear of what may happen to the elder deemed to be "at risk", or it may arise from a fear of what may happen to the professionals who are, or feel themselves to be, responsible for the elder's actions and any grave consequences these may have for the elder or for other people (see page167). Professional decision making is often portrayed as an intellectual process of data collection and analysis, and difficult decisions appear to be those in which either there is insufficient data or in which the professional's analytical skills are inadequate. However decisions are not made solely on an intellectual basis, emotional factors are also involved, particularly the level of anxiety which the situation generates. Professionals make decisions not only to solve the problems of other people but also to allay their own anxiety(10). As soon as the case has been referred to the community physician the anxiety of those directly involved may be reduced if they feel that the responsibility for the ultimate decision is transferred to him. This is seen in many other branches of medicine in which referral to a consultant can reduce the general practitioner's level of anxiety. As soon as the decision is made or the letter written, the general practitioner is relieved of the sole burden of responsibility. If he were to meet the patient's anxious relatives in the street he could remove the focus of their anxiety from himself by saying that he had decided to refer the person for a second opinion or had already done so; and other professionals act in the same way.

> A social worker had been closely involved with an elderly lady who was a serious fire risk and was under considerable pressure from neighbours to persuade her to enter a home, pressure which she had resisted for weeks. Late one Friday

> afternoon, however, she felt she had to refer the case to the community physician. He was not in when she phoned so she asked his secretary not only to make a note of the fact that she had phoned but to record the precise time at which the phone call had been received. From this time she felt relieved because she had passed some of her anxiety, sufficient to restore it to tolerable levels, to him.

There can be few professionals who have not made use of referral to relieve their anxiety. Some professionals are reluctant to admit that they are anxious as though this were a weakness, a trait unworthy of a trained worker, but the opposite is true. The professional who claims he is never anxious, or more accurately, who never admits his anxiety, is not only ineffective but may be dangerous because he may initiate certain actions to reduce his own anxiety levels which may have adverse effects on the person who is the cause of his anxiety. The professional who admits and shares his anxiety is probably less liable to initiate such actions. Once the community physician has visited, the anxiety may be further reduced, particularly if he explicitly states that he is now responsible and, should the elder set fire to himself and others, fall down, be run down or suffer hypothermia, that he will appear in the Coroner's Court or answer the Press, if either of these authorities wishes someone to be accountable. By acting as an "earth" the community physician helps the anxiety of the professionals drain away from intolerable, dysfunctional levels to those which are tolerable and functional as an electric earth allows electric charges to drain from a system. The community physician can also reduce the anxiety level by suggesting practical measures which could be tried. The process by which taking practical steps such as arranging for the purchase of a low voltage electric blanket or phoning the Gas Board for a safety check reduces anxiety would be called magical by anthropologists. The idea that magic is a primitive form of science has long been dispelled by anthropologists, in classics such as Malinowski's Science, Magic and Religion[11] and Evans-Pritchard's Witchcraft, Oracles and Magic among the Azonde, but this view still prevails. To the anthropologist

magic is the use of ritual to allay anxiety in times of uncertainty. It can and does co-exist with science and not only in "primitive" cultures. In the words of Keith Thomas, one of the greatest of modern historians who has bridged the gap between history and anthropology, "in such circumstances (where there is uncertainty and anxiety) it is hard to say where "science" stops and "magic" begins.....if magic is to be defined as the use of ineffective techniques to allay anxiety when effective ones are not available then we must recognise that no society will ever be free from it[13]".

No matter how mundane the measure suggested, if it be no more than the proposal that a flask and Tuperware box be bought and tea, milk and sandwiches be left beside a chairbound and unstable old person so that she can obtain some sustenance without leaving her chair, it can allay anxiety sufficiently to allow the supporters of an old person to continue caring even though the major problems still remain.

Similarly, if the community physician is able to absorb some of the anger, to divert it from those who are trying to support the elderly person, they may be enabled to continue caring for the elderly person if his own home. Professionals who are identified as being responsible are often the focus of the community's anger, resulting from guilt (see page 127). This is a particularly severe problem for health visitors and social workers, for many members of the public attack them directly, rather than doctors of whom they may stand in awe.

These are the functions which the community physician serves for the individual who has been referred to him and for the other professionals involved in the case, but he also has two uses for society as a whole. One is laudable, his duty to protect the rights of the individual (see page 54). The other is less praiseworthy, being the part he may have to play in warehousing elderly people because there are inadequate resources available to support them in the community (see page 214).

Reaching a decision

The community physician has to bring together all these themes to

come to a decision. He has to analyse all the information, having made allowance for the biases imparted; to defend the liberty of the individual; to be careful that he is not forced into compulsorily removing the person because of inadequacies in the community services; and, most important, to be aware of the effect which the anxiety and anger of others has had on his own emotions. Being personally involved he cannot make an objective assessment of the situation as though he were a micrometer, and, in the words used by Miller and Gwynne to describe their method of working with physically disabled people, has "to accept that one uses oneself as a measuring instrument and to try to develop means of calibrating it so as to correct some of the distortions. Personal psychoanalysis is one such mechanism. Discussions with colleagues not directly engaged.....help to identify.....prejudices and to regain some detachment"(14). Other community physicians can provide invaluable support and help the responsible community physician decide what he thinks the decision should be. Although the responsibility for the decision rests with the community physician he does not reach it in isolation. It is usually reached by consensus, that is, by the agreement of everybody involved, except the elder concerned. Of particular importance is the agreement reached with the elder's general practitioner because it is usually he who is the other "registered medical practitioner" certifying that the person requires immediate removal if the powers of the 1951 Amendment Act are being invoked. Often the request for compulsory removal has been initiated by the general practitioner but it can happen that the community physician is the one to suggest to the general practitioner that compulsory removal is, in his opinion, indicated. The former is more common, not only because the general practitioner is usually involved in such cases before the case is referred to the community physician, but also because his relationship to the problem differs from that of the community physician in a manner which can influence him to see compulsory removal as a solution to a problem before the community physician would. The reason for this is that the general practitioner has a much closer relationship to the elder and her

social environment than the community physician, at least at the time when the latter is first called in. This is partly because the general practitioner is more accessible to the community. Even though receptionists can shield a general practitioner the anxious relatives, neighbours and friends of the elder know where he works and how to find his phone number, and can usually get through to speak to him. The community physician is much more remote and less accessible, at least until the relatives and neighbours find out his telephone number, and therefore is less likely to be so much affected by the community's anxiety about such risks as fire or hypothermia. Furthermore, even if the community physician is drawn into the small part of the community in which the anxiety and anger, which may develop in such cases, is focused he knows that this involvement will only be temporary. I have visited people for years following the initial referral but the involvement of the community physician is usually of limited duration. The general practitioner on the other hand is aware that he may have to continue treating the elder after the crisis and that he will probably meet, and may have to treat as patients, the relatives, neighbours and friends of the elder for the rest of his professional career. The general practitioner therefore is under more pressure than the community physician, at least in the early stage of the latter's involvement, and may become more anxious. To offset this, however, is the fact that general practitioners are much more accustomed to the management of this type of anxiety than community physicians and will have had much greater opportunities to develop techniques to manage anxiety by means other than those which impinge upon or affect the person who is the source of that anxiety. This applies particularly to those who have been fortunate enough to have been through a vocational training scheme, with the support of a sensitive trainer, which has allowed them to gain some insight into the emotional factors within themselves which influence their intellectual analysis of a patient's problems. Unfortunately, the training of community physicians is not so well suited to this purpose (see page 201).

THE USE OF THE POWERS IN OXFORD

In Oxford where the population has been about 100,000 since 1948, the powers have been used about thirteen times; on seven occasions the powers of immediate removal of the 1951 Amendment Act were used. I have been involved in six of these cases from 1973 onwards. Although it is difficult to draw many conclusions from such a small number, the details of the cases from 1952 are worth including because they give a good impression of the type of case in which the powers are used or considered, and because they will be referred to in the argument which follows. The reports of cases which were included in the Annual Reports before I assumed responsibility are reproduced in Appendix III.

In 1972 I started work as a medical officer in the Medical Officer of Health's department in the City of Oxford - a county borough - and as I took a special interest in the problems of elderly people I was responsible for Section 47 powers. On the reorganisation of the National Health Service I became a community physician with the Oxfordshire Area Health Authority but the nature of my job changed very little. As Oxfordshire was a single district area one community physician, the Specialist in Community Medicine for Environmental Health, had to assume responsibility for giving medical advice on housing, environmental health and infectious diseases to five local authority district councils. This was obviously too big a task for anyone to tackle single handed, so three other community physicians were also nominated to be "proper officers" to the five district councils. I was nominated proper officer to the Oxford District Council, in addition to an interest in the problems of elderly people in the county as a whole, and two colleagues were each given responsibility for four predominantly rural district councils. As a nominated proper officer to Oxford District Council I continued to work much as I had done while employed by the City of Oxford, and retained responsibility for the powers of compulsory removal, powers which I have exercised on six occasions in the six years from 1972.

On each occasion I found the experience extremely disturbing, as I did also on those occasions on which I was requested to use the powers but refused. I was disturbed not only because compulsory removal is naturally a harrowing experience for all concerned, but because I was uncertain how the legislation should be interpreted; and no-one was able to advise me. More experienced community physicians were very helpful but there seemed to be neither an accepted ethical principle to justify such an action nor any agreed interpretation of paragraph 1 of Section 47. The Department of Health neither issued guidelines nor even counted the number of times on which Section 47 powers were used, although detailed records are kept of compulsory removal under the Mental Health Act. I came to consider it necessary to study how the legislation operated, and to examine the ethical justification for this inroad on personal liberty for which I was responsible.

Before giving my accounts of these cases it is necessary to express the difficulty which I experienced in writing these summaries. It is impossible to be objective about events in which one has played a central part, particularly when the events are as upsetting as these compulsory removals were to all who were involved. The summaries give the impression that the compulsory removal was eventually effected because it was intellectually impossible to reach any other possible outcome. What does not come across from the case histories is the intensity of the emotional reactions of those who were involved and the influence which they had on the outcome of the community physician's involvement. An attempt will be made to analyse the influence of anxiety and anger in the section of this chapter on the role of the community physician, and in the chapter on attitudes towards older people.

1973

Miss N. was the youngest of three sisters living in a large Victorian house. After the death of her two sisters, she had come

to depend on a young neighbour who was willing to help but found the caring an increasing burden as Miss N. became progressively more disabled. Miss N. refused to allow her to ask for help from health or social services. Matters came to a crisis one cold Friday afternoon when Miss N. fell and could not rise. Although she was adamant that her neighbour should not seek help, the neighbour eventually felt she had to, and phoned the general practitioner. He saw by the outward rotation of Miss N.'s foot that she had broken her femur. The basement in which she was lying and in which she had lived for years was cold and filthy. Miss N.'s hands were cold to the touch, her face was puffy, her lips were blue and she was breathless, but she refused to allow her general practitioner to examine her or to go to hospital, so he phoned the Medical Officer of Health and said that he thought a compulsory removal was indicated. A medical officer came to see Miss N., who still refused to move; he obtained an order under Section 1 of the National Assistance (Amendment) Act 1951, and she was carried out to the ambulance with no protest. Thirty minutes after her admission she smiled at the medical officer and said that, "I didn't want to go to hospital because I was ashamed I was so dirty".

After two months in hospital she moved to an old people's home, and although she sometimes said she wished she was back home she was happy in the home and admitted that she would not be able to manage if she did go home. She died in 1977.

1973

Mrs. P. had lived in almshouses for a number of years. She had been a pleasant and popular resident, but she had become progressively more disabled until she was bedfast. Eventually it was obvious that she was dying, and she began to require a great deal of care. Even with the daily home help and district nursing she was calling the warden four or five times during the day and night, and as she was incontinent and immobile it was evident that her skin would soon ulcerate. As she was not dying from cancer she did not qualify for

help from any of the charities which can pay for night nursing, and it was not possible to arrange any other form of night sitting service. Although she refused to go to hospital she was removed without protesting to a geriatric hospital, using the powers of the National Assistance (Amendment) Act 1951, and she died 10 months later.

1976

Miss P., aged 74, had always kept herself to herself. She lived in the ground floor flat of a small detached house and although she had links with the local church she had little to do with her neighbours and rarely consulted her general practitioner. On Christmas Eve it was reported to her doctor by a neighbour that she was in trouble. He found her in bed in a very cold room, apparently unable to stand. She refused to be properly examined, although he was able to determine that she had a painful hip. She refused to allow him to light a fire, or send in domiciliary services, and refused to consider or discuss going to hospital. The community physician obtained an order under the 1951 National Assistance (Amendment) Act and she was admitted to the Accident Service. It was found that she had not broken the neck of her femur but had chipped a piece of bone off the greater trochanter. Five days later she was transferred to a geriatric hospital, and after two months there she was transferred to the psychiatric hospital, whence she went back home. She accepted meals on wheels and was very well supported by a local Church group.

On the 28th December 1977 she was admitted voluntarily to the geriatric hospital, and houseman describing her as a "pleasant co-operative alert old lady". She went home after a month's stay, but was admitted again a month later and stayed in until she died in June 1978.

1978

Mr. W.'s background was uncertain. He had come to Oxford from Crystal Palace with his labrador and was placed in temporary

accommodation by the Housing Department. He said he was related to the Romanovs and would discuss them if asked, but he never volunteered information and spent all day walking the streets with his dog. The dog was a major problem. It was fierce and had to be locked in another room before anyone could enter the wooden prefab in which he lived: interviews were rather disconcerting as the dog either barked loudly or attacked the door of the room in which the interview was being conducted. Mr. W. finally qualified for proper council housing and was offered a ground floor flat, with its own front door, in a rough but friendly neighbourhood with good voluntary services co-ordinated by the community worker based in the community centre which was nearby. For over a year he lived happily but with increasing difficulty. He became doubly incontinent; frequently he went round to neighbours without his trousers on; and he had difficulty lighting his gas fire. His dog was the crux of the problem. Its fierceness had not abated; indeed, it had increased, aggravated by Mr. W.'s decreasing ability to care for it. He had difficulty in buying and opening his tins of dog food: even when he managed to open the tins successfully he did not put the food in the dog's dish, so the dog had to try to eat out of tins with jagged edges. The dog became more and more frustrated, leaping on the table to eat the meals on wheels as soon as they were opened, and rushing with bared teeth at any visitor. This made the provision of home help, district nursing, and voluntary help very difficult. Finally, the dog bit two children, then bit the policeman who came to investigate the complaint, so was taken into custody, allowing community services to help Mr. W. Unfortunately, the Court which considered the dog's case decided that it should not be put down because it was not causing any trouble at the time of the hearing, which was not surprising as it was being well cared for in kennels. Although they appreciated it would cause problems if it returned home, the court felt that was the only decision which could legally be made, so the dog came home to a warm welcome from Mr. W. and the vicious cycle started again. Mr. W. refused to have the dog adopted or placed in kennels, and refused to accept care for himself, although by this stage it was thought that he would be unable to manage even if the dog were removed. One

Friday he was found half naked; he had been unable to dress and had been walking about undressed without shoes for some weeks, incontinent, cold, and hungry; the dog having eaten all his food. He was removed to an old people's home, which he had been attending for meals, using the powers of the 1951 Act. His dog was placed in kennels under Section 48 of the National Assistance Act which lays down "the duty of councils to provide temporary protection for property of persons admitted to....accommodation provided under Part III of this Act". Two years later both Mr. W. and the dog remain in care (the dog supported by the ratepayers at £1.00 per day). Both seem happier for it and they meet once weekly. Mr. W.'s main worries are now, as always, about his health, but he stopped saying he wished to go back home after a couple of weeks in the old people's home. He still wanders the pavements and, to the alarm of the local residents, the streets nearby.

1978

Mr. A. had lived with his sister until she was admitted to an old people's home. He found a room in a multioccupied house in a part of the city with a high immigrant population, in which there was a fairly good community network. He lived a self-contained life. He walked into town, about half a mile, breakfasted in Littlewoods and had lunch and tea in an old people's day centre. One day he felt dizzy and collapsed while walking, and was taken to the Infirmary, where he was found to be severely anaemic. A duodenal ulcer was diagnosed; he underwent an operation; received a blood transfusion; then was discharged, unwillingly, with arrangements for home help, meals on wheels, domiciliary nursing, and day care, but he only received meals on wheels because of poor liaison between hospital and community services.

Mr. A., who lived in an upstairs room, fell on the stairs and was unable to walk to the toilet which was four steps down from his room. He was also unable to answer the front door, which was locked, so the professionals who came to the door were unable to gain entrance

except the meals on wheels deliverer, who went to his landlord who lived only ten houses away. His meals on wheels were supplemented by boiled eggs and bread prepared by the man who occupied the next room - a man severely affected by schizophrenia. Mr. A.'s meagre diet was further reduced after someone broke into his room and stole his money while he lay helpless in bed. After three weeks of immobility, lying on a mattress sodden with faeces and urine, his general practitioner referred him to a consultant in geriatric medicine, who was willing to admit Mr. A. to hospital - he was emaciated, had a productive cough, and a swollen and painful knee - but Mr. A. refused to go. The community physician replaced, and destroyed, his mattress and bedding, and Mr. A. was given a bed bath, so was no longer in insanitary conditions, but his bronchitis appeared, on clinical examination, to be deteriorating into a lobar pneumonia and he was admitted, using the powers of the 1951 Amendment Act, to a geriatric hospital. Two months later he was discharged to the new Church Army Hostel, able to walk once more.

1979

Mrs. L. had been widowed for four years, since when she had lived alone in a three bedroomed house on a busy road. She had begun to deteriorate about six months before referral, the main problem being that she was unwilling to cook food for herself. Her son and son-in-law referred her because she was standing on her doorstep with the door open until two or three in the morning calling out to passers by and inviting them in for a chat. Unfortunately her invitation was taken up by three Irishmen, two of whom, it was learned subsequently, were wanted by the Special Branch. They got her drunk and stole her money, and she was found the next morning with a cut eye, although it was not clear how she had sustained this injury. Unfortunately she was forgetful and could not identify the men when confronted with them at the police station. They were therefore allowed to go and returned to her house the next night, again drunk, and vomited in her bedroom before running away. Mrs. L. still refused to leave her home because she had promised her husband she would look after it and was standing

on the open doorstep with the snow blowing at her when the community physician called. An order for compulsory removal was obtained, although she left home without too much distress or complaint and settled very happily in an old person's home where she soon made very good friends with two other residents.

THE DENOMINATOR

What differentiates my approach to Section 47 removals from that of most other community physicians is that the majority of my work is with elderly people and I am involved with, and visit, many more elderly people than those who are referred for consideration for compulsory removal. Each year the housing applications of several hundred elders are referred to me for medical assessment, and I visit a proportion of them. I also become involved in many cases in which the elderly person is not fitting into either health or social services provision, and is the cause of a dispute between the two, and I visit one or two elderly people at home every working day.

The reason why most of my work is with elderly people is that I was asked to look at their problems when I returned to work as a Senior Medical Officer in the City of Oxford following my Diploma in Public Health in 1972. Although the health department took a population based approach to the problems of children no-one had taken the same sort of overall view of the problems of elderly people, although about half of the health department's budget was spent on elderly people. Dr. J. F. Warin, then Medical Officer of Health, therefore suggested that the problems of this group required the same sort of approach as public health had previously given to children and infectious diseases. I maintained this special interest after 1974, assisting the Specialists in Community Medicine for Environmental Health and Social Services and trying to overcome the divisions of responsibility for services for elderly people by focusing on their problems and trying to analyse how much of their difficulties were unnecessarily caused by bureaucratic and professional conflicts and confusions.

The reaon why I see so many elderly people and am involved in so many cases is that I believe that this approach is the best way to obtain information about the attitudes, values and beliefs of those who are involved in the provision of services, either as professionals or relatives or as volunteers. Social serveys provide one type of information but I believe that close involvement with professionals and members of the public in cases which are causing concern offer the opportunity of acquiring information of another sort which is equally valuable.

What level of disability does the hospital service think that an old people's home should be able to cope with, and how does a home define a "hospital case"? What does a social worker think a health visitor does and should do, and what does a health visitor think that a social worker does and should do? It is the answers to this type of question which I regard as being essential for an understanding of the problems elderly people and community physicians face with health, social and housing services, and it is this type of information which I believe is best obtained by involvement with cases, by a method which owes more to social anthropology than to sociology.

Chapter 3

THE USE OF SECTION 47 POWERS IN ENGLAND

OFFICIAL DATA

In Circular 3/49 which instructed the Medical Officer of Health how to prepare his Annual Report, in the typically subjunctive mood of missives from central government, the Minister of Health, Martin Rowland, wrote that

> "if action has been taken by the Council under this Section, a brief note of the circumstances of each case may be included in the Report. The note should include information as to the reason for the Council's action, the period named in the Order of the Court, the type of accommodation to which the person was removed, the ultimate result of the Council's action and any other information on the case which it is considered might be of interest".

The Circular "advising" Medical Officers of Health on the contents of their annual report in 1951, Circular 42/51, was more definite in tone and Mr. Rowland now stated that a "note of the circumstances should be included in the report". Subsequent circulars in this series made no specific reference to Section 47, referring the Medical Officer of Health to Circular 42/51 each time for the data which was expected routinely, and stipulating only subjects in which the Ministry had a special interest at the time the circular was drafted.

Table 1: The use of the powers of compulsory removal in England 1949-1955.

Year	Total number of orders	Type of accommodation			Comments
		Hospital	Part III	Not stated	
1949	169	64	68	37	"10 died before the application could be dealt with".
1950	126	56	47	23	"13 died before the application could be dealt with"
1951	198	95	80	23	
1952	211	106	82	23	
1953	"about 250"	N O T A V A I L A B L E			
1954	"about 280"	N O T A VAA I L A B L E			
1955	"about 200"	N O T A V A I L A B L E			

The tone of the Ministry's annual reports was, as is customary with reports from central government, quietly confident. In the Report for 1951, for example, readers were reassured that "the majority of cases... were eventually persuaded voluntarily to enter appropriate institutions or were otherwise satisfactorily dealt with without recourse to proceedings" and that "a number of those were removed.... settled down in that accommodation and decided to remain of their own free will". The Report for 1955 stated that "it is to be hoped that as effort, both statutory and voluntary, is increasingly directed towards preventive work and arresting deterioration in its earliest stages, the need to invoke this Section may gradually diminish". Perhaps as a result of wishfulfilment the section of the annual report referring to the compulsory removal of people using Section 47 powers was omitted in subsequent reports and the Department of Health no longer collects information about their use.(15)

THE SURVEY

A questionnaire was therefore sent to all the community physicians who were the "proper officers" to local authorities with environmental health responsibilities - Specialists in Community Medicine for Environmental Health in those Area Health authorities which were not subdivided into health districts, and each District Community Physician in those Area Health Authorities which were divided into districts (see page 20). Each community physician was asked:

1. How often they had used the powers in each of the four years since the first of April 1974?
2. In what number of cases had Section 47 of the 1948 National Assistance Act which requires seven days' notice to be given, been used?
3. To what type of institution the removals were made?

4. What number of cases were suffering from "grave chronic disease" and what number were living in "insanitary conditions". This was included in an attempt to elucidate the manner in which Paragraph II (a) of Section 47, which is identical in the 1951 Amendment Act, is interpreted (see page 234).

5. What number of these removals could have been avoided if a hospital-at-home scheme had been available?

6. By whom had pressure been applied on the community physician to act?

7. Was it considered necessary to amend the legislation in any way and, if the community physician thought an amendment to be necessary, how he or she considered it should be altered.

Of the 185 community physicians circulated, 168 replied, a response rate of 90.8% A second letter and questionnaire was sent to those community physicians who had not replied within three months to the questionnaire. Several reasons can be advances to explain the failure to achieve a one hundred per cent response.

Some of the community physicians to whom I wrote may have retired or moved to other jobs, leaving unfilled posts.

Some of the replies were made by community physicians other than those to whom I had written, for example in some areas the specialists in community medicine for environmental health had passed the questionnaire to the specialist in community medicine for social services, and there may have been questionnaires which did not reach the responsible officer.

Some community physicians may not have replied because the necessary information was not available; of those who did reply twelve stated that they could not give the information requested because they had newly come to the post and there were no records of the work of the previous holder of the position.

Some community physicians may have been busy with more important work and lacked enough secretarial support to be able to extract and collate the information requested. The questionnaire was kept as short as possible in the knowledge that community physicians are all deluged with paper.

RESPONDENTS

Of the 162 community physicians who stated their position, the majority were District Community Physicians.

102 District Community Physicians
35 Specialists in Community Medicine for Environmental Health
10 Specialists in Community Medicine for Social Services
16 "Other" Community Physicians

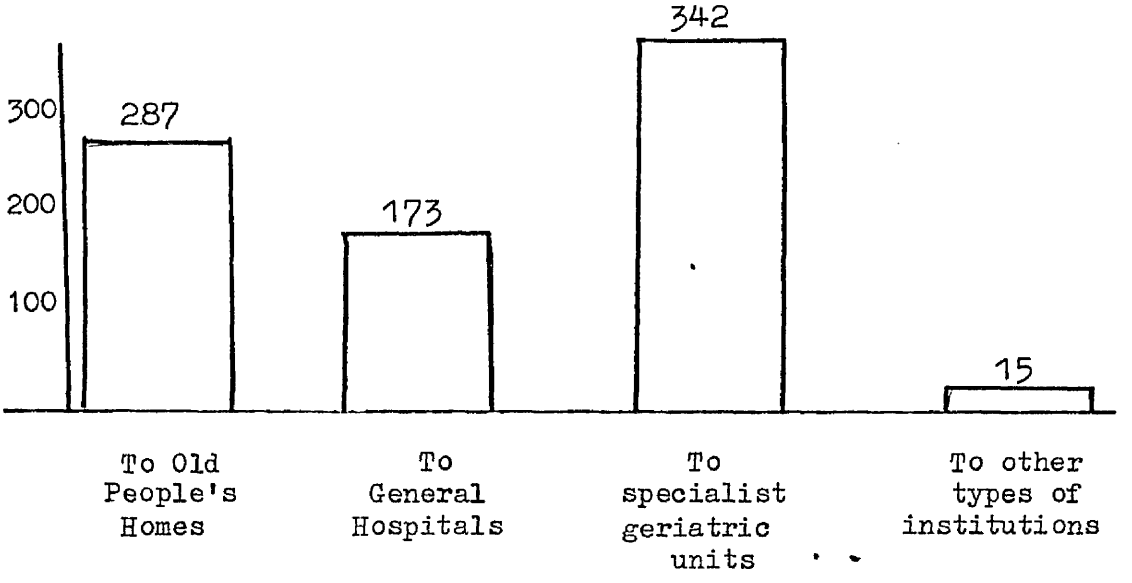
The "other" community physicians comprised both specialists in Community Medicine (District support) who are consultants and those, like myself, who were not consultants but had delegated powers. It is important to recognise that many community physicians other than the District Community Physicians and Specialists in Community Medicine for Environmental Health have these powers. In Oxfordshire, for example, a single district health authority with five local authority districts within its boundaries, and a population of just over half a million, the Specialist in Community Medicine for Environmental Health is assisted by three senior medical officers, two of whom are proper officers to two districts each, the third being the proper officer to the City of Oxford. At the time of reorganisation it appeared that each district council wished to have only its own "proper officer", as it had had its own Medical Officer of Health, and one other community physician as the "named alternative". However, this arrangement made for difficulties in arranging for cover so the district councils agreed to consider all the community physicians as proper officers in emergencies although each district council had a special relationship with one of them for routine work such as the consideration of the medical aspect of housing applications and, in co-operation with the

chief environmental health officer, investigation of infectious disease. In Oxfordshire in addition to the four who were proper officers the other consultants in community medicine - the Area Medical Officer and the Specialists in Child Health and Social Services - were also nominated to, and accepted by, the district councils as being able to act in emergency. Thus, although the powers are officially vested in one community physician six others are able to use them.

The fact that nine health authorities should have nominated the Specialist in Community Medicine for Social Services as the officer responsible was of considerable interest because of my belief that this piece of legislation is more closely related to social services than to environmental health (see page 116 and page 222). However the reason why social services specialists had been given responsibility rather than the Specialist in Community Medicine for Environmental Health appeared to be due not so much to a decision that this arrangement was bureaucratically more appropriate but to the fact that certain individuals had more experience with elderly people and their problems.

SUITABLE HOSPITALS AND OTHER PLACES

Information about the type of institution to which the person was removed was given for 817 cases:



Eleven were admitted to psychiatric hospitals and one each to a tuberculosis hospital, a multiple sclerosis unit, a general practitioner unit and a private nursing home (the relatives agreed to pay for this person).

Table 2: Institutions to which people were admitted, England 1974-78.

The majority were admitted to hospitals, the minority being admitted to social services old people's homes, but before drawing any inference from these figures by suggesting that the majority required treatment which could only be given in hospital, it is necessary to state several factors which have to be taken into account.

Firstly, the fact that 173 people were admitted to general hospitals does not necessarily signify that their problems were qualitatively different from those people admitted to specialised geriatric units. In some cases their needs would have been different, for example in those cases in which operative treatment such as the fixation of a fractured neck of femur was required, or was thought to be required, for such people have to be admitted to an Accident and Emergency Unit in a general hospital. In other cases, however, it is probable that

the reasons for admission to a general hospital related not so much to the condition of the person being removed as to administrative or professional reasons. In some parts of the country emergency admissions of elderly people out with the hours during which routine support services such as radiology or haematology are staffed can only be obtained by referring the case to the medical team "on take" or "receiving" in the district general hospital. Therefore the reason why the general practitioner elects to refer the case to a general hospital may simply be that it is easier to find a bed in a general hospital than in a geriatric unit. Furthermore, referral patterns vary from one part of the country to another and from one general practitioner to another and the choice may be based on as opposed to a consultant in geriatric medicine may be based on referral habits rather than for any specific clinical objective. For these reasons I have chosen to consider admission to both types of hospital together.

The meaning of the difference in the numbers of people admitted to old people's homes compared with those admitted to hospital must also be surmised with caution. Can it be inferred that the people admitted to hospitals were those suffering from "grave chronic disease" and that the people who were admitted to the old people's homes were those who were "Living in insanitary conditions", that is, that the types of problem admitted to the two types of institution were qualitatively different? In some cases this difference was certainly present, not only where fractures were either present or suspected but where it was thought that treatment of the kind available only in hospital, for example intravenous therapy, was necessary or where the general practitioner and community physician were uncertain about the diagnosis of the problem underlying the person's incapacity.

It is not uncommon, however, for general practitioners to have to try to find a place in an institution for a person who does not require the medical expertise concentrated in a hospital but who requires a level of nursing care greater than that which is available in the person's own home or in an old people's home. This type of person is too fit for hospital but not fit enough for an old people's home and the doctor usually has to admit her to hospital either disguising the real reason for his referral, perhaps by stating that he thinks she has had a stroke or has pneumonia, or by simply stating to the houseman that the social circumstances are such that domiciliary care is impossible.

To summarise, it is not possible to draw any firm conclusions from the numbers admitted to different types of institution. Some of those removed to hospital will have been removed because of a need for skilled nursing andmedical care - that is because of "grave chronic disease" - others will have been admitted to hospitals solely because their dependence was so great that an old people's home would not accept them, and there will probably have been some who were admitted to old people's homes who had undetected medical conditions which would have benefited more from hospital admission.(16)

Of the 409 cases for which the age was available, only 13, 3.17% were less than 65 years old. The findings of Amelia Harris(17) were that one third of all severely handicapped people were under the age of 65 so it is reasonable to conclude that old handicapped people are many times more likely to be removed than young handicapped people. A more precise comparison is impossible because the figures in Amelia Harris's Report do not give the numbers of severely handicapped people living alone by age. The preponderance of use on elderly people justifies

its being regarded as a piece of legislation for old people and for the use of thepopulation aged 65 and older as the denominator for the calculation of rates.

REMOVAL RATES

In the four years since the first of April 1974 the powers of compulsory removal were used 830 times:

Table 3: Annual use of the powers in England

1974 - 75	180
1975 - 76	199
1976 - 77	236
1977 - 78	215
	830

If those who did not reply used the powers at a similar rate, perhaps an unjustifiable assumption, the total number of times the powers were used would be over 900, about 225 times per year in England. In 49 cases, 5.9%, the removal was sanctioned by Section 47 of the 1948 Act; in the remainder removal was immediate using the powers of the 1951 Amendment Act.

The removal rate, calculated with respect to the number of people aged over sixty-five, varied considerably from one part of the country to another.

Table 4: Rate at which the powers were used.

Number of community physicians	Number of persons removed per million persons over the age of 65 during the four year period
35	0
40	.001 - .100
33	.101 - .200
11	.201 - .300
9	.301 - .400
4	.401 - .500
9	Greater than .500
141	

Only 141 community physicians supplied sufficient data for rates to be calculated.

EXPLAINING THE VARIATION

Social reasons

A great many factors can be gathered under this rubric, all of which are very difficult to measure. For example, it could be that parent-child relationships differ from one part of the country to another but I know of no work done on this subject, nor would I know how to measure the quality of the relationship even if I were able to draw on comparable data. Some societies are undoubtedly closer and more supportive than others. Villages or well-established housing estates often have elaborate systems of mutual aid in comparison with those districts in large cities in which a large proportion of the property is multi-occupied and the rate of population turnover is rapid.

However, the closeness of a well-integrated community also has its disadvantages. This type of community, it could be argued, is bound together by a system of implicit unspoken rules which are much more precisely defined than the less tightly structured neighbourhood. The cohesion of the former type of community allows voluntary aid to be organised and people to be noticed at an early stage if they begin to deteriorate. The corollary of a loosely structured social system of rules is a poorly ordered definition of deviance, and the "problem family" or old person who is careless of his appearance or environment may escape notice, censure and referral, and intervention, for much longer in a bed-sitter area than in a more intimate, "more caring" community. There was no evidence from the data that people were removed more frequently in large cities than in predominantly rural districts, or in the industrial north of England less frequently than in the south-east.

A comparison of the removal rates of five large Northern conurbations illustrates this clearly:

Table 5: Rates of use in five large Northern conurbations

	Compulsory removals/1,000 persons over 65 in 1974 - 78
A	0
B	.027
C	.688
D	0
E	.050

Service reasons

The level of services provided for elderly people varies very widely from one part of the country to another but it is impossible to calculate an indicator which allows the whole range of services in one part of the country to be compared with those in others. Figures are available for the amount of money spent by local authorities on elderly people but these are misleading and not really helpful - deficiencies in social services may be complemented by the more generous provision of health services or, more usually, vice versa. Similarly, an authority which provides less statutory services for its elders than another may do so because its local voluntary services are better. There is, however, one type of community in which it is generally agreed that services are more strained - retirement areas.(18) To test this hypothesis the rates for the health districts in the six counties with the highest proportion of elderly people in their populations - East Sussex, West Sussex, Isle of Wight, Devon, Dorset and Cornwall - and the mean for these retirement areas was compared with the mean of the whole and was found to be lower

in the retirement areas.

Table 6: Agerage removal rate in retirement areas compared with the average rate in other parts of the country

Mean rate for 9 retirement areas	0.123
Mean rate for rest of country, 131 districts	0.223

Reasons relating to professional practice

In my experience the knowledge that this power exists is by no means universal and among these professionals who know of the existence of Section 47 comprehension of the conditions under which it can be invoked is often incomplete. This point was raised by many of the community physicians who said that they often received inappropriate requests for compulsory removal due to a misunderstanding of the legal requirements and objectives of the Section. One community physician made the point that publicity given to Section 47 would generate more demands for its use because more professionals and members of the public would be aware of its potential, but I do not believe that the publication of agreed guidelines of interpretation should be influenced by such considerations (see page 198). Although there is probably a wider knowledge of the powers of compulsory removal in some parts of the country than in others I do not think that this could explain the wide range in the frequencies with which these powers are used. In my opinion the more important factor is the attitude of the community physician who is responsible for the execution of the legislation.

It is inevitable that any power which depends upon the discretion of an individual will be interpreted in different ways by different individuals. This is one of the dangers of discretionary powers.

The terminology of the National Assitance Act of 1948 is open to differences in interpretation in many places, particularly in the case of Section 47 not only because it consists of prose drafted more than fifty years ago but because Section 47 decisions have never been contested in the Court - a process which greatly clarifies the interpretation of a law, or sets new and more clearly worded criteria in those cases in which the intentions of those who originally drafted the legislation are unclear. There are obviously difficulties in reaching agreement on what is meant by "suffering from grave chronic disease" (see page 198), or "insanitary conditions" or "proper care and attention" (see page 200).

In addition to these semantic and grammatical difficulties which are inherent in all legislation, there is one other major factor affecting the interpretation of the Act - the ethical beliefs of the community physician who is the responsible officer. The relative value placed on the liberty to continue living at home, on the one hand, and on the liberty from unnecessary discomfort, or pain or disability, on the other, obviously varies widely from one person to another. Eleven community physicians felt very strongly about this matter, so strongly that they were of the opinion that it should be repealed. Some of those who believed that repeal was necessary had made use of the powers during the period covered by the study.

able 7: Use of compulsory powers correlated with attitude towards repeal

	Not in favour or repeal	In favour of repeal
Number making no use of compulsory powers during study period.	28	6
Number making use of compulsory powers during study period	98	5
TOTAL	126	11

$n = 137$

$x2 = 5.64$

$0.2 > p > 0.01$

The community physician's use of his discretionary powers, however, is not only influenced by ethical considerations. It is also influenced by his ability to tolerate the pressure which such situations inevitably generate. As has been emphasised, it is important to recognise that professionals do not make decisions on a solely factual basis. They do not merely collect information about an elderly person and see if that conforms with their interpretation of the meaning of the Act and their personal beliefs; the level of anxiety aroused by a situation and the professionals' response to that anxiety are also important. For example, the anxiety generated in the community physician may be greatly increased if the general practitioner requesting the compulsory removal responds to the community physicians' refusal to use his powers in a hostile fashion. If the general practitioner writes to a number

of other professionals informing them of the community physician's decision, stating that he is of the opinion that the community physician's decision is wrong and that he holds him responsible if anything should happen to the elder in question or to her neighbours, the community physician's position is inevitably more difficult than if his decision is accepted without rancour. Similarly, threats of legal action and involvement of the press by frustrated and angry relatives, hostile phone calls from neighbours, and similar pressures create anxiety and this anxiety influences the manner in which decisions are taken. I am not suggesting that community physicians compulsorily remove old people from their homes solely to relieve their own anxieties but wish to emphasise that no analysis of professional decision making can ignore the part which anxiety plays in the process, or the great variation in the levels of anxiety which different individuals can tolerate. I believe, however, that although these emotional factors are important they contribute much less to the range of rates observed than the difference in ethical attitudes towards the liberty of the individual.

The need for official data

Undoubtedly there is a need for central collection of data relating to Section 47 removals and the Department of Health should institute this. I doubt whether the adoption of the type of investigation conducted on maternal deaths would be helpful but believe that the cases can be very useful at local level. Policy makers can learn a great deal from individual cases and the review of this type of case by a Joint Care Planning Team could be very instructive to its members.

Chapter 4

ABUSED OR UNDER-USED?

Much of this thesis is devoted to an analysis of the ethical justifiability of Section 47 but the ethical defensibility of a law is not a question which is prominent in the minds of those who have to implement it or who wish to invoke it. They have to deal with the law as it is, not the law as they think it should be. However, the dangers of not continually being aware of the distinction between legislation as it is and legislation as it should be are great, no matter how little influence the individual may think he has on the legislature. In Fascist Italy and Nazi Germany, for example, the unquestioning passivity of some of the judiciary contributed to the legally sanctioned murder of millions of people. The dangers of Tolstoyan passivity are beautifully illuminated in Chekhov's short story Ward 6. In this the doctor who adopts a position of intellectual aloofness and cannot be bothered to tackle the barbarous conditions in the asylum to which he has been appointed finishes up as a patient in it himself(19). Every professional has a duty to question the legal framework, a citizen's duty, in addition to his professional duty to implement it. Once Section 47 was on the Statute Book Medical Officers of Health had to implement the law as it was, whatever their reservations about its ethical justifiability and their opinions on what the law should be. In this chapter, however, I wish to consider whether or not these powers have been abused or underused, leaving aside the question of whether or not they are ethically justifiable.

ABUSE

Abuse of the power

Have many people been forcibly removed from their homes although the conditions laid down in the Act were not fulfilled? This is a difficult question to answer, not least because it is not clear exactly what the law stipulates. The criteria appear straightforward. Paragraph 1 of Section 47 has two sub-paragraphs which state that the powers can be used for persons who

"(a) are suffering from grave chronic disease or, being aged, infirm, or physically incapacitated, are living in insanitary conditions, and

(b) are unable to denote to themselves, and are not receiving from other persons, proper care and attention".

Does this mean that there are only two criteria, one of which is that the person is not receiving proper care and attention, and the other that the person is either suffering from grave chronic disease, or does it mean that there are three conditions which must be fulfilled - grave chronic disease, and living in insanitary conditions, and not receiving proper care and attention? This was certainly the manner in which some community physicians interpreted it. In response to the question asking how many of the people removed had been suffering from grave chronic disease and how many had been living in insanitary conditions, some respondents stated this opinion unequivocally. One wrote "insanitary conditions was one of the three conditions which must be fulfilled in all cases"; another replied that "grave chronic disease" and "insanitary conditions" were "not alternatives under the Act", and there were others who stated that both conditions were present in all cases, but did not make clear whether or not they regarded both conditions as necessary prerequisites. The phrase "grave chronic disease" is also open to a variety of interpretations. One doctor replied that he had been asked to remove a person suffering from pneumonia but had refused to do so because he did not regard pneumonia as a "grave chronic disease". In this he was correct, for pneumonia is a grave acute disease, but it seems probable that many community physicians use the powers when a crisis occurs, precipitated by an acute exacerbation of a chronic illness or an acute illness (see page 199).

The decision in the case of Miss N. was made on the basis of the suspicion that her leg was fractured, and that she was suffering from congestive cardiac failure (see page 32), the decision to remove Mr. A. was based on the belief that he was developing acute pneumonia (see page 36). In both cases grave chronic disease was present

but the decision was made because of acute illness. That this interpretation of the Law is defensible, although Section 47 stipulates that the disease must be chronic, is supported by the fact that the 1951 Amendment Act was introduced because of the need to have powers to act in emergency, the particular case which stimulated the introduction of the amending legislation, and which was considered by the House, was one in which the need for the powers of immediate removal resulted from a fractured neck of femur (see page 112). There are also difficulties in interpreting what is meant by "insanitary conditions" (see page 198), and "proper care and attention" (see page 200), and the definition of these terms is at the discretion of the community physician.

Although there are difficulties in interpretation it does not seem that these have led to abuse of the powers; in fact the opposite appears to be the case. Those community physicians who have interpreted the legislation differently from the majority have done so in a way which makes it less rather than more likely that they will use it. That is, the lack of clarity may lead to under-use rather than abuse, for example by a community physician considering that both grave chronic disease and insanitary conditions were necessary pre-conditions when only one need be present.

The possibility of abuse is further reduced by the attitude of community physicians whose replies to the questionnaire made it plain they felt that their principal responsibility under the Act was to defend the liberty of the individual. This has been evident from the early years of these powers. It was the the London County Council Medical Officer of Health, Dr. F. N. Kay Menzies, who respectfully, but firmly, restrained his authority from considering these powers as means by which slum clearance could be facilitated, pointing out that their primary intent was to help individuals (see page 100), and it seems that the Medical Officers of Health acted as Counsel for the defence for those people who were referred for compulsory removal under the various local Acts. The opinions expressed in the Commons during the debate on the

National Assistance Bill in 1948 certainly gave the impression that the Medical Officers of Health were relied upon to ensure that the rights of the individuals were upheld (see page 104).

Many of the community physicians who replied stated that they were "put under pressure" or "pressurised" from a number of directions. "Inexperienced social workers, fortunately less frequently since 1974", general practitioners and community nursing staff who are "worried that the old person cannot be left alone over the weekend - the Friday Night Syndrome" or who are themselves under pressure from relatives or from "excessive demands on their services" apply pressure on the community physician as do environmental health officers, relatives "hoping to get the cottage", or to "gain possession of the house" and neighbours "afraid of fire". The readiness with which community physicians "succumb to the pressure", as one respondent expressed it, depends on a number of factors, not only his interpretation of the terms in which the powers are expressed, but the manner in which he copes with the anxiety which his involvement with a highly charged situation inevitably generates (see page 25), and his ethical views (see page 55).

Some of the people who have been removed would have undoubtedly been left at home had they been visited by another community physician. Some of the community physicians with whom I have discussed the people I have had removed would not have acted as I did. I regret every occasion on which I made use of the powers but I do not consider I have abused them although I am fully aware that other community physicians might well be of the opinion that I had.

Abuse of persons

There is, however, one other way in which the powers may be said to be abused, one other aspect of the community physician's role in which he could be accused of not acting in the interests of the person whose compulsory removal is being considered. This relates

to the meaning of paragraph 1(b) which lays down that people can only be removed if they "are unable to devote to themselves, and are not receiving from other persons, proper care and attention". What does this mean? If the reason that the person is not receiving proper care and attention from other persons is that they are refusing domiciliary care the community physician can only consider institutional care. Similarly, if the person has some problem which can only be treated in hospital, for example, a fractured neck of femur, an institution is the only place where he can be given proper care and attention, but let us consider the community physician's position if the old person's requirement is for care of a type which could be given in her own home provided that sufficient resources were available. Miss P., for example, really required two or three visits daily from a home help to prepare food and attend to her housework and laundry, three visits from a district nurse daily, and a nightsitter. In how many cases is the community physician told when he first visits that the person "needs" care in hospital or an old people's home when her problems could be solved equally well by the provision of domiciliary services in sufficient quantity? In one urban authority with 45,000 people over the age of sixty-five "all compulsory removals have been avoided partly because a hospital-at-home service has been available during this four year period" (see page 214). It seems certain that community physicians have often been asked to remove people compulsorily, not because community care has been impossible but because it has been impracticable with the resources currently available. In some cases the real "need" of the person is not for institutional care but for more community services than society is prepared to pay for.

The professional definition of need is frequently couched in terms which relate only to the individual's problems but need is also a function of the availability of services. Such a definition of need, which fails to state this constraint explicitly is common in health and social services. In renal transplantation, for instance, there is an upper age limit for acceptance of patients for

dialysis or transplant facilities with "transplantation being considered the first line of treatment for patients under the age of 56"[20]. This definition of need is partly based on sound clinical evidence. Patients over the age of 55 fare less well after transplantation, in general, than those aged less than this age, but the same could be said for the age of 56, 54, 57 or 53, or equally well for the ages 45 or 65. The choice of 55 as a means of defining need is based on financial consideration. Age limits are means of rationing resources, and as the services expand the definition of need by age also changes. In the case of transplantation the upper age limit rises. A survey conducted in 1977 showed that in the main European countries, in which transplantation and dialysis facilities are more plentiful than in the United Kingdom, seventy per cent of centres imposed no age limit, twenty two per cent excluded excluded patients over 65, and thirty seven per cent excluded those over 55 years ago[21]. Need is defined with respect to the availability of resources.

The same principle holds in many problems, including the definition of the needs of elderly people for residential care. The need is usually defined in terms of the person's inability to devote to himself proper care and attention; rarely is any mention made of the amount of support she is receiving in the community and the relevance of this to the person's inability to continue living at home. In many parts of the country home help is very limited at weekends, and is available no more than once daily on weekdays. Elderly people living in such areas may be defined as being "in need" of residential care when they are receiving home help no more than once a day on only five days of the week, with no-one questioning this statement. Professionals define need within the constraints imposed by limited resources, but it would be more accurate to call this a re-definition, for what takes place is a re-definition of the individuals' definition of their situation. To the old person the need is for someone to live in with her: to the professional the need is for residential care.

One of the reasons why professionals are unwilling to raise this issue forcefully whenever one of their patients or clients is deemed to be in need of institutional care when it is obvious that they could be given much more help at home is that every such professional has other patients or clients being served by the same finite home help or nursing service and realises very clearly that the consequences of devoting large amounts of resources to one person must inevitably detract from the care given to the others to whose problems they are equally sensitive. Each professional has to operate on Utility or Greatest Happiness principles[22] commonly known as the utilitarian principle - the greatest good for the greatest number - and this approach inevitably means that some individuals or groups have to suffer or, to be more accurate, that everyone has to suffer a little so that all can receive some benefit[23]. The community physician is under less severe constraints when faced with a person said to require compulsory removal. Most community physicians do not see a person with a view to compulsory removal more frequently than once a week, therefore rarely do they have a number of cases at crisis point simultaneously. The home help organiser on the other hand may be responsible for the provision of services to several hundred people many of whom are in severe difficulty as may a district nursing officer or social services director. The community physician can therefore make demands on these services, intellectually aware that any increase in service to one person will affect others, yet far enough removed from these other cases to be able to be relatively remote, emotionally, from the suffering which such a shift in resources would entail. How hard should he fight? Should he refuse to approach a magistrate until the person is being given home help twice daily with at least two visits from a nurse? Should he demand a night sitter, and for how long - a week, a month, or a year - before he agrees that the person's needs can only be met by institutional care, before he agrees that the person should be warehoused?

The term warehouse has been used to describe a style of institutional management concerned more with containment than with the continuing growth and development of its residents - as opposed to the greenhouse style[24]. The term warehouse is, however, apt in another sense, connoting a place in which a surplus of goods is stored. Attempts have been made to conceal this abuse, to prevent ourselves from becoming aware of it by talking of individuals "needing" residential care, either in a Home or hospital, without adding the rider about the amount of resources they are receiving and by arguing that residential care was more expensive than community care, as though we were being more generous in institutionalising our elders. It is now obvious that this is not the case. Community care may be very much more expensive if it is provided at an adequate level and this is the crucial point. The comparative cost of institutional and domiciliary care is not a function of the locus in which each is provided, whether in an institution or in the person's own home, but is determined by the quality of the service provided. It is more expensive to look after someone in a well-staffed, purpose built old people's home than to leave her in a house built before the First World War, paying a rent of less than one pound a week, receiving home help and district nurse only once a week, meals on wheels no more than twice, paying for her own chiropody and failing to claim an extra heating allowance. If, on the other hand, such a person were to be offered, and accept, a new sheltered flat with warden services, home help seven days weekly, district nursing thrice weekly, NHS chiropody, and help with rent, rates and heating costs, the equation would swing the other way and community care would then be more expensive.

The task of the professional working with elderly people is often arduous and exhausting enough without having to face up to this issue every working day. Furthermore, the individual may feel impotent to change the system, but professional organisations have a responsibility in this area and a welcome trend is their increasing involvement in campaigning for more resources for their clients as well as campaigning for more resources, that is, higher salaries for themselves. Few professional organisations, however, have the

courage to admit that the two objectives may be mutually exclusive[25, 26, 27]. Neither are many older people prepared to demand more help at home when told that they need institutional care. The biography of the generation is such that their expectations are very limited and they are not prepared to fight for the right to stay at home. Most are very grateful for what they receive; at present, only a few are prepared to challenge the experts' view of their needs.

> Miss B. was 86. Physically very disabled, she was mentally alert and demanded high standards of all who helped her - she was said to be a "difficult" old person. Eventually, to the relief of her supporters in the community, she was admitted voluntarily to hospital. She recovered and was eventually discharged from hospital to the consternation of the warden in the block of flats in which she lived. She demanded the same level of service as before her admission - two visits daily by both nurse and home help - but she was frequently incontinent, fell on a number of occasions, and made very heavy demands on the warden. Finally a case conference was held in her flat, and it must have been obvious to her that the intention was to persuade her that she could no longer manage there and was in need of institutional care because she carefully answered "no comment" to every question bearing on her ability to look after herself. After weeks during which she was repeatedly told she "needed care", she "would benefit" and "would like" living in a nursing home she agreed she would go into a home saying, resignedly, "I don't want to go, there'll be no-one for me to talk to, but if you won't give me any more help here then I suppose I have to go".

Miss B. had received as much or more help than anyone had every been given (this was some years ago) but saw clearly what was meant by her "need" for institutional care. It is likely that the elderly people of the future, namely ourselves, will be much more demanding and "difficult" than today's elders because our biography is so different. We will fight for our right to live at home.

This argument about "warehousing" is neither an indictment of modern society nor of the modern family. There is no evidence that elderly people were cared for any better in times past. A few were wealthy and lived well but the old and poor had to struggle to survive and many were consigned to that system of warehousing which grew out of the Poor Law of 1601 - the workhouses. The work of contemporary historians such as Keith Thomas[28], Peter Laslett[29] and Robert Moroney[30] makes this quite clear. Moroney's work showed that the proportion of elderly people in institutions, hospitals and homes in 1973 - 2.99 per cent - was just over half the proportion it had been in 1911 - 5.17 per cent - the small increase since 1952, from 2.10 per cent to 2.88 per cent being explicable by the ageing of the elderly population - the relatively greater increase in numbers among people aged over eighty. Large numbers of elderly people in the past were warehoused in the workhouse because of the absence of financial practical help.

Gerald Dworkin finished his critique of Mill's view on paternalism (see page 154) with the suggestion that the least restrictive alternative way of accomplishing the desired end without restricting liberty then although it may involve great expense, inconvenience, etc. the society must adopt it". The admission of old people to hospitals and homes who could be maintained in their own homes provided that they received much more domiciliary care - perhaps at the level of that given in hospital-at-home schemes[31] - does not satisfy this principle.

UNDER-USE

It may seem surprising to suggest that powers which deprive a person of her liberty might not be invoked often enough but if it is accepted that a piece of legislation, such as Section 47 of the 1948 National Assistance Act, is ethically justifiable and that it is beneficial to some people, then the possibility that there might be other people who could have benefitted from its powers should also be examined.

There are two means of examining this possibility: firstly by reviewing a number of cases in which the use of powers was considered without being invoked; secondly by scrutinising the process by which the "voluntary" decisions were reached in cases in which Section 47 was not used, that is the great majority of the admissions to homes and hospitals.

People left at home

> Mr. P. had been a widower for five years. In that time he had neglected himself and his house until the latter was full of rubbish - old newspapers, boxes of mouldering crab apples, and old clothes lying in heaps. He refused both home help and district nursing although he had difficulty in washing and dressing and had a large leg ulcer. He only allowed the health visitor to help him, and she had to call every day to perform duties which were not really her responsibility and which interfered with her other work with families in difficulties. After he had started a number of fires in the house and garden shed, which abutted on to the neighbouring house, the community physician was asked to visit with the health visitor and social worker who were being phoned frequently by angry and worried neighbours demanding Mr. P.'s removal. His next door neighbour had three small children. The community physician visited, was of the opinion that Section 47 was inappropriate, and left Mr. P. who waved goodbye cheerily, wearing a voluminous warm dark overcoat. The community physician had to explain his decision to the distraught neighbours who had had to call out the fire brigade again the previous night. He was able to mollify them but not to satisfy them and said he would review the situation in a week in which time he hoped the health visitor would be able to introduce a home help to Mr. P. in the manner he suggested.
>
> At five o'clock that day, in deepening twilight, Mr. P. was knocked down wearing his dark grey overcoat on his way to buy an evening paper, and died in intensive care forty-eight hours later.

This argument about "warehousing" is neither an indictment of modern society nor of the modern family. There is no evidence that elderly people were cared for any better in times past. A few were wealthy and lived well but the old and poor had to struggle to survive and many were consigned to that system of warehousing which grew out of the Poor Law of 1601 - the workhouses. The work of contemporary historians such as Keith Thomas(28), Peter Laslett(29) and Robert Moroney(30) makes this quite clear. Moroney's work showed that the proportion of elderly people in institutions, hospitals and homes in 1973 - 2.99 per cent - was just over half the proportion it had been in 1911 - 5.17 per cent - the small increase since 1952, from 2.10 per cent to 2.88 per cent being explicable by the ageing of the elderly population - the relatively greater increase in numbers among people aged over eighty. Large numbers of elderly people in the past were warehoused in the workhouse because of the absence of financial practical help.

Gerald Dworkin furnished his critique of Mill's view on paternalism (see page) with the suggestion that the least restrictive alternative was a useful concept. He wrote "if there is an alternative way of accomplishing the desired end without restricting liberty then although it may involve great expense, inconvenience, etc. the society must adopt it". The admission of old people to hospitals and homes who could be maintained in their own homes provided that they received much more domiciliary care - perhaps at the level of that given in hospital-at-home schemes (31) - does not satisfy this principle.

UNDER-USE

It may seem surprising to suggest that powers which deprive a person of her liberty might not be invoked often enough but if it is accepted that a piece of legislation, such as Section 47 of the 1948 National Assistance Act, is ethically justifiable and that it is beneficial to some people, then the possibility that there might be other people who could have benefitted from its powers should also be examined.

All the professionals could be critised for failing to foresee the risk which his dark clothes caused, a risk too often forgotten, but it is unlikely he would have worn a luminous arm band or lighter coat even if they had thought of this danger and advised him accordingly. The community physician could be criticised for not obtaining a removal order using Section 47 powers but many people would probably say that he had been right to leave Mr. P. at home and that the latter had been fortunate to have such a speedy end. What of the car driver, however: how did he feel when he was informed of Mr. P.'s death, and how does he feel now? No-one made any attempt to counsel him or to deal with his feelings of guilt. In any case, could counselling dispel the guilt resulting from being the cause of the death of another human being, no matter how great the mitigating circumstances may have been? The guilt which the community physician and other professionals would have felt if they had had him removed was transferred to someone else.

Miss J. was over eighty - her exact age was uncertain. She had not gone past her front gate for twenty years and lived solely on the ground floor of her large privately rented house with a number, also uncertain, of cats. Although her landlords were willing to improve her dwelling - she had an outside toilet which was blocked, no hot water and no bath - all their offers were refused. She had refused to allow her gas cooker to be changed when North Sea gas had been introduced, and frequently burned pans on the burners which were unsuitable for the new type of gas. Although she had been a ballroom dancing champion and proudly displayed the photographs of herself in elegant attire, she was dressed in rags. Small, bowed, white-faced, with matted hair and swollen purple-hued legs, she presented a bizarre picture when she opened the door, which she only did to her long-suffering neighbour, refusing all other offers of help. Finally the neighbour's patients broke, after Miss J.'s drains had blocked three times in a week and she had had two fires. The neighbour asked for help, but professional offers were spurned, so the

community physician was asked to visit. Miss J. allowed him to enter with the trusted neighbour, but said that "everything was all right". When told that her neighbour was worried and was feeling the strain she replied that "she shouldn't worry, but if she is I'll get help from some other friends", although she had none who could or would help. When the community physician pointed out an example of a typical cause of the neighbour's anxiety - blue smoke issuing from the sausages burning on the gas - Miss J. said calmly to him "but that would never have happened if you had not come to the door when you did". There was no evidence of a severe degree of dementia.

The community physician decided not to use Section 47 powers. The burden on the neighbour was lightened by a social worker taking over all the financial responsibilities, such as payment of rates - Miss J. kept large sums of money at home and not infrequently accused neighbours of theft - and by assuring her that no more could be done and that the community physician was now responsible should any criticism be made if Miss J. were to die.

Miss J. continued to live in the same manner, not depressed but looking forward to her death and reunion with her mother, sister, and former dancing partner. Like Miss Havisham in Great Expectations, her life seemed to have come to a halt with his death. Eventually she was found dead on the floor by her neighbour six months after the case was first referred. Post mortem examination suggested she had died suddenly of a heart attack.

It could be argued that the community physician acted correctly, that it was right to leave this woman in squalor, but was it justifiable to leave a woman in conditions which would probably have shocked and revolted her were she to have seen them when she was thirty years younger. All professionals have had the experience of visiting

People in inadequate circumstances whose initial response was to refuse help but who eventually agreed to home improvements being carried out. Miss J. was visited once a week by the community physician; was that sufficient or should he have visited for an hour every day for weeks or months on end to build up the sort of relationship on which such an elderly person can contemplate changing her environment? She might not have lived any longer had she agreed to environmental improvements, but the fact that she would die within six months could not be predicted at the time she was first seen and she might have had to endure many more freezing winters because a decision was made not to remove her compulsorily and insufficient effort was put into persuading her to raise her standards to those which she had had previously.

People who enter institutions "voluntarily"

The other group of people which should be studied to test the hypothesis that the powers of compulsory removal are not used often enough consists of those who have entered institutions apparently as the result of a decision made voluntarily. The term "apparently" is used because there has been a tendency to consider admission to institutions as being either "voluntary" or "statutory", that is compulsorily using powers laid down by statute. Because statutory, compulsory admissions are identified as a distinct group, all the other admissions are also grouped together, but these non-statutory admissions are not all equally voluntary. "Non-statutory" and "voluntary" are not synonymous. Some of those admitted to institutions are keen to go, but others go unwillingly only after persuasion, a popular word among those working with elderly people. Three areas allow this to be studied in more detail - the era before compulsory powers were available; professional practice in the present day; and research in the related field of admissions of people who are deemed to be mentally ill.

The Poor Law Era

In times past Poor Law officers had little need of compulsory powers; people could be "driven to the workhouse" by refusing them outdoor relief, but there must always have been a few who refused

to be starved into submission in this way. Were such people removed forcibly from their homes? The evidence is scattered and difficult to sift but Anne Crowther, an authority on the Poor Law's history, is of the opinion that "some boards of guardians did use considerable pressure to remove the incapacitated to the workhouse, usually on the advice of the medical officer. The Poor Law inspectors certainly wished for compulsory powers from the 1870s, and guardians did exceed their authority for infirm and senile cases. Of course, if the guardians refused outdoor relief to such people they could more or less force them to enter the workhouse. A medical officer, lacking other powers, could also certify a person as insane, and get him into a workhouse or asylum that way.(32) This high handed approach is movingly described by that observer of Oxfordshire rural culture in the nineteenth century, Flora Thomson, who describes the removal of the Major in Lark Rise.

> "The good, kind Major was in no danger of being forgotten by the family at the end house. Mother made his bed and tidied his room, and Laura was sent with covered plates whenever there was anything special for dinner. She would knock at his door and go in and say in her demure little way, "Please, Mr. Sharman, Mother says could you fancy a little of so-and-so?"
>
> But the major was too old and ill to be able to live alone much longer, even with such help as the children's mother and other kind neighbours could give. The day came when the doctor called in the relieving officer. The old man was seriously ill, he had no relatives. There was only one place where he could be properly looked after, and that was the workhouse infirmary. They were right in their decision. He was not able to look after himself; he had no relatives or friends able to undertake the responsibility; the workhouse was the best place for him. But they made one terrible mistake. They were dealing with a man of intelligence and spirit, and they treated him as they might have done one in the extreme of senile

> They did not consult him or tell him what they had decided: but ordered the carrier's cart to call at his house the next morning and wait at a short distance while they, in the doctor's gig, drove up to his door. When they entered, the Major had just dressed and dragged himself to his chair by the fire. "It's a nice morning, and we've come to take you for a drive", announced the doctor cheerfully, and, in spite of his protests, they hustled on his coat and had him out and in the carrier's cart in a very few minutes.
>
> Laura saw the carrier touch up his horse with the whip and the cart turn, and she always wished afterwards she had not, for, as soon as he realized where he was being taken, the old soldier, the independent old bachelor, the kind family friend, collapsed and cried like a child. He was beaten. But not for long. Before six weeks were over he was back in the parish and all his troubles were over, for he came in his coffin.(33)

Current practice

What happens nowadays if the community physician is not immediately able to come to a crisis, or has decided not to use the Section 47 powers, either because he thinks the case does not fulfil the necessary criteria or because it is his opinion that the conditions are not grave enough for him to act? In some cases the old person will be freed from further attempts at persuasion, the professionals will become less anxious because the community physician has accepted some of the responsibility. This may perhaps be called the positive results of refusing to use Section 47. The consequences may, however, be less satisfactory, and the old person may be admitted to hospital with the aid of deceit, drugs, coercion, or overpowering.

Deceit is commonly practiced by professionals. In most cases this is a deceit by omission, although the professional concerned may not themselves have been deceitful. For example, when asked to visit an old person with a view to effecting his or her compulsory removal using the powers vested in my position by Section 47, I would not mention to the old person on our first meeting that this was the reason for my involvement. I may say that I am a doctor interested in

helping old people live in their own homes, or that their general practitioner has asked me to visit to see if they need any further help or dissemble in some other way. I may also feel it necessary not to reveal the reason why the request for compulsory removal was made if I am uncertain what the elder's relatives wish to be revealed, as it is not always possible to meet them beforehand, or if I do not wish to reveal how serious other people think the elder's condition may be.

> Mrs. K. lived near her daughter who looked after her every need. Her daughter became worried by Mrs. K.'s loss of weight, by finding bloodstains on her sheets, and by a peculiar smell in the house. Mrs. K. refused all offers of help, so the community physician was asked to visit. He visited Mrs. K. saying that he was working with her general practitioner and as it was some time since she had consulted the doctor he and the G.P. had decided to visit her. She let him in and seemed pleased to see him. The community physician then spoke to her daughter who said that her mother had complained of pain in her breast. The community physician advised the general practitioner to be direct in his approach, to say that Mrs. K. did not look well and that he wanted to examine her chest. He took this line, and Mrs. K. undressed revealing a cancer of the left breast which had advanced so far that the whole breast area was one large discharging ulcer. As it was agreed that hospital treatment would not help Mrs. K. it was decided to treat her at home with domiciliary nursing and Mrs. K. allowed the nurse to visit thereafter.

Such an approach might be called tactful by professionals and considerate by relatives but there is no getting away from the fact that it is untruthful. If a community physician is unwilling to remove a person compulsorily, is it not possible that their relatives and professional advisers may be tempted to deceive the old person

either by omission, for example by now answering her question as to when she will be coming home from the institution to which she is being driven, or by commission, for example by telling an old person that she is going away for a holiday when she is in fact being taken to hospital, or that she is only going away for a week when it is the relatives' intention to sell her house as soon as she is admitted? How many people are still treated like the Major in Lark Rise?

Drugs which tranquillise the mind damp down the spirit of resistance among their many other effects. A high proportion of elderly people receive tranquillising drugs and many more are prescribed antidepressant and hypnotic drugs which can also influence their ability to make decisions. The most careful study of drug prescribing in general practice, which was conducted in Oxfordshire, found that 13.3% of men and 20.2% of women over the age of 75 had had more than five prescriptions for psychotropic drugs during the year for which data was collected.(34) The contribution of psychotropic drugs to the elder's decision to agree to enter a hospital or home has never been fully assessed but these cannot be without an effect on the elderly person's ability to reach a decision voluntarily. Such an effect would be classified as a side effect, but are the psychotropic drugs ever prescribed to achieve this objective, to make the elderly person less resistant to the suggestion that she should enter an institution? This is probably uncommon, although I have evidence from dependable sources that this practice does occur. More common is the problem which results when the person falls between the criteria necessary before they can be compulsorily removed using the Mental Health Act in the opinion of a social worker or psychiatrist, and the criteria necessary for removal using Section 47 of the National Assistance Act, in the community physician's opinion. The general practitioner may then be left with the responsibility of managing a person with severe behavioural problems, often without support from a psychiatric community nurse or clinical psychologist. In an attempt to control disruptive behaviour he may have to resort to tranquillising drugs and, if these are not initially successful, he may have to

increase the level of medication producing effects which make the elder unable to answer the question "would you like to go into a home or hospital?" Furthermore, the poor compliance with instructions given to elderly people about how they should take drugs which have been prescribed for them means that some of the elderly people who are failing to cope and are told that they "need" institutional care will probably be suffering from drug side effects[35, 36, 37].

To coerce is defined in the Shorter English Dictionary as "to constrain or restrain by force, by authority resting on force". Most community physicians will have used the possibility of compulsory removal as the last line in their argument to persuade people to go into hospital (see page 79). This could be construed as an attempt to coerce, as could the whole procedure, but it is not coercion in the proper sense of the word because the community physician is legally invested with his authority and is legally accountable if he decides to remove a person by force. Other people do not have this legalised authority and the community physician may himself be used as the threat. It is not uncommon for the community physician to realise that much of the behaviour of the old person he is visiting can be explained by the fact that she had been told that "if you won't go into hospital the Medical Officer of Health can have you taken away" (see page 125). How many people agree to enter an institution only because they have been coerced? Probably a considerable number.

Finally, how many people agree to go into a home or hospital because they have been overpowered? Overpowering may seem a strong term to use. It has connotations of physical power, of ambulance men carrying a struggling elder to their vehicle even though they have no legal warrant to do so. This probably never happens because ambulance staff are resourceful and independent, and it is extremely unlikely that both members of a two man crew would obey the directions of a relative, doctor or any other professional to remove a person against her wishes. Occasionally, however, a general practitioner sends for

the ambulance even though the person is refusing to go to hospital, relying on the fact that the old person will change her mind when she sees the ambulance arrive, which often transpires, but this could not be considered a physical overpowering for the ambulance men would not remove the person unless the old person agreed, or appeared not to be refusing, to go with them. Such a course of events is not physical overpowering but it could be considered to be mental overpowering, as could the process of persuasion.

A voluntary action is defined by the Shorter English Dictionary as one "performed or done of one's own free will, impulse, or choice; not constrained, prompted or suggested by another". Some people do decide to enter residential care voluntarily, social services departments receive such applications from people who have made the decision voluntarily. Admittedly many will have made it in the context of the struggle which disabled elderly people have to make to survive at home with inadequate services and had twice daily home help and district nursing been offered as an alternative a different decision might have been made (see page 199), but those people who initiate a demand for a place in an old people's home or hospital for themselves may be considered to be voluntary applicants.

What of those for whom the suggestion of a place in an institution comes from someone else, from a relative or professional in most cases? Those who accede to the suggestion immediately and gratefully, having been previously unaware that such a move was possible, may also be considered as voluntary applicants, but what of those people whose initial response is negative, who refuse to accept or even discuss the possibility that in their terms they should "be put in", or in professional terms "need to go to" an institution? Can these people be considered as having been admitted voluntarily when they finally agree to go to the institution if they have had to be persuaded to make this decision over a long period of time? The words "persuaded" and "persuasion" are commonly used in this situation as in "some persuasion was necessary", or "this lady had to be persuaded to accept help". The word "persuasion", from the Latin suadere, which has the same meaning, is defined in the Shorter English Dictionary as meaning either "to prevail upon a person to do something", or "to induce a person to

believe something". The verb to prevail has the meaning "to be superior in strength or influence" and some old people are persuaded to change their decision solely because another person is superior in strength and influence. To accept a decision made in such a manner would be unacceptable to many professionals, who would regard such a decision as the result of the old person having been overpowered by another, stronger, person, and however the decision was actually reached the recollections of many elderly people about the process attribute the main responsibility for the decision to their general practitioner. The recollections of three women in a London home illustrate this.

> "I got very depressed after my husband died and had to go into hospital. My doctor came to see me there and said 'You can't go home. You need to go into a Home'. They tried to fix me up but it was going to take some time and I wanted to go home. He said 'I'm not going to let you home because I know you wouldn't leave it again'. I'm happy now, I like it here."

> "I was taken ill in the middle of one night and my doctor came to see me and said 'You can't stay here, you know'. I said 'Why not?' and he said 'You need to go into a Home'. I didn't want to leave my home. I had to sell up. I was very lucky and managed to sell up in three months. The Home is very nice and all the staff are very kind."

> "It was my doctor said I had to come into a Home. I was having these falls, you see. I didn't want to leave my home but I suppose it was for the best."

Although instances do occur in which the elderly has been overpowered by the influence of their doctor or some other person, it would be wrong to envisage "a battle of wills" and the other meaning of the word "persuade" - to induce a person to believe something - is more relevant to the quotations cited above.

During the persuasion process other people try to make the old person "listen to reason" or "see the reality of her situation", or "be more rational". However, this implies that there is only one reality as there is only one Eiffel Tower, whereas each individual constructs his own version of the social reality from the phenomena which he perceives and from the preconceptions he brings to his analysis. The person who talks about trying to make an old person see the reality of the situation is in fact trying to make that person accept his reality or, to be more precise, his view of the reality of the situation. The person is persuaded to believe this by argument or merely by the frequent repetition of the fact that "you should go into a home, it will be better for you". As Turgenev said of Nickolai Petrovich in Fathers and Sons "(he) has become an arbitrator in the land reforms and puts all his energy into the work; he is constantly driving about the district to deliver long speeches (he) holds the opinion that the peasants must be made to "listen to reason", meaning they must be worn down by frequent repetition of one and the same phrase."

Comparatively little research has been done on the process by which decisions are actually reached - the process by which an elder's situation is defined as a problem and then the process by which it is decided that the most appropriate solution to the problem is admission to an old people's home or geriatric hospital. One study of the transitions between home and institutions, in this case old people's homes, found that 32 of the 46 cases considered had been referred by other people and that this was reflected in the wishes they expressed(38).

Source of referral	Attitudes towards admission	
	Wish to become resident	Do not wish to become resident
Self	13	1
Friends	3	0
Family	4	5
Officials	11	9

TABLE 8: Attitudes towards admission correlated with source of the refferal. (39)

One study of referrals for hospital admissions paid particular attention to the social factors which influenced the consultant geriatrician's decisions and contributed to "total admission pressure"(40) and found that nearly one half of the elderly people in the study expressed strong feelings about the suggestion that they needed hospital care.

Feelings expressed by the elder about entering hospital	Numbers	Percentage
"hate"	24	10
dislike	90	39
would like	54	23
want	26	12
equivocal, or communication not possible	36	16
Total	230	100

TABLE 9: Attitudes towards hospital admission. (41)

Many elderly people agree to enter an institution after they have been persuaded but in some cases they have not changed their minds: they have just given up and given in.

There is a possibility that the same strategems - deceit, drugs, coercion, and overpowering - are used in those areas in which the community physician is known to be unwilling to remove an old person compulsorily. The process by which cases are referred to a community physician for consideration for compulsory removal are affected by so many variables that I did not attempt to study them. However, I believe that general practitioners and other professionals working with elderly people do not refer so many cases to a community physician who makes it clear that he or she is very unwilling to exercise his powers and has not chosen to do so for many years. Professionals are humans and are discouraged from repeating actions which do not have rewarding consequences. After one or two occasions on which they have referred a case for the community physician's opinion, having had to delay their intended course of action until this has been obtained and then been told that compulsory removal is not possible, the motivation to repeat the process may be reduced (especially if, during the course of the delay, further deterioration renders the person "unfit" for the old persons' home

which had been willing to accept her at the time the referral was first made). Some community physicians have told me with pride that they had not used Section 47 for many years. The assumption was that the elders they had seen had been allowed to remain at home or had subsequently changed their minds but I believe that the elders in their districts would have been admitted with the use of deceit, drugs, coercion or overpowering because the professionals had been frustrated in their attempts to obtain legal compulsory removal.

Non-statutory admissions to psychiatric hospitals

In recent years there has been growing public concern about the abuse of psychiatric power, largely focused on the misuse of the powers vested in statutory provision for the compulsory removal from their homes of those deemed mentally ill. In Russia it appears that such powers are used for political ends, although the possibility exists that there may be genuine confusion between political protest and mental illness in a totalitarian state in which the prevailing political philosophy is considered to embrace all that is rational(42). In Britain and America concern has also been expressed about the misuse of such powers, but the criticism is set in a social, not a political, context. The Mental Health Act of 1959 gives doctors the power to remove people to a hospital. Section 25 allows the compulsory admission of a person for observation for twenty-eight days, provided that two doctors' recommendations are obtained, and an application is made by a social worker or the nearest relative; Section 29 allows admission for observation for a period not exceeding seventy-two hours with only one medical recommendation, and an application by a social worker or any relative; and Section 26 allows admission for treatment following two medical recommendations.

TABLE 10:

Number of compulsory admissions and percentage of total admissions which are compulsory: 1974-1975 in England.

		1974		1975	
		Number	Percentage	Number	Percentage
MEN	65 - 74	691	10.59	720	10.32
	Over 75	461	10.20	467	10.31
WOMEN	65 - 74	1,410	10.90	1,399	9.71
	Over 75	1,239	10.63	1,218	9.82
All under 65			14.16		11.20

TABLE 11:

Relative frequency, by percentage, of the different Sections used in 1974 and 1975, in England.

	Over 64	Under 65
Section 25	43.5	32.1
Section 26	1.4	3.4
Section 29	55.1	64.5
	100 (7,607)	100 (31,983)

Inpatient statistics from the Mental Health Enquiry for England 1974 (Statistical and Research Report Series No. 17 (HMSO 1977) and No. 20 (HMSO 1978) amplified by information from the Statistics and Research Section of the Department of Health and Social Security.

Elderly people are less frequently admitted using the "emergency" powers of Section 29 which suggests that the situations which necessitate compulsory removal are less urgent, possibly because they are probably less frequently potentially suicidal or homicidal than younger mentally disturbed people. The fact that a smaller proportion of the total number of admissions of elderly people to psychiatric hospitals are formal admissions also appears to suggest that the types of mental

disorder which affect old people give rise less frequently to the need for compulsory removal. (The percentages in Table 2 would be even lower if the number of formal admissions was expressed not only as a percentage of all hospital admissions, but also as a proportion of the number of admissions to old people's homes necessitated by mental rather than physical disorder. It could be argued, however, that the lower proportion of old people compulsorily admitted could also be explained by the manner in which mental health problems were dealt with in different age groups, rather than as being due to intrinsic differences in the problems in the two age groups; that is, old people may be admitted without Mental Health Act powers being used although they are not "voluntary" patients.

One standard psychiatric textbook refers to the patients who are of informal status as "free citizens"[43], but how freely are their decisions made? Leaving aside the broader philosophical aspects of the concept of free will and using the common sense definition of free decisions, it can be argued that it would be wrong to assume that all these "informal" patients can be considered to be voluntary.

If a scientific meeting which I had planned to attend were cancelled and I decided to make use of the time thus liberated by going to watch a football match, that would be regarded as a voluntary decision, being the resultant of numerous influences, for example the desire to feel that I belonged to a large group and the pleasure of watching twenty two men kicking about a piece of leather which I have learned to appreciate during the process of socialisation, but it can be regarded as a voluntary decision in common sense terms. How many of the elderly people who are informal patients in institutions have made the decision to enter with this degree of free will or, to use a closer analogy, with the free will they use to seek the help of a dentist when afflicted by toothache? In the opinion of the most extreme protagonists of the "conspiratorial model"[44] of mental illness, who claim that what we call mental illness is merely what is conventionally defined as being an illness by the majority, all those who are admitted to mental hospitals are wrongly treated by society. Thomas Szasz is

the best known advocate of this view[45, 46]. Others are less extreme, arguing that the person who becomes a psychiatric patient does break some rule, but that although the infraction in itself is of little harm to other people or to society, the person is eased into the position of a psychiatric patient by the well-intentioned interventions of other people. Such views are held by sociologists of deviance, notably Becker and Scheff (see page 173)[47, 48], by R. D. Laing[49] from a psychotherapeutic standpoint, and by Erving Goffman, whos anthropological approach has been very influential. In the Moral Career of the Mental Patient, Goffman states that "a relatively small group of pre-patients come into the mental hospital willingly, because of their own idea of what will be good for them, or because of whole-hearted agreement with the relevant members of the family"[50]. The majority, in Goffman's view, are initially referred by a "complainant" and are then processed along a "betrayal funnel" into the psychiatric hospital like cattle into a corral or salmon into the blind end of the net. In what proportion of voluntary cases this betrayal process takes place is difficult to estimate, partly because there is often no sharp demarcation between the volunteers and the pressed men, partly because the subject is so sensitive that many obstacles stand in the researcher's path.

One study of eighty two patients under the age of 65 showed that only thirty two accepted responsibility for their admission, the other fifty attributed it to other people[51], but little research has been conducted on the admission of elderly people. There is little doubt, however, that many elderly people have their situations defined as a problem by other people, have that definition refined as a mental health problem by others, and have institutional admission defined as the most suitable solution by others without ever agreeing with any of these definitions and without the powers of the Mental Health Act being invoked to legalise the admission. It is true that some old people are intellectually unable to care for themselves or discuss hospital admission with their professional advisers, relatives and friends, but it could be argued that such people should

be admitted under Section, for they are not voluntary patients. Many elderly people, however, appear to fall into neither formal or compulsory or informal or voluntary categories laid down by the Mental Health Act but can be classed together in a third, "confused" category. This is highlighted by the status of those thousands of elderly people who are detained in institutions without legal justification. There are a large number of old people who live in hospitals or old people's homes, who repeatedly say they want to go home, but are either diverted by staff who suggest they wait until after the next meal, hoping that they will forget their desire, or for whom the necessary arrangements are neither made or contemplated because it is thought the elder is "better off" in a home.

On the 31st December, 1975 28,104 people over the age of 65 had been resident for a year or longer in psychiatric hospitals in England. However, in 1975 only fifty eight Section 26 orders were made with respect to people aged over 65, thus no more than 0.2 per cent of people residing in psychiatric hospitals are detained legally; that all of the remainder are voluntary patients must be open to question.

TABLE 12:

Length of residence	65 - 74	over 75
1 - 2 years	936	1,563
2 - 3 years	667	1,146
3 - 5 years	925	1,448
More than five years	10,045	11,375
TOTAL	12,572	15,532

Source: Table A271
In-patient statistics from the Mental Health Enquiry for England 1975
Statistical and Research Report Series No. 20 (HMSO) 1978

Although great caution is necessary when drawing analogies between mental and physical disorders this argument has relevance for the consideration of Section 47 powers because the types of problems referred to the community physician and the consultant psychiatrist are similar (see page 199), and the use, or underuse, made of the powers of the Mental Health Act where old people are concerned suggest that Section 47 is similarly underused.

PART II: THE SOCIAL CONTEXT OF SECTION 47

Chapter 5

THE HISTORY OF COMPULSORY REMOVAL

METHODOLOGICAL PROBLEMS

In trying to determine the reasons why a particular piece of legislation was introduced at a particular time it is necessary to try to ascertain what was believed at that time about matters such as divine will, the spread of disease and insanity; the values placed on different conditions, in this case life, liberty and cleanliness, and the attitudes to those who appeared not to be conforming. The objectives of a piece of historical research are comparatively easy to define. Much more difficult is the investigation necessary to achieve them.

In the first place some of the relevant written records are missing. For example the Committee papers concerning the introduction of the powers of compulsory removal into the 1933 Oxford Corporation Act are missing. All that remains is a simple statement that it was agreed that a clause permitting the Medical Officer of Health to remove "infirm and diseased persons in certain cases" be included in the Bill. Who initiated this proposal, who supported it and the reasons for their support, and who opposed its introduction and the reasons why they did so, remain mysteries. Secondly, those written records which have survived - minute books, committee papers, and records of debates - although valuable, have many deficiencies. One important deficiency is that they do not reveal all the unconscious influences at work. That could not be expected of such records of conscious deliberations, because it is the task of the historian to divine the unconscious forces, but the records which are available for analysis are often deficient in their representation of the attitudes and values, of which those involved were conscious. Those who take

minutes and prepare Committee papers concentrate on facts, or what they believe to be facts, rather than on the more discursive themes of attitudes and values. Those who record the Parliamentary exchanges for Hansard are, of course, an exception for they take down every word and attempt to convey the spirit of the more notable interjections but even Hansard is not a complete record, as anyone who has compared the report of a debate with his impressions from the public gallery can testify. Hansard does not capture the mood of the House: the number of Members present; the rate at which they enter and leave the Chamber; the level of background chatter by Members; the number of Members who shake their heads in angry disagreement; and the number who try unsuccessfully to catch the Speaker's eye are all valuable indicators of the mood of the House, reflectors of attitudes and values, but none are recorded in Hansard. A sensitive journalist can give a more accurate impression. Furthermore, no matter how full the record of a discussion may be it can only record what is said and many people who speak at meetings at which other people whom they do not know well or trust are present, or at which they know minutes are being recorded, are guarded in their revelation of attitudes and values. A further difficulty is that any inferences about the attitudes, values and levels of knowledge which prevailed at the time at which the legislation was drafted and introduced have to be based on the contributions of those who contributed to the written records, whereas decisions were also made by those who did not contribute or whose contributions were not recorded, and these silent people cannot be assumed to have held the same beliefs or opinions as those whose beliefs and opinions have been recorded. For example, although the Bradford Act was passed in an era in which the bacterial transmission of disease was understood by the medical profession and by many members of the public and their

representatives it is probable that there were still many others for whom the nineteenth century concepts of disease transmission, which will be discussed in more detail (see page 155), were of relevance.

What were the prevailing attitudes towards deviant elderly people and what value was placed on institutional life in which "proper care and attention" was given as opposed to life at home in insanitary conditions receiving inadequate or, by derivation, "improper" care and attention? In what context did this legislation evolve? Sally McIntyre's excellent history of Old Age as a Social Problem[52] reveals that between 1910 and 1940, between the Reports of the Poor Law Commissioners and Beveridge, there was little interest in the problems of elderly people, paternalistic or otherwise. It is true that the Old Age Contributory Pension Act was introduced in 1925 and that the pension age was reduced to 65 for both sexes by this Act three years later but it could be argued that the motivation for this piece of legislation sprang as much from the wish to relieve unemployment as from any desire to allow people aged sixty-five to retire instead of requiring them to work until seventy before they qualified for a pension from the State.

These are major obstacles but the deficiencies in the sources from which conclusions have to be drawn present less of a problem than the deficiencies of the person who is trying to analyse the records - the historian. Allowance is made by the historian for the biases in the records he is studying, but it is much more difficult to make allowances for his own bias - a difficulty which is particularly severe for one who has not been trained as a historian. Consciousness has a history,

just as technology or the Conservative party has a history, but the history of consciousness is much more subtle and its study much more difficult, not only because of the nature of the subject but because the putative historian is steeped in the consciousness of his own time. His analysis of the attitudes and values of the past is made through the lens of his own times and he cannot discard his bais. The best he can hope for is that he can compensate for it in some degree by discussing his thoughts about the subject with his colleagues and by trying to be aware of his own beliefs and prejudices.

THE POOR LAW ERA

As Section 1 of the National Assistance Act 1948 is titled "Supercession of existing poor law" my first approach was to try to identify this type of power in one of the superseded Poor Laws. The seventh Schedule of the 1948 Act lists seventeen Poor Laws which it repeals and as six of these Acts were Poor Removal Acts my conclusion, on first reading the 1948 Act, was that these Acts would contain powers similar to those in Section 47 of the National Assistance Act. I was wrong. The term "removal" in this context refers not to the removal of persons in need of proper care and attention from their own homes but the removal of paupers from a union in which they had no legal right to seek relief to one in which they had legal right. The Acts were drafted to discourage vagrancy. There were powers to detain inmates who were ill, for example, Section 53 of the 1927 Poor Law Act, stated that "If an inmate of a workhouse is suffering from delirium tremens or from bodily disease of an infectious or contagious character, and the medical officer of the workhouse upon examination reports in writing that the inmate is not in a proper state to leave the workhouse without danger to himself or others, the board of guardians may direct the master to detain him therein, or, if the board are not sitting the master may, until the next meeting of the board, detain him therein, and the inmate shall not be discharged from the workhouse until the medical officer certifies in writing that discharge may take place".

There were no powers, however, to remove people to the workhouse who were suffering from physical disease in any of the Poor Laws, a deficiency highlighted by both the Majority and Minority Reports of the Poor Law Commissioners. The Majority Report stated that "Wherever we have gone we have heard of the one or two cases, generally of old

people, who are living in a terrible state of neglect, and to whom the Guardians are forced to give out relief, because they are powerless to remove them to an institution against their will. Very often they are senile, and incapable of taking a resolution on their own behalf. Their homes and persons become indescribably loathsome, so much so that there are cases in which even district nurses and undertakers have refused their services; and they are a source of constant danger to themselves and to their neighbours. We recommend that powers should be given to the relief Authority, under due precautions, to remove such cases to an institution. There are, no doubt, objections to such a course; but they are no greater than those which can be brought against the compulsory removal of infectious cases. And, as with infectious cases, so it would be here when once the removal has been effected, it would almost invariably cease to be felt as a hardship. We have had strong evidence from many witnesses as to the pressing need for this addition to the powers of the Guardians; and we think that those who oppose it can hardly have realised the evils which it is designed to meet".(53)

"it is chiefly with reference to the aged that the powers of removal which we have recommended in a previous Chapter are asked for. The evidence in favour of such powers is very strong, and comes from all quarters. It is only in a small number of cases that the need arises; for the most part the old people who are too infirm to look after themselves, and have no friends to look after them, are glad to find a refuge in the infirmary or workhouse, before their state becomes such as to call for active intereference. But the difficulty is so great as to lead to very weighty evidence in favour of granting no outdoor relief at all to the aged. The representatives of the

Association of Poor Law Medical Officers say:-

> "The opinion of Poor Law medical officers is overwhelmingly in favour of provision in institutions. The replies are all to the same effect, that the aged are kept cleaner and in better health in institutions than if you give them outdoor relief, and that they really suffer in health and in every other way if they are left to provide for themselves outdoors".
>
> "And that opinion is given in face of the fact that it would tend to deprive the present district medical officers of their employment? - I take it so. There is no doubt as to the general tendency of the replies. These replies come from both workhouse officers and from district officers. Medical opinion seems quite clear in favour of institutional provision. The British Medical Association gave evidence to the same effect, and there is little doubt that from a medical point of view it is much more easy to deal with the aged in an institution than in their own homes. We think, however, that to a large extent, this difficulty might be met by a better supervision of the people on out-relief, and that the number of cases becoming so neglected as to require compulsory removal might be diminished if they were properly looked after from the first. Under the present arrangement it often, one might almost say, generally happens that many months elapse between one visit of the relieving officer to the home and another, and when the pauper is unable to come for the relief, he may not even be seen by anyone in authority".(54)

The type of case for which the Commissioners thought such legislation necessary were those who were "suffering from incurable malignant diseases, aged sick persons living alone who have no friends or relatives to look after them and phthisical cases". They were also concerned about the type of cases which led to fatal accidents "chiefly through the patient falling into the fire, or otherwise setting fire to himself".(55) In the Minority Report the Webbs wrote that:

> "There is no subject brought before us on which there has been such unanimity of testimony as the need, in the public interests, for some power of compulsory removal of infirm old men or women who refuse to accept an order for admission to the Workhouse, and who linger on, alone and uncared for, in the most shocking conditions of filth and insanitation".(56)

They saw a clear need for this type of legislation, but did not consider that it should be the responsibility of the Poor Law Authority:

> "Besides the persons in this condition who come voluntarily to the Workhouse, for lack of better refuge, there are, as many witnesses have told us, many helpless aged persons who struggle on, sometimes among their friends, more often in their lonely lodgings, with their tiny pensions or Friendly Society pay, their casual pittance of alms, or, at present, their dole of Outdoor Relief, whose conditions become steadily more insanitary and their wretchedness more extreme. These, too, will become much more numerous when the national superannuation allowances become payable. But already such cases are frequent enough to cause much trouble to the Destitution Authorities, which have sometimes to watch them day by day so as to prevent actual starvation or death from neglect. But so long as the only accommodation available is the General Mixed Workhouse, deliberately made deterrant, and publicly stated to be intended for the undeserving, no Parliament could possibly grant compulsory powers of removal to, and detention in, such an institution".(57)

These proposals that legislated powers of compulsory removal should be introduced should not be taken to imply that everyone who entered the workhouse did so voluntarily. The situation was quite contrary to this. During the latter part of the nineteenth century there was, of course, no need for powers of compulsory removal because it was possible for the "Destitution Authorities" to coerce people to enter institutions by failing to offer any domiciliary service if the person was ill and by refusing outdoor relief to those who had insufficient means for the basic necessities of life. The House of Commons Select Committee which considered the Cottage Homes Bill in 1899 stated that it was the exception to relieve the aged and deserving poor in the workhouse and it was only in cases in which "the infirmity of the applicant for relief or other circumstances render it practically impossible for him to live elsewhere than in an institution" that admission was necessary".(58) The amount of help which was "practically" possible was, of course, much less than is available today and varied very widely from one part of the country to another. The Reverend Blackley, Vicar of St. James-the-Less, Westminster, reported to the Royal Commission on the Aged Poor in 1893 that he had been able to keep a "sick and infirm....decent and respectable women supported at home

by the efforts of 'the district visitors' saving her from having to spend her last days in the infirmary".(59) Many elders, therefore, both deserving and undeserving, had to be admitted to workhouse infirmaries because of the lack of domiciliary services: they were, in the words of the Select Committee on the Aged Deserving Poor "obliged to accept the shelter of such an institution".(60)

It was, however, recognised that the provision of an old age pension alone would not preclude the need for compulsory admission. The Committee on Old Age Pensions (the Rothschild Committee) reported to Parliament in 1898 that those "who are bedridden, those who are suffering from senile inability, those who have lost their power of self-control, and have fallen into insanitary habits, and, finally those who are no longer capable of the economical application of a small pension must in any case find asylum. The cost of indoor relief will not therefore be appreciably diminished by the operation of any system of old age pensions".(61) However, the cross-examination of the Reverend Blackley by this Committee revealed that, in his opinion, many elderly people were "driven to the workhouse" by deficiencies in the system of outdoor relief. Although he qualified this by stating that those who were so driven were "of indifferent character",(62) that is were the undeserving aged, and it seems certain that large numbers of elderly people were forced to enter the workhouse by such a refusal of financial help. Those who "had shown signs of thrift.... are living in cleanly homes who are sober and respectable" were offered outdoor relief(63) bu the undeserving "should only have the offer of the house made to them".(64) The Majority Report of the Poor Law Commissioners was even more forthright stating that "we do not consider it at all desirable that old people who are given to drink or

are of dirty habits, should be enabled to remove themselves from control either by a pension or the granting of outdoor relief"[65] because such cases were believed to be a "very potent influence in perpetuating pauperism and propagating disease".[66] That is, the Commissioners were of the opinion that there were a small number of elderly people who could not be sustained in their own homes, either by the provision of an old age pension or by other forms of outdoor relief. There were those who were suffering from grave chronic disease and those who were deviant and both of these types were envisaged as requiring legislated powers of compulsory removal, for the good of the former, or in the case of those with
for the good of their families, and for the control of the latter.

LOCAL INITIATIVES

Dr. Buchan's innovation.

In spite of the agreement of the Major and Minor Reports that it was desirable to introduce legislation which would allow the compulsory removal of old people from their homes, central government took no action and it was not until 1925 that any such powers were introduced in Britain. The initiative came, as did a number of other public health initiatives, from Bradford, or to be more precise from its energetic Medical Officer of Health Dr. J.J. Buchan. He was appointed in 1913 and introduced a number of innovations, notably the take over of the local infirmary to set up a Municipal General Hospital in 1920(67) and the Bradford Corporation Act of 1925 was drafted to consolidate many of the steps which had been taken since he assumed responsibility. There were three clauses in the Bill which concerned the "removal of infirm and diseased persons in certain cases" and these were passed almost unanimously - fifty five for, one against with no-one neutral. There was little controversy when they were debated in Council on November the 18th 1924, part of the reason why probably being that public and political attention was focussed on the clauses dealing with the compulsory notification of the veneral disease.(68)

Section 56 of the Act stated that

> If the medical officer certifies in writing that any person:
>
> (a) is aged or infirm or physically incapacitated and resides in premises which are insanitary owing to any neglect on the part of the occupier thereof or under insanitary conditions; or
>
> (b) is suffering from any grave chronic disease and that such person is unable to devote to himself or to receive from persons with whom he resides proper care and attention and that thorough inquiry and consideration have shown the necessity in the public

> interest and in the interests of the health of such person or any person with whom he resides for the removal of the person from the premises in which he is residing the medical officer may make application to a court of summary jurisdiction and such court upon oral proof of the allegations in such certificate and subject to examination of such person by a registered medical practitioner to be nominated by them if they think fit may make an order for the removal of such person to a suitable hospital infirmary poor law or other institution or other suitable place provided within the city or within a convenient distance of the city and for the detention and maintenance of such person therein for such period not exceeding three months as may be determined by such order or such further period of periods each not exceeding three months as may be determined by any further order or orders made under and in accordance with the provisions of this section. Provided that not less than three clear days before making any application under this sub-section for the removal of any person the medical officer shall give to the board of guardians of the poor law union in which the said person is residing notice in writing of his intention so to do".

This piece of legislation gave Bradford Corporation a new type of authority, the power to remove a person "in the interests of the health of such a person", if it was the opinion of the Medical Officer of Health and a registered medical practitioner that he should be removed. The removal order could not exceed three months and three clear days notice had to be given before the order could be granted. In the Annual Report of the Medical Officer of Health for 1926 it was recorded that one person had been removed, "a female residing alone and aged 75 years. She was so physically enfeebled as to be unable to attend to herself or to keep her house in a fit and sanitary state". In 1927 two persons were removed. "The first case was that of a female alone and aged 70 years. She was of intemperate habits and so physically enfeebled as to be unable to attend to herself or to keep her house in a fit and sanitary state. The second case was that of a male, aged 79 years, who by reason of a cerebral haemorrhage was quite incapable of caring for himself or of keeping his house in a sanitary

condition. He was living alone and had no-one to take care of him".

It seems likely that section 56 was Dr. Buchan's innovation, part of his strategy for improving the "public good" but this is supposition because the factors which led to the concept and wording of Section 56 are not known. One interesting possibility is raised by the fact that similar legislation had been introduced in New Zealand seven years earlier.

Compulsory powers in New Zealand.

New Zealand Public Health Amendment Act of 1918 laid down that

> "any person living in insanitary conditions and without proper and adequate regard to healthy food and clothing could be ordered by the district health officer to be removed to an institution and in the event of refusal he could be summoned before a Justice who would make such order as he deemed fit".(69)

The 1920 Public Health Act amended these powers. Section 142, now section 126 of the 1956 Public Health Act, stated that,

> (1) If any aged, infirm, incurable, or destitute person is found to be living in insanitary conditions, or without proper care or attention, a Stipendiary Magistrate may, on the application of the Medical Officer of Health, make an order for the committal of that person to any institution established under the Hospitals and Charitable Institutions Act, 1909, and available for the reception of such persons.
>
> (2) If any person in respect of whom an order is made under this section refuses to comply with that order, any Inspector under this Act or any constable may, without further warrant than this section, take that person and place him in the custody of the manager or other person in charge of such institution as aforesaid, who shall have authority to detain such person pursuant to the order of committal.

The terms of Section 56 of the Bradford Act are very similar but it is not clear if there was any direct relationship between the two. Nor is it clear how the 1929 Rest home Act (New Zealand 20 Geo V No. 31)

came to give the power of complaint to a Magistrate to "any reputable person".

Adoption in London.

When this section of the Bradofrd Corporation Act was considered by the London County Council in 1926 its potential was first examined from the point of view of the public interest: it was considered as a possible means of facilitating slum clearnace. The Bradford initiative was initially considered by the Housing of the Working Classes Committee. Their Valuer reported "that the Council in its work of slum clearance... constantly had to deal with the difficulty of removing from the old houses persons who would fall within the category mentioned in the clause in this Act. For a number of reasons the Valuer "had considerable hesitation" in advising the Committee to make use of such powers. As so often happens in a bureaucracy faced with a difficult ethical issue, the matter was referred to other committees, the Public Health, the General Purposes Committee, and to the Medical Officer of Health. Neither Committee thought that any action should be taken, but the Medical Officer, Dr. F.N. Kay Menzies, wrote that he did not wish to comment on the use of such powers "for facilitating possession of unsanitary properties in improvement schemes undertaken by the housing authority", but considered them a matter of public health interest, commenting,

> "The operation of the section is, in other words, a matter rather of public health interest than a means of securing supplementary powers for facilitating possession of insanitary properties in improvement schemes undertaken by the housing authority. It is in this aspect only that I propose to comment on the section.
>
> It is a common experience of medical officers of Health to find the most serious insanitary conditions existing in houses due to residence therein of persons in the later stages of chronic disabling disease. The circumstances of the patient, incapable of attending to his own fundamental requirements and still less to those of the house in which he lives, frequently associated with the foul

discharges which, in the later stages of such diseases as cancer, so commonly occur, produce conditions so grossly insanitary that it becomes imperative that something should be done to amend them.

The repugnance of the patient to which, in his report the Valuer refers, to remove to a poor law institution overrides the obvious need for such removal in the absence of adequate personal attendance. Such cases are far from uncommon and there is, generally speaking, no power to deal with them. The section in the Bradford Corporation Act is obviously directed to meet the need of such cases. If acquired under a General Powers Act by the Council the administration of the powers presumably would rest with the local sanitary authorities (the councils of the metropolitan boroughs). The question is one in which the Public Health Committee is primarily interested and they may desire to consult the borough councils as to the need for securing such powers for metropolitan authorities".

(Sgd.) F.N. Kay Menzies
Medical Officer of Health

The County Hall
S.E. 1

These comments are of particular interest because they stress that the legislation should be used for a public health context, by which he meant it should be used for health and welfare purposes rather than for environmental improvement, which he called the "ulterior purposes" of the Act: a point which will be further discussed when the transfer of Section 47 powers to District Councils in 1974 is considered (see page 116). On the suggestion of Dr. Kay Menzies the subject was referred to the Metropolitan Borough's Joint Standing Committee because the 28 boroughs and the City of London were the authorities responsible for public health services. In May 1927 the Metropolitan Borough's Joint Standing Committee replied to the County Council that of the twenty-nine borough councils only two opposed the proposal, two were indifferent, and the remainder were in favour, of whom five - Lewisham, Stepney, Poplar, Shoreditch and Hampstead - had previously applied to the London County Council individually for the Bradford Legislation to be adopted by London County Council. The Metropolitan

Branch of the Society of Medical Officers of Health had also been consulted and many of the Councils who were in favour were undoubtedly influenced by their Medical Officers. The submissions of two Councils are of particular interest. The Medical Officer of Lewisham wrote that

> "These persons are often mentally deficient but not sufficiently so to be certified"

and the Borough of Shoreditch was of the opinion that

> "Such powers should be limited in their application to aged persons only".

On the 21st June, 1928, almost two and a half years after the subject was first considered, the Parliamentary Committee accepted a draft which followed the wording of the Bradford Act very closely, but two important changes had been introduced. Firstly, it was decided to delete "in the public interest" and to stipulate that removal could be effective only "in the interest of the health of such persons, and for preventing injury to the health of or serious nuisance to the other persons"; secondly, it was stipulated that the responsibility for taking proceedings should rest with the Medical Officer of Health. The legislation was introduced as Section 28 of the London County Council (General Powers) Act of 1928. These powers were subsequently transferred to the Public Health (London) Act of 1936, with only one significant change. In the 1928 Act, as in Section 56 of the Bradford Act, it was stated that the court need only receive the evidence of or the findings of an examination made by a registered medical practitioner, "if they think fit"; in the 1936 Act this phrase had been deleted, and the court was obliged to nominate a "legally qualified medical practitioner" to examine the person for whom the application was being made.

CENTRAL CONSOLIDATION

Although about 70 local authorities - including Leeds in 1927, Rotheram in 1928, Birmingham in 1929, Brighton in 1931 and Oxford in 1933 - had introduced local Acts of a similar nature, all using Bradford's terminology as a model, it was section 224 of the Public Health (London) Act 1936 which was taken as the model for Section 47 of the National Assistance Act. It was included in the National Assistance Bill as Clause 45 at the suggestion of the Interdepartmental Committee chaired by Sir Anthony Rucker which had been set up to consider "The Break-Up of the Poor Law" and their opinion on this matter appears to have resulted from pressure by the Association of Municipal Corporations(70) whose papers relating to this period have unfortunately been destroyed.

In the Second Reading of the Bill, powerfully opened by Aneurin Bevan paying a generous tribute to the Webbs, on the 24th November, 1947, Lieut. Col. Elliot, Member for the Scottish Universities, asked the Minister for more information on Clause 45 of the Bill, which was to become Section 47 of the Act. Speaking from the opposition benches he challenged the Minister

> LIEUT.-COL. ELLIOT: There are certain provisions in the Bill about which we should like a little more information. For instance, in Clause 45 there are very sweeping powers with which it is proposed to endow permanent officials. These powers have previously existed in local hands, but it is now intended to spread them far and wide over the whole country. Any person who is aged or infirm can be removed from his house on the certificate of one medical officer of health, supported by the court. Such a person may be removed and placed in a hospital, or other place, either within or without the area of the appropriate authority and detained therein, and that detention order may from time to time be extended by the court,
>
> > "for such further period not exceeding three months, as the court may determine".
>
> I think the Minister will agree that in the case of the other people who are subject to detention, the certificate of one

medical officer alone -

MR. BEVAN: It comes to the court.

LIEUT.-COL. ELLIOT: Yes, I said it goes before the court; but, remember, in the case of other classes of persons who are so detained, the person is summoned before the court. This makes no provision at all for the person being examined by the court or summoned. The only person who has to conduct an examination in the matter is the certifying officer.

MR. BEVAN: He is the medical officer of health.

LIEUT.-COL. ELLIOT: He is the medical officer of health, it is quite true, but I think the right hon. Gentleman will find that in most cases at least two certificates are necessary before taking the pretty grave step of removing a citizen from his house and detaining him under an indeterminate sentence on an indeterminate order. Before that step is embarked upon and maintained I think more than one certificate is usual.

DR. BARNETT STROSS (Hanley): Does not the right hon. and gallant Gentleman agree that only one medical certificate is needed on a three day order, in order to remove a person from his home if he is deemed to be insane?

LIEUT.-COL. ELLIOT: But subsequently two certificates must be obtained. The removal is all very well, but after that two medical certificates must be obtained and, what is more, the person then comes within the purview of the Board of Control. I am simply arguing that, in giving these sweeping powers, it would be as well to consider, perhaps during the Committee stage, whether, for the nation as a whole, something much wider in safeguards for the persons in question might not be necessary.

MR BEVAN: I think the right hon. and gallant Gentleman would agree that where an old person is living in a house and is utterly incapable of looking after himself, who has no one at all who can look after him, and where such people are in a very bad state of health and sanitary condition, some authority must be responsible for looking after them, and someone must do something about it. It is in the interests of the old people themselves that this power is taken, and not in the interests of a tyrannical State. If the right hon. and gallant Gentleman looks at all the other Subsections of the Clause, he will find protection after protection for the liberty of the subject.

LIEUT.-COL. ELLIOT: The right hon. Gentleman naturally states the extreme case. "We must remember that it is the borderline cases where injustices may arise. No one willquarrel in regard to the extreme case of a person living in very insanitary conditions, who is totally incapable of looking after himself; but these cases shade away to a point where a legitimate difference of opinion might reasonably arise".

THE SECRETARY OF STATE FOR SCOTLAND (MR. WOODBURN): The court decides:

LIETU.-COL. ELLIOT: Yes, but in such cases, in the tradition of our country, the court does not decide simply on the evidence of one man. In mental cases, either the individual is summoned before the court, or the court has the individual examined. We do not think these wide and sweeping powers should be lightly put on the statute book. They will apply not merely to the extreme cases, but to the borderline and marginal cases, and that is where injustices might easily arise. It is one of the examples of what inevitably occurs when this House is brought in as a final determining authority. The Board is connected with the Minister, and it is only through the Minister that we are able to raise questions about the actions of the Board and other actions arising out of this Bill.

MR. HECTOR HUGHES (Aberdeen, North): Is the argument which the right hon. and gallant Gentleman is propounding not an imputation upon the medical profession, of which he is such a distinguished ornament?

LIEUT.-COL. ELLIOT: I do not think the desirability of having two certificates has ever been held to be an imputation on the medical profession. In fact, in many cases it is regarded as being a protection. I do not think that consultation has ever been regarded as an imputation. Up to now I have not heard that medical men in general regard the previous provisions regarding this kind of thing as any sort of imputation on their profession.(71)

The Clause was also discussed at some length by Standing Committee C on the 10th December 1947, the Government spokesman on this occasion being Mr. John Edwards, Parliamentary Secretary of the Ministry of Health. The Chairman of Standing Committee C, Mr. Butcher, Member for Holland with Boston allowed a member of Members to introduce amendments. Mr. Somerville Hastings, Member for Barking, was concerned that the wording of the London Act which stated that the powers could be applied to a person "unable to devote to himself, or to receive from persons with whom he resides, proper care and attention" implied that old people should be living with other people, and that this was contrary to the wishes of most elderly people. This Amendment had also been suggested by the National Old People's Welfare Committee, whose view was advanced by Mr. Fred Messer, Member for Tottenham South. The Parliamentary

Secretary opposed this Amendment as he thought that it would weaken the powers of the "Medical Officer in removing to more suitable accommodation persons who are living alone in insanitary conditions. If these word were deleted it would mean that the Medical Officer of Health would have to go into the whole question not only of whether any persons outside were in fact giving care and attention, but whether they could give care and attention. That seems to be undesirable".
Mr. Hastings was not satisfied and requested that Parliamentary Secretary to look at his Amendment again.

This the Minister promised to do and stated that "if there is a doubt I will bring in the necessary change".(72)

Lieut. Commander Hutchinson, Member for Edinburgh West, proposed that the Clause should be modified to require "that the Court before making any such order shall hear and consider any objections or any proposal of alternative menas of looking after the person made by him or somebody on his behalf". In reply the Minister said that the Clause was worded "in such a way as fully to safeguard the liberty and independence of the individual", and the proposed Amendment was not accepted.(73)

Committee stage continued on the 4th February. Mr. Messer begged to move that seven days' notice be given instead of the three days stipulated in both the Bradford and London Acts, an Amendment supported by the Public Assistance Committee of the County Councils' Association, whose records for reasons why this longer period was requested were primarily administrative. Mr. Messer argued that:

> three days might provide reasonable excuse for there not having been the necessary opportunities to get all the furnishings required, and, indeed, permitted of some reasonable excuse for the managers of houses and hostels to say, "We simply could not get out material in time". In addition, three days does not give sufficient time in which to deal with accidents, so that three days' notice might very well mean consulting an officer who usually could not be obtained immediately. It was thought that seven days was a more reasonable period than three days.
>
> I will say no more than to ask the Minister whether his purpose would be served by seven days' notice instead of three, and whether anybody would be injured were that extension granted? It is important that nobody should have a reasonable excuse which might have been avoided with the granting of a little more latitude.(74)

The exchange which followed is worth quoting in detail because it illustrates the style of the exchanges during the Committee stage of a Bill and because the seven days' delay which the Ministry eventually accepted for administrative reasons proved unsatisfactory and led to the 1951 Amendment Act. (See page 112). Sir Harry Webbe, Member of the Abbey Division of Westminster, attacked the Minister:

> SIR HAROLD WEBBE: I hope the Minister will think again. This is a question not of fundamental principle, but of practical policy and management of institutions. All this talk about delay is very much beside the point. What is the delay proposed here? It is a delay of four days. Surely, cases in which application for removal is made do not arise suddenly, at an hour's notice. They arise as the result of a series of circumstances, the ultimate effect of which has been becoming more and more obvious, probably for weeks, and possibly for months. We do not want to impose a minor restriction of this kind to save possibly, but not necessarily, four days, in cases where the matter has been under consideration, in all probability for many weeks. From the point of view of those managing the institutions, in many cases three days are not enough. I do not quite know what the Minister means by "our experience". Quite frankly, the officers of the Ministry have no experience of managing these institutions.
>
> MR. EDWARDS: If I spoke of "our experience" I was referring to the knowledge we have, at the Ministry, of the experience of local authorities. I referred specifically to one Act, and there are a number of other local Acts containing exactly the same provision.

SIR. H. WEBBE: I am not trying to be rude to the officers of the Ministry, but they hear only of the serious things which have gone wrong; they do not hear of the minor troubles which occur from day to day in the many thousands of institutions over which they exercise some kind of supervision. I would be much more ready to trust the experience of the hon. Member for South Tottenham (Mr. Messer) who speaks with many years' experience of the practical running of institutions, than that of a Ministry official who has not been in the job, but has merely heard about only serious trouble. Local authorities do not write to the Ministry of Health on every little thing. I hope the Minister will reconsider this matter, as no big principle is involved. This haste to get everything done at a moment's notice does not make for good administration, and a little bit of elbow room for those engaged in this job is, surely, quite reasonable and sensible. We are here fighting over something which is not worth fighting about, and deciding a point on arguments which have no real validity, however logical they may sound.

MR. THOMAS BROWN: I cannot understand the Parliamentary Secretary being so rigid on this Amendment. It would appear that when we put down Amendments to ease and improve the operation of the Bill reference is made to the London County Council, or some other large body. I would draw the attention of the Parliamentary Secretary to what will happen in the rural districts, where long distances have to be travelled, and where there are difficulties in obtaining conveyances to remove furnishings. Three days is altogether too short, and I cannot understand why the Parliamentary Secretary, or his Department, is so rigid in this matter. It does not necessarily follow that seven days will be required, but if the limit were seven days it would assist local authorities to deal with such cases. I beg the Minister not to adopt such a rigid attitude towards this Amendment.

MR. MOLSON: I was in doubt about this until I heard the Hon. Member for Ince (Mr. T. Brown) point out that this is only the notice that must be given, which might be of importance in some instances. We know that this accommodation is very overcrowded at the moment, and, that for some years to come, there will be very little opportunity to add to it. I think seven days' notice of an additional responsibility thrust upon a local authority is not too much, and I ask the Minister to say that he will consider this matter between now and the Report stage.

MR. EDWARDS: In view of the feeling expressed on both sides of the Committee I will look at the matter again.

MR. MESSER: I would have gone into further details, but in view of that undertaking I beg to ask leave to withdraw the Amendment.

Amendment, by leave, withdrawn.(75)

Sir Harold Webbe then returned to a point raised in the previous day's debate by Mr. Law, Member for Kensington South, and by Lieut.-Colonel Elliot in the Second Reading, that the law should require two medical practitioners to apply to the court. The 1936 Act laid down that the court may make an order for removal

> "subject to the examination of the person in question by a legally qualified medical practitioner, to be nominated by the court", but clause 45 only required one.

> SIR H. WEBBE: I hope the Committee will forgive me if, to some extent, I traverse the Debate which took place last Thursday. I am very unahppy about this Clause. It makes me tremble almost to think of the responsibility and terrific power which we, as Members of Parliament, have over the lives of ordinary human beings. The purpose of this Clause is unexceptional. Its provisions are intended to help those who cannot help themselves, and to safeguard old, infirm, and sick people who might otherwise suffer from neglect or lack of proper care. It is a tremendous step to take old people away from their own surroundings; from the human point of view it is about the most drastic thing that can happen. The solution which this Clause provides is highly efficient; it is hedged round with all sorts of restrictions. But it does lack humanity. I sometimes wish the Minister of Health were an ordinary man like you and me, Mr. Butcher, instead of an all-powerful demagogue, because I do not believe he realises the tremendous tragedy that is caused in the last days of the lives of these old people when they are up-rooted, and taken out of their own surroundings, even though they are cramped and insanitary.

> 10.45 a.m.
> THE MINISTER OF NATIONAL INSURANCE (MR. JAMES GRIFFITHS): I am sure that anybody like my right hon. Friend the Minister of Health, who has lived in South Wales for 25 years, does realise that.

> SIR H. WEBBE: It is possible to live in the worst of surroundings and miss some of the obvious things if one's mind is a little bit outside them. I know that the Minister of National Insurance, with the wealth of his human experience, at least will know what a serious thing it is to these old people to be picked up and taken away to an institution. It will be done by the medical officer of health, a man whom the old person had possible never seen, whom he knows as an official rather analogous to a policeman. I have the highest opinion of medical officers of health. I am quite certain they are not giving these certificates, or applying for removal of people without the fullest investigation of the circumstances, without the most serious desire to help them, and with the most profound belief that what they are suggesting is on the whole good for them. But, from the point of view of the old people

themselves, I wish the Minister had been able to accept the Amendment negatived at our last meeting, which wished to provide that someone should be associated with the medical officer to take the steps necessary for removal, that the certificate should be supported by some other doctor. That, in most cases, would not enable the removal to be effected without the approval of the old person's own doctor, someone whom they know and trust. That would be a much more personal way of doing it".(76)

Mrs. Braddock, Member for Liverpool Exchange, pointed out that the National Assistance Bill did not stand in isolation and that the National Health Service Bill gave each individual the right to choose his own doctor. She maintained that Sir Harry was still thinking with a "Poor Law Mind", that the days of the Poor Law doctor were over, and that "if a person's own doctor feels he cannot deal with the situation, that the conditions under which the person is living, and the health of the person, are detrimental either to himself or the rest of the people in the house, then he can make his case to the medical officer of health".(77) The Chairman brought the discussion to an end by reminding the Committee that the Amendment on the need for the medical practitioners had already been considered and "negatived".

In the Report Stage of the Bill on the 4th of March Mr. Edwards brought the Amendments back to the floor of the House from his discussions with civil servants in the Ministry.

He begged to move the deletion of the words which implied that the Act related only to people residing in the same dwelling as other people, incorporating the Amendment proposed by Mr. Somerville Hastings and, through Mr. Fred Messer by the National Old People's Welfare Committee he also begged to move that the word "three" relating to the number of days' notice required, be left out and the word "seven" inserted, an Amendment which arose "from the view that was stated by a number of

hon. members with experience of Local Government work, who said they had found that the provisions in the local Acts and in the London Acts, which gave only three days' notice, were not really adequate".

Clause 45 was agreed without debate when considered by the Committee of the whole House of Lords and was included as Section 47 of the National Assistance Act which received Royal Assent on the 13th May 1948.

DR. BROUGHTON'S AMENDMENT

The final stage in the evolution of the legislation began in Morley, in Yorkshire, when a woman who had fallen died as a direct result of the seven days' delay required by Section 47. The Magistrate's Clerk, who had been approached by those wishing to remove the lady to hospital, reported the distressing sequence of events to the late Sir Alfred Broughton, then Dr. Alfred Broughton, Member for Batley and Morley. His account of the Amending legislation, written in January 1979, emphasises the unanimity of opinion that the Amendment was necessary.

The Magistrates' Clerk, Mr. James Albert Hullah (who died on 28th September, 1978, aged 80+) was a friend of mine and it was he who told me of the case. I did not see the patient.

The M.O.H. was a Dr. Hill, whom I knew well, and for whom I had a high regard. Both he and Mr. Hullah were ex-soldiers who had served in the trenches in World War I (Dr. Hill had the D.S.O.) and must have seen some very unpleasant sights, yet they, and many other people in Morley, were emotionally very upset by this case whilst the woman lay on the floor of her living room.

Hildry Marquand was the Minister of Health and he was a friend of mine. I told him about the case and later, I was informed by the Chief Whip that the Government had decided that amending legislation was necessary to deal with this matter which had not been considered when the National Assistance Bill had been going through Parliament. As I was the one who had drawn attention to the problem, I was to have the privilege of piloting the measure through the Commons.

On 6th June, 1951 I presented the Bill. I did not enter from the Bar; but, following instructions, I entered from behind Mr. Speaker's chair and handed a copy of the Bill to the Clerk of the House who read its title, thus giving the Bill its First Reading.

I had enlisted support from Dr. Stross (later Sir Bernard Stross) and (in order to balance the medical men) from Dr. Charles Hill (now Lord Hill of Luton) and Dr. Reginald Bennett who then sat on the Opposition Benches. I chose Mr. Mitchison because of the interest he had shown when I asked him for his legal advice, and Mr. Messer, Mr. Linstead, and Mr. Dryden Brook because of their interest in medical legislation. All were Members who were respected by colleagues.

The Bill was given a formal Second Reading on 4th July, 1951 and the Committee Stage (when I spoke about it) and the remaining stages on 10th July, 1951.(79)

Dr. Broughton's speech on that occasion at the Committee stage of the Bill described the case in Morley:

> "Perhaps I can best explain the Clause by telling the Committee of a case that occurred in my constituency. This is the type of case that does actually occur, and the purpose of the Clause is to alleviate the suffering and anxiety that is present in such cases. Towards the end of last year there was a spinster, aged 52, who lived alone and who was described by a relative as being "eccentric and stubborn". She had a fall in the street and broke her thigh bone. She was helped home by a neighbour and she then refused all further assistance. She lay on the floor and would not accept the services of doctor, nurse, or home help. The medical officer of health who was informed of the accident promptly visited the patient and advised her removal to hospital. The woman rejected this proposal, as she did all other offers of much needed care and attention. In those circumstances, the medical officer of health had no alternative but to give her notice than an application would be made to the magistrates' bench for her compulsory removal to hospital.

> Section 47 of the National Assistance Act, 1948 lays down in subsections (3) and (7) that seven clear days notice must be given to the person concerned before an application can be made to the justices for the removal of any such cases. In practice this period amounts to a minimum of nine days, and this unfortunate and misguided woman lay on the floor with a broken thigh without attention of any sort for nine days. The local authority was powerless to help her during that time. Lying on the hard floor caused a number of sores which became infected with tetanus. At the end of the enforced long waiting period the magistrates gave the necessary order, and shortly after admission the woman died of lock-jaw. Needless to say that waiting period was a time of great anxiety for the mayor, the medical officer of health, and other officials of the authority.
>
> If this woman had been suffering from an infectious disease she could have been removed to ensure speedy attention under Section 169 of the Public Health Act, 1936. If she had been certifiable she could have been removed to a mental hospital, and had the accident occurred before the National Assistance Act came into operation the relieving officer would have taken immediate steps to protect her against her own insistence on neglect.

I reported the case to the Minister of Health, and in his reply he stated:

> "I understand that similar representations have been received from a small number of local authorities".

I learned after that, that the Association of Municipal Corporations had passed the following resolution on 26th January this year:

> "That the Ministry of Health be asked to introduce legislation whereby in urgent cases local authorities may remove persons in need of immediate care and attention to hospitals, or other institutions, under a procedure similar to that concerning persons of unsound mind; and more expeditions than that provided in the National Assistance Act, 1948".

It was after learning these facts that I presented this Private Member's Bill to Parliament. This Bill has the support of medical men, and I would like to give the assurance that in no way is it an attempt to impose orthodox medicine upon unwilling recipients. I believe that if a person wishes to be treated by means of herbalism, Christian Science, or by any other unorthodox means he or she should be allowed to be so treated. This Bill merely has to do with those persons who are destitute of care and attention, who are seriously ill and requiring

immediate treatment.

Dr. Broughton continues:

"When the Bill went up to the House of Lords I had to ask a peer to pilot it through their Lordships.

I well remember that it came bouncing back with a much needed amendment which was readily accepted on 27th July, 1951. I had spent many hours working on this Bill, I had been advised by Richard Mitchison, Q.C., M.P. (later Lord Mitchison), I had had the services of Government draughtsmen, it had been given blessing by the Association of Municipal Corporations; and yets its examination in the House of Lords revealed the need for an important amendment. This experience of mine, together with countless observations throughout my 30 years of Parliamentary Life, convince me of the great value of the House of Lords for improving legislation, and is one of the reasons why I am strongly in favour of retaining a second chamber.

Thus two different powers were available to the Medical Officer of Health. Section 47 of the National Assistance Act gave him the power to approach a court of summary jurisdiction and, after a period of seven days' notice had elapsed, obtain an order which allowed him to remove a person for a period not exceeding three months. Using the powers of the 1951 National Assistance (Amendment) Act the Medical Officer of Health was able to effect a more expeditious removal. Provided that he had obtained the opinion of another registered medical practitioner and that the removal required to be made without delay, he could approach a justice of the peace, who could issue an order for immediate removal, without having to hear the evidence of the person managing the premises to which the person was to be removed.

THE EFFECT OF REORGANISATION

Following the amendment of the legislation in 1951 a circular was sent out from the Ministry of Health to all local authorities[81] reminding them of the paragraphs in the main National Assistance Circular sent out in 1948[82] and drawing their attention to the new powers "to enable them to deal expeditiously with certain cases". The number of times that the powers were used was recorded in the Annual Reports of the Ministries for Health until 1955 after which time the information was not included (see page 40). During the late sixties and the first few years of the nineteen-seventies the reorganisation of local government and the National Health Service was discussed extensively but no specific mention was made of Section 47 powers during these discussions. During this period the role and function of doctors working as medical administrators, either in the Department or with Regional Hospital Boards or as Medical Officers of Health was also under consideration, and the nature of the community physician, who would be best suited to work in these reorganised services was discussed in the "Hunter Report"[83] Although a detailed and careful review of the work of the Medical Officer of Health, it made no mention of his responsibility for Section 47 powers. This was perhaps understandable as the Committee which prepared this report left much of the detailed discussion on the arrangements for the provision of medical advice to local authorities by community physicians to the Working Party on Collaboration between the N.H.S. and Local Government, set up by Sir Keith Joseph. Unfortunately there is no written record of this subject ever being dealt with by this Working Party,[84] neither is there any record or recollection of its being discussed by the Association of District Councils, the Association of Metropolitan Councils or the Association of County

Councils[85] who submitted evidence to the Collaboration Working Party. One civil servant closely associated with the Working Party did remember its discussion but stated that it was fairly quickly decided that it was most appropriate that it should be transferred with environmental health responsibilities to district councils although the district councils in non-metropolitan counties were not to be given the responsibility for social services which are so often involved in the cases considered for compulsory removal. So the powers of compulsory removal of elderly people in need of proper care and attention were delegated to the authorities responsible for housing and environmental control, a move which would have distressed the Webbs.

THE USES OF HISTORY

History is much more than an accurate account of the sequence of events which led up to a particular piece of legislation. The chronological approach is useful but limited. It is certainly important to describe the chain of events but the individual events which from the links in the chain and the chain itself have to be considered in context, the context being the attitudes, values and beliefs which prevailed during the time in which the events were taking place. The importance of taking this approach to history is that a study of the attitudes, values and beliefs which formerly prevailed allow a clearer understanding of the attitudes, beliefs and values which prevail to-day, a benefit eloquently described by Keith Thomas: "The justification of all historical study must ultimately be that it enhances our self-consciousness, enables us to see ourselves in perspective and helps us towards that greater freedom which comes from self-knowledge".(86) I propose to devote a separate chapter to the attitudes towards elderly people, and, three chapters to the beliefs and values on which the legislation was introduced, dividing this material into three sections because a useful approach to the analysis of legislation is to consider it as a means of protecting the individual who is controlled, as a means of protecting other individuals, or as a means of protecting society as a whole.

Chapter 6

PERTINENT ATTITUDES TOWARDS OLD PEOPLE

THE IMPORTANCE OF ATTITUDES

Attitudes, values and beliefs are closely related to one another. The value which is placed on a concept such as liberty or health is a reflection of the prevailing attitudes. Furthermore, the beliefs about the factors which promote or detract from liberty and health are also influenced by, and have influence upon, the prevailing attitudes and I have included a whole chapter on attitudes towards elderly people at this point in my thesis because I believe it is necessary for an understanding of both the motives behind the introduction of this legislation and of the reasons why it has been so little discussed hitherto.

Although Section 47 powers are not restricted to people who over a certain chronological age, the great majority - 96.8% - of people who were removed were over the age of sixty-five and it is my impression that those who introduced the legislation in Bradford in 1925, those who adopted it in other local authorities, those who promoted its incorporation in the National Assistance Act and those who have used or tolerated its existence since 1948 have all shared certain attitudes towards older people. I believe that an understanding of these attitudes is essential for an understanding of the values and beliefs involved in this issue. I also believe that such an understanding has been necessary for professionals in practice with elderly people. The attitudes of other people influence the timing and the nature of the referral, they bias the professional's response to the referral and his analysis of the problem and they may also influence the reader's interpretation of the material presented in this thesis. For these reasons I have included a whole chapter on attitudes.

THE ETHICAL VACUUM

John Stuart Mill's essay On Liberty, published in 1859, embodied "one very simple principle".... "That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him or reasoning with him, or persuading him or entreating him, but not for compelling him".(87)

These fine and moving words are still widely known and influential and they are frequently quoted in debates on freedom yet paternalistic intervention is commonly practiced and, in many cases, almost universally accepted. Income tax and national insurance contributions are two paternalistic measures enforced by law which are designed to ensure that services will be provided should we need them and that pensions will be available when we reach the age of compulsory retirement. People may complain about the level of taxation, some try to evade paying tax, but there is very little opposition to the principle that some taxes are necessary. Of course, it is possible to argue that taxation is a matter of our own choosing, that our elected representatives would repeal taxation if there was sufficient resistance to it, but there is widespread acceptance of the principle of the paternalistic state. However there is passionate resistance to certain paternalistic measures, such as the introduction of legislation to make the wearing of seat belts

compulsory, fluoridation, or cannabis legislation.(88) One reason is that these are measures which affect small and more readily identifiable groups of individuals in contrast to income tax, which affects everyone.

The objective of Section 47 is to prevent self-destructive behaviour, by ensuring that the person in need is removed from his own home to a place in which he can receive "proper care and attention". In this it differs from the use of legislative powers, such as power to raise the tax on cigarettes, because this type of legislation is designed only to make the individual stop or reduce his self-destructive behaviour; it does not put him into the care of other people. The gravity of the action legalised by Section 47 is largely due to the fact that it allows an individual to be compulsorily removed from his own home, and there is a close similarity to the powers of compulsory removal vested in the Mental Health Act of 1959. The powers of the Mental Health Act are justified by the premise that there is a condition called mental illness, in which the individual is divorced from reality and therefore unable to make rational decisions. Some have argued, notably R.D. Laing and Thomas Szasz, that "mental illness" is an arbitrary and artefactual condition existing only because it is deemed to exist by a concensus of the majority of influential people in society, a view with which J.S. Mill would have had some sympathy, but such views have not been totally accepted by the majority of psychiatrists. However, these radical views have been influential and the boundary between what is called mental illness and what is called normality is accepted to be much less distinct than it was considered to be previously. Nevertheless, most doctors and social workers are prepared to recognise conditions in which a person is not rational and use the powers of the Mental Health Act. The acceptance of the concept of mental illness, in which

people are unable to make rational decisions, provides ethical justification for the paternalistic powers vested in the Mental Health Act. Section 47 exists in an ethical vacuum.

At no stage in the evolution of the amended legislation in use at present have the underlying ethical questions been discussed. Concern was expressed that removal might be too easy, that the safeguards were not strict enough; the proposed means of implementing the legislation were questioned in detail but no-one questioned the ethical justification of the legislation itself. It was accepted by both local and central representatives that the measure was ethically acceptable, although it was never debated. It has not been debated by the Central Ethical Committee of the British Medical Association, a member of whose secretariat stated that her "own feeling (was) that it does not come within the Committee's remit. It seems to me that the question..... relates to the freedom of the individual rather than to the ethics of the medical profession",(89) and the ethical aspect of Section 47 removals has never been referred to the three medical defence societies.(90)

Why was this so, and why has the ethical vacuum persisted when the pressure of public and political interest in the liberty of the individual has increased in so many other aspects of professional intervention? One reason is perhaps that the power is infrequently invoked, only about two hundred times annually in England, but rarity does not necessarily lead to indifference. There are sufficient well-organised and alert pressure groups to take up an issue like this and give it considerable publicity if they considered that it was unethical. The reasons for the ethical vacuum are more profound and relate to the group of people who are most frequently compulsorily removed - elderly people.

To Mr. Bevan it was self-evident that "where an old person is living in a house and is utterly incapable of looking after himself, who has no-one at all who can look after him, and where such people are in a very bad state of health and sanitary condition, some authority must be responsible for looking after them and someone must do something about it. It is in the interests of the old people themselves that this power is taken and not in the interests of a tyrannical state". (see page 104). The ethical implications of the difference between the words "can" and "ought" have already been emphasised (see page 104). The word "must" has yet another shade of meaning. It implies an action that is ethically even more justified than those which it is considered ought to be taken. Details of Mr. Bevan's proposal were attacked but not his unjustified assertion that something "must" be done, and it could be argued that it was the adjective "old" which, in his opinion, and in the opinion of both Houses, gave the moral imperative for the unchallenged introduction of these powers. This statement, and its acceptance, both derive from an attitude towards elderly people which prevails as widely today as it did in 1948 - the over-protective attitude. Many people adopt different attitudes to old people who are at risk than towards young people exposed to danger of equal, or even greater, degree.

All of us are at risk every day; some of us, for example cigarette smokers and car drivers, are more at risk than others, but little anxiety is generated among members of the public by risk-taking behaviour in young people. No-one phones a man's general practitioner or the social services department if he is observed smoking high tar cigarettes, but if an old person is thought to be "at risk" public concern is quickly aroused and the anxiety of neighbours, relatives and friends may lead them to exhort the elderly person to go into a home "to be looked after"

and to put pressure on the health and social services to "do something".[91,92]

Why are people so much more anxious about old people than they are about younger people? This attitude stems partly from the knowledge that certain of the diseases which occur more commonly in old age increase the risk of accidents and reduce the person's ability to be aware of their increased risk. Certain disorders of the blood vessels of the brain increase the risk of falls and hypothermia; muscular weakness increases the risk of tripping; and failing vision predisposes elderly people to many dangers. In addition, the effects of the normal ageing of brain tissue and of the related, but distinct, condition of dementia reduce the ability of some elderly people to be aware that they are morevulnerable because of such physical failings or to appreciate and adapt to situations in which their disabilities put them at risk. Many old people accept such disabilities as part of the price which has to be paid for longevity, some, unfortunately, accept disability too readily believing it always to be an immutable consequence of the process of ageing when it is often a treatable consequence of disease. They accept that they are at greater risk than they were and that they could reduce that risk by going to live in an institution but prefer to continue living at home. Even if it is obvious, however, that an elderly person is aware of the risks she is running, and accepts them, other people may be anxious and maintain that her failure to admit to the gravity of her situation is itself a cause forprofessional intervention.

Anxiety and the wish to protect are the mainsprings of caring; people who do not develop some degree of anxiety if they see an elderly neighbour deteriorating are more accurately described as indifferent than tolerant and

ndifferent people are, by definition, careless. Too much anxiety owever, can be as damaging to an old person's prospects of life in the ommunity as too little. If people become over-anxious they may waylay ey supporters, such as the district nurse, or home help, and put pressure on her "to make her see sense". They may continually harangue the old person until she feels so persecuted that she may be diagnosed as being paranoid; and may refuse to continue providing any help in an attempt to force the professional to "do something". Excessive amounts of anxiety are generated by two particular attitudes towards elderly people which prevail in our society - the ageist attitude and the over-protective attitude.

Ageist attitudes

Ageism is a prejudice based, like racism or sexism, on the belief that everyone who shares a single characteristic shares many other characteristics and it is therefore assumed that everyone over the age of sixty-five is considered as being members of theoone homogenous group - "the elderly". The ageist attitude presumes that all old people are of declining intelligence, asexual, and incapable of learning; in the most extreme form the biological process of ageing is assumed to be identical with a process termed "dementing", as in "dementing old people". The consequences of the ageist prejudice are many. For example, it can produce and exacerbate mental disorder, it can cause and aggravate behavioural problems, and it can lead to psychiatric referral even when the person is not mentally ill. This is not the place to enlarge upon these problems but they, and all the other harmful consequences of ageism, are due to one common factor - underestimation of the intellectual capabilities of elderly people. The phrase "second childhood" sums up the ageist attitude, expressing the belief and perpetuating the myth

that elderly people regress to childhood. Admittedly certain mental and physical characteristics of elderly people are similar to those of children, their predisposition to delirium for example, but it is wrong to assume that there is a second childhood. This belief is widely held, however, providing an intellectual justification for speaking to elderly people as though they were children and giving an ethical justification for according them the legal status of children.

It is also true that most people over pension age share certain common characteristics, for example low income and political impotence, and all share the experiences which affected their generation but they differ from one another in so many ways that generalisations about "the elderly" have to be treated with great caution. The term "the elderly" like "the blacks", perpetuates the prejudice and I prefer to use the term "elderly people" because "the elderly" implies that the most important characteristic of all people over pension age is their chronological age, and that they are all the same. Each is an individual whose age in years is one of his least important characteristics. To make assumptions about "the elderly" is like making assumptions about "women drivers" or "blacks" and ageism is as reprehensible as sexism or racism.

Over-protective attitudes

Not uncommonly professionals attribute the anxiety of relatives to guilt, because many professionals believe that the British family does not care as well for its elders as it did previously. This is not the case.[93, 94, 95] Elderly people are cared for by their families as well as they ever have been but there is no doubt that the anxiety

which is felt by some relatives does stem from guilt, even among those who have no apparent cause to feel guilty.

Guilt is also a common cause of anxiety among neighbours of elderly people who are considered to be at risk or are observed to be failing to cope. The history of witchcraft is very helpful in understanding the feelings of guilt aroused by poor old people. Witches were not, as is sometimes supposed, usually people affected by disorders which we would now call schizophrenia or hysterical states; they were very often poor elderly women, as Keith Thomas describes in his brilliant book Religion and the Decline of Magic.(96) The social context in which accusations were made was one in which social relationships were changing.

> "Moreover, there is some reason to think that during the Tudor and Stuart period these village conflicts grew particularly acute. The old manorial system had done much to cater for widows and elderly persons by a built-in system of poor relief. The widow enjoyed the right of freebench; that is, of succession to a portion of her late husband's holding, ranging from a quarter to the whole, according to local manorial custom".(97)

> "The decline of the manorial system has not yet been charted by modern historians, and the working of the laws of inheritance also awaits fuller study. But it seems clear that this period saw the decay of many of these traditional arrangements. Population pressure eroded many of the old customary tenancies, and led to the taking in of the commons and the rise of competitive rents. These changes are disadvantageous to the widow. So were the enclosures and engrossing which broke up many of the old cooperative village communities. This deterioration in the position of the dependent and elderly helps to explain why witches were primarily women, and probably old ones, many of them widowed".(98)

The second important factor was the Poor Law of 1601, as Keith Thomas emphasises.

> "But there was one innovation of the sixteenth century which did undoubtedly sap the old tradition of mutual charity, and that was the national Poor Law, created by a series of Tudor statutes which set up overseers of the poor, charged with levying a rate and making provision for the dependent members of the parish. Nothing did more to make the moral duties of the householder ambiguous".(99)

> "This uneasy conjunction of public and private charity exacerbated the uncertainty with which contemporaries viewed the poor. They hated them as a burden to the community and a threat to public order. But they also recognised that it was their Christian duty to give them charity when no public relief was forthcoming. The conflict between resentment and a sense of obligation produced the ambivalence which made it possible for men to turn begging women brusquely from the door, and yet suffer torments of conscience after having done so".(100)

The third important factor was the Reformation because it removed a very effective means of allaying guilt. When a misfortune, such as an illness or a fire, affected a person, it was easier to suppose that it was not the fact that he had not shown charity to the poor which was the cause, a just punishment and a credible explanation by the standards of time, but the consequence of the curse directed at him by the old woman he had wronged, for the old woman who were turned away from houses from which they had received aid for years often uttered a curse as they walked down the path. This argument is developed by Alan MacFarlane's study of Witchcraft in Tudor and Stuart England. Although he was unable to make a detailed study of the ages of women accused of witchcraft because their ages were not recorded it seems that "the likeliest age for a witch was between fifty and seventy", but that the reason for an accusation lay not just in the age of the accused but in the relationship between the accused and her accuser.

> "Witchcraft prosecutions in Essex centred on the relationship between middling to rich villagers and their slightly less prosperous and older neighbours. These neighbours were usually women, and often widows. It seems, therefore, that, as well as that of suffering, two other problems were of particular importance in witchcraft accusations: the first was that of poverty, the second was that of the old. Neither of these was narrowly confined in a sixteenth-century village.

> The problem of 'poverty', viewed broadly, included the relative wealth of villagers, their interdependent labour co-operations, their mutual insurance and help in periodic economic crises. Within the problem of 'old age' was included that of the relations between the old and young in matters of authority, as well as the burden of old people and the methods of inheritance of possessions.
>
> It could be argued that the significant changes during our period were twofold. Firstly, it seems that population growth and changes in land-ownership created a group of poorer villagers whose ties to their slightly wealthier neighbours became more tenuous. People increasingly had to decide whether to invest their wealth in maintaining the old at a decent standard of living or in improvements which would keep them abreast of their yeomen neighbours. Secondly, it seems that there were two stages in the response to such changes. During the period between 1560 and about 1650 the informal institutions which had dealt with the old and poor, Church relief, the manorial organisation, and neighbourly and kinship ties were strained. This was the period of witchcraft accusations. People still felt enjoined to help and support each other, while also feeling the necessity to invest their capital in buying land and providing for their children. The very poor were not the problem. They could be whipped and sent on their way, or hired as labourers. It was the slightly less affluent neighbours or kin who only demanded a little help who became an increasing source of anxiety".(101)

Keith Thomas expresses the problem clearly. "The tensions than produced witchcraft allegations were thus those generated by a society which no longer held a clear view as to how its dependent members should be treated; they reflected the ethical conflict between the twin and opposing doctrines that those who did not work should not eat and that it was blessed for the rich to support the poor".(102)

The same situation obtains today. People are uncertain where neighbourly help stops and where professional help starts. Members of thepublic see social problems in their society and maintain that professionals should do the caring but feel guilty that they themselves are not caring, just as in seventeenth-century England, with one difference. The accusations are no longer directed at the poor elderly people but at the professionals the term "witch-hunt", used to describe the

the search for professional culprits when an old person is found dead or a child in care is killed, symbolises this attitude dramatically and clearly. The public do not wish the old people punished, in the sense in which the word is used today, but many people wish them "put away", or in their terms "cared for", to alleviate guilt and reduce anxiety.

PART III: THE ETHICS OF COMPULSORY REMOVAL

Chapter 7

SECTION 47 ON TRIAL

It is important to distinguish between a law as it is and as it should be. Laws are used so that the actions of individuals can be judged against some yardstick but the laws themselves are on trial. The whole system of appeals offers not only a means of redress to an individual who believes that he has been treated unjustly as a result of a certain legal decision but also provides a means of testing, re-interpreting and modifying the law by which that decision was reached. Unfortunately Section 47 had never been contested in a higher court prior to the time of my research so there had been little legal discussion of it except in the Justice of the Peace newspaper. One case is currently proceeding to a higher court but is still sub judice so could not be included in this thesis.

In this section of my thesis I wish firstly to review the attitudes, values and beliefs which justified Section 47 at the time of its introduction and to consider whether or not they are still relevant. Secondly, I wish to discuss whether Section 47 is justifiable on the basis of current attitudes, values and beliefs, and on the basis of the principles which are used by jurists to examine laws, or whether it is now redundant.

Some laws are more permanent than others. It would be hard to imagine, for example, a society in which there was no law against murder although the sanctions employed to punish murderers have changed from time to time and willprobably change again. Other laws have, however, become redundant. Some have become redundant as attitudes and values have changed and have had to be replaced by laws which are more relevant,

as the 1948 National Assistance Act was introduced as the means of "supercession" of the existing poor laws, or have had to be repealed, as the 1961 Suicide Act "abrogated ... the rule of law whereby it is a crime for a person to commit suicide". Some have become redundant because beliefs have changed, as early public health legislation was superceded by laws drafted in the light of knowledge about the bacterial transmission of disease.

A person is judged with respect to a law: a law is judged with respect to a set of ethical principles which have been established by philosophers of law each of which requires attitudes, values and beliefs to be examined. The first principle against which a law can be tested to judge whether or not it is justifiable is the traditional principle: can the law be said to be necessary to protect other people from the actions of the person whom it is intended the law shall control? The second principle is the paternalistic principle; can the law be justified as a means of protecting the individual who is controlled by the powers vested in the law? To this can be added a corollary: does the benefit which the person will receive justify the infringement of his liberty? The third of the principles may be called the principle of morality or the principle of deviance; can the law be justified as being necessary to impose moral rules or punish deviants to preserve the society which laid down the law and of which the law is an integral part.

These are the ethical principles against which compulsory removal by legislated power must be judged. Can Section 47 be justified on traditional or paternalistic grounds, or on the grounds that it is a means of controlling deviance or, to put it in other terms, imposing moral values?

Chapter 8

SECTION 47 AS PATERNALISTIC LEGISLATION

We are constrained by many paternalistic laws. Income tax and national insurance are two obvious examples which affect almost every employed person. Although evasion of income tax is common and many people complain about the levels of taxation there is little opposition to the principle of income tax. However Section 47 differs from income tax in three important ways. Section 47 is used to control certain individuals, whereas income tax and national insurance affect every person who falls within certain clearly defined criteria. It is true that individual cases do not fall within the rules administered by the Inland Revenue but there is a clearly understood system of dealing with such cases, whereas Section 47 decisions are made arbitrarily on the discretion of the community physician. Secondly the sanction is much more severe in Section 47 cases. Only very severe transgressions of the law relating to income tax lead to imprisonment, every Section 47 order leads to removal of the individual from her own home. Finally the sanction for the compulsory removal of the old person may not benefit her. Indeed it may kill her due to the relocation effect, which will be discussed in detail later in this chapter. However I first wish to consider the premise on which paternalistic intervention of this sort could be justified. There are two possible premises in which it could be defended; insanity and incompetence.

INSANITY

The acceptance of the concept of insanity to use an old fashioned term, justifies removals using Mental Health Act powers and a number of people who are referred for Section 47 removal are mentally disordered.

Some are suffering from an acute confusional state, formerly called delirium, due to the effect of physical disease on the metabolism of the brain which is common, especially among elderly people. By the same mechanism certain chronic diseases such as myxodema can cause mental disorder, termed an organic psychosis. The case of Miss P (see page 34) was one in which it is probable that an acute physical illness contributed to her refusal to accept help, because a year later she was admitted to hospital voluntarily as a "very pleasant co-operative alert old lady". Cases of delirium or organic psychosis could be, and are, dealt with by the Mental Health Act, but it could be argued that if a person were suffering from a physical illness and is refusing help solely because of the effects of this illness it would be wrong to treat him as though he were mentally ill and compulsorily remove him from his home using the powers of the Mental Health Act. The National Assistance Act provides the means of dealing with this type of case without attaching the stigma of the Mental Health Act to the person removed.

In the case of delirium it may be unnecessary to invoke any legal power. In the opinion of a lawyer who has made a special study of refusal to consent such people should not be considered as being insane. He discusses "the special case of the acutely ill patient who may be quite capable of giving or refusing consent, but whose current condition predisposes him to refuse it". It could be argued that these cases are best dealt with as ones of temporary incapacity, but such an approach would not always do justice to the facts. Nor is it reasonable to expect a doctor to rely on the probability that, if he does no more than restore the patient to a condition when he can make a reasoned

decision, proceedings will not be brought against him. A more satisfactory approach would be to provide a justification.. so that where there are grounds for believing that if a patient is restored to a better condition he would be likely to consent to the procedure in question, the doctor would be justified in doing whatever was necessary to restore him to this condition. Such a justification would further, rather than restrict, the interest in self-determination".(103)

Others whose primary problem is dementia may also be referred for Section 47 removal if it is thought that they are not so severely disturbed as to allow the Mental Health Act to be used. They neither need admission for treatment, because there is not treatment which can be offered, nor need admission for observation because observation in a psychiatric hospital would add nothing further to what is already known. This type of person is usually called "confused" which is an unsatisfactory term. The Medical Officer of Health of Lewisham had suggested in 1927 that the powers of the Bradford Corporation Act would be useful for those "persons (who) are often mentally deficient but not sufficiently as to be certified". Many of the people referred to the community physician for compulsory removal are those who are unable to cope because of dementia, but in most cases it is usually unnecessary to use compulsory powers for such people. If compulsion is necessary the Mental Act is more appropriate, although the distribution between the two pieces of legislation is not clear cut. Mr. W (see page 34) was admitted using the 1951 Amendment Act but the underlying causes of his problems were schizophrenia and dementia. In other similar cases the Mental Health Act has been used.

> Miss T. had been an independent and hardworking woman, retiring eventually in her late seventies. She lived alone with few surviving friends, and no relatives near her. She coped well for a few years, then she began to neglect some aspects of her life. She would dress and walk down to town saying she was going to work, returning hom only in the evening. She refused to put on any heating and ate only when prompted, although she bought plenty of food, which mouldered. She became doubly incontinent, using papers and clothes to clear up the mess, but leaving these everywhere, including her larder. She said that she had no problems and refused help from either a district nurse or home help. She was admitted to hospital using Section 25 of the Mental Health Act and is still alive there two years later. She does not appear happy to be there but seems no less happy than when at home.

There are a number of people whose condition does not fall neatly into one or other category, which is not surprising because there is no evidence that Section 47 was taken into consideration when the Mental Health Act was being drafted. If there is uncertainty I am in favour of using Section 47 not only because the labelling effect is much less but also because it does not invalidate the person to such a degree. What is implied when Section 47 is used is not that the person is insane but that she is incompetent.

INCOMPETENCE

The concept of incompetence has received little discussion in the medical, nursing and social work literature on elderly people. It is a legal concept which is of central importance in two particular types of situation - when there is doubt about an old person's capacity to make a will or manage her own affairs and when consent to treatment is witheld by the person to whom it is offered.

A sound disposing mind

For a will to be valid the testator must be of testamentary capacity but much of the case law on which the law is based was laid down in the nineteenth century. The legal test is a functional test. Because a person has been compulsorily admitted to a psychiatric hospital does

not mean that he is ipso facto incompetent and unable to make a will or manage his affairs[104; 105] The decision that a person is not of testamentary capacity is made by the solicitor who has been asked to help the person make his will. It is, therefore, difficult to obtain a clear overall picture of the standards used to make this assessment. A clearer picture can be obtained of the standards by which elderly people are deemed to require surrogate management of their property because this decision is made by a court. An American study of court procedure found that many states had introduced legislation to deal with the problems of incompetent elderly people which was completely distinct from the legislation concerning insane elderly people. The study also concluded that there had been "medicalisation" of the definition of incompetency. That is, the definition was made principally on the basis of the medical evidence. The conclusion reached was that in New York State "the study revealed that labelling replaced analysis and that the real decision maker albeit by default, was the examining physician... Seldom was any attempt made to inquire into the actual manner in which the disease affected economic value judgements".

The Court of Protection's explanatory leaflet states only that it will consider applications on behalf of "a mental patient" who "is incapable of managing his own affairs" but the court's criteria for defining incompetence and the relative importance of the legal and medical aspects of the evidence is not clear[106]

Refusal of consent to treatment

Some of the people referred for consideration for Section 47 removal are incompetent due to the effect of disease. Others however, are not incompetent although they are living in the muddle of insanitary conditions or have treatable diseases for which they are refusing treatment.

> Miss W - T is in her eighties. She lives in a ten bedroomed house. All the ground floor windows are now blocked with corrugated iron to keep out burglars and squatters who have broken in and attacked her on a number of occasions. She conducts her affairs by letter, reads the Times in detail and listens to music and current affairs programmes. When police broke into her house after the squatters had set fire to it they found that the toilets were overflowing with faeces.
>
> She says she is quite content and that she just wishes to be left alone.

This lady, like many others, is regarded by her neighbours and by some professionals as being unreasonable but no-one is unreasonable without good reasons; the person who is acting unreasonably always has reasons which satisfy her or himself. In some cases, the person's assessment of his predicament is inaccurate. She may fail to appreciate the gravity of her situation, or the fact that her condition will deteriorate if she does not receive proper care and attention. Not infrequently an elderly person is unreasonable when her supporters are desperate solely because no-one has told her how much strain they are under.

Not only may a person fail to appreciate the nature of her problem, and the problems of others, she may also misunderstand the nature of the help which is being offered. The person may think that she is being taken to the Workhouse; for some elders that institution still exists in their fears, as it often still does in bricks and mortar. Alternatively

she may think that she will never return to her home due to an over-pessimistic view of the treatability of her condition. Many old people believe that their disabilities are due to the ageing process, that is they are the irreversible and immutable effects of ageing, when the disabilities are often due to diseases whose effects can be mitigated.

Some of the reasons for this blend of fatalism and hopelessness are more easily understood if the biography of the generation who are now over seventy years old is considered. They were born in a confident era, albeit one in which there was substantial material deprivation, they volunteered enthusiastically to fight in the War to End All Wars which would be 'Over by Christmas'. They fought to build Homes Fit for Heroes, but many of those who returned endured years of unemployment and bad housing, were beaten again in the General Strike, struggled through the thirties, then faced another war in which they were attacked in the security of their own homes. They belong to a generation which grew up in a culture in which authority was much more powerful than it is today; landlords and employers had much more power and the grim test of the Workhouse remained an ever present threat. For these biographical reasons they are modest in their wants and demands, and their expectations are low. The feeling of impotence and helplessness, of being subject to immutable processes, is derived not only from the person's social background[107] it also stems from the prevailing public beliefs about the ageing process which assume that all the disorders which occur in old age are due to ageing and are therefore intractable, and from the experience of becoming progressively more disabled and dependent. The feeling of helplessness can be fostered by well meaning professional help which does things <u>for</u> the disabled elder rather than working <u>with</u> her so that she can regain the power to

do them herself; a facet of the over-protective attitude which pervades our concept of caring.

There are a small number of elderly people who neither suffer from dementia nor depression who are not incompetent, who do not fear hospital and who appreciate that they are being offered help in a spirit of goodwill but who continue to refuse the offers of help. It has been proposed that they suffer from the Diogenes syndrome(108) but I do not believe that they should be considered as members of a group. Each is an individual with unique problems, although they share some features. Such people are not insane neither do they appear to be incompetent except in one specific area - self care. They neglect themselves and their surroundings and often refuse offers of help. They appear indifferent to the deterioration of their physical condition and living conditions. Some are indifferent to the prospect of death.

SELF DESTRUCTION IN OLD AGE

Can it be argued that the person who is indifferent to the prospect of death or is actually looking forward to death, and refuses treatment for such a reason is committing suicide? If it is the case that the failure to take proper care and attention of one's self and the refusal of treatment constitutes suicide then the ethical justifiability of Section 47 can be considered using the arguments which have been much more widely discussed with respect to suicide (A paternalistic justification for intervening when someone is attempting to commit suicide is, of course, only one reason why legislation has been used to control suicide, the other reason why suicide legislation remained on the Statute Book until 1961 was, I shall argue later in the thesis,

as a means of laying down standards of behaviour and of imposing morality (see page).

Before considering the argument in detail it is necessary to review some of the debate about the nature of the self-destructive behaviour. Thr mortality from suicide has decreased in the last two years but the reasons for this are not clear. Any apparent trends have to be interpreted with caution as the notification of suicide as the cause of death is influenced by a number of social factors, such as a wish to spare the relatives from publicity and possible stigmatisation but it seems that there has been a real decline. Better treatment of dep depression, the conversion of gas supplies to North Sea supplies, the activities of the Samaritans, an amelicration in the conditions under which elderly people live are all possible contributory factors.(109)

Old people kill themselves more frequently than young people but the numbers of elderly people admitted to hospital as a result of having attempted suicide show the opposite trend;

Rates "attempting suicide" in the City and County of Oxford.

Rates per 100,000 people in each group, 1972-73

Table 13: People "attempting suicide" in the City and County of Oxford. Rates per 100,000 people in each group, 1972-73.

	Men		Women	
	City	County	City	County
15 - 24	316	231	1016	489
25 - 34	538	203	635	528
35 - 59	160	61	349	181
60 ---	37	27	74	117
TOTAL	245	120	472	291

(110)

It could therefore be argued that older people apparently attempt to commit suicide less often than younger people but succeed in their attempt in a higher proportion of cases. This premise depends however on the assumption that those who were admitted to hospital with self injury or self poisoning and those who die as a result of such activities are not members of different populations but are members of the one homogeneous population with the difference in outcome being determined by differences in their "degree of intent", as well as by fortuitous factors.[111] For example, someone whose "degree of intent" is low and who has a desire to die may make a fatal mistake in calculating the dose of drugs they take and consume a fatal amount whereas someone whose "degree of intent" is high may be found by accident in time to allow treatment to be instituted although they had taken steps to preclude this possibility.

The factors which predispose elderly people to attempt to destroy themselves are obvious enough - social isolation, physical illness and the effects of bereavement are particularly important[112; 113; 114] The depression caused by such forces undoubtedly precipitate some people into committing suicide, but the easy identification of precipitatory factors should not lead to the symbolic meaning of the act, which was emphasised by Simone de Beauvoir[115], being overlooked. The relationship between suicide and mental illness is difficult to determine. Is attempted suicide ipso facto a sign that the person is mentally ill? The answer to this depends upon one's view about the nature of mental illness; some people would reply in the affirmative, others that the depression which is the most common mental characteristic should not be regarded as an illness and that suicide may be a logical reaction to the elder's social situation.

Two aspects of self neglect or a failure "to devote to (oneself) proper care and attention" differ from suicide as the term is conventionally used. Firstly, neglect is an act, or a series of acts, of omission; and suicide is more usually the result of an act of commission, for example, self-poisoning, the most common method among elderly women, or hanging, the most common method among elderly men. Although death by self-neglect is uncommon it is classified as suicide when it does occur, someone who dies as a result of a hunger strike, for example, would be officially classified as dying from suicide or self-inflicted injury (ICD 950-959). More difficult to reconcile with the usual conception of suicide is the speed at which self-destruction by neglect takes place. Suicide is usually considered as a dramatic and quick act whereas death from neglect may take months or years. If the definition of suicide were to embrace such acts then many of those whose deaths could be attributed in whole or in part to poor drug compliance could also be regarded as suicides, but as no definition of suicide contains any reference to time the type of behaviour which qualifies an individual for removal using Section 47 powers can be considered suicidal behaviour.

The author of one of the most influential papers on medical procedures without consent, Dr. P.D.G. Skegg states "The generally accepted view is that in these circumstances (where the need for life -saving treatment does not result from any act of the patient taken with the intention of ending his own life) a doctor is bound by a patient's refusal of consent".(116) This is also the view expressed in the British Medical Association's Ethics Handbook.(117)

It is not uncommon for elderly people who are isolated and dependent, who have survived spouse, siblings and friends, to say they wish they were dead. Death is not a frightening prospect for such people - on the contrary, it is often considered with warmth and hopeful anticipation because it will allow them to rejoin those who are dead. In comparison with their lonely and arduous life the after-life is a welcoming prospect. In my experience this attitude to death is not uncommon, and it makes the decision of whether or not to intervene very difficult.

> Miss J. was 83. In her youth she had been a ballroom dancing champion - a belle of the many dance halls in her home town. She had lived with her mother and sister, the young man with whom she had danced having been drowned in a boating accident.
>
> After the death of her mother and sister she never passed her front gate, and for twenty years lived alone with a number of cats in a house which became progressively dirtier and more broken down. She was supported by one neighbour, refusing home help, district nursing or any other source of support. She could shuffle from room to room but the house smelled of incontinence; she was white faced and bowed; her hair was filthy and matted; and her feet were very swollen. She burned the bottom out of a pan every week; her sink was frequently blocked; every winter her pipes burst, and the house was full of mouldering food. When the community physician came to see her, the possibility of compulsory removal having been raised, she said that she didn't want to go to a home, that she was just wanting to die to join her mother and sister. The responsibility of dealing with her financial affairs was taken overy bu social services, and the neighbour was satisfied that it was right to leave Miss S. where she was. She was visited weekly by the community physician until she died three months later, the neighbour finding her on the floor when she made her morning call.

Miss S. had lost interest in life, and was waiting for death. Whether her behaviour had accelerated her death or not is impossible to say, but the house was cold and she was undoubtedly malnourished. It could be argued that the community physician was wrong in not using his powers in this type of case.

The case of Mr. A. (see page 36) exemplifies this fatalistic approach to disease. After he had been washed and his bed had been changed, cleaning him of the filth of three weeks in bed, he was much more comfortable and very grateful, but it was evident that he was developing pneumonia. He still refused to go to hospital. The community physician challenged him; after telling him he would never walk again, and would probably die if he stayed where he was, he asked

"Do you want to die?".

Mr. A: "No I don't want to die".

Community Physician: "Do you want to walk again?"

Mr. A: "Yes".

Community Physician: "Will you go to hospital?".

Mr. A: "No".

Community Physician: "Well, I will obtain a legal order to take you there".

Mr. A: "That's not right".

Community Physician: "You may think that, but it is legal".

In hospital Mr. A. was soon walking and independent. The social worker arranged for him to visit a new Church Army hostel but Mr. A. said he would go back to his room although he knew he would not be able to manage the stairs from his room to the toilet. He was adamant that "It would be alright" but when asked why he wanted to go back to this room he said "it could be worse"; he was then asked if he had ever thought that things could be better, to which he replied in the negative but he started to think of trying to improve his conditions, with the social worker's help, and eventually visited the Church Army hostel, accepted the place, and admitted he was very much happier than he had been in his room.

Even when a person fully understands the gravity of his situation, and the sources of help which are available, he may still value liberty higher than better quality of life, or even higher than life itself - what are the rights of such a person? What would have been the correct course of action for the community physician to have taken if Mr. A. had replied in the affirmative to his question "Do you want to die?". Should he have left him to die, or should he have requested his removal using the powers of the Mental Health Act on the grounds that he must be deeply depressed to want to die. For those who work with elderly disabled people conventional ideas of suicidal have to be revised. I do not think that the type of situation for which Section 47 is appropriate should be considered as being analogous to suicidal behaviour although attitudes towards people who neglect themselves have been and still are, confused with attitudes towards suicide

THE RELOCATION EFFECT

So far the argument used to justify paternalistic intervention have implied that the individual will benefit from the intervention. If, however, there is a possibility that the individual will not benefit or, even worse, will be worse off as a result of the intervention this must also be taken into account when trying to decide whether or not the intervention is justifiable.

If a person perceives that she has a problem and approaches a professional for help she hopes he will be as diligent and careful as he can be and that he is more skillful and conscientious than the average number of his profession. She is also probably prepared to accept the fact that a successful resolution to her problem cannot be guaranteed and that no assurance can be given that some further difficulty will not result from the professional's attempts to help her. For example, when a person approaches a doctor for relief of a symptom she is usually prepared to accept treatment which offers no more than a possibility of relief and to make this decision even though she is told that the treatment suggested is not without risk. In what detail the doctor should elaborate on the risks entailed is a matter for his professional judgement, some people wish to know more than others, but both parties should appreciate and accept that cure cannot be guaranteed and that side-effects may occur. That is the contract when the professional's intervention is initiated by the patient. When it is the professional who initiates intervention, however, the contract is different. A much higher certainty of success, ideally absolute certainty, and a much lower possibility of harmful side-effects, preferably zero probability, is desirable. This principle has been established in

recent years following the debates relating to a number of measures suggested by professionals. Some of the resistance to, and suspicion of, petussis vaccination was a result of the fact that the damage which occurred to those children who suffered from severe reactions could be attributed to, or blamed on, professional initiatives, for it was the doctor or health visitor who suggested the vaccination in the first place.[118] (Similarly parental reluctance to have their infants vaccinated stemmed, in part from their preference to run the risk of damage resulting from random infection rather than the risk of brain damage resulting from their own parental initiative). In screening, this principle is also of crucial importance and although, in theory, new therapeutic initiatives should be rigorously evaluated to ensure that they are effective and efficient[119] in practice lower standards are adopted than those used to evaluate proposed screening measures[120,121] It is, however, when we come to consider the legal enforcement of paternalistic intervention that the ethical issue becomes even more important. The resistance to fluoridation[122] and to the Road Traffic (Seat Belts) Bill[123] was partly based on the belief that these measures might do harm, even though it was admitted that some benefits would accure, and on the principle that the State should not be responsible for harming some of its citizens, even though the measures which caused this harm were of benefit to a greater number of people. In summary, it be stated that a piece of paternalistic legislation should be scrutinised very carefully not only because it interferes with the liberty of the individual but because particular attention must be paid to the possibility that will expose the individual for whose benefit the legislation has been drafted to some other hazard and that, if this can be shown to be the case its ethical justifiability is even more suspect than if the only issue concerns the liberty of the

individual. This principle is of relevance because there is evidence that the removal of elderly people from their homes because they are, or are thoughtto be, "at risk" exposes them to other risks which result directly from this act.

An article with the startling title Slow euthanasia, or "she will be better off in hospital"[124] received considerable publicity following its publication but Baker's work was only a more dramatic presentation of ideas which had been developed over a number of years by research workers in America - notably by Morton Lieberman[125, 126] called the relocation effect. Lieberman, and other workers, have demonstrated an excess in both mortality[127] and morbidity[128] greater than that which would be expected for people of the same age, among elderly people who move from one environment to another. The effects on those who do not die are physical, mental and behavioural but the relocation effect requires more precise definition and the term really refers to a negative or noxious relocation effect for many elderly people improve physically and mentally following admission to hospital, an old people's home or sheltered housing. Furthermore, the negative relocation effect varies widely in its severity. Some people suffer no more than inner temporary disturbance such as many younger people feel who move house or change jobs. It is only in a small proportion that the effect is severe and two studies suggest that its importance has been overemphasised, partly due to the methodological difficulties.[129] It is, to cite only two problems, very difficult to select a comparable control group or to measure the effects of relocation of an elderly person from her own home to an institution because the principal reason why the elder requires admission is, in many cases, a deterioration in her physical or mental condition.

However, there is no doubt that there is a negative relocation effect and that the probability that the effect will be severe is a function of three variables:

The style of the institution to which the elder is to be admitted.

The preparation for the move

The personal characteristics of the individual who is moving.

Most of the professionals who meet an elderly person in her own home have little influence on the style of the institution which the elder is to enter, they may not even be able to choose which one she is to go to and often they have little opportunity to prepare the person for the move when compulsory removal is being considered. In the case of Miss P. who refused to communicate with the professionals it was impossible to prepare her in any way.

The lack of preparation inevitable when a person is compulsorily removed using Section 47 powers, or those of the Mental Health Act, increases the probability that the old person will be seriously affected. On top of this the very characteristics which bring theperson to such a condition as to be considered as a candidate for compulsory removal are precisely those which research has shown to be associated with severe harmful relocation effects. Physical illness, disorientation, memory failure, depression, despair and feelings of hopelessness are all factors which lead to social breakdown and are all associated with a high probability that harmful consequences will occur if the person changes her abode.

The influence of the element of compulsion is difficult to measure accurately partly because there are difficulties in defining the "voluntarinees" of those moves which are not the result of Section 47 or Mental Health Act powers (see page 75). In the words of Lieberman "voluntary commitment and participation in decision making is a myth shared by the social agency, the older person himself, and by his family".(130)

The number of cases admitted compulsorily in Oxford is too small to allow any valid conclusions to be drawn but the results have been good, at least in terms of mortality. The mean survival time was just under two years and this in a group who were seriously unwell at the time of removal and who exhibited many of the characteristics identified by Lieberman as being suggestive of risk of a negative relocation effect. Neither was there any evidence of morbidity due to relocation. All five improved physically and mentally, the definition of improvement being made with respect to what could be surmised about their condition six months before compulsory removal. They seemed to return to a functional level at least as good as had been the case six months before the crisis, the usual pattern of events being a progressive deterioration over a month or two before referral with rapid deterioration in the day or two immediately preceding removal, the latter being the crisis period.

I also gathered information about the twenty-one cases admitted within the Oxford Region during the period 1974-79. This was insufficient to allow one to evaluate the effect of compulsory relocation on physical well-being, psychological performance or behaviour but does allow some

inferences to be drawn on mortality. Of the seventeen cases for which there was data about survival three died within three weeks of admission but they were so ill at the time of admission that longer survival at home would have been extremely unlikely.

Although these findings could be considered to be encouraging it seems certain that compulsory relocation has severe effects on some people who are removed and that this particular law is one which imposes a risk upon those it is intended to help.

SUMMING UP

How would a jury consider the case made out in this chapter? It is important to think in this way as it is an ethical issue. It is not for professionals to state whether or not this piece of legislation is justifiable on paternalistic grounds. It is for them to state the reasons why they think it necessary and to outline its possible harmful effects but it is for the public to make ethical judgements. Professionals, of course have ethical opinions but that does not give them the right to do more than participate in decision making of this sort.

A Judge would probably sum up by reviewing the evidence set out in this chapter, and then cite the views of recognised authorities on this subject of which the most prominent is John Stuart Mill. In On Liberty Mill wrote "With respect to his own feelings and circumstances the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by any one else(131).... Most persons take a juster and more intelligent view of their own interest, and of the means of promoting it than can either be prescribed to them by a general enactment of the legislation or pointed out in the particular case by a public functionary..... He (the person) is the man most interested in his own well-being; the interest which any other person, except in cases of strong personal attachment, can have in it is trifling, compared to that which he himself has.(132) Mill further emphasised that "all errors which the individual is likely to commit against advice and warning are far outweighed by the evil of allowing others to constrain him to what they deem good".(133) A Judge would also point out to the jury that Mill made one exception to his

condemnation of paternalism and that was in relation to the act of selling oneself for a slave. It could be argued that choosing to stay at home when one was suffering from a severe disabling and potentially fatal illness was equivalent to selling oneself for a slave, for the consequent death or disability would take away the individual's liberty as effectively as servitude.

Finally the Judge would propose that the jury base their decision on the criteria laid down by Professor Gerald Dworkin who states that "In all cases of paternalistic legislation there must be a heavy and clear burden of proof placed on the authorities to demonstrate the exact nature of the harmful effects (or beneficial consequences) to be avoided (or achieved).... If there is an alternative way of accomplishing the desired end without restricting liberty then although it may involve great expense, inconvenience etc. the society must adopt it".(134)

Chapter 9

SECTION 47 AS A MEANS OF PROTECTING OTHER PEOPLE

A traditional, and widely accepted, role of law is that of protecting individuals from being harmed by other people and the explicit justification for Section 47 is based partly on this principle. Paragraph 2 states that "if the medical officer of health certifies in writing to the appropriate authority that he is satisfied after thorough enquiry and consideration that.... for preventing injury to the health of, or serious nuisance to other persons, it is necessary to remove any such person as aforesaid from the premises in which he is residing" he may apply for a removal order. Therefore if it could be proven that a person who is suffering from "grave chronic disease" or who are living in "insanitary conditions" can cause an "injury to the health of, or serious nuisance to, other persons". Section 47 would be ethically justifiable in principle, although that would not necessarily mean that it was ethically justified.

If the World Health Organisation's definition of health - "complete physical social and mental well being and not merely the absence of disease or infirmity" - is used then it could be argued that people who were gravely ill or living in insanitary conditions were injuring the health of others, because many people find the thought of someone who was gravely ill but was not receiving proper care and attention injurious to their feelings of mental and social well being, as the term to injure may mean no more than to impair according to the Shorter English Dictionary. Of course, the World Health Organisation definition, now the subject of criticism for its all-embracing Utopianism, was not in existence when the wording of Section 47 was first drafted and although the definition must have been moulded round

some earlier concept of health it is probable that the meaning of the word health in the legislation is much narrower, implying no more than the absence of disease, and that the meaning of the phrase "injury to health" means disease. It could be argued therefore that the legislation was drafted to prevent disease of, or serious nuisance to, other persons, and these alternatives are more closely related than the current meanings of the words would suggest.

Old people as "nuisances"

Let us consider the old person who is a "nuisance". The stipulation that removal could be justified if the person was a nuisance to other people was not in the original legislation. The Bradford Corporation Act stated that the person could be removed if "through enquiry and consideration have shown the necessity in the public interest and in the interests of the health of others" and it was this phraseology which the London County Council General Puposes Committee, after consultation with the Parliamentary Committee, suggested that the Council promote, but it was not these words which were placed on the statute book. Section 28 of the London County Council (General Powers) Act stated that thorough inquiry and consideration had to have shown "the necessity... for preventing injury to the health of or serious nuisance to other persons" before a person can be removed, and it is this formulation which was transferred to the National Assistance Act. Why was this change introduced? Was the phrase "in the interest of health of others" regarded as being too loose and too open to abuse; or was it just that a draftsman in the London County Councils solicitor's office preferred the weightier prose of "for preventing injury to the health of or serious nuisance to, other persons"? The existing records offer no explanation.

The word nuisance suggests something minor or trivial, but this is a comparatively recent meaning. The Shorter English Dictionary gives four meanings for nuisance of which the most recent is "a source of annoyance", first recorded in 1831. Earlier meanings of the word are, however, much more closely related to the etymological origin of the word which is the old French verb "nuir" meaning "to hurt". A nuisance was "anything obnoxious to the community or individual by offensiveness of smell and appearance", a meaning first identified in 1661. The earliest of the four meanings in the Shorter English Dictionary is even more explicit - "anything injurious or obnoxious to the community or to the individual as a member of it, for which some legal remedy may be found" which is recorded as having been first noted in 1464. This concept was elegantly expressed by Sir John Simon who stated that "the interests of health and the interests of common physical comfort and convenience are in various cases identical" and was of central importance in public health policy making in the nineteenth century, as exemplified by the title Inspector of Nuisances, and the several Nuisances Removal Acts. The Nuisance Removal and Disease Prevention Act of 1846, for example, increased the powers of "any Town Councils or other like body having jurisdiction within any Separate Town, Borough, City or Place" to effect "the more speedy removal of certain Nuisances". Phenomena which we would now regard as aesthetically displeasing, for example a foul smell or decomposing food were formerly regarded as nuisances which were likely to cause illness; a view which is understandable when it is remembered that the miasmatic theory of the spread of infectious diseases by vapours had such widespread support. Fortunately and fortuitously the actions taken to abate nuisances, for example the development of more effective methods of disposing of night soil and the separation sewage from

water controlled the real causes of some of the most terrible common diseases of that century.

The measures which led to the decline of cholera offer a paradigm of the success of the approach based on the nuisance concept. Although the dramatic example of John Snow's removal of the handle of the Broad Street pump is often cited as an early example of the effectiveness of the epidemiological approach many important steps had already been taken before Snow demonstrated that water was the vehicle of disease transmission. For example, the Nuisances Removal Acts of 1846 and 1848 and the important Public Health Act of 1848 had been passed and many other steps had been implemented by the time of Snow's dramatic and much dramatised action. By the time of Koch had succeeded in isolating the bacteria which was the cause of cholera in 1884 most of the more important measures necessary for its prevention had been taken by the implementation of policies directed towards the abatement of nuisances.

The concept of the nuisance was probably still influential in the nineteen thirties. Even though the bacterial transmission of infectious diseases had been widely accepted for many years by the scientific community the ideas which prevailed among the community at large, and among its representatives, would not have been so advanced. How relevant is this concept of a "nuisance" today? There are still some people who regard nuisances such as offensive smells as health hazards and demand that the smell be controlled because it is affecting their health. This relationship between offensive environmental problems and health has been statutorily institutionalised in the evolution of the Inspector of Nuisances. His title was changed to

Sanitary Inspector in 1921, to Public Health Inspector in 1956 and most recently to Environmental Health Officer in 1974. The Environmental Health Officer is certainly a key figure in the prevention of illness, concerned with such matters as lead in the atmosphere and the sterile preparation and sale of food, but he is also the officer responsible for the control of nuisances, such as noise, an increasingly common nuisance, and smells. Although smells do not cause physical illness and the level of noise which is the cause of most of the complaints of noise nuisance is not sufficient to cause any impairment of hearing, smells, noise and other nuisances can cause illness - mental illness. It can be argued therefore that nuisance can still be regarded as causing illness, that the concept of a nuisance is still valid and that compulsory removal can still be justified on the basis of this concept, but with twentieth century "nuisances" being accepted as causes of mental illness whereas the nuisance in the nineteenth century was considered to be a cause of physical illness. However it could not be argued that an old person who was making other people feel guilty or anxious was a cause of mental illness.

Some elderly people are referred for compulsory removal because they are a nuisance, in the more modern sense of the word.

> Mr. S. is an elderly man of uncertain age who has been on the road for many years. For the last few years he has taken up a position near a busy roundabout sleeping in a shed nearby. He is tee-total, not criminal and is not mentally ill - he was very annoyed that a doctor put down "nervous disability" on his last sick note. He was referred to the community physician, having no general practitioner because he was unable to stand. The community physician found that he had ulcers on one foot probably the result of frostbite and a cellulitis. He refused antibiotics but accepted dressings from a district nurse. He refused invitations to the Church Army hostel, the Cyrenians hostel and the offer of hospital admission but caused increasing concern because of his habits. He threw food wrappings all over the

> place, threw the food he did not want in the hedgerow, encouraging rats, and urinated in the street.
>
> However the community physician maintained that he was not an appropriate case for Section 47 removal and should be dealt with under the Vagrancy Act of 1824. One of the community physician's main difficulties was to persuade the community that someone had to make a complaint to the police because that would invalidate the man to a lesser degree than defining him as incompetent or insane.

In this case the man was a nuisance to the whole community. The decision is more difficult when theperson is a nuisance to one other person, either a relative, or a neighbour, as in the case of Miss N. (see page 32) or a warden of a sheltered housing block.

> Captain McL was 92. He had fallen on hard times and was referred to social services having been found sleeping in a basement. He was rehoused in a sheltered flat where he proved an increasing problem for the warden. Imperious, garrulous and strong willed he alienated everyone who tried to help him and grew to become increasingly dependent on the warden. He refused help from all other sources except her and eventually she was having to go to his flat five or six times a day and to endure frequent visits to her own flat whenever Captain McL wished a cup of tea, change for his meter or help with electrical equipment. He was filthy because he refused to allow a nurse to wash him, incontinent of urine, dressed in worn out clothes because he refused to buy any new clothes and frequently without food or milk because he refused to pay his bills, although he had plenty of money.
>
> He was not ill enough for a general hospital, nor disturbed enough for a psychiatric hospital but he was not considered fit enough for an old people's home so remained in the flat to the detriment of the warden's health. Eventually he was "persuaded" to go to a private old people's home, his resources being put under the control of the court of Protection, although it would probably have been more honest to have obtained a Section 47 order because he was by no means convinced that this move was a good move for him to have made.

Wardens are particularly vulnerable because their role is not clearly specified, they are resident, usually work alone and they are often very poorly supported by their superiors or by health and social services. As the population within sheltered housing ages the elderly person who places a heavy burden on the warden is an increasingly

common problem in which the community physician is often involved, (135, 136).

Old people as a cause of "injury to the health of...other persons".

Faeces do contain bacteria, some of which are harmful, but before accepting that the powers of compulsory removal vested in Section 47 can be justified in cases in which incontinence is present, as it commonly is, it is important to remember that there are powers of compulsory legislation specifically drafted to halt the spread of bacterial disease. Part V of the Public Health Act of 1936 gave local authorities the right to seek legal approval for compulsory removal in certain circumstances. Section 169 provides for the "removal to hospital of persons suffering from notifiable disease where (there is) serious risk of infection being spread", this being an amended version of Section 124 of the previous "great" Public Health Act, that of 1875. The next Section of the 1936 Act gave the Justice of the Peace the power to "order the detention in hospital of infected person without proper lodging to return to", which replaced Section 12 of the Infectious Disease (Prevention) Act of 1890. This was necessary because Section 169 gave only powers of removal, not powers of detention. Section 172 of the 1936 Act gave a court of summary jurisdiction the power to order the removal and detention of "persons suffering from tuberculosis of the respiratory tract". All these powers were considered justifiable because they protected those who were not infected and Section 169 stipulates that a person can only be removed if "his circumstances are such that proper precautions to prevent the spread of infection cannot be taken, or that such precautions are not being taken; and that serious risk of infection is thereby caused to other persons". It is, however, difficult to justify that this type of legislation is necessary to

prevent other people from contracting illness arising from insanitary conditions. In theory, a person who is suffering from bacillary dysentery, a notifiable disease, could be removed using the compulsory powers of Section 169 of the 1936 Public Health Act but simple hygiene precautions such as handwashing and the use of an antiseptic are sufficient to prevent the spread of the bacteria which causes dysentery, those of the genus shigella, and similar measures can prevent the spread of salmonella. Furthermore, there are a number of pieces of legislation which allow the local authority to require such insanitary conditions to be cleaned up, or to act in default and recover the costs from the person responsible for such conditions, as the following case illustrates:

> Mrs. S. was in her sixties. She was an active lady, able to go out on her scooter to visit friends and help her married daughters. She was cleanly and neatly dressed but her house and garden were dirty; in the front and rear gardens were decomposing rags, carpets, waste paper and vegetables, and the house was full of similar material, although it was not so bad, as the house was dry. The problem was complicated by her dogs, six of them,who lived in a filthy and dilapidated hut. The neighbours complained not only of the smell but about rats and fleas which flourished in these conditions.
>
> She gave repeated assurances that she would clear the house and garden but never took any action, saying that the neighbours had no right to complain because she had helped them in the past. Her daughters said that they had no influence over her and theproblem increased until the Environmental Health Committee of the City Council took legal action. Under Section 4 of the Prevention of Damage by Pests Act, 1949, she was required to "cut down and clear all garden vegetation. Dig out and level ground containing evidence of rodent infestation"; under Section 83 of the 1936 Public Health Act, as amended by Section 35 of the 1961 Public Health Act, she was required to remove all the refuse and to cleanse and disinfect the house and garden after this was done; and under Section 93 of the 1936 Act she was required either to "properly keep and groom all animals kept on the premises to ensure they are, and remain, free from vermin" or to "have the animals permanently removed from the premises or destroyed". Although she was given fifty six days to abate the nuisances she did nothing, so the Council acted in default, under the supervision of the environmental health officer who had been negotiating with Mrs. S. Although initially upset by the procedure Mrs. S. soon got over the intrusion; she remained on good terms with the environmental health officer who had for months been trying to persuade her to clean her property and keep house in a state of reasonable cleanliness thereafter.

The powers of the 1936 Public Health Act (26 Geo V) and were amended by the Public Health Act of 1961 (9 and 10 Eliz II Ch. 69) and a wide range of powers now exists which allows for the compulsory cleaning up of a dirty environment without requiring the elder to be moved from it.

Problem	Legal Solution
Blocked toilet Leaking drains Blocked sewers	Section 17 of the Public Health Act 1961 gives the local authorities power to require the owner or occupier of the premises to remedy the defect within 48 hours. If the work is not carried out the local authority can themselves carry out the work, recovering the expenses from the person on whom the notice was served. Section 18 of the Act allows the local authority to require the repair of drains and sewers and, as in the case of Section 17 powers, carry out the work themselves if the person to whom the notice is served does not. In many local authorities local Acts of Parliament may also be invoked for this purpose. In Oxford, for example, the Environmental Health Officer may use Section 57 of the 1925 Oxford Corporation Act which requires the toilet to be cleared within 24 hours or Section 57 of the 1953 Act, Oxford Corporation Act, which allows seven days for the work to be done. A local authority may supply "temporary sanitary conveniences", under Section 23 of the 1961 Act, while such repairs are being carried out but it would be easier to arrange for a commode to be lent from the medical loans service if one were necessary.
Foul smells	These can be treated as nuisances, using Section 93 of the 1936 Act.
Accumulations of rubbish or rotting food or vegetable matter in the house or garden.	Section 83 of the Public Health Act 1936, amended by Section 35 of the 1961 Public Health Act, allows the local authority to require the owner or occupier of premises which are in "such filthy or unwholesome conditions as to be prejudicial to health" to cleanse and disinfect them, carrying out the work itself if he does not. The phrase "prejudicial to health", or course, can lead to difficulties in interpretation and it may be more practicable to define the situation not as being "prejudicial to health" but as a "statutory nuisance" (see page). Action can then be taken under Section 93 of the Public Health Act of 1936 and "an abatement notice" can be served.

Problem	Legal Solution
Flea infested cats and dogs, accumulations of animal excreta.	This type of problem can also be treated as a nuisance, using Section 93 of the Public Health Act 1936. The abatement notice can be so worded as to cover specifically the type of problem which constitutes the nuisance.
Soiled clothing and bedding.	Section 84 of the Public Health Act 1936 allows the local authority to have "filthy or verminous articles.... cleansed, purified, disinfected or destroyed, as the case may require.... and, if necessary for that purpose to be removed from the premises". Section 278 of that Act instructs the local authority to "make full compensation" for such damage.
Rats, mice, fleas, flies or other pests breeding in filthy conditions.	The local authority can require that the owner or occupier improve the conditions encouraging such pests using the powers of the Prevention of Damage by Pests Act 1949.
Aspects of a building which is dangerous to other people, for example, slates falling from a roof requiring repair.	Section 58 of the Public Health Act 1936 gives local authorities powers to require the owner to "execute such work as may be necessary to obviate the danger" to persons in adjoining buildings or premises. Section 24 of the 1961 Public Health Act extended this power to buildings which are dangerous to "persons in a street".

If there appears to be no need to remove someone from insanitary conditions to prevent injury to the health of, or serious nuisance to other people, there is one type of situation in which "aged, infirm or physically incapacitated" people put others at risk, a situation which is common and a source of grave concern to both professionals and public - the risk of fire.

FIRE RISKS

The risk of fire is a common cause for concern - and rightly so, because the risk of dying from fire is much greater in older people as the data collected by the Fire Research Station, part of the Department of the Environment's Building Research Establishments demonstrate.

Age group	Deaths per 100,000 per year
Under 5	3
5 - 64	1.5
65 - 74	3
75 - 84	7
Over 85	1.5

Table 14: Mortality rate from fire, by age, England 1975

The most common cause of a fatal fire is the ignition of bedding or upholstery by cigarettes, a pipe, or matches. A modest consumption of alcohol is another factor which increases the probability of a smoker starting a fire. The second most common cause is the result of an old person coming in contact with a gas or electric fire, and the third most common cause is spread from an open fire in a grate. This frequently results in a fire which causes little damage to the room in which it starts but produces a great deal of smoke and reduces the oxygen level sufficiently to cause death from asphyxia.

Anxiety about the possibility of fire stems from two sources - anxiety about the old person herself and anxiety about the safety of others.

Greater anxiety is often felt for the safety of other people, although it may be expressed as anxiety for the elderly person. Fear that the elderly person will harm or kill others by setting fire to her own dwelling is felt by three classes of people. There are those who are directly threatened or feel that their children are at risk, usually next door neighbours or those in flats above. There are those who feel themselves to have some responsibility for the elderly person and her actions. A social worker or a doctor who is supporting an old person in her wish to continue living at home is not completely responsible for all aspects of the life of that old person or for her every action, neighbours who are worried by the risk of fire frequentky hold the professional to be completely responsible for the fact that they are at risk because the professional does not agree with their opinion that the old person should be in a home or hospital. The social worker may be confident that she had made the right decision, and be supported in her decision by professional colleagues not directly involved in the case, but the social workers' anxiety about the risk of fire cannot be completely dispelled. Finally, there are those people who are being put at risk, or who are thought to be put at risk by the behaviour of the old person.

Housing managers, the managers of old people's homes and hospitals, and the councillors and health authority members of the public authorities providing such services are in this class; concerned that they will be held responsible and publicly castigated should a number of people die in a fire. It appears that the risk of death or injury from fires started by other people is relatively uncommon, people who start fires are usually the only people to suffer. Although the data on which to base this assumption do not allow this assertion to be made with

confidence as the Fire Research Station does not collect data on the composition of the households in which old people killed or injured by fire were living, there is good reason to suppose that other people are affected in no more than a minority of fires started by elderly people. Furthermore, research has shown that elderly people are less likely to die from fire in an old people's home than are those who are living at home on their own.(138) Nevertheless, because elderly people living in sheltered housing or in homes or hospitals are considered to be in the care of the managers of the institution, acting as agents of society, higher safety standards are expected by the public; or, to be more accurate, it is assumed by those responsible that the public expect higher standards, an assumption which has some justification if the press reports of institutional fires are representative of public opinion.(139) To summarise, it can be said that some of the anxiety about fire as a cause of injury to the health of other people is justified but that the degree of anxiety felt by many people is exaggerated, in view of the infrequency with which other people come to harm, but understandable if the emotional origins of their anxiety are remembered. Neighbours often have a deep seated, almost atavistic fearof fire compared with their attitudes towards some of the more common hazards of modern life; professionals, institutional managers, and elected representatives often fear that they will be subjected to a wave of public anger and recrimination should a fire occur as a result of the actions of someone for whom they are in some way responsible.

Could Section 47 be justified on the grounds that the removal of a person is necessary to prevent injury to the health of others as a result of a fire started by that person? Before such a step could be considered it would have to be shown that "proper care and attention"

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Could Section 47 be justified on the grounds that the removal of a person is necessary to prevent injury to the health of others as a result of a fire started by that person? Before such a step could be considered it would have to be shown that "proper care and attention"

could not be given to the problem in the person's own home, and many steps are possible to reduce the risk of fire, and therefore to lower the risk and the anxiety levels of neighbours, professionals and elected representatives. Smoking habits are not easy to modify, but the substitution of a lighter for matches can reduce the risk of fire. It is also possible to make the person's heating apparatus safer in many cases, although concern tends to focus on paraffin heaters which are not a common cause of fires, rather than on the other forms of heating which give rise to many more fires. Both gas and electricity boards will carry out free safety checks for elderly and disabled people and local authority maturity loans are avilable to pay for any major repairs which may be required for rewiring. For those who wish to replace open fires which they can no longer manage safely financial help is sometimes avilable. Social services departments can pay for the replacement of a coal fire if a person is unable to manage it independently, using the power given them by the Chronically Sick and Disabled Persons Act, and supplementary pensioners can apply for an exceptional needs payment to cover the cost of dangerous or worn out heating apparatus.(140) Although there are a number of ways in which the risk of fire can be reduced the anxiety about fire cannot always be easily assuaged. In some cases health and social service professionals are not aware of all the possibilities for solving these environmental problems but in other cases the old person refuses the help which is offered. In institutions - sheltered housing, old people's homes and hospitals - a different approach is adopted, and different standards. The approach is to accept that people will smoke, the risk from heating apparatus and open fires being minimal in institutions, and to plan their environment so that any fire which does start is detected as quickly as possible are limited to as small a volume as possible. The

safety standards are higher, much higher, reflecting partly the anxiety generated by the knowledge that the person who starts a fire in an institution exposes others to a much greater degree of risk than if she starts a fire in her own home and partly the anxiety generated by the feeling of responsibility for the residents of institutions and of public accountability should a fire occur.

Even after every possible step has been taken the risk of fire remains. The powers of compulsory removal could be used to remove people who were "fire risks" but there is no evidence that it is used for such purposes, indeed three of the community physicians who replied stated spontaneously that they resisted requests to remove such people for this reason. If the Act were interpreted in this way, and if this were to become widely known, it is probable that pressure would be brought to bear on community physicians to use their powers to remove people who were behaving in a manner which was thought to be likely to lead to injury to the health of other persons.

SUMMING UP

In summing up the evidence concerning the justifiability of Section 47 on paternalistic grounds there was little which could be discussed in terms of fact: the debate was one about attitude and values. In summing up the evidence presented in this chapter it is possible to be a little more precise. A judge would remind a jury that for a law to be justifiable on traditional grounds, that is as being necessary for the protection for third parties, it must be proven that the removal of the elderly person is necessary "for preventing injury to the health of or serious nuisance to other persons". He would probably state the official definition of health - complete physical, mental and

social well being was so broad as to be unhelpful, but that the concept of a nuisance was still valid. He would ask the jury to consider whether the mental anguish suffered by someone observing the plight of an elderly person whom they thought should be in an institution could constitute a severe nuisance or not, and would remind them that a great deal of other legislation existed to deal with a person suffering from tuberculosis or other notifiable disease. The evidence concerning the fire risk is difficult to sum up because some of the most important data is missing. It is not known how many other people are injured or killed by fires started by elderly people. But on the basis of figures which are available it seems probable that some people are injured in this way, but to set this in context the judge would say that the numbers were very much smaller than those who were killed or injured by drinking drivers.

SECTION 47 AS A MEANS OF CONTROLLING DEVIANCE

THE USES OF DEVIANCE

A third type of argument can be advanced to justify a law. It can be argued that even though a law can neither be claimed to be for the benefit of the individual directly affected, nor for the benefit of other individuals, it can still be justified on the grounds that it is for the protection and preservation of society as a whole. To some people it would seem artificial to distinguish between laws designed to protect other people from the actions of an individual and laws which are designed to protect society. They would aruge that "society" was just other people. To someone who takes a sociological view of the world in which he lives, whether or not he has been formally trained in sociology, this may seem a naive view but it is important to take into account the opinions of those who are hostile to the sociological approach, a group which includes a number of doctors. For the purpose of this argument however, the term society will be used to mean the cultural entity composed not only of the individuals who feel they belong to it but the myths, values and attitudes which distinguish that society from others. The term "the state" will be used to describe the political, legislative and administrative parts of society.

What evidence is there to suggest that some laws have been drafted to protect society? Laws against treason, subversion and sedition are laws drafted to protect and preserve the state and such laws have had many supporters. Wilhelm von Humboldt, for example, accepted that the state should protect "citizens ... from the attacks of others"(141) but argued that the primary role of law was to secure the security of

the state in writings which, rather curiously, influenced that sturdy defender of individual liberty J.S. Mill. It can be argued that laws which protect the state protect society, this has certainly been argued in Russia and Nazi Germany, but are there laws which have been drafted to protect society rather than the state?

The wording of laws appears to support the view that the concept of "society" is one which has played little part in the evolution of the legislation in use to-day. By taking the explicit definition of the objectives of the laws on the Statute Book laws appear to have been designed either to benefit individuals or to protect them, the term society features very rarely yet the opinion that the implicit role of law is to preserve and protect society, whatever its explicitly stated function may be, has recently gained support from three different disciplines - anthropology, jurisprudence and sociology. It has been argued that legislation has been introduced to control certain types of behaviour which were thought to be subversive not to the political administrative framework of the state but to the moral framework of society.

From this perspective the law, a term which describes an institution which is greater than the sum of all the individual laws, is not a set of juristic tools, like spades or spanners, which allow individuals to achieve certain objectives; the law expresses and defines certain attitudes and values which are of central importance in the society in which it has evolved. Mary Douglas used an elegant analogy when she wrote that it was more appropriate to consider society as a single integrated unit like the modern frameless car rather than as a collection of interlocked individual components which was the way in

which cars were formerly constructed[142]. She wrote this when describing E.E. Evans - Pritchard's anthropological classic The Nuer[143] in which he argued that institutions such as the law or religion had to be considered in the context of the whole society not as isolated, albeit interrelated, phenomena. Durkheim had argued that religion "had not existed for the saving of souls but for the preservation and welfare of society"[144]. In Durkheim's view, a view which has been challenged, religion was society and religious laws expressed the consensus of society defining the taboos, those objects and actions which are polluted as distinct from those which were pure.

The rules laid down by Moses in Deuteronomy and Leviticus are examples of this type of legislation. Some authorities have suggested that these laws were drafted to prevent disease, that they were hygiene rules invested with religious authority to lend them weight. While it is true that those who observed Mosaic, or any other set of religious rules, probably believed that breaking the rules led to ill health, it is likely that they believed this on the basis that an illness, or some other misfortune, would follow rule-breaking as a punishment from the god in whose name these rules were made solely because the rule had been broken rather than as the end result of a chain of events stemming from the proscribed actions. It is true that the consumption of swine flesh was forbidden and that this may have protected many people from Echinococcus infection and the proscription of incest, for example, which was a similar type of offence with a similar type of punishment can also be accorded a retrospective medical justification but this is not the case with all taboos. The selection of certain objects as totems and other objects or actions as taboo was probably partly based on practical grounds, perhaps on the wish to prevent illness, but was

also based on symbolic and aesthetic grounds. The important aspect of totems and taboos lies not in the individual significance but in the importance of the system of totems and taboos. The set of religious laws define the boundaries between totems and taboos, it defines the margins of holiness.

In societies of simple technology the relationship between the law and morality is close as is the relationship between law and religion. In societies which become more secularised religion and the law diverge and the secular system of law becomes increasingly important; the decline of the powers of the ecclesiastical courts illustrates this clearly. Furthermore, law and morality diverge and the right of the state to define and control morality by legislation is also challenged, a trend which has been a subject of serious study in sociology and jurisprudence. Sociologists have suggested that there are close similarities between behaviour which is immoral, that which is illegal and that which is insane. The three conditions are distinguished from the three complementary normal states - morality, legality, and sanity - by an arbitrary definition, as totem is distinguished from taboo. They argue that the three conditions are not discrete nosological entities but different manifestations of the condition of deviance.

> Deviance is not a quality of the act a person commits but rather a consequence of the application by others of rules and sanctions to an offender. The deviant is one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label.(145)

> From a sociological standpoint, deviance can be defined as conduct which is generally thought to require the attention of social control agencies - that is, conduct about which 'something should be done'. Deviance is not a property inherent in certain forms of behaviour; it is a property conferred upon these forms by the audience which directly or indirectly witnesses them. The critical variable in the study of deviance is the social audience

> rather than individual persons action, since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviation.(146)

> Forms of behaviour per se do not differentiate deviants from non-deviants; it is the responses of the conventional and conforming members of the society who identify and interpret behaviour as deviant which sociologically transforms persons into deviants.(147)

The use of this term is of recent origin but the study of deviance is of longstanding. Thomas Hobbes was of the opinion that deviance was dysfunctional and subversive and that the Leviathan, the state, should try to eradicate deviance but writers in the nineteenth century appreciated the fact that deviance was not dysfunctional. On the contrary Durkheim and Marx stated clearly that those who were deviant served a very valuable purpose.

> Crime brings together upright consciences and concentrates them. We have only to notice what happens, particularly in a small town, when some moral scandal has been committed. They stop each other on the street, they visit each other, they seek to come together to talk of the event and wax indignant in common. From all the similar impressions which are exchanged, there emerges a unique temper ... which is everybody's without being anybody's in particular, That is the public temper.(148)

> The criminal produces an impression now moral, now tragic, and renders a 'service' by arousing the moral and aesthetic sentiments of the public ..... the criminal interrupts the monotony and security of bourgeois life .... he protects it from stagnation and brings forth the restless tension, that mobility of spirit without which the stimulus of competition would itself be blunted ... crime, by its ceaseless development of new means of attacking property calls into existence new measures of defence and its productive effects are ... great... in stimulating the invention of machines.(149)

Those who are deviant who are, by definition, in the minority define the margins of acceptable behaviour for the majority and the Church, the law and the medical profession arbitrate if there is any doubt.

In the field of jurisprudence theuse of legal powers and sanctions to maintain this system of conventional morality by the definition and proscription of deviance has also been challenged. Hans Kelsen's book on The General Theory of the Law and the State[150] was very important in stimulating the interest of jurists in this topic and the manner in which legislation was used in totalitarian states to control, punish and attempt to exterminate racial, religious and political deviance made the relationship of law and state an issue of burning interest which was articulated and stimulated by Karl Popper's monumental work The Open Society and its Enemies.[151] The arguments of Popper range over many topics rather than the role of the law to impose a morality on those who are governed by it, his work is more in the area of political freedom, yet it is of relevance to the debate about moral freedom. In Britain the debate on moral freedom was further fuelled by "the Wolfenden Report"[152] the Report of the Committee on Homosexual offences and Prostitution - which was published in 1957. This evoked strong emotional responses from a number of prominent jurists notably Lord Devlin, Master of the Rolls, and H.L.A. Hart, Professor of Jurisprudence in the University of Oxford. Lord Devlin was of theopinion that "there are certain standards of behaviour or moral principles which society requires to be observed; and the breach of them is an offence not merely against the person who is injured but against society as a whole ... the suppression of vice is as much the law's business as the suppression of subversive activities ... there are no theoretical limits to the power of the state to legislate against treason and sedition, and likewise I think that there can be no theoretical limits to legislation against immorality".[153] Professor Hart opposed Lord Devlin's view that the state should be involved in "the enforcement of morals",[154] supporting Mill's famous

dictum that "the only purpose for which power can rightfully be exercised over any member of a civilised community is to prevent harm to others" and refusing to accept that the use of criminal law to enforce moral standards was justified on the grounds that such use of legislation prevented harm to society.

To summarise; every society has a set of rules which govern behaviour. In some societies the basis is completely religious, in others, like our own, the basis has become secularised although the principles on which they are based reflects the religion which prevails. Certain rules are common to almost all societies, for example the proscription of murder, these are referred to as mala in se, but there are many other rules which are not found universally, the mala prohibita Cows are sacred in India and the killing of cows forbidden, yet they are slaughtered without a qualm in Britain; certain types of homosexual behaviour which were proscribed in Britain were acceptable in some Arab countries. Whether society considers the mala prohibita as being insane, illegal, sinful or immoral depends upon the particular culture in which the definition is made, and within any one culture the definition may change with time. In industrialised countries, for example, there has been a general shift in the consideration of deviant behaviour from sin to crime to illness, a trend which has been referred to as medicalisation.(155) Each society defines its own patterns of deviance and decides on the sanctions which will be applied to those who are detected deviating. This system of rules is not only designed to facilitate the functioning of the society, it is an integral part of the structure of the society. Those who are deviant are both threatening and reassuring to society. They threaten the rules they break because they demonstrate that the rules can be broken and suggest

that they are not so important as the majority believe them to be but they are also reassuring because they define the margins of society; they demonstrate the distinction between "them" - the outsiders, the deviants, the mad, the abnormal - and "us".

Two aspects of the behaviour of people who may be compulsorily removed using section 47 could be regarded as being deviant - their dirtness and their apparent disregard for their health or life.

DIRTINESS AS DEVIANCE

A strong case can be made out to defend the proposition that Section 47 powers were drafted as a means of expressing and allowing the enforcement of the rules of cleanliness and order which prevail in our society. That is, it could be argued that Section 47 powers of compulsory removal were not only intended to help the person deemed to be "in need" and to protect others but were intended to punish the rule-breaker, the person who was not devoting to her or himself "proper care and attention".

This may seem a far-fetched and ridiculous hypothesis because the wording of the Act gives no indication that it has been drafted to protect society. It states quite clearly in paragraph 2 (see page 230) that compulsory removal is allowed "in the interests of any such person....or for preventing injury to the health of or serious nuisance to, other persons", but the fact that the protection and preservation of society is not explicitly cited does not exclude the possibility that the law has this as an implicit objective. As has been emphasised before, if it is accepted that the whole system of laws is part of the structure of society and not merely a haphazard collection of rules the meaning of any single law has to be considered on two levels; the explicit and the implicit, or the obvious and the hidden. A law may have more functions than those which are explicitly stated. The legislation which controls obscenity, the Obscene Publications Act of 1959, states in Section 1 that "an article shall be defined obscene if its effect is ... such as to tend to deprave and corrupt persons who are likely, having regard to all relevant circumstances, to read, see or hear the matter contained or embodied in it ..."; this is the explicit objective of the Act, yet it can be and has been

argued that obscene material does not cause depravity and corruption but is the result of it. The implicit objective of this Act is that defined and supported by Lord Devlin, and attacked by Professor Hart, as the enforcement of morals, the expression of moral standards by the definition of their limits. Similarly the Street Offences Act of 1959 merely defines the illegality of prostitution and certain related offences, whereas its real concern is with morality. Therefore the fact that Section 47 does not mention that it is intended to protect society from subversion by deviant behaviour does not preclude the possibility that it has this intention, albeit an implicit intention. There are more positive arguments which can be advanced in support of the hypothesis, arguments based on the attitudes towards two particular patterns of behaviour which are commonly exhibited by people who are considered for compulsory removal - dirtiness and self-destruction.

In the broadest sense of the word dirt can be construed as meaning disorder. Societies depend upon order to survive and the maintenance of order is of prime importance. The whole system of laws, rules, customs and rituals are both expressions and instruments of order; disorder is threatening to this system, either political disorder, revolution, administrative disorder, anarchy, or physical disorder - dirt. Dirt is in the eye of the beholder, it is what the individual wishes to define as dirt. One housewife will be of the opinion that her house is clean while another considers it dirty, or an even stranger word "filthy"; one man will regard his vest and pants are clean while another who sees them in a rugby changing room will be disgusted. There is no universally accepted standard against which dirt can be judged, each person has his own definition of the limits of acceptability. The limits of acceptability, of tolerability, vary from one person to

another but there is a general concensus about very dirty conditions which everyone would agree as intolerable - everyone that is except the person living in the conditions. This is the situation which obtains when Section 47 powers are considered necessary, everyone is disgusted except the person living in the insanitory conditions who says that she is 'alright' (see page 145). It could be argued, of course, that fear of dirt and pollution is due to the knowledge that diseases can be spread by dirty or polluted substances but few of the laws against pollution are based on bacterological or medical evidence. One of the oldest of lists of substances which pollute and are therefore forbidden, or taboo - Deuteronomy Chapter XIV - illustrates this point. In verse seven "the camel, the hare and the rock badger" are proscribed not because they are less orderly or cleaner than the "roe-buck, the wild goat, the fox, the antelope and the mountain sheep"; both sets chew the cud or have the hoof cloven but the former are forbidden and the latter are not. The camel, the hare and the rock badger are forbidden, polluting species not because they are disorderly or dirty but because certain species have to be forbidden to create order, to define the margins of the culture, or more accurately, to define margins so that the culture can define itself. These species are selected arbitrarily to define deviance. The attack on disorder is not designed to destroy disorder but to create order. It helps to define not only the margins of the society built, but its internal structure.

Old people who are dirty and live in disorderly and dirty houses break the rules, they are deviant and have to be controlled to demonstrate that they are in the wrong. Public anxiety about such a situation stems not only from a desire to help the old person but from a fear

of disorder, partly that disorder will overwhelm us but also that we may succumb to its temptations, for in a society which the majority of people expend large amounts of energy struggling to keep up appearances for the benefit of others the person who appears to have shrugged off this yoke is in an enviable position. A similar mixture of emotions is evoked by those who predominantly are homosexual or by those who have serious drinking problems, for the majority of people have some homosexual tendency and a certain reliance on the effects of alcohol. It is not so much "the homosexual" or "the alcoholic" who is feared but the predisposition towards homosexuality or addiction which lies within us. The anxiety about a person "in need of proper care and attention" is heightened if he or she becomes incontinent of faeces or urine, because the person who is incontinent has not only lost control but he has lost control of the management of a substance which is particularly prescribed in many cultures.

In Deuteronomy Chapter 23 careful instructions are given:

> 10 If there be among you any man that is not clean by reason of uncleanness that chanceth him by night,
>
> then shall he grow abroad out of the camp, he shall not come within the camp.
>
> 11 But it shall be, when evening cometh on, he shall wash himself with water: and when the sun is down, he shall come into the camp again.
>
> 12 Thou shalt have a place also without the camp, wither thou go forth abroad:
>
> 13 And thou shalt have a paddle upon they weapon; and it shall be, when thou wilt ease thyself abroad, thou shalt dig there with, and shalt turn back and cover that which cometh from thee.
>
> 14 For the LORD thy GOD walketh in the midst of thy camp, to deliver thee and to give up thine enemies before thee, therefore shall thy camp be holy: that he see no unclean thing in thee, and turn away from thee.

Of course it can be argued that incontinence is not usually the persons fault, that it is not simply a loss of control but a loss of the ability to control bladder and bowel evacuation, which is very different but the word incontinence implies that the person has lost control, the former meaning, and it has moral implications. The Oxford English Dictionary defines it as a "want of continence or self-restraint. With reference to the bodily appetites especially the sexual passions". The medical definitions are also given in the Dictionary and although they are also of ancient origin, Pliny mentioned incontinentiae urinae. the usage of the word in the last five hundred years has implications of weakness and immorality and these remain in the collective unconsciousness of our society. The word incontinence has had connotations of immorality and these still persist. Similarly the immoral connotations of dirt still persist in our society. Consider the meanings implicit in the words pure and spotless and the symbolic importance of the colour white. Consider also how often the adage "cleanliness is next to godliness" is still used two hundred years after it was first publicised in John Wesley's sermon on Dress - ". Let it be observed that slovenliness is no part of religion; that neither this, nor any other text of scripture, condemns neatness of apparel. Certainly this is a duty, not a sin. Cleanliness is, indeed next to Godliness'.

The evidence recorded by the Royal Commission and Select Committees which sat in the 1890's makes it quite clear that those who were dirty were the undeserving and required the control which only indoor relief could offer(156, 157, 158, 159). The Poor Law was seen not only as instrument for dealing with the indignant but as a symbol and expression of certain social values, those of the bourgeousie. In the twentieth century the same attitude prevailed. Dr. Buchan, the

Medical Officer of Health stipulated that a person could be compulsorily removed if it were "in the public interest". This phrase was deleted when London County Council adopted this legislation, but reflected Dr. Buchan's approach which was to promote "the public good". The New Zealand legislation also reveals this confusion between care and control. The Rest-homes Act of 1929 was introduced to provide "Rest-homes for Destitute Persons who by Reason of Age and Infirmity are unable to take Proper Care of Themselves" including those admitted compulsorily. However the inhabitants of these homes were referred to as inmates and the Act included provision for the arrrest without warrant of escaped inmates so the nature of the 'rest' offered may be imagined.

SELF DESTRUCTION AS DEVIANCE

In some societies suicide has been condoned, even encouraged, as an appropriate and proper response to certain situations. Malinowski's study of the Trobiand islanders showed that suicide by poison or by jumping off the top of a palm tree was expected of and, apparently, willingly chosen by those who had violated some taboo. In Japan the right of a feudal chief to order one of his followers to commit hari-kari, self-disembowelling, was legally prohibited in 1868 but voluntary hari-kari was regarded with favour for some time after that, and other eastern cultures such as Buddhism or Brahminism condoned suicide in certain circumstances. In European cultures, however, suicide has been regarded differently and it has long been regarded as an action which should be discouraged by the state.

In ancient Rome there were laws against suicide although, it is possible that these were designed as much to discourage slaves from committing suicide, a common occurrance, as for paternalistic reasons. The

Christian Church reinforced these secular proscriptions. At the Council of Arles in 452 suicide was declared to be indicative of diabolical possession and it was decreed that those who killed themselves should not be given a Christian burial. This became part of Canon Law at the Council of Nimes in 1184, although suicide is not explicitly forbidden in the Bible as it is in the Koran. Opinions vary on the origin of suicide as a criminal, as opposed to an ecclesiastical, offence in England but it was certainly a crime by the end of the fifteenth century. From 1554 suicide was equated with murder as a result of the suicide of Mister Justice Hales, and it remained a crime until the Suicide Act of 1961, although suicide legislation had been repealed much earlier in other European countries - in 1790 in France for example - and had been frequently flouted in England for many years.(160)

Suicide, or attempted suicide, is now officially regarded as an illness deserving sympathetic treatment rather than as a crime which merits punishment but public attitudes towards acts of self-destruction still tend to be disapproving. One study of professional attitudes towards suicide showed that one half of the junior medical staff were unsympathetic, as were two-fifths of the nursing staff: only 5 out of the 39 junior medical staff and out of the 15 nurses included in the survey were sympathetic to those who had taken an overdose.(161) It could be argued that such professional attitudes do not reflect public attitudes accurately because the self-destructive act creates work for tired and harrassed professionals, whereas it does not impinge directly on members of the public. It could also be argued that a study of attitudes towards those who are admitted having taken an overdose does not accurately reflect attitudes to self-destruction because many

professionals are of the opinion that overdoses are more often due to a manipulative rather than to a self-destructive motive. Another study of professional attitudes showed a discrepancy between attitudes towards acts interpreted as resulting from depression, and attitudes towards those acts which were considered to have been motivated by a desire to manipulate and respondents classified most overdoses in the latter category. This probably reflects public attitudes more accurately and different attitudes probably prevail towards those who appear to be attempting to punish themselves, the "true" or "genuine" suicides and those who appear to be attempting to punish other people, the "manipulative" or "parasuicides". The work of Beck suggests that those who attempt to destroy themselves cannot be divided into two distinct population differing from one another only in their "degree of intent", that is the determination with which they pursue the objective of their own destruction.(172)

A vast amount of literature recording the attempts of workers from many disciplines to explain suicidal behaviour exists. Explanations range from those which see it as the result of external social forces, the sociological approach stemming from Durkheim's influential but unsound study Le Suicide, to those which see it entirely as a consequence of internal psycho-dynamic forces, derived from Freudian theory, particularly his essay Beyond the Pleasure Principle. Few would now dispute that both social and psychodynamic forces were important that the suicide rate is influenced by social factors, the striking effect of Goethe's novel The Sorrows of the Young Werther on the suicide rate in Europe bears testimony to this, but that psychodynamic factors, that is those which are determined by familial factors, determine which individuals are most likely to commit suicide.

Suicide is both an individual and a social act. It has social causes and social consequences. Like other forms of deviant behaviour it is both threatening and reassuring, threatening to other people because it is the ultimate rejection of the society in which they live and believe to be valuable, but also reassuring because it defines the margins of that society. "We" do not commit suicide, "we" work for a better society; "they", "the suicides", are different. Legislation prohibiting suicide has been used to protect other individuals, that is it has been based on traditional principles: in Rome suicide was prescribed to prevent debtors from benefiting their families at the expense of their creditors. It has also been introduced for genuine paternalistic motives, as when suicide was proscribed to discourage girls who had been raped from taking their own lives, but the most common reason appears to have been motivated by the desire to control self-destructive behaviour for the benefit of society; that is as a means of controlling deviance. Initially it was by making suicide a sin, proscribed by Canon Law; then by making it a crime, punishable by secular law; finally, since the Suicide Act of 1961, it has been regarded as an illness.

SUMMING UP

How would a judge direct a jury in this case?

He would probably open by stating that every society requires a set of rules to provide a stable framework, that these rules were usually set as proscriptions, that is as forbidding certain activities, and that a number of these proscribed activities were selected in an arbitrary fashion. These activities, which constitute what sociologists call deviant behaviour or in lay terms immoral behaviour, did not injure other people, nor were they necessarily harmful to persons acting in a deviant or immoral fashion, for example by being homosexual

or blasphemous. However those who wished to claim membership of the society which laid down the arbitrary rules had to observe them and had to agree to the use of sanctions to discourage and punish deviance or immorality to maintain the stability of the society. The Judge would remind the jury that the definition of deviance and decisions whether or not a particular individual's behaviour was deviant could be by the Church through Canon law, by the State through secular law, or by the medical profession through the process of diagnosis.

The jury would have to decide on two points when considering whether or not Section 47 was ethically justifiable on the ground that it was a means of controlling deviance and therefore of maintaining the stability of society. Firstly, they would have to decide whether the State should be involved in the control of deviance, that is in the enforcement of morality, or whether it should restrict its legislation to activities which affected only the security of the State, as opposed to the security of the society, or the safety of other individuals. He would summarise the views of H.L.A. Hart and Lord Devlin, the former believing that morality was not the business of the State, the latter that the State should be involved in the enforcement of morals.

If the jury were also of this latter opinion they would have to decide whether the situations described in Section 47 could be interpreted as being deviant or immoral behaviour. Two aspects of the type of case which Section 47 was drafted to deal with could be considered under the rubric of deviance - the dirtiness of the individual and the self-destructive nature of the behaviour. He would

point out to the jury however that a number of other laws currently on the Statute Book could be used to deal with a dirty environment without the necessity of removing the person from it and that the law which stipulated that suicide was a criminal offence had been repealed in 1961.

PART IV: THE NEED FOR CHANGE

Chapter 11

THE CASE AGAINST REPEAL

A strong case can be made in favour of repeal.

As a means of controlling deviance Section 47 is of little significance, and is in my opinion, injustifiable. The powers are seldom used as a means of protecting other people and could therefore be repealed without harming other people and it is also open to criticism when considered as a piece of paternalistic legislation. Not only does compulsory removal not guarantee any improvement in the health of the person who is removed it actually exposes that individual to a new risk to her health and life due to the relocation effect,

This dilemma is keenly felt by many of the Community Physicians involved in compulsory removals. Of the 140 community physicians who replied to the questionnaire, eleven were unequivocally of the opinion that these powers of compulsory removal should be repealed and two were of the opinion that the powers should be repealed if they were not amended; one suggested that the legislation should be re-drafted or repealed, the other that the responsibility for their execution should be transferred to the social services departments. Of the eleven in favour of repeal, five had made no use of the powers in the few years since 1974; three used it once, two twice, and one had used it four times. Of the 126 who did not want repeal, 28 had made no use of the powers, but with such small numbers it is difficult to state with any confidence whether the attitudes of those wishing repeal had a significant effect on the readiness with which they exercised their discretionary powers: it seems probable, however, that it did.

The reason why most community physicians wished to see the powers repealed was that they considered them to be unethical, but one stated that it was not only a deprivation of liberty but that "with many elderly women, the removal from their usual environment is tantamount to a death sentence". I am of theopinion that the Act should not be repealed because I believe there are hidden benefits which derive not from the use of the powers but from their existence.

The existence of a law proscribing certain behaviour does not of itself stop people from acting in that way. Some, fortunately a large proportion of the population, are influenced by the existence of a law. They know that they "should not" behave in a certain fashion because it is wrong - it is "against the law" - although there are others who desist only because of the sanctions which exist to punish those who break the law and because there are authorities to detect and apprehend law breakers.

There are however, many laws which were introduced not to prohibit certain types of action but to regulate behaviour. These are laws concerning contracts established between two parties, for example laws governing marriage, divorce, and business transactions. These obviously benefit the parties directly involved in such contracts for they provide them with a framework in which they can operate, one which they know will be familiar to the courts if either party wishes to challenge the contract. The laws of contract are also of benefit to those who are not directly involved in such contracts. The fact that there is a law, or set of laws, concerning marriage not only benefits those who marry but it gives people who are considering getting married or are living together a framework of reference. They

can define the contractual aspect of their relationship with reference to the legally defined state of marriage. Similarly the legal rules about divorce allow married couples who are considering divorce to judge their present position and their options against a set of rules which provide a code of practice. In the same way the existence of Section 47 emphasises that there are occasions where the admission of an old person to an institution is considered necessary by other people but not by the person herself and lays down a code of practice for her compulsory admission if she is not willing to go voluntarily. The repeal of Section 47, although it apparently increases the freedom of elderly people would not have this effect. It would, in fact, have the opposite effect.

I have argued in an earlier chapter (see page 66) that the powers are underused, that all these people who are admitted to hosptial without the use of Section 47 powers or those of the Mental Health Act being invoked can not necessarily be assumed to have sought admission readily and willingly. Some will have brrn deceived, others will have been coerced, or confused by the side effects of drugs or submitted to unremitting pressure by other people who call their approach persuasion. In many of these cases it would have been more honest to obtain legal permission to remove the person, using Section 47.

What would I have done in the cases in which I have used Section 47 powers had they not existed? I think I would have managed to "persuade" the people removed to accept the idea of admission but that would not make them voluntary admissions. I believe that the liberty of elderly people is better respected in the process of legal compulsion than

during the course of persuasion because the professionals must involve someone who is independent, the magistrate, and because one officer, the community physician, is ultimately responsible for the decision thus giving the person removed a single accountable person who can be held responsible should they wish to seek redress.

The existence of Section 47 does not of course make all cases either black or white. There are, and always will be, many grey cases but if Section 47 powers were more widely known and if the criteria were more precisely defined it would serve as a code of practice for the admission of old people to institutions.

> Mrs. P. who had been a nurse had lived alone for four months, since her neice had left home. Relatives bought food but little of it was eaten and she had a number of large ulcers on her legs which may have resulted from burns. She refused meals-on-wheels, home help and nursing, tearing the dressings off her legs on those occasions when the nurse persuaded her to allow her to try to treat them. The community physician visited twice but thought there were no grounds for Section 47 removal as she could walk to the door and say "I'm all right, tahnk you".
>
> On his third visit there was no answer. He asked a neighbour, who had helped Mrs. P. if he could go through his house and over the back fence and saw her lying on the floor.
>
> She was not hypothermic but had obviously been there for a few hours, and could not rise. The community physician said to her he thought she should go to hospital but she replied "No, I've looked after lots of people. I'm all right". The community physician tried to persuade her to change her mind but she started talking about her neice and her house, whether to change the subject or whether as a result of delirium was uncertain, but at that moment an ambulance arrived for the neighbour had phoned without asking the community physician.
>
> The ambulance men came in and started to prepare her for the stretcher. She co-operated quietly with them and was taken to hospital.

This is the type of situation which general practitioners frequently have to face. Should the community physician have told the ambulance men to go away because he would have to obtain a Section 47 order or knowing it might take several hours to obtain an order, was he right to wait and see how the lady would react when she was being lifted onto the stretcher and taken out of the house. Such a situation, which occurs not uncommonly, is always a matter for regret but the existence of Section 47 makes the professional aware that he may have participated in an act which was not only regrettable but illegal. It is this aspect of Section 47 which is of importance in focusing the mind of the professional.

For these reasons I believe that Section 47 should not be repealed but I am of the opinion that it should be amended.

Chapter 12

THE CASE FOR AMENDMENT

If the powers are not repealed they should certainly be amended. Laid down when there were no voluntary admissions to psychiatric hospitals, no home help services, and very little home nursing - to mention but three of the many differences between 1925 and 1980 - the legislation has been overtaken by a whole series of important Acts and by many developments in both statutory and voluntary services.

THE CRITERIA

Firstly, the criteria for removal should be changed. In my opinion, it should be explicitly stated that an order for compulsory removal can only be granted for the benefit of the individual who is to be removed and that there should be no grounds for removing a person for the good of others. Therefore the statement that an order can be granted by the court "for preventing injury to the health of, or serious nuisance to, other persons" (Paragraph 2) should be deleted. There is no evidence that an old person can cause physical injury to a neighbour, except by starting a fire (see page 166) and although the risk of fire is often a cause for concern it is inappropriate to legislate against individuals who are creating fire risks. Besides, there are other ways to deal with this type of problem.

The second important amendment is that the phrase "in insanitary conditions" should be deleted. There is no need to remove a person from insanitary conditions because there are a number of other powers available to do so, particularly some of those in the Public Health Act 1936 (26 Geo. VI, 1 Edw. VIII Ch. 49) and the Public Health Act 1961 (9 and 10 Eliz. II Ch. 64). (See page 156).

This type of legal action is also upsetting for the old person concerned but its effects are probably less harmful than those of relocation (see page 147). In any case these powers are rarely used, because they are regarded as the last resort by the environmental health officer. Although his role is very much shaped by his statutory responsibilities the environmental health officer rarely uses his statutory powers, preferring to try education and persuasion rather than to immediately invoke legislation as soon as he identifies a problem which contravenes some section of the immense body of public health legislation. He tries to persuade people to act for the reasons which lay behind the introduction of the legislation rather than to act solely for the reason that there is legislation which can be used to compel if they won't take his advice. Furthermore, many environmental health officers are very experienced in speaking and listening to elderly people and, in my experience, are as good at communicating with them in a supportive and constructive manner as many of the professionals who work in the health and social services. The environmental health officer may visit an elderly person for years before even considering the use of statutory powers, hoping that as the person comes to know him she will trust him and allow him to help her improve her "insanitary conditions" without the use of legal sanctions.

I also believe that the words "aged, infirm and physically incapacitated" should be deleted from the Act - it is quite unjustifiable to do anything to anyone solely because he is "aged" and this phrase should be deleted. The phrase "insanitary conditions" can also be deleted from paragraph 1(a) because they can be dealt with using the Public Health Acts of 1936 and 1961, as I have described. This would leave only the stipulation that those who were suffering from "grave chronic disease" could be considered for removal, providing that they also satisfied the second criteria laid down in paragraph 1(b), that "they are unable to devote to themselves, and are not receiving from other persons, proper care and

attention". "Grave chronic disease" is imprecise but it is no less vague than the concepts of "mental disorder", "observation" and "treatment" on which rest the justification for compulsory removal using the powers of the Mental Health Act. The adjective "grave" could be replaced by one which was morespecific, such as life-threatening, or by one which justified removal, such as "treatable" or "curable", but I do not think that this is so important. However, one change in this phrase which is necessary if the powers are to be retained is the insertion of the adjective "acute" in addition to chronic, because removal is often necessitated by an acute illness, or an acute exacerbation of a chronic illness, as was recognised by those who introduced the 1951 Amendment Act (see page 112). Although it is probable that most community physicians will aplly for a removal order in acute illness, one community physician stated explicitly that he would not and theremay be others who would not but who did not reveal this because opinions on this were not explicitly sought in the questionnaire.

The phrase "proper care and attention" was inserted in the legislation at a time when domiciliary care services were rudimentary and also requires amendment. Nowadays it is possible to maintain a person in her own home unless she requires very frequent attention from skilled nursing staff, for example two hourly turning, or unless she needs the diagnostic and treatment facilities which are provided only in a hospital. If it is necessary to move someone on nursing grounds, that is, if hospital nursing is considered to constitute the "proper care and attention" which the person requires, it can be argued that she is being removed because it is not possible to provide the <u>quantity</u> of care which can be provided in her home: that is, she is removed because the community services are unable to provide a hospital-at-home service. Similarly, if a person

requires removal on social grounds, it could be argued that the elderly person is to be removed because the social services department does not provide full-time care assistants to attend people in their own homes. In one large city with 45,000 people over the age of sixty-five the presence of a hospital-at-home service able to offer nursing visits three times during the day, and three times during the night to back up a night-sitter service, and up to four hours of home help a day seven days a week, Section 47 was not required during the four years of the survey. If, on the other hand, it is decided that the person has to be moved for medical reasons, that is, she requires the diagnostic and treatment facilities only available in hospital, it can be argued that she is being moved because she requires a type of care and attention <u>qualitatively</u> different from that which can be given by a general practitioner; for example, radiography or operative repair of a fracture. Because it is only doctors who can appreciate the full implications of this type of decision I believe that the recommendation should continue to be made by a doctor, although I believe that a social worker should also be involved.

In practice, of course, it is not so easy to distinguish those who require the type of care which can only be provided in a hospital from those who merely require more care than it is possible to provide in their own homes. A more important distinction in practice is between those who are refusing all offers of "proper care and attention" and those who are willing to accept domiciliary care and attention but are unwilling to enter an institution. It is within this latter group that there is a need to distinguish between those who need hospital services and those for whom admission is necessary solely because they cannot be given sufficient services in their own home. The community physician should be prepared to apply for a compulsory removal order for those who are refusing

all domiciliary help and for those who are refusing admission to an institution when this appears to be the only type of service which can meet their needs, when, for example, a fracture is suspected. However, the community physician's decision is much more difficult if the person refuses to be examined, it being theopinion of the legal expert replying to a question in the Justice of the Peace that "action, in cases where consent for examination is withheld, must be taken on the basis of such inquiry and consideration as may be possible".

I am of the opinion that it should still be possible to remove a person compulsorily to an old people's home. Some of the people who are refusing domiciliary help do not need a hospital but do require care and attention. Mrs. L. was such a case (see page 37).

PROCEDURES

The procedures are also in need of amendment. The phrase "the person managing the premises", obviously drafted in the poor law era, has to be clarified. Of even greater importance, however, is the need to decide which professional is the most suitable to be ultimately responsible, in the position formerly occupied by the Medical Officer of Health and currently by the Community Physician.

The central part played by Medical Officers of Health in the evolution of this legislation has already been emphasised. They helped it develop not only by supporting the legislation but by belonging to an identifiable and acceptable professional group which could be trusted with the execution of these powers: the confidence felt in the House of Commons if easily discerned in the reports of the debates on the National Assistance Bill (see page 103). The Medical Officer of Health was selected partly for his medical background, although the emphasis of his training in those

days was much more towards infectious diseases than towards the medical problems of old age, and partly because of his position within the local authority bureaucracy: of it but not in it; independent yet accountable. He was known, respected, and trusted by the local community who were familiar with both the person and the role. His psan of control was wide. Although Illich has castigated the medical profession for the "medicalisation" of society there are many examples of de-medicalisation. The Medical Officer of Health in the nineteen twenties was more influential than his present day colleagues. Housing, for example, was the responsibility of the Ministry of Health and the Medical Officer of Health was closely involved in all aspects of the policies for the "Housing of the Working Classes". Not only was the Medical Officer more influential, he was more powerful; he had considerable resources at his disposal. The welfare services, the community nursing services, the public health inspectors and, before 1948, hospital beds could be marshalled and deployed by the Medical Officer of Health. In spite of the fact that such services were in many respects less adequate than their present day equivalents the ability of the M.O.H. to command them allowed him, more than any other doctor or local government officer, to assess and deal with the problem of a person in need of proper care and attention.

The power and position of the present day medical officer of environmental health - the community physician who is the medical adviser to the district council are very different from those of the Medical Officer of Health. He is no longer directly employed by, or accountable to, the authority responsible for the implementation of the powers of compulsory removal: he is an employee of the National Health Service. He can no longer direct other workers to intervene: the community nursing, welfare, and environmental health services are no longer under his control, and

the management of hospital beds is now the responsibility of the hospital consultants. Is it still appropriate, therefore, that he should remain the officer to discharge the powers of compulsory removal?

The appropriateness of the Medical Officer of Health as the responsible officer was so obvious that there was no discussion about his suitability, so it is impossible to decide which of his many attributes - his medical training, his social position, or his powers - were the most important. Only the first of these is unchanged: the social position and the powers of the community physician have both changed significantly. Furthermore, other professions have developed which have absorbed some of the power and influence formerly monopolised by Medical Officers of Health - social work, environmental health, community nursing, psychogeriatrics and geriatric medicine. It could be argued that one, or more than one, of these professions could be trusted with the powers of compulsory removal, but I firmly believe that community physicians are the professionals who should continue to be responsible for the implementation of this legislation, provided that they are properly trained for it. The principal reason for this opinion is that the crucial factor in the analysis of a case is often medical and that medical aspects are always important.

Some community physicians think that community medicine should have nothing to do with Section 47: the opinion was expressed by one community physician, one who is not responsible for Section 47 removals, that "It does seem an extraordinary business for medical people to spend time on, when virtually all the administration could be done by a trained monkey". It could be argued that a consultant in geriatric medicine should assume responsibility playing a part analogous to that of the psychiatrist in the Mental Health Act. I believe this would be unwise. Not only do I doubt whether consultants in geriatric medicine would welcome this power, but I am of

the opinion that this would make their decision-making on the allocation of that very scarce resource, their hospital beds, even more difficult than it is at present. The contribution of a consultant in geriatric medicine is certainly of great importance and most community physicians would not consider compulsory removal until they have obtained a consultant's opinion, but it is probably better that they are involved in this way rather than being made ultimately responsible for implementation.

Eight of the community physicians who replied were of the opinion that these powers should be transferred to other professionals; four thought social workers should take on this duty, two that general practitioners and psychiatrists should be responsible, one that an environmental health officer should be involved, and one merely expressed the feeling that "someone else" should be responsible. One other community physician stated that geriatricians and "certain" social workers should also be nominated as proper officers in addition to the community physician. Many of those who replied expressed their dislike of the legislation, but were willing to continue to implement it. Those who wished to abrogate this responsibility held this opinion because they felt that the position of the community physician was now very different from the position of the Medical Officer of Health when this law was drafted but it seems that the community physician is still the most appropriate professional to hold the ultimate responsibility. If community physicians are to retain this responsibility, however, the Faculty of Community Medicine must give immediate serious consideration to the training of those who will be responsible in future.

Although the orientation of the Medical Officer of Health was principally towards infectious diseases and the health of children every doctor who worked in a local authority health department acquired a range of relevant

skills and a store of pertinent knowledge. Working with public health inspectors and housing officers gave experience of insanitary conditions; close liaison with mental health officers, welfare officers and home help organisers offered opportunities of meeting many people who were having difficulty coping because of physical and mental incapacity; and community nursing colleagues kept the medical officers aware of the consequences of grave chronic disease. The community physician of today is expected to have a different set of skills. The Report of the Working Party on Medical Administrators, the Hunter Report[165] proposed that training should include "Medicine and Human Biology, Epidemiology and Environmental Health, Statistics, Social and Behavioural Sciences, Social Administration and Health Service Management", but there is no record to suggest that they ever considered the need for training which would equip the community physician to make an adequate assessment of a person referred to him for compulsory removal many of the community physicians who are currently responsible were, prior to 1974, Medical Officers of Health or doctors with long experience of work in local authority health departments, but what of the community physicians of tomorrow? Will they be able, or willing, to perform this duty with the expertise and commitment necessary to prevent serious assaults on the liberty of disabled elderly people?

The 1959 Mental Health Act allows recommendation for compulsory removal to be made solely by "a (medical) practitioner approved....by a local health authority as having special experience in the diagnosis and treatment of mental disorder". These elderly people considered to require compulsory removal using the powers of the National Assistance Act should not be allowed to be recommended for removal by a doctor who is any less experienced. These community physicians who are currently responsible are well prepared for such work, having served apprenticeships in local health authorities before 1974. Those in training now are

not being prepared adequately for this type of work and it is essential that they should be. Not only did the Hunter Working Party fail to consider this, but neither did the "Duncan" nor "Preston" Reports[166, 167], nor has the Faculty of Community Medicine.[168]

In reply to a letter of enquiry the Faculty of Community Medicine stated that "It had no policy as such on Section 47 of the National Assistance Act", and saw the training of community physicians in the operation of this Act as part of the in-service experience that trainees should receive while working with a Medical Officer for Environmental Health. To obtain a clearer picture of the preparation of community physicians for this responsibility, a letter to the Faculty's training adviser in each of the fourteen health regions was written. Eleven replied and all reported that reliance was placed on the apprenticeship approach, namely learning by watching, by the trainee accompanying the responsible community physician on assessment visits. However, as the total number of such visits made is low, the trainee is unlikely to go on many during his attachment to a community physician who is a proper officer, for such attachments are usually only for six months or less, of which some will be spent in academic "modules" during which the trainee will be unable to visit any cases which might arise. Each trainee will therefore be involved in no more than a few cases, for example one respondent stated that trainees carry out "one or two Section 47 investigations whilst on their District Attachments".

For those trainees who have not had experience of general practice this approach is completely inadequate as the trainee is given little opportunity to appreciate the normal range of conditions in which these old people who are not referred for compulsory removal by Section 47 live. Some may

be fortunate enough to spend a week or more accompanying a home help or a district nurse but the complexities of Section 47 cases require, in my opinion, a more formal approach than the apprenticeship method of trainigg. This limited survey, which received replies from only eleven regional advisers, discovered only one Area Health Authority in which formal training was organised, although there may be others, and one other authority's three page list of training requirements made no mention of Section 47.

Finally, responsibility for Section 47 should be transferred from the councils responsible for environmental health to those responsible for social services and therefore to the community physician who is the specialist in community medicine for social services, if these titles remain in being, not because he would act any more carefully or skilfully but because these powers are inappropriately placed among environmental health powers.

To summarise, I believe three opinions should be obtained. The community physician should continue to have responsibility for the legislation but his opinion should be accompanied by the opinions of a social worker and of a consultant in geriatric medicine.

THE ORDER

At present there are two types of order. The order made under Section 47 of the 1948 National Assistance Act requires seven days' notice to be given but only one medical opinion, that of a community physician, and allows for three weeks' detention wit out requiring notice of compulsory removal to be given, but requires two medical recommendations, that of the community phsycian and that of another registered medical practitioner.

Fourteen of the community physicians were of the opinion that Section 47 should be repealed retaining only the powers of immediate removal, but the seven days' notice required by Section 47 is sometimes useful. It gives time for the elder to change her mind and enter hospital "voluntarily", although a decision made in such circumstances cannot be regarded as a free decision and could be considered as one reached by coercion (see page 71). It also allows time for other services to be marshalled, which may forestall the need for order to be enforced when the seven day period has elapsed.

I believe that there is also need for an order of detention, such as is included in the New Zealand legislation to detain the person who wishes to leave hospital when to return home would place her in severe danger. This applies particularly to those who have been admitted voluntarily but wish to go home before they or their home are properly prepared. This might appear to be a very despotic suggestion but at present a number of elderly people are detained to institutions by a variety of means without legal authority. It would be more honest to lay down legislation which would allow for this to be done legally.

It is also necessary to define how much force can be used to implement the order for compulsory removal. Section 169 of the Public Health Act 1936 states that the local authority officer or "any officer of the hospital or institution may do all acts necessary for giving effect to the order for removal to hospital of persons suffering from notifiable disease where serious risk of infection being spread". Section 47 does not specify the amount of force which may be used but the expert replying to a question addressed to the Justice of the Peace newspaper was of the opinion that the person could be "forcibly removed" and that "with rather less certainty....the premises can be forcibly broken into".(169) This

requires discussion and clarification if the legislation were to be amended.

THE RIGHT OF APPEAL

The right of the individual to be heard by the magistrate or court of summary jurisdiction should be calrified, as should his right of appeal. The community physician should ensure that the person understands the steps which are being taken and should give him the opportunity to speak to the magistrate. All community physicians do this but a code of practice should be established. This code of practice should stipulate the person's right of appeal, the manner in which an appeal can be lodged, and assume responsibility for informing him of his rights. The Justice of the Peace or the court should ensure not only that the person needs removal, in the opinion of the professionals but also that the person does not wish to speak directly to him, and that he understands the means by which he can appeal against the decision.

EVALUATION

The responsible community physician should report the number of times the Act is used to the local authority, his employing health authority, and the Department of Health and Social Security, which should publish the number of orders authorised throughout the whole country in the annual Health and Personal Social Service Statistics, as happened until 1956 (see page 41). The possibility that a more detailed review of the cases in which compulsory removal has been sanctioned would provide useful information, as the Confidential Review of Maternal Deaths, should be investigated by the Department.

Chapter 13

POLICY IMPLICATIONS

THE RIGHT TO DOMICILIARY CARE

Professor Gerald Dworkin suggested that the least restrictive principle should be used when assessing the acceptability of a certain policy or set of policies involving paternalistic intervention. This he expressed in the following terms: "If there is an alternative way of accomplishing the desired end without restricting liberty then although it may involve great expense, inconvenience etc. the society must adopt it".(170) The strict application of this principle would mean that there were no grounds for moving people to hospital compulsorily. In theory it is possible to provide any of the treatments which are provided in hospital in a person's own home. Special operating theatres have been set up in Buckingham Palace when members of the Royal Family have required operations and it would be possible to do the same in many other dwellings. This is an example of the least restrictive principle but it could not be universally applied because of the cost and because lack of space would seriously hamper such procedures, or make them impossible, in many homes. It is, however, only in the last forty years that operations at home, for example forceps delivery, tonsillectomy and appendectomy, have become extinct because it was recognised that it was more practicable and safer for operative procedures to be carried out in hospital. Patients have accepted this trend, with the exception of the decline and threatened extinction of domiciliary confinements. A small number of women wish to deliver at home but find it impossible to exercise this right until they can find a general practitioner willing to accept responsibility for their care. Very few old people are prepared to propose, much less defend, their right to domiciliary care in this way because their biography is very different from the biography

of the type of young woman who demands the right to deliver her baby at home (see page 139). Older people are prepared to accept the inadequacies of the services offered and the definition of other people that they "need" institutional care when they are not even receiving help from the community health and social services on every day of the week. In one large city with more than 43,000 inhabitants over the age of 65 it has been possible to avoid removing any old people using compulsory Section 47 powers in the years 1974-1978 by the provision of a hospital at home scheme, but the levels of care provided were much higher than are available in many other authorities.

1. Nursing

   Nurses can visit 3 or 4 times a day seven days a week if absolutely essential and the night nursing service can provide up to 3 visits per night. Nursing auxiliaries can visit 7 days a week acting as dressers and bath attendants.

2. Physiotherapy

   A small domiciliary service is available under the supervision of one of the consultant physicians in geriatrics. Home assessments made by hospital staff.

3. Occupational Therapy

   Available from hospital units for home assessment and from the social services department for aids and adaptations.

4. Chiropody

   Domiciliary service available.

5. Loan Equipment

   Free issue of nursing aids and personal aids is available and purchase of special items of equipment is possible.

Incontinence pads and pants are also issued free and condemned hospital sheets are given to patients via the loan equipment service.

6. Home Helps

Can be provided up to 4 hours a day seven days a week and visits made twice a day.

7. Night Sitters

Employed by social services department and available 7 nights a week to work with the night nurses to relieve families of the care of very ill patients.

8. Family Helps

Employed by social services department 7 days a week to supplement home helps and to act as housekeepers and care workers.

9. Meals on Wheels

Available 7 days a week."

It is probable that a very high proportion of admissions both voluntary and compulsory, to old people's homes, psychiatric and geriatric hospitals, could be avoided if this level of service were available but the provision of this level of service for those who were on the brink of admission to an institution would detract from the services available to other people. This is where the least restrictive principle requires amplification because the cost of providing an increased proportion of a finite service to one person, or one group, has to be measured not just in financial terms but with respect to the consequences which such a shift of services would have on other individuals. This is where the least restrictive principle is weak. The allocation of large amounts of service to one individual to preclude his admission to an institution would satisfy the first part of the principle but it is not just

"society" which would suffer inconvenience; it would be other slightly less disabled people whose problems would be significantly increased if the least restrictive principle were applied to the needs of one person. The distribution of resources among the total number of potential recipients has to take into account not only the least restrictive principle but the Law of the Commons.

Should the available domiciliary services be deployed to help the fifty old people who are most disabled in a certain geographical area or should they spread more thinly to help five hundred? Secondly, whatever number of people are chosen to receive services, should the services be spread evenly or should the managers of such services concentrate on those whose problems are greatest? This is a dilemma which is fundamental to resource allocation. For example, should the resources available for cardiological services be devoted to heart transplantations or coronary by-pass surgery? No single principle can be used to solve such problems of resource allocation and neither cost benefit nor cost effectiveness studies can make decisions which are ultimately ethical decisions.(2) The principle which is commonly used implicitly, if not explicitly, is the utilitarian principle - the greatest good for the greatest number.(3) Attractive though this doctrine may superficially beit has its drawbacks. The least restrictive principle advocates the concentration of resources on a small number of people; the utilitarian principle that they be spread more evenly, albeit more thinly. The former principle means that those whose problem is less severe, for example those who require coronary by-pass surgery or two days' home help, will suffer: the utilitarian principle means that those whose problem is more severe, for example those requiring cardiac transplantation or seven days home help a week will suffer. The Department of Health explicitly proscribed cardiac transplantation because the results, "the good", were not

considered to be a sufficient return on the resources invested in comparison with "the good" which could be obtained were the same amount of resources to have been invested in other services. In many parts of the country domiciliary services on all seven days of the week at the level provided by the hospital at home scheme cited are not allocated to those who could be kept at home iff they were supplied for similar reasons.

I believe, however, that an explicit standard should be set and that no old person should have to enter a home or hospital unless they required treatment which could only be given in hospital, such as an operation or E.C.T., or unless they had been offered and refused at least two visits from a nurse and home help daily. Some people require more help than this and would still require admission even though they did not require specialised treatment. Others would have to be admitted before they were receiving this amount of help either because it proved impossible to provide this amount of home help - some old people alienate all possible sources of help - or because they wanted to go into a home and refused alternative means of support. In spite of these factors the adoption of a standard of this sort would allow need to be defined with respect to criteria which could be objectively measured. If such a definition of need were introduced it would be found that there were many parts of the country in which people were admitted before they were receiving this amount of help and that the proportion would vary from one part of the country to another. The collection and comparison of such data would allow the services to be audited using criteria which related much more closely to policy objectives than the financial or manpower data used currently.

If local and health authorities were to shift resources so that they could achieve this objective, that is so that they could be sure that no person who lived alone was admitted to a home or hospital for care as opposed to specialised treatment, unless and until they had been offered a full medical examination and two hours of home help and two visits from a district nurse seven days a week, the consequences would be important. If no resources were switched from other client groups to pay for the expansion of services for elderly people such a policy would require those who were receiving smaller amounts of service to lose their service for the benefit of those who had to receive seven days home help and district nursing. The impact on old people's homes would also be significant because the average level of disability of people entering the homes would be greater. Nevertheless I believe that such an approach should be adopted and that those whose needs are less should have their problems dealt with by voluntary help supplemented by small amounts of skilled professional help for special tasks such as the dressing of varicose ulcers, and that old people's homes should be changing to accept and cope with this degree of disability.

Whether or not the adoption of this standard would lead to claims being made that people had the right to receive this level of care before they had to agree to go into home or hospital, except for some treatment which could not reasonably be expected to be given in a person's own home, is uncertain. If such a claim were made it would need to be tested in the Courts as the right to renal transplantation may be tested in the near future. This type of issue - the right to health care or to any other welfare services - is of itself a subject of immense scope, raising such questions as the role of the judiciary in determining human rights standards and the impact which a judicially enforced Bill

of Rights, which our membership of the E.E.C. may lead to, will have.[171,172]

IMPLICATIONS FOR PROFESSIONAL PRACTICE

Preparation for practice.

There is not one profession which is properly prepared for work with elderly people. Even within the constraints imposed by over-crowded curricula and financial restrictions professionals could be much better prepared than they are at present.

Firstly, professionals need to be better informed about the practical measures which are available to help old people who are cold, have housing or financial problems, or who are at risk to themselves or a risk to other people. Those in the health services require to be taught more about the social services, including housing and social security, and those in the social services should be taught more about physical and mental illness and the measures which can alleviate them. Furthermore, it is necessary for the members of each profession to have a more accurate appreciation of the skills, limitations and expectations of the members of other professions. Heating problems, for example, are often left to social workers by professionals in the health service who classify them as "social problems" rather than health problems, but the social workers do not all regard people whose primary problem concerns their heating as having the type of problem with which they should deal. I believe that all professionals should receive training about, and be prepared to initiate action on, problems such as poverty or bad housing. I do not expect a general practitionerto spend his time helping someone apply for a house renovation grant but if he is the person whose opinion is most respected by the elder he may be the most suitable person to suggest that she apply for a grant and overcome her

reluctance to accept what she believes to be charity. He should also be prepared to drop a note to the environmental health officer rather than refer the case to his health visitor for her to make the necessary connection with the appropriate service. However, he can only behave in this way if he is aware that such grants are available, knows that the environmental health department is the source of professional advice and accepts that it is as much his job to perform this simple task as it is to prescribe diuretics.

Secondly, professionals require much more training about the attitudes towards elderly people which prevail in the society in which they work and about the attitudes of old people themselves. An appreciation of the former will help the professional understand the manner in which old people who do not perceive that they have problems are referred by other people whose perception is that they do. It would also help him understand the origins of the pressure which may be subsequently brought to bear on both the old person and himself to admit her to an institution and to react constructively to the anger and hostility which may be directed at him if he does not act in the way which the referrers think he should.

Finally, the professional has to be helped to appreciate his own attitudes towards elderly people, a process more accurately designated education rather than training. Professional practice, particularly medical practice, was formerly envisaged as a technical process with the professional using his skills to solve problems, as a car mechanic deals with an engine that will not start. It is now appreciated, in medicine largely due to the influence of workers such as Michael Balint[7] as well as to the influence of other professions, notably nursing and social work,

that professional practice also involves a personal relationship. When dealing with the problems of mind or behaviour which occur in old age the personal qualities of the professional are as important as his technical skills and he must be as aware of his personal limitations and biases as he is aware of his technical limitations and biases.[173]

Style of practice

An important part of the preparation of professionals for working with elderly people should be to stimulate them to think not only about their skills but about their style. Not only are elderly people less mobile than younger people and less likely to have a telephone but they have lower expectations and are less demanding, and these factors necessitate a different style of practice from that suitable for young, mobile and demanding people. The survey of handicapped and impaired people in Great Britain[174] clearly revealed the higher prevalence of disabling disease in older age groups but the wants and demands of elderly disabled people are less well articulated than the wants and demands of younger people. This was given prominence in Williamson's careful study of the "unreported needs of elderly people"[175] although this had been emphasised in earlier studies such as that in Rutherglen[176] and the earlier classics of Rowntree[177] and Sheldon.[178]

The enthusiasm for multiphasic geriatric screening as a means of overcoming this problem was, however, tempered by the general doubts about the effectiveness of screening which developed in the late sixties and by specific attacks on the concept, notably that of Archie Cochrane.[180] Nevertheless the work by Ferguson Anderson and his colleagues[176, 181] has shown clearly that even if full multiphasic screening is inappropriate services for elderly people should be based on a much greater degree of

professionally initiated contact than is customary when dealing with younger age groups. Professionals must develop means by which they will quickly be informed if an elderly person for whom they are responsible develops a problem, be it no more formal than developing a relationship between primary care and the home help service which means that a home help feels she can phone an old person's general practitioner directly. Secondly, there must also be a much greater commitment to follow-up. This is particularly important when a drug has been prescribed, because side effects are more common and more serious and because compliance is lower among older age groups, but it applies to any service given to someone who is immobile, undemanding or has difficulty with communication. Haringay health and social services authorities have a "Committee for the Elderly at Risk" which meets monthly which ensures that cases which have been identified as being at risk are not forgotten once the initial crisis is over and this type of approach has much to commend it. Finally, the professional has to encourage the use of his service more vigorously where old people are concerned to counteract their low expectations and overcome their belief that all their problems are due to the immutable inexorable ageing process, a point specifically made in a report on elderly people with failing vision. (182)

Care has to be taken that the individual's right to privacy is not infringed but in the past professionals have probably been too cautious as well as being too pessimistic.

IMPLICATIONS FOR HEALTH AND SOCIAL SERVICES

Shared objectives

In broad and general terms health and social services share the same objectives in the services they provide for elderly people. These may be expressed as 'helping old people to live in the community for as long as possible', or 'helping old people to live with dignity as independently as possible', or in similar general terms. However, when we get down to examining operational objectives, there are some important differences which have to be taken into account when considering they way the services relate to one another. I propose to use the term 'care' for the service offered by social services to elderly people and the term 'treatment' for the service offered by the health service, although this does not mean that treatment is without care, or that some of the treatment principles are not used during the process of care.

The treatment contract has been studied in detail by sociologists. The person who consents to treatment, and I realise of course that the whole topic of consent is one which is fraught with difficulties when considering elderly people, gives up certain rights. If he goes into hospital he loses his rights, along with his clothes and other personal possessions, and his social security, but accepts this because he believes that the objective of the professionals treating him is to cure his disease - to make him "better" - and he concurs with that objective. Because the contract is one which is based on the treatment principle, professionals are able to say to an elderly person "I know that your knees hurt, but you have really got to keep walking if you want to get better", or "I know the diet is not very pleasant, but if we are to bring your diabetes under control you have to lose weight". There is a degree of control over the lives of individual elderly people who become

patients which is not acceptable in social services care. Although those who work in social services are keen to encourage independence among their clients there is a belief which prevails among many members of the public that "care" means doing things for people and the consequences of this interpretation of the word "care" can lead to opposition to attempts made to promote independence. I believe that this is a manifestation of society's guilt about the plight of old people. Many people feel guilty about the plight of elderly people they see but rather than take steps themselves to try to improve their situation, they prefer to put pressure on the social services to do something, to remove the person to an old people's home, or to look after the people 'very well' in their homes. By 'very well' they may mean ensuring that the old person has as much done for her as possible, even though it is argued that it is good for people to perform as many activities and make as many decisions as possible as an effective means of preventing physical and mental detioration. I have evidence from several parts of the country of instances in which a great deal of pressure has been brought on the staff of old people's homes who have attempted to increase the amount of independence of their residents by encouraging them to perform some tasks for themselves which were previously performed by staff.

It must also be said that there is resistance among residents to becoming independent, as some of them see "care" as a process by which things are done for them as opposed to a process by which they are taught how to do things for themselves. This difference between health and social services is increased by the fact that old people may pay what seems to them a considerable sum of money to stay in an old people's home, whereas they do not make the same direct payment from capital or income,

other than from their social security, if they go into hospital. The influence of payment on behaviour is exaggerated by the discovery of those who pay that some people in the same home who are receiving the same services do not pay in the way in which they do: a matter which is discovered even though the staff do not reveal who pays and who does not.

The difference between care and treatment can be easily demonstrated. What is the response of a worker in an old people's home if a person says "my knees are painful - push me down to the dining room in a wheelchair", or if the son of someone says "why don't you push my mother in a wheelchair like all the other people"? If such statements were made in a treatment setting it would be explained to the elder and her relatives that the objectives of the short-term discomfort were long-term improvement in health and well being. However it is very difficult for people working in care to refuse if the person complains of pain or some other symptom which may result from serious underlying disease. Similarly, what is the response of a home help if an old person who is on a diet asks her to go out and buy cream buns, or if someone who has been known to have been drinking heavily asks her to go and buy a bottle of sherry every day? If the old person were to ask her general practitioner to do this, he would refuse, in most cases, saying that he was there to treat her for her diabetes and that she must take appropriate dietary steps herself to get better. In general, therefore, it can be said that the health services have more control over individuals than social services, that they can be more directive, and can expect the person to do more for herself. This has benefits, in the physical and mental sense, as it undoubtedly prevents deterioration but it has disturbing social implications, and the lesser degree of control which those working in social

services have over elderly people has many advantages for the elder from a social or ethical perspective.

Health and social services have to look much more closely at their objectives but reaching agreement on objectives will not solve the interface problems. There is an urgent need to review the criteria employed, the process by which decisions about individual cases are reached and the facilities which are available.

Shared criteria

It is important to lay down a set of criteria against which an elderly person can be judged but the limitations of such criteria must be recognised. The deficiencies of criteria which relate only to the elderly person are that they do not reflect changes in the social environment for which the old person is being assessed, for these also have to be taken into account. For example, the ability of a warden to consider accepting a disabled old person depends not only on that old person's level of disability but also on the total amount of disability already in the scheme for which she is responsible. Similarly, the decision of an old people's home officer as to whether or not an old person is fit for her home depends not only on the disability of all the other residents currently in the home but also on the strength of the staff. If the complement of staff is weakened by sickness or any other factor then they will be less able to cope than if all the staff are present, fit andworking closely and harmoniously with one another. It is this type of factor which makes it essential to have procedures by which individuals can be assessed partly with the relation to the criteria which has been agreed on but also with respect to the needs of the community into which the old person is to move. This requires shared procedures for reaching decisions.

Shared procedures

Because the decision of the staff working in one institution that the old person is an appropriate admission to their institution is effected by factors relating to their own current work load and social situation there is a need for institutions to be more aware of one another's strengths and weaknesses, not just in broad general terms but in specific terms. What is required is some type of procedure by which decisions are jointly reached by a group of people who haveworked together long enough to get to know and trust one another and to appreciate fully the limitations and problems of each other's services.

There is a further aspect to this problem. There appears to me to be considerable misunderstanding on the part of workers in the Health Service about the way which decisions are reached without Social Services and similarly social workers are not fully aware of the way decisions are reached in the Health Service. This relates both to individual cases and, perhaps to a greater extent, to the way in which policies are formed. For example, it must appear very perplexing to someone who has worked in the world of local government all his career how the health authority with a whole lot of independent consultants and general practitioners can arrive at a unified workable policy. Similarly, to people who have worked in the Health Service the relationship of the Director of Social Services and senior management staff to operational staff is not clearly understood.

It is probably only by breaking down services into small co-terminous geographical areas, to minimise the number of people who have to get to know one another well, that it is possible to achieve the level of initial understanding and trust necessary for decisions to be reached without the unnecessary quarrelling and misunderstanding which take up so much time.

and energy. There is also a need for a "court of appeal", a small group of people of high enough status to consider and decide on cases on which no agreement can be reached by the procedure which works well for the majority of cases.

Shared facilities

Perhaps the best way to deal with an interface problem is to develop some type of shared facility, although it must be remembered that any new type of facility which was shared by a health authority and a local authority social services department would create one more interface because such a shared facility would have an interface with old people's homes on the one side and with hospitals on the other, instead of the direct interface which exists at present.

However, it seems that thereis a need for a new type of institution, one which can cater for those who are too fit for hospital but not fit enough for a home. There are major problems in trying to develop such a facility which are much greater than merely financial or administrative difficulties, but stem from the difference between care and treatment.

Health and social problems are not naturally different. All health problems in old age have social implications, and all social problems have to be considered as being caused wholly or partly by disease until that possibility has been excluded by careful medical examination. The problems of old people are both medical and social and may require a joint approach by the two services but the difference in style of the services which has developed to give two different forms of contract - the treatment contract and the care contract - present real difficulties when considering working closely together on this problem.

Encouraging steps have been taken in recent years but the professional and bureaucratic inertia is considerable and change is slow. However, the rate of change may increase stimulated not by more enlightened professionals and bureaucrats but by the constraints imposed and the problems created by the social policies of a monetarist decade which will force us to make more effective and more efficient use of our resources. Although elderly people and those who try to help them may face difficulties in the short term the eventual consequences may be better integrated, more appropriate and less disabling services than those which we have today.

PROSPECTS FOR CHANGE

There has recently been an upsurge of interest in Section 47 (183, 184, 185, 186, and 189). I hope that the legislation will be amended and that the debate concerning Section 47 will also highlight and change the attitudes and values which the powers of compulsory removal both reflect and express.

APPENDIX I : The use of the powers in Oxford.

1952 Annual Report

"It was found necessary to use the powers given to the Council under Section 47 of the National Assistance Act, 1948, on one occasion during the year.

The person concerned was a lady of over 90 years of age, living in a ground floor flat without any means of artificial lighting other than candles. She had completely refused offers of Part III accommodation throughout the year, but was assisted by the Home Help Service until her condition deteriorated to such an extent that she constituted a danger to herself and other persons living in the block of flats.

Action was accordingly taken and it was certified that she was then in need of nursing treatment, and removal to Cowley Road Hospital was effected.

Once the removal had taken place, it was not found necessary to extend the order as the lady amenable to her new surroundings and did in fact voluntarily relinquish the tenancy of her flat.

1953 Annual Report

"It was found necessary to use the powers given to the Council under Section 47 of the National Assistance Act 1948, on one occasion during the year. The person concerned was a man suffering from a grave and chronic disease, and was living in insanitary conditions. During the time he was under observation, he had persistently refused to enter some suitable accommommodation, and a short order was obtained in accordance with the requirements of the National Assistance Amendment Act, 1951, requiring the man's removal to hospital.

When the ambulance called at the home, the man had become amenable to his removal, and did in fact offer no objections. At the end of the three week period, he elected to stay in hospital, and there was no necessity to obtain a further order".

1954 Annual Report

It was again found necessary on one occasion to use the powers given to the Council under Section 47 of the National Assistance Act, 1948. The person was a woman (over 90 years of age) who was suffering from a chronic illness and was not receiving adequate care and attention. During the preceding period she had persistently refused help from the local health and welfare authority, and when her condition began to deteriorate it was considered necessary to enforce the removal to hospital. Again, it transpired that her objections had diminished by the time of the arrival of the ambulance and she then entered hospital voluntarily. The disease was however, unresponsive to treatment and she died within the statutory period of the original order.

1956 Annual Report

"It was found necessary to use the powers given to the Council under Section 47 of the National Assistance Act, 1948, on one occasion during the year. This was in the case of a Deaf/Blind person living alone in dangerous and insanitary conditions and without adequate care and attention . Numerous attempts were made to persuade this case to leave the house and reside in the safety of some suitable home, all of which were without avail. After a period of 7 weeks in Residential Accommodation the person improved in her physical capabilities and agreement was reached with relatives for adequate care to be provided in her home, to which she returned."

1959

"In 1959 it was necessary to exercise the Authority's powers under Section 47 of the National Assistance Act, 1948, in one instance.

The case concerned an aged woman who was living alone in the City. She was infirm, physically incapacitated, and in need of continuous help which was

not available to her. The general practitioner requested assistance in providing for her care, and as she was unwilling to accept help voluntarily, she was removed under order to the Cowley Road Hospital, where she later died.

1962 Annual Report

"It was necessary for action to be taken under Section 47 of the National Assistance Act 1948, in one case.

This old lady had lived in apalling conditions for many years and repeated offers of occommodation in an Old People's Home had always been refused. Finally her general condition deteriorated to such a degree that she was quite incapable of caring adequately for herself and was admitted to Cowley Road Hospital".

1968

"During the year, an elderly lady was compulsorily removed under Section 47 of the National Assistance Act and admitted to a Part III home.

This lady lived in condemned property which was due for demolition. There was no water, light or heat at the house, which was in an insanitory condition. Attempts had been made for over six months to get this lady to remove to better accommodation, but without success.

After a period of severe cold weather, she was found one morning, shivering in a chair unable to move, and had not eaten for several days. It was felt that if she had remained in this condition she would have died from Hypothermia. She was therefore removed to an old people's home, where she has settled well and has made a good recovery".

Removal to suitable premises of persons in need of care and attention.

47. - (1) The following provisions of this section shall have effect for the purposes of securing the necessary care and attention for persons who -

(a) are suffering from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitory conditions, and

(b) are unable to devote to themselves, and are not receiving from other persons, proper care and attention.

(2) If the medical officer of health certifies in writing to the appropriate authority that he is satisfied after thorough inquiry and consideration that in the interests of any such person as aforesaid residing in the area of the authority, or for preventing injury to the health of, or serious nuisance to, other persons, it is necessary to remove any such person as aforesaid from the premises in which he is residing, the appropriate authority may apply to a court of summary jurisdiction having jurisdiction in the place where the premises are situated for an order under the next following subsection.

(3) On any such application the court may, if satisfied on oral evidence of the allegations in the certificate, and that it is expedient so to do, order the removal of the person to whom the application relates, by such officer of the appropriate authority as may be specified in the order, to a suitable hospital or other place in, or within convenient distance of the area of the appropriate authority, and his detention and maintenance therein:

Provided that the court shall not order the removal of a person to any premises, unless either the person managing the premises has been heard in the proceedings or seven clear days' notice has been given to him of the intended application and of the time and place at which it is proposed to be made.

Part IV Cont.

(4) An order under the last foregoing subsection may be made so as to authorise a person's detention for any period not exceeding three months, and the court may from time to time by order extend that period for such further period, not exceeding three months, as the court may determine

(5) An order under subsection (3) of this section may be varied by an order of the court so as to substitute for the place referred to in that subsection such other suitable place in, or within convenient distance of, the area of the appropriate authority as the court may determine, so however that the proviso to the said subsection (3) shall with the necessary modification apply to any proceedings under this subsection.

(6) At any time after the expiration of six clear weeks from the making of an order under subsection (3) or (4) of this section an application may be made to the court by or on behalf of the person in respect of whom the order was made, and on any such application the court may, if in the circumstances it appears expedient so to do, revoke the order.

(7) No application under this section shall be entertained by the court unless seven clear days before the making of the application, notice has been given of the intended application and of the time and place at which it is proposed to be made -

(a) where the application is for an order under subsection (3) or (4) of this section, to the person in respect of whom the application is made or to some person in charge of him;

(b) Where the application is for the revocation of such an order, to the medical officer of health.

(8) Where in pursuance of an order under this section a person is maintained neither in hospital accommodation provided by the Minister of Health under the National Health Service Act, 1946, or by the Secretary of State under the

Part IV Cont.

(8) contd.

National Health Service (Scotland) Act 1947, nor in premises where accommodation is provided by, or by arrangement with, a local authority under Part III of this Act, the cost of his maintenance shall be borne by the appropriate authority.

(9) Any expenditure incurred under the last foregoing subsection shall be recoverable from the person maintained or from any person who for the purposes of this Act is liable to maintain that person; and any expenditure incurred by virtue of this section in connection with the maintenance of a person in premises where accommodation is provided under Part III of this Act shall be recoverable in like manner as expenditure incurred in providing accommodation under the said Part III.

(10) The provisions of section twenty-seven of the National Health Service Act, 1946, and of section sixteen of the National Health Service (Scotland) Act 1946, (which respectively require local health authorities and the Secretary of State to secure that ambulances and other means of transport are available for the conveyance of certain persons) shall apply to the conveyance of persons in respect of whom an order is made under this section as they apply to the conveyance of the persons specified in the said sections twenty-seven and sixteen.

(11) Any person who wilfully disobeys or obstructs the execution of, an order under this section shall be guilty of an offence and liable on summary conviction to a fine not exceeding ten pounds.

(12) For the purposes of this section, the appropriate authorities shall be the councils of county boroughs and county districts and the authorities which are sanitary authorities for the purposes of the Public Health (London) Act 1936, and in Scotland the councils of counties and large burghs.

26 Geo. 5 & I Edw.8.c.50.

Part IV Cont.

(13) The foregoing provisions of this section shall have effect in substitution for any provisions for the like purposes contained in, or having effect under, any public general or local Act passed before the passing of this Act:

Provided that nothing in this subsection shall be construed as affecting any enactment providing for the removal to, or detention in, hospital of persons suffering from notifiable or infectious diseases.

(14) Any notice under this section may be served by post.

CHAPTER 57

An Act to amend section forty-seven of the National Assistance Act, 1948 (1st August 1951)

Be it enacted by the King's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled and by the authority of the same, as follows:-

1. - (1) An order under subsection (3) of section forty seven of the National Assistance Act 1948, for the removal of any such person as is mentioned in subsection (1) of that section may be made without the notice required by subsection (7) of that section if it is certified by the medical officer of health and another registered medical practitioner that in their opinion it is necessary in the interests of that person to remove him without delay.

(2) If in any such case it is shown by the applicant that the manager of any such hospital or place as is mentioned in the said subsection (3) agrees to accommodate therein the person in respect of whom the application is made, the proviso to that subsection (which requires that the manager of the premises to which a person is to be removed must be heard in the proceedings or receive notice of the application) shall not apply in relation to an order for the removal of that person to that hospital or place.

(3) Any such order as is authorised by this section may be made on the application either of the appropriate authority within the meaning of the said section forth-seven or, if the medical officer of health is authorised by that authority to make such applications, by that officer, and may be made either by a court of summary jurisdiction having jurisdiction in the place where the premises are situated in which the person in respect of whom the application is made resides, or by a single justice having such jurisdiction, and the order may, if the court of justice thinks it necessary, be made ex parte.

(4) In relation to sny such order as is authorised by this section the provisions of the said section forty-seven shall have effect subject to the following modifications:-

(a) in subsection (4) (which specifies the period for which a person may be detained pursuant to an order) for the words "three months" in the first place where those words occur, there shall be substituted the words "three weeks" and subsection (6) (which enables an application to be made for the revocation of an order) shall not apply;

(b) where the order is made by a single justice, any reference in subsections (4) and (5) to the court shall be construed as a reference to a court of summary jurisdiction having jurisdiction in the same place as that justice.

(5) In the application of this section to Scotland for any reference to a court of summary jurisdiction or a single justice there shall be substituted a reference to the sheriff, and paragraph (b) of subsection (4) shall not apply.

2. - (1) This Acy may be cited as the National Assistance Amendment Act 1951, and this Act and the National Assistance Act 1948, may be cited together as the National Assistance Acts, 1948 and 1951.

(2) This Act shall come into operation one month after the passing of this Act.

(3) This Act shall not extend to Northern Ireland.

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