Editorial

'Your lack of planning does not constitute my emergency' – caring for obstetric patients with mental illness

The sentiments of the judge, Baker J, in the recent court ruling *Re CA* (natural delivery or caesarean section) [1] are paraphrased perfectly by a sign that hung above the desk of Sandy, the most ferocious anaesthetic secretary I ever knew:

> *Your lack of planning does not constitute my emergency.*

Less than two weeks before her expected date of delivery, the Trust caring for CA applied to the Court of Protection for a permissive order authorising a planned caesarean section and use of proportional restraint, if needed, to facilitate this surgery. It was the timing of their application which so enraged the judge as it left the Court precious little time for due consideration.

Like our secretary, Baker J did not mince his words as he criticised the Trust for their 'failure' to plan ahead resulting in an 'extremely unsatisfactory situation'. He stated forcefully that the Court will no longer tolerate lack of foresight when managing cases such as this.

The facts are as follows: CA was a 25-year-old patient with a diagnosis of autism and learning difficulties. Born in Nigeria, CA moved to the UK at 15 years old. She became pregnant while living in a supported housing placement, a fact which came to the attention of her parents at around 30 weeks' gestation. CA's engagement with medical services was extremely reluctant and she refused all routine antenatal care, allowing only ultrasound scanning to be performed. CA had very limited understanding of what would be involved in labour and expressed her desire to deliver on her own at home. Despite the best efforts of the midwifery and obstetric teams to provide information, CA retained a fixed belief that labour would be painless and that babies, 'just come out when they're ready and that's it'.

Of note, her mother reported that, as a child, CA had been subjected to two episodes of cutting. The first, performed with the intention of 'releasing bad blood' during an episode of illness, was evidenced by abdominal scars radiating from her umbilicus. The second was of female genital mutilation, the grade of which was unknown because CA would not allow examination. As she neared term, CA became increasingly unco-operative. Medical staff were concerned about her condition and her refusal of admission finally prompted their application to the Court.

The issues with which the judge wrestled were: (1) whether CA had the capacity to make decisions concerning her medical treatment and, in particular, the management of her pregnancy; (2) if not, whether it was in her best interests to undergo a planned caesarean section.

When considering these questions, Baker J followed the guidance handed down by Keehan J in *NHS Trust and Others v FG* [2]. Keehan J's guidance dealt specifically with the medical care of pregnant women with diagnosed psychiatric illness. It resulted from a series of cases demonstrating the profession's general failure to plan ahead, their ignorance of legal procedure and of the correct timing of Court applications. In *Re CA*, Baker J states unequivocally, '*Hereafter, all NHS Trusts must ensure that their clinicians, administrators and lawyers are fully aware of, and comply with, the important guidance given by Keehan J in respect of applications of this sort*' [1].

This editorial will attempt to clarify Keehan J's guidance and to give it context. The whole judgement can be found at http://www.bailii.org/ew/cases/EWCOP/2016/51.html.

The Mental Health Act and the Mental Capacity Act

To distinguish, the Mental Health Act 1983 (MHA) [3] is the

legislative framework concerned with detention and treatment of patients with diagnosed psychiatric illness. The Mental Capacity Act 2005 (MCA) [4] is an entirely separate piece of legislation concerned with the management of patients who lack capacity to consent to treatment.

All patients over the age of 16 are assumed to have capacity unless proven otherwise. This is no different for those with a psychiatric diagnosis as mental illness does not, de facto, render a person incapable. When making a decision, a patient with capacity can:

- understand and retain the relevant information for long enough to
- weigh it in the balance
- use it to make the decision and
- communicate that decision.

Capacity is not an 'all-or-nothing' state, and so a patient's ability to make a choice may depend on the complexity of the factors involved. Capacity may fluctuate, and where possible, clinicians should defer decision-making if capacity is likely to return. Everything practicable must be done by the medical team to help the patient achieve capacity. A capable patient has the right to absolute autonomy over their body and may refuse investigation or treatment even if this might seem illogical or result in dire consequences, including death.

The majority of patients requiring psychiatric treatment receive it on a voluntary basis. However, if a patient refuses and their condition is considered serious enough to warrant compulsory treatment, the MHA permits their detention under Section 2 (28 days) or Section 3 (longer term) for treatment of their mental illness only. The MHA does not authorise nonconsensual treatment of physical ailments unconnected to the psychiatric problem. For example, involuntary nasogastric feeding might be permitted in a patient with anorexia nervosa as malnutrition may prevent meaningful engagement with therapy. If a psychiatric patient lacks capacity to consent to physical treatment unconnected to their mental health, then we must look to the MCA for guidance.

Section 5 of the MCA dictates that when we are providing treatment outside the scope of the MHA 1983 to a patient lacking the capacity to consent to it, we must act in their best interests. Best interests amount to more than just medical interests; we must take into account, 'medical, emotional and all other welfare issues' [5] and we must choose the least restrictive treatment option.

Returning to the case of CA, the judge ruled that she did not have capacity to make decisions about her mode of delivery. Despite the best efforts of her team to promote capacity, she understood neither the labour process nor the potential complications that could arise. In the complex best interests' analysis that followed, Baker J concluded that delivery by planned caesarean was in CA's best interests. Despite her previous 'traumatic experience of men cutting her abdomen' and the uncertainty of how this might impact her psychological recovery, he felt caesarean delivery would afford the team more control and result in a safer delivery for both CA and her child. Of note, while the fetus has no rights or legal personality until birth [6], it is factored in the analysis in-so-far as it is generally accepted that giving birth to a healthy child is in the mother's best interests. Having decided thus, Baker J judged that general anaesthesia would be the best anaesthetic option for all and recognised that CA might need to be restrained to facilitate its administration.

This leads us to consider the laws governing restraint. The MCA permits restraint, including physical and chemical sedation, provided that it is necessary and proportionate to the harm that we are trying to prevent [7]. However, if prolonged or complete restraint becomes necessary, clinicians may cross the line into depriving the patient of their liberty. This requires separate legal authorisation.

What constitutes a deprivation of liberty?

Article 5 of the European Convention of Human Rights (ECHR) states,

> *Everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law*
>
> *—[8].*

In general, it is necessary to apply an 'acid test', namely to ask whether: the patient is subject to constant supervision and control; and not free to leave [9].

If the 'acid test' is met, then the patient must be able to give their capacitous consent to the arrangements, otherwise it will amount to a deprivation of their liberty. If it does, then the Deprivation of Liberty Safeguards must be used as the 'procedure prescribed in law' which is triggered when it proves necessary to deprive a patient of their liberty to protect them from harm.

The law in this area has been recently clarified by the Court of Appeal [10], which confirmed that, in general, patients who are being given life-saving medical treatment in the intensive or urgent setting are not be considered to be deprived of their liberty even if, superficially, the acid test appears to be met and the patient cannot give their consent to the arrangements. Importantly, this is only the case if the arrangements being made for the patient do not differ from those being made for any other patient in that setting.

As the Court of Appeal identified, there will, however, still be some circumstances in which deprivation of liberty is relevant in the hospital context, in particular where specific arrangements are made to cater for the fact that the patient needs to be under a particularly restrictive regime or contingency plans need to be made to ensure that they do not leave hospital. This may well be the case where a patient who is subject to the MHA 1983 requires treatment in a general hospital and specific concerns are identified about the risk to that patient if they leave the hospital. FG, mentioned above, is an example of such a case [2], the woman in question having been transferred from the psychiatric hospital where she was detained to give birth in a general hospital.

How is deprivation of liberty authorised?

Where the situation of a patient amounts to a deprivation of liberty which requires authorisation, then the Trust must fill in a Standard Authorisation form and submit it to their supervisory body, usually the local authority. This can be done up to 28 days in advance. Within 21 days, the supervisory body will assess the request to ensure that it meets the various legal safeguards, for example, the patient does lack capacity, proposed management is in their best interests and is minimally restrictive. Successful applications result in a deprivation of liberty authorisation that is valid for a maximum of 1 year, although it must be cancelled when no longer needed. Authorisation cannot be extended; instead, a new application must be made.

In sudden, unforeseeable situations, Trusts may authorise themselves to deprive a patient of their liberty for up to 7 days (extendable once by another 7 days) by completing an Urgent Authorisation form. However, as Keehan J warned in FG, 'if the need for the deprivation of liberty in relation to the proposed care was foreseeable but the Trusts omit to seek a standard authorisation, the use of an urgent authorisation may be unlawful' [2].

The courts and birth planning

It is important to emphasise that there is no need to make any application to the Court of Protection in relation to the delivery of the vast majority of women with psychiatric illness because '*the MCA provides a sufficiently flexible framework within which trusts can lawfully manage patients who lack capacity in relation to their obstetric care*' [2] and standard authorisations of deprivation of liberty can be issued by the supervisory body in the usual way.

However, Keehan J lists four situations where Trusts must apply to the Court of Protection to obtain the necessary orders relating to the psychiatric patient's obstetric care.

Category 1: the interventions proposed amount to serious medical treatment [11].

In the context of obstetric care, vaginal delivery and uncomplicated caesarean section do not amount to serious medical treatment unless the proposed caesarean is: high risk; may result in worsening of the psychiatric condition; refused by the patient who wants vaginal delivery; or is finely balanced in its merit.

Category 2: there is a real risk that the patient will be subject to more than transient forcible restraint during labour.

Keehan J counselled caution stating, 'It is not intended that applications to the court should become routine'. There needs to be genuine concern that the patient will require restraint of this nature. A patient who has been hitherto compliant is likely to fall outside of this category and require no Court referral.

Category 3: there is serious dispute as to what obstetric care is in the patient's best interests, either

between clinicians themselves and/or those whose views must be taken into account (e.g. carers, donee of lasting power of attorney or court appointed deputies) [12].

Category 4: When there is a real risk that the patient will suffer a deprivation of her liberty which, without a Court order, would be unlawful under the provision of the MCA [13].

For example, managing a patient under 18-years-of-age (deprivation of liberty safeguards only apply to those over 18), or when a donee of lasting power of attorney refuses to consent to the management plan.

This list is not exhaustive and Trusts should seek judicial advice where uncertainty exists.

Keehan J concluded his judgment with comprehensive guidance for the process of applying to the Court for a permissive order. The perinatal care of women with psychiatric illness may prove challenging. Therefore, they should be identified early by the lead healthcare professional, likely to be the consultant psychiatrist when the patient is detained under the MHA ('sectioned') or the midwifery team if they are living in the community. The patient should be discussed regularly at minuted, multidisciplinary meetings, and detailed plans made for her care. Trusts should involve their legal teams early and planning must include provision for the assessment of capacity, consideration of whether deprivation of liberty safeguards might be invoked, and whether the Court itself will need to authorise obstetric care. Any application to the Court should be submitted as early as possible and no later than four weeks before the expected date of delivery. Applications should include a detailed obstetric care plan, including any anaesthetic intervention, and a restraint plan detailing, in a step-wise fashion, the measures to be taken and by whom.

Late applications will be viewed very dimly by the Court because they increase the likelihood of their being heard by an out-of-hours judge and seriously limit the time available to gather evidence, consult with experts and deliberate. This is reinforced by Baker J in his ruling in *Re CA* when he berates those responsible for the timing of the application and demands an investigation into their failure.

Thus, the Court has unequivocally ruled that tardiness of this nature will not be tolerated in future and ignorance of the law will provide no defence. It may be the consultant obstetrician who leads the Court application, but the unenviable task of restraining the patient and depriving her of her liberty will undoubtedly fall to the anaesthetic team. For this reason, if no other, it is incumbent upon us to understand these two rulings lest we find ourselves practicing, unwittingly, on the wrong side of the law. We must heed the Judge's warnings to plan early and comprehensively. We need to identify in advance whether the particular arrangements to be made for a patient may deprive them of their liberty. We may, in turn, only then deprive them of that liberty when the formal legal safeguards are in place. If we fail to follow the Court of Protection's instruction then we will face grave legal consequences.

By way of postscript, on 17th November, CA gave birth to a baby boy by planned caesarean section. The baby was, in fact, discovered to be in the breech position. She required only minimal restraint to hold her hand while intravenous anaesthesia was given.

Acknowledgements

No external funding or competing interests declared.

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Keywords: birth planning; ethics principles: autonomy; liberty; pregnancy

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doi:10.1111/anae.14098

