

# Section 47 – assault on or protection of the freedom of the individual? A short response to Greaves

J A Muir Gray Oxford

## Author's abstract

*Section 47 of the 1948 National Assistance Act allows incompetent people, usually old people, to be removed from their homes. It can be considered as a repressive tool, designed to infringe personal liberty, but in this article it is argued that it can also be considered as being legislation which governs and controls professional practice and protects the old person from public prejudice.*

A law can be both a tool and a symbol. The paper by Greaves (1) describes Section 47 as a tool for removing individual older people from their homes, and as a symbol of the paternalistic approach to old people which reflects the confusion and guilt that elderly people in difficulty arouse in our society. It is certainly appropriate to describe Section 47 in this way for it serves the functions described but there is another way to consider Section 47. It can also be considered as a tool to protect older people and as a symbol of society's desire to protect the individual from the ministrations of well-intentioned professionals and bureaucracies and this aspect of Section 47 can best be understood when it is considered in its historical context.

## The historical context

The need for powers of compulsory removal were first advocated by the Webbs in their *Minority Report on the Poor Laws*, published in 1909. They pointed out that many older people were forced from their homes by the simple act of withholding Outdoor Relief. They were concerned that people were driven to the workhouse on the whim of an official and said that powers should be introduced to control this process.

It was not until 1925 however that the first such powers were introduced by Bradford through a local Act of Parliament. The Bradford legislation, which is used virtually unchanged today was adopted by a number of local authorities in the thirties which saw the need not only to remove older individuals in need of care and attention, but also to protect them, for example from removal by officials keen to get on with activities such as slum clearance. In the debate leading

up to the 1948 National Assistance Act the need both to remove and protect the individual was recognised and the Medical Officer of Health was seen as the person who could best do this.

Thus, Section 47 has evolved as a means not only of removing individuals but of protecting them from professional or bureaucratic manipulation.

## Informal does not equal voluntary

Most debates on Section 47, and on the powers of compulsory admission of the Mental Health Act, focus on the use of formal legal powers to effect the admission of people who are not willing to go to hospital voluntarily. Such formal admissions are involuntary but the converse is not true. Not all those people admitted to hospital without the use of legal powers go voluntarily.

Many different approaches can be used to 'persuade' people to go into hospital, often unconsciously, as when people are told they have to go to hospital when they are only getting home-care for three or four days a week, or on other occasions consciously, when professionals simply send for the ambulance, hoping that the appearance of officials in uniform will make the old person give up and accept admission.

Some people have argued that Section 47 should be abolished, and that there is no place for it in modern society, but it can also be argued that those populations in which Section 47 is never used should be closely examined for it cannot be assumed that all the people who have gone into hospital in those populations have done so voluntarily. A case can be made for introducing tighter controls on hospital admission, particularly to long-stay institutions. For example, it would not be unreasonable to have a code of practice to say that an old person should not have to be admitted to institutional care unless it had been demonstrated that home care on all seven days of the week was ineffective in maintaining an adequate quality of life.

Section 47 undoubtedly needs amendment and it may be that it has to be repealed but it would in my view be wrong to leave all professional practice informal and unregulated and a case can be made for reducing the draconian powers of Section 47, which are

## Key words

Right to refuse treatment; old age.

Please turn to page 204

child's best interests were taken to be equal or subordinate to considerations from a wider context. In the case of the four-year-old boy (case 1), the interests of the family, and in particular a younger sibling, were of considerable importance in coming to a decision to give palliative care only. In the case of the teenage girl whose family had ceased to care for her (case 3), the interests of the young woman were considered in conjunction with those of society as a whole; and in the research case, the interests of society were given the greatest emphasis.

As Schoeman (11) points out, it can be argued, as it was in this session, that parents may be 'permitted to compromise the child's interests for ends related to ... familial goals and purposes'. In addition, Schoeman argues, in the context of medical decision-making with respect to children, we should 'broaden our understanding of the context of the decision, and acknowledge that interests are at stake in addition to those of promoting the child's best interest'.

In arriving at the decisions described above, a variety of viewpoints was heard from staff and students. This diversity of opinion arose as much from differing individual perspectives as from different academic orientations. For example, some clinicians (and students) saw it as their primary clinical duty to advise and act in their patient's best interest. 'Who will be advocate for the child, and only the child, if we are not,' they asked. Other clinicians (and students), although acknowledging this as a very important duty, saw it as equally important to take into consideration familial and societal goals. As in previous sessions, the superior knowledge of the students in some theoretical areas was counterbalanced by the experience and knowledge of the paediatricians about the constraints and problems encountered in clinical settings.

The planning and organisation of new teaching

sessions in medical ethics has proved unexpectedly stimulating for the staff members involved. In clarifying issues for students, inconsistencies or problems emerge which were unthought of before being exposed to the rigorous atmosphere of the lecture theatre.

*Valerie J Grant, MA, PhD, is Senior Tutor in Behavioural Science and Chairman of the Interdisciplinary Teaching Committee in Medical Ethics, Auckland School of Medicine, Auckland, New Zealand.*

## References

- (1) Grant V J. Advanced medical ethics symposia for fifth-year students. *Journal of medical ethics* 1989; 15: 200–202.
- (2) Elkind D. *Children and adolescents: Interpretive essays on Jean Piaget*. New York: Oxford University Press, 1974.
- (3) Sund R B. *Piaget for educators*. Columbus, Ohio: Bell and Howell, 1976.
- (4) Mason J K, McCall Smith R A. *Law and medical ethics*. London: Butterworth, 1983.
- (5) Redmon R B. How children can be respected as 'ends' yet still be used as subjects in non-therapeutic research. *Journal of medical ethics* 1986; 12: 77–82.
- (6) Brody B. *Life and death decision making*. New York: Oxford University Press, 1988: 103.
- (7) Beauchamp T L, Childress J F. *Principles of biomedical ethics*. New York: Oxford University Press, 1989: 263.
- (8) Tranoy K E. Research in bioethics. *Bulletin of medical ethics* 1990; 55: 18–22.
- (9) See reference (8): 20.
- (10) O'Neil R. Determining proxy consent. *Journal of medicine and philosophy* 1983; 8: 389–403.
- (11) Schoeman F. Parental discretion and children's rights: background and implications for medical decision-making. *Journal of medicine and philosophy* 1985; 10: 45–61.

*Continued from page 195*

used on but a small proportion of the population, and replacing them with a code of practice which would apply much more broadly to all disabled and elderly people who want to stay at home and who are unwilling to enter hospital.

*J A Muir Gray, MD, is a Consultant in Public Health*

*Medicine at the Radcliffe Infirmary, Oxford.*

## Reference

- (1) Greaves D A. Can compulsory removal ever be justified for adults who are mentally competent? *Journal of medical ethics* 1991; 17: 189–194.