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'Section 47'

J A Muir Gray *Community Physician, Oxford*

Editor's note

Dr Gray discusses a section of English Law which allows certain community health doctors to apply to a court for compulsory removal of people, usually old people, from their homes, even when they are not mentally ill.

He discusses four ethical issues which arise from the law—compulsory removal on the grounds of risk to others; compulsory removal on the grounds of risk to the person compelled; compulsory removal when the reason is simply inadequate public provision to support the old person at home; and removal in order to control deviance.

The compulsory hospitalisation of people who are mentally ill has received a great deal of attention in recent years because of the ethical issues involved. There is, however, one similar piece of legislation which is much more difficult to justify on ethical grounds but which has received much less attention—Section 47 of the National Assistance Act—for it allows the compulsory removal of people who are not mentally ill.

'Section 47', as it is known among doctors and social workers, concerns 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.

It lays down that they may be removed from their homes if it is in their 'interest', or if it is necessary to prevent 'injury to the health of, or serious nuisance to, other persons'. The power to approach a magistrate for a removal order was given to the Medical Officer of Health in 1948, and is now vested in the Medical Officer for Environmental Health to the District Council in which the elder lives, because, rather surprisingly, it was given to district councils in 1974 along with environmental responsibilities rather than to the authorities responsible for health or social services. The Medical Officer for Environmental Health, a community physician, has to apply to a court or a magistrate, giving seven days' notice of the intended removal. If an order is issued, the person can be detained for three months in 'a suitable hospital or other place'.

The National Assistance (Amendment) Act 1951 allows for immediate removal but the Medical Officer for Environmental Health must include the recommendation of another doctor, usually the person's general practitioner, that the person be removed without delay, but an order for immediate removal allows the person's detention for no more than three weeks. This Amendment Act was introduced as a Private Member's Bill, with government support, by the late Sir Alfred Broughton, a doctor, who was member for Batley and Morley. His constituents had been shocked by the death of a lady who had lain on the floor of her house, refusing all offers of help, watched by shocked neighbours and officials while the seven statutory days' notice expired, and who had developed a pressure sore and tetanus during this period.

The use of 'Section 47' powers

The Department of Health does not collect statistics on the number of times the powers are used, which is a serious deficiency in governmental statistics. I therefore conducted a survey of responsible community physicians in England, ninety per cent of whom replied, and have been able to calculate how often community physicians use these powers.

In England alone about 200 people are compulsorily removed from their homes each year. Ninety-seven per cent in my survey were over 65, although the legal provisions are not restricted to older people. In 94 per cent of cases the powers of immediate removal given by the 1951 Amendment Act were used and two-thirds of the people were removed to hospitals, most of the remainder being admitted to old people's homes.

Perhaps the most interesting finding is that the use of the powers varied widely. Thirty-five of the 141 community physicians who replied did not use the powers at all and among those who did the rate of use, calculated with respect to the number of people aged over sixty-five, varied six fold; that is some community physicians used it six times as often as others. This variation is not explained by social factors. For example 'Section 47' was not used more frequently in urban areas or 'retirement areas' and in my opinion the main factor is probably the attitude of the responsible community physician.

Are the powers abused?

I wrote letters to four professional journals asking for information about cases in which 'Section 47' powers had been abused and appeals to the public were also made but serious concern was voiced from only one local authority, from which the Medical Officer of Environmental Health has now left. The criticism which most community physicians face is that they are too unwilling to remove people and it is my impression that most of my colleagues set off to interview the elderly people who have been referred to them with the intention that they will avoid compulsory removal if they possibly can. It is important to state, however, that it is probable that some medical officers would disagree with my use of 'Section 47' powers in some of the cases in which I have used them, just as I am sure that I would disagree with their use in some of the 200 cases removed by my colleagues each year. The decision rests very much on the judgment of the individual doctor who is responsible and opinion varies from one doctor to another, just as it does in many aspects of medicine, but I do not believe that there has been serious abuse of 'Section 47' powers. The doctor who is asked to see such a case usually acts like a counsel for the defence for the elder whose liberty is threatened.

Ethical issues

I have used these powers six times in seven years, and have found this the most disturbing aspect of my work because of the ethical problems involved, and because of the emotional factors which make the analysis of the situation so difficult. The community physician is often assailed by anxious neighbours, relatives and professionals who claim that the elder is 'at risk' and has to try to communicate with an anxious elderly person maintaining that he or she is 'all right'.

Four important ethical issues have to be considered by the community physician. Two of these are explicitly set out in 'Section 47', the other two are related to the implicit, or hidden, functions of the legislation.

The first explicit issue is the justifiability of removing an elderly person for prevention of 'injury to the health of, or serious nuisance to, other persons'. To remove an elderly person for the benefit of others would be difficult to justify but is rarely necessary because the Public Health Acts of 1936 and 1961 permit the compulsory cleaning of an old person's house and garden if either is in an insanitary condition. The risk of the elder starting a fire and harming other people is one situation which causes much concern and gives rise to some referrals but in my experience it is always possible to reduce the risk of fire by means other than the removal of the elder.

The second explicit ethical issue is the paternalistic removal of an old person from her home. The closest analogy is the removal of an elderly person using the powers of the Mental Health Act but the removal of someone who is mentally ill is justified by the concept of mental illness. However those who are removed with a 'Section 47' order are not insane, to use a legal term. Some are mentally disordered, usually as a result of dementia, and may be considered to be incompetent. That is, they are not so disturbed as to be removed using the Mental Health Act but sufficiently disordered to be deemed unfit to manage their own affairs just as many of the people whose cases are referred to the Court of Protection are more appropriately considered as incompetent rather than insane (1), (2). Others, however, are not in any way incompetent. They are mentally alert, being neither depressed nor demented, but refuse offers of help, and the ethical problems presented by this type of person is similar to that posed by the person who refuses consent to treatment (3). Some old people who refuse the services offered are ashamed of the dirt in which they live or are ashamed of their incontinence; some fear permanent institutionalisation and some still fear 'the workhouse' when offered a place in hospital.

The justifiability of the compulsory removal of people for paternalistic reasons has, like other pieces of paternalistic legislation, to be assessed by comparing the possible benefits with the certain infringement of liberty. Furthermore, the risks of removal have also to be considered because the very removal of a person from her home carries a risk of physical and mental deterioration and in some cases it will have fatal effects (4). Of the six people I have removed five improved and the one who died soon after admission was a lady whom I considered to be dying uncomfortably at home when I saw her who, in my opinion, died in greater comfort and dignity in hospital. The improvement was marked in every case. A survey of twenty-one cases in which elderly people had been removed compulsorily by colleagues working in the Oxford Region found that the average survival time was two years (5). Nevertheless, some people are adversely affected and some may die prematurely as a result of compulsory removal.

There are two other ethical issues which are implicit in the legislation which also have to be taken into consideration. Firstly, the community physician has to be aware that the principal reason why the elder is being referred for removal may be that there are insufficient resources to support her in her own home. Some people undoubtedly need treatment in hospital, the person with a fractured femur for example, but the need of others is for more frequent visits from the domiciliary services than are available in the area in which they live.

How should the community physician respond when asked to apply for an order for an old person who does not need the type of treatment which can only be given in hospital but who is refusing to go into a home, if she is receiving only one visit from a home help and one from a nurse seven days a week? Should he apply for an order or demand more services? If he does demand more services how much more should he demand before he too is prepared to accept that the elder 'needs' to go into an institution? In theory almost anyone who does not need specialised *treatment*, as opposed to general *care*, can be kept at home if enough services are provided. This is similar to the manner in which a shortage of resources may influence the professional's definition of need in other areas of medicine such as in defining the need for renal transplantation with respect to age.

The second implicit issue is that one of the objectives of 'Section 47' is to control deviance. In the nineteenth century cleanliness, temperance and thrift —continent behaviour—was deserving behaviour; undeserving incontinent behaviour was deemed to need the control which 'the House' afforded. Both Majority and Minority Reports of the Royal Commission on the Poor Law recommended compulsory removal both to help and to control the individual who was incapable of maintaining 'proper' standards. 'Section 47' reflects the attitudes which prevailed in the nineteenth century towards old people who did not conform with conventional 'proper' standards and such attitudes still persist although they are less frequently expressed nowadays (6), (7).

Should 'Section 47' be repealed?

Since the legislation was first introduced as 'Section 56' of the Bradford Corporation Act 1925 much has changed although only minor alterations have been made to the wording of the law. Attitudes, values and beliefs have all changed considerably, and domiciliary services have grown, but I do not believe that it should be repealed, although I am sure that it should be amended.

What would happen if it were repealed? Would disabled elderly people, who were refusing to go to hospital for the treatment of some life-threatening disease or those who were refusing domiciliary services, be left at home? I do not think that they would. It is probable that the Mental Health Act would be used to remove some of them and I believe that the effects of this type of removal are even more serious than 'Section 47' removal. When I use 'Section 47' I am in effect saying 'I respect your opinion, I believe that you are sane and that it is a valid opinion but I also believe that it is wrong', whereas the Mental Health Act implies that the person is incapable of making decisions and that his opinions are invalid. The use of 'Section 47' is based on the legal concept of incompetence whereas the Mental Health Act is based on the premise of insanity and removal using the powers of the Mental Health Act may irreversibly label the individual as a 'psychogeriatric'. Not all would be removed using Mental Health Act powers, however. Others would be deceived, drugged, coerced or overpowered as many elders are today and I have evidence from many parts of the country that these practices take place. Deceit is still common with old people being told 'It's only for a holiday', or 'It's only for a few weeks'. Drugs are not commonly used for the sole purpose of overcoming a person's resistance, although that does happen, but the judgment of many older people is clouded by drugs.

Coercion is also used—'if you won't agree to go, we can have you taken away', and the Medical Officer of Environmental Health sometimes finds that he has been used in this way, as the official who will take the elder away if she does not agree to go 'voluntarily'.

Finally, many people are overpowered; I don't mean physically overpowered—ambulancemen are too honest and cautious to go along with that sort of practice—but many elderly people give up and give in as a result of sustained pressure from friends, relatives, neighbours and sometimes from professionals, although the latter usually take the side of the old person. The term often used is 'persuasion'—'she has been persuaded to go'—and in some cases the old person has been persuaded as a result of cool and rational argument; in others however she has been forced to change her mind as a result of sustained pressure.

Why has this issue been ignored?

It is interesting to speculate why this issue has been ignored for so long. I believe that there are two reasons. The first is that many people believe that all very elderly people who behave in any unconventional way do so because they are 'demented' and incapable of understanding their position. This type of ageist attitude allows many people to justify such legislation for elderly people whereas they would not accept it if it were applied to someone who was thirty-five or forty years of age. Mr Bevan expressed this clearly during the Second Reading of the National Assistance Bill when he said: 'I think the right honourable 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 some one must do something about it' (8). There was no use of the word 'should' or 'ought' because old people were concerned Mr Bevan used

the word 'must' and no other Member quarrelled with the principle this implied.

The second reason is that I believe that other people are greatly relieved when an old person is tidied up and tidied away and that the pressure to institutionalise an old person who is in difficulty is generated as much by our guilt as by our compassion.

I believe it is now time to review and amend 'Section 47' and our attitudes towards our elders.

References

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