

Observations on consent to treatment and review of clinical judgment in psychiatry: a discussion paper¹

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There is no issue at the interface of law and psychiatry which is so controversial as that of consent to treatment (SK & F 1980). The current law does not provide guidance as to whether a person compulsorily admitted to hospital may be compelled to receive medical treatment (Committee on Mentally Abnormal Offenders 1975, Gostin 1979, Jacob 1976). Indeed, legal concern for the welfare and rights of the individual has traditionally ceased at the hospital door on the assumption that, while the law could reasonably set procedural and substantive standards in respect of compulsory admission, it could not interfere in the clinical relationship which must be established following admission. The ambiguity in mental health legislation is unsatisfactory, for it disregards the fundamental interest of the patient to know whether his common law right to refuse physical treatment is restricted and the interest of his doctor or nurse to know his professional rights and obligations in administering treatment (Royal College of Psychiatrists 1979, Confederation of Health Service Employees 1979). In this paper I will examine medical, legal and ethical principles for regulating the therapeutic relationship. I will focus particularly upon the reasonable concerns of the medical profession toward interference with individual clinical judgment. To set the argument in context, I will first examine widely accepted medicolegal assumptions about the nature of the therapeutic transaction.

Current legal position of the psychiatric patient

It is widely accepted that informal psychiatric patients have the same right to refuse treatment as patients suffering from physical illness (Department of Health and Social Security 1976). Accordingly, treatment cannot be administered to informal patients without their consent, except in cases of urgent necessity. The doctrine of 'necessity' is not clearly defined in law but would clearly include the use of a life-saving procedure performed where the patient could not provide the necessary consent (e.g. by reason of unconsciousness) and where the patient was not known to object to the particular treatment (Skegg 1974). Indeed, the doctrine of 'necessity' might be construed more liberally to include treatment or restraint administered in the course of an emergency – for example, to restrain a patient during a violent episode by the injection of a tranquillizer. An emergency is taken to mean circumstances in which immediate action is necessary to preserve life or to prevent serious deterioration of the patient's condition. It would include circumstances in which a patient became violent and was likely to be imminently dangerous to himself or others, and treatment or physical restraint was imposed for the purpose of controlling him. The physical or therapeutic intervention would have to be reasonable and limited for the purpose of bringing the emergency to an end (HM Government 1978, Committee on Mentally Abnormal Offenders 1975, Gostin 1979).

The legal position of the detained psychiatric patient, however, is unclear, notwithstanding the commonly held medicolegal assumption that involuntary admission is intimately connected with a patient's subsequent treatment. The conventional view is that the powers

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pertaining to compulsory admission must necessarily subsume forcible treatment (Royal College of Psychiatrists 1979, HM Government 1978, Committee on Hospital Complaints Procedures 1973, Medical Defence Union 1972). It would be a curious legal position if a patient could be involuntarily admitted for the purpose of providing treatment without the doctor being empowered to administer that treatment in the absence of consent.

The wisdom of this traditional medicolegal assumption is being increasingly questioned (Committee on Mentally Abnormal Offenders 1975, Jacob 1976, Gostin 1979, Williams 1973, Confederation of Health Service Employees 1979). The Mental Health Act 1959 does not expressly govern the therapeutic relationship between doctor and patient; the relevant part of the Act is concerned exclusively with involuntary admission to hospital and is silent in respect of any express regulation of treatment or consent. In the absence of any such specific statutory provision, the common law right to refuse treatment given to physically ill patients does not appear to be automatically abrogated in the psychiatric context.

An intermediate legal view is that an admission 'for treatment' under section 26 of the Mental Health Act authorizes the doctor to administer treatment without consent, but an admission 'for observation' under section 29 or 25 does not. The use of the term 'observation' instead of treatment may be regarded as a purposeful distinction made by Parliament (Gostin 1975, 1979).

The most informed conclusion that one can draw from these contradictory legal opinions is that the position of the detained psychiatric patient is unclear under existing law; to date there have been no cases decided by the courts in this controversial area. It is likely that a court would not adopt a simplistic solution but would take into account a number of diverse factors: the particular form of treatment, including its intrusiveness, whether it is established by clinical research and contemporary practice, whether it is irreversible or carries significant risks; the section of the Act under which the patient is detained; and the competency of the patient and his reasons for refusing consent.

Minors

It is sometimes assumed that minors automatically lack competency to consent to treatment and that in certain circumstances parents or lawful guardians can consent on their behalf. However, the current statutory position is that the consent to medical treatment of a minor who has attained the age of sixteen is legally effective as if the minor were of full age (Family Law Reform Act 1969, section 8). This legislation, moreover, does not revoke any common law right of a minor below the age of sixteen to consent on his own behalf. In this regard, the preferred view is that a minor's competency depends upon whether he is able to comprehend what is involved in the medical procedure in question (Skegg 1973). The parent or guardian does not have the right to substitute his consent for that of a competent minor. Indeed, even if a minor were incompetent, a parent or guardian could not consent to treatment which is plainly not in the minor's best interests. In *re D (a minor)* (1976), the court used wardship to protect a mentally handicapped child against a proposed sterilization procedure which was to be performed with the consent of the parent and doctor. The court intervened on the grounds that the sterilization was not for the minor's benefit, either for medical or social reasons.

In summary, the competency of a psychiatric patient is a question of individual fact to be determined on the basis of whether the person understands the nature and purpose of the proposed treatment. There are no fixed rules based upon age, legal status or clinical diagnosis.

Competency of detained patients to understand the nature and purpose of treatment

A particularly pernicious medicolegal assumption is that a person's general competency is conclusively determined by his compulsory admission status. The fact is, however, that involuntary admission to hospital does not, either in law or practice, suggest that a person is wholly incompetent (Gostin 1979). Psychiatric illness – even if accompanied by a formal legal determination that involuntary admission is warranted – does not render a person entirely

unable to make choices about the treatment he is to receive; an involuntary patient possesses varying degrees of competency to make rational decisions about his own health and body. An involuntary patient may be able to understand the nature, purpose and effect of one treatment but not another, and his capacity to understand may vary from time to time (HM Government 1978). This view is widely shared by experienced psychiatric (Royal Commission 1957, Russell-Davis 1979) and legal (Williams 1973, Kennedy 1976) observers.

It is fundamental to any analysis of consent to treatment to emphasize that a person's legal status does not, by itself, establish whether he is competent in any specific area of functioning. The medical condition of patients on a hospital ward and their competency to make rational treatment decisions do not systematically vary according to legal status. It would be impracticable and inequitable if a valid refusal by an informal patient were accepted, while the same refusal of an involuntary patient with equal mental faculties were over-ridden. Indeed, if it were possible to draw firm conclusions as to a person's competency solely on the basis of legal status, it would be that an informal status might sometimes indicate a greater lack of understanding than a compulsory status. A patient is admitted informally if he consents to admission or if he is unable to make a decision. The latter category of patient may be termed 'non-volitional' – e.g. severely mentally handicapped or severely depressed people who are unable to express their will. These patients, because they are classified as informal, are paradoxically presumed to be competent to make treatment decisions. The use of compulsory admission procedures are restricted to those who are volitional and able cogently to state an objection. Here, there is at least a *prima facie* indication of competency, but they may be automatically presumed to be unable to make any decision about psychiatric treatment.

This observation is put forward to underline the concept that it would be wrong to withhold safeguards from an individual solely because he may possess a compulsory status. It is reasonable to assume that people in an unfree situation require not fewer safeguards, but special protection.

Unsoundness of mind is usually disabling in limited respects only. Scientific and clinical comparisons of the total range of behaviour and cognition of mentally disordered and 'normal' people show significant overlap (Morse 1978). Mentally disordered people are normal in many areas of functioning and for significant periods of time. Even when patients are actively experiencing the symptomatology of a mental illness, much of their behaviour and cognition will be normal. Further, during periods where their symptomatology is in remission, their behaviour and cognition are not reliably distinguishable from normal persons.

In respect of competency then, mentally ill patients – even if validly under detention – are to a significant extent capable of rational thought and behaviour. This is not to suggest that a refusal to receive prescribed treatment cannot sometimes be a product of a patient's distorted cognition or affect. However, this should not be the inevitable presumption of the law. Indeed, patients in large institutions may sometimes experience side effects and adverse reactions from medication or other treatment before they are adequately observed or heeded by nurses or doctors, who may not have the time to listen carefully when faced with excessive caseloads. Respect for a patient's observations about how he feels and how treatment affects him is necessary not merely to safeguard his rights; a patient's feelings and experiences are also highly relevant to the medical and social decision to be taken about his welfare. His observations must not automatically be disregarded simply because he is detained and presumed incompetent.

Independent multidisciplinary review of psychiatric treatment

The White Paper, 'A Review of the Mental Health Act 1959' (HM Government 1978), proposed an amendment to the Act to make it clear that doctors in certain circumstances or in a medical emergency could treat patients without consent. This would apply only to patients detained for medium or long-term periods and not to short-term admissions.

Where a detained patient is incapable of giving valid consent, the consultant should be authorized to impose such treatment as he considers necessary to alleviate or cure the mental

disorder. Where, except in an emergency, there is uncertainty as to a patient's competency, a second opinion should be sought.

Where a detained patient is competent to give consent but refuses, the consultant should not impose treatment except if he considers that it is necessary to save the patient's life, prevent violence, or prevent deterioration of the patient's medical condition. Treatment which fulfils any of these three conditions could be imposed only by obtaining a concurring second opinion.

Treatments which are hazardous, irreversible or not fully established, should not be imposed without the consent of an informal or a compulsorily detained patient except to save life. Even where such a patient does consent, or in any other case, treatment should only be imposed with a concurring second opinion. A second opinion should be sought where there is any doubt as to whether a particular treatment is hazardous, irreversible or not fully established. The second opinion would be obtained from a multidisciplinary panel established for the purpose by each Area Health Authority.

There follows an examination of the concept of multidisciplinary review of psychiatric treatment. I shall explore the foundation issue of whether it is ever justified to interfere in individual clinical judgment and the form such review should take. I will not examine in detail the specific criteria for compulsory treatment given in the White Paper, as this is dealt with elsewhere (Gostin 1979).

On what grounds should compulsory treatment be justified?

In order to justify an independent review of a treatment decision, we would either have to question the wisdom of the doctor in taking the decision or we must point to some specific criteria which are neither medical nor even quasimedical but are ultimately nonmedical, which makes the doctor the wrong person to apply them. The well-established principle of self-determination in law is that it is improper to impose physical treatment on a competent adult while conscious and cogently expressing an objection (Robertson 1981, Scarman 1981). Accordingly, competency and consent should logically be seen to be the foundation of any decision to impose treatment on a patient. These concepts are not medical but essentially lay and legal. The question to be put is not whether the patient is able to make a more informed and expert medical decision than the doctor, but whether he is able to understand the nature, purpose and risks of the treatment and to express his will rationally. A doctor may well be able to tell us the benefits of a particular treatment, but the decision about whether it is proper to impose it upon an unwilling patient is ultimately a social and lay judgment and should not rest on medical grounds alone.

If a psychiatric patient is competent and expressly refuses to consent to treatment, his views should be respected. This is the position in general medicine and, if a psychiatric patient is competent, there are no rational grounds for distinguishing his legal position from that of the physically ill patient. This is not necessarily to suggest that it is in a patient's best interest to refuse treatment, but only that it would be an unjustifiable affront to his human dignity and self esteem if treatment were to be imposed directly against his express wishes. There can be no greater intrusion on a competent human being than to compel him to receive physical treatment which he does not want. The medical profession, moreover, would consider the imposition of treatment on a competent patient inconsistent with a therapeutic relationship; one would not expect to find many occasions where a doctor thought it proper to administer treatment in these circumstances. However, it sometimes occurs that treatment is given without consent and where it is not in accordance with established clinical research and contemporary practice (for example, the use of electroconvulsive therapy without consent has been documented in several reports: Committee of Enquiry into St Augustines Hospital 1976, Health Service Commissioner 1977, *The Times* 1977, Gostin 1981).

The parameters of the argument should therefore be placed in perspective. There should be no interference with individual clinical judgment where, as is the usual case, there is consent to an established and safe treatment. The White Paper envisages a measured safeguard only

where there are strong indications showing the need for closer examination of a proposed treatment. Accordingly, the second opinion would be required where a competent patient was expressly withholding consent. Here, one would expect some form of review which took account of the patient's reasons for refusal. The only other instance where a second opinion would be required is where the treatment was classified as hazardous, irreversible or not fully established. The White Paper definition of 'hazardous' is that the benefits of the treatment do not clearly outweigh its risks; the definition of 'not fully established' is that the treatment does not conform to any medical orthodoxy in the sense that it is not established by clinical research and contemporary practice. It is intuitively self evident to a lay observer that if a treatment fulfils one of these conditions, an independent review would be warranted. This would also be the case in respect of irreversible treatments – notably psychosurgery (Gostin 1980, Society of Medical Ethics 1980, Clare 1980). Thus, if a treatment poses disproportionate risks, does not conform to any medical orthodoxy or irreversibly affects body functioning, it would be proper to require the doctor to explain and justify his decision to administer the treatment to an independent authority. This proposal does not seek to prohibit the treatment but only to have the decision considered within a wider therapeutic, social and lay context and to give the patient a sense of involvement in the decision-making process.

Compulsory treatment in psychiatry – whose choice?

If the premise is accepted that a psychiatric patient, if competent, should be permitted in law to refuse to consent to treatment, then a much more difficult question arises – who decides whether the patient is competent to withhold consent to treatment? The self-evident answer, the doctor would understandably assert, is the responsible medical officer. The consultant in charge of treatment has had the opportunity to observe and assess a patient's capacity for making rational decisions and would make the most informed judgment of his competency. However, the same question should be answered from the perspective of the patient and the layman. The treating doctor is charged with the responsibility and duty to prescribe medical treatment in the patient's best interests. Having received the person into hospital on a compulsory basis and prescribed a particular course of treatment, it can be taken that he has already formed the view that the patient is properly detained, the procedure is medically indicated and that the patient's refusal in the circumstances should be over-riden. It is to be reasonably expected, then, that consideration of a patient's medical interests would take precedence over his legal right to make his own decision in respect of medical treatment. This dilemma – between a patient's health and his rights – has been characterized by psychiatrists as allowing a patient to 'die with his rights on' (Treffert 1974, Hoffman 1977). Once the issue has been framed in this way, it is implicit that it is more important to maintain a patient's health than to safeguard his rights. This would be the position adopted by most members of the medical profession and one would not want to be critical of the medical ethics inherent within that position.

From the patient's perspective, however, he is engaged in a therapeutic relationship which, in his mind, has broken down; he is unable to agree with the doctor as to where his best medical, social and personal interests lie. For one partner in the transaction, who has already stated his view that the treatment is important and warranted, to decide that the other is not competent to refuse and then to substitute his judgment for that of the person to be treated, would be seen by the patient or layman to be unjust. It would also suggest a great deal about the inequality and non-reciprocity of the doctor/patient relationship and where the authority lies. Again, this is not to suggest that the doctor who is proposing a specific treatment has made the wrong decision or that it is desirable, merely for the sake of it, to monitor his decisions. Rather, it is fundamental to the way citizens perceive their own rights and autonomy that they should have access to some decision-making body which is seen to be independent.

It may be helpful to state a concrete example of a case which would warrant an independent second opinion. Electroconvulsive therapy has been shown empirically to be effective in the

treatment of severe endogenous depression (Freeman *et al.* 1978), although there is some evidence that the convulsion is not the critical factor (Johnstone *et al.* 1980). However, there is no medical consensus as to its benefits in the treatment of other psychiatric conditions such as schizophrenia (Royal College of Psychiatrists 1977). Consider the example of a consultant who proposes to administer ECT in the treatment of schizophrenia. I specifically choose this example because it is common in large psychiatric hospitals, but there is no accepted medical orthodoxy in respect of ECT in the treatment of schizophrenia. The patient may understand the nature and purpose of ECT but refuse to give consent because of his genuine fear of the procedure. One is not making a judgment about the competence or intentions of the doctor's judgment by suggesting that ordinarily it would not be right to impose treatment on a genuinely unwilling patient, particularly if there were some uncertainty within the profession as to the prospect of benefit in the particular circumstances. Further, as stated earlier, I do not believe that most doctors would wish to impose the treatment without consent. However, if the doctor did wish to proceed, it would be proper to have an independent review; it would be reasonable to expect him to explain and justify his decision to give ECT, despite the patient's firm objection and in the absence of any clinical consensus as to its benefits. This would safeguard the right of the patient to self determination and would also protect the doctor in respect of any legal or other proceedings that were subsequently brought.

This example illustrates the principal point of disagreement at the interface of law and psychiatry. Psychiatrists properly observe that ECT is an effective and safe treatment: there is considerable evidence of its effectiveness in the treatment of chronic depression, the empirically documented risks are minimal and the majority of patients subjectively express their satisfaction (Clare 1978). Accordingly, the medical view is that safeguards are not warranted and that the treatment should be prescribed without legal fetters. The lawyer, however, is concerned not with the proper administration of ECT on a willing patient and in clinically indicated circumstances, but with the imposition of treatment without consent or in circumstances which are not justified by past research or agreed practice. The desired balance is to find a method of holding professionals accountable while not encumbering them in such a way that would reasonably detract from valid medical objectives.

Similar illustrations could be envisaged with treatments ranging from psychosurgery to the major tranquillizers. The human right in question, however, is that all patients should not be treated as legal children and automatically denied the right to make choices about their own health and well-being. If a patient has a sincerely felt concern about the side effects of psychotropic medication based upon past experience, or if he is troubled by the irreversible consequences of neurosurgery, or if he has a genuine fear of ECT, his views should be heard and his will, if it is not a product of his illness, should be respected.

'Why should your profession control mine?': The sanctity of the doctor/patient relationship as the foundation of medicine

The principal concern of psychiatrists about independent review of their clinical judgment is that the legal profession is perceived as seeking to control medicine and to interpose legal procedures between the patient and the doctor. This is seen as undermining the patient/doctor relationship which is the foundation of medicine (Bridges 1980). Lawyers, as a professional group, have no unique expertise or inherent entitlement to control or monitor the medical profession. Any profession, however, must operate within the framework of the law. It is the law which authorizes the medical profession to detain and to treat patients. Treatment given without consent is administered by the doctor only with the authority of the law; so too, must the law place reasonable fetters and boundaries on the exercise of that authority. It would be inherently wrong to delegate power to any professional group and not to counterbalance that power with criteria for its use and safeguards against its possible misuse.

The law would impede its own objectives if its fetters on the medical profession interfered unreasonably with the doctor/patient relationship. The therapeutic relationship is indeed the foundation of medicine. This relationship is based upon trust or at least agreement; it

demands that rights and duties are placed upon each partner. There is a duty to engage in a continuing discussion. The doctor should provide the patient with appropriate information to enable him, where possible, to form a judgment. It is the patient who is to take the decision to accept treatment, based upon medical advice. The doctor should explain the nature and purpose of the treatment, its alternatives, benefits and risks. (This is a proposal based upon social and moral, as opposed to strictly legal, considerations: *see* Chatterton *v* Gerson 1981, Robertson 1981.) The patient, on the other hand, must accept that he is in hospital for the purpose of receiving treatment and he should expect to be guided by his doctor in matters of his care and treatment. The law should intervene only after the foundation of the therapeutic relationship – trust and agreement – is no longer present; where full discussion has not occurred or where, after receiving information, the patient does not accept the doctor's advice. A safeguard which operates in these circumstances does not undermine the clinical relationship for, manifestly, that relationship has lost its viability. In these circumstances, it is the law, not the doctor, which must be the arbiter of the relationship.

Who has ultimate clinical responsibility?

The question may arise as to who would have ultimate clinical responsibility for the patient where an independent authority does not concur with the judgment of the doctor. It is increasingly recognized in medical ethics that, following a dissenting second opinion, the consultant responsible for the patient is not obliged to administer a treatment to which he is opposed. It would be unethical to oblige a professional to administer a treatment which, according to his own judgment, was not therapeutically indicated (British Medical Association 1980). The power of review, then, is a negative one; it cannot require that a particular treatment be administered. The sole obligation of the doctor would be to refrain from giving a particular treatment if, after review and discussion, the recommendation was that it should not be proceeded with. The expectation would be that the doctor would examine alternative forms of treatment and discuss these with the patient. There would be no reason why the doctor should not command the confidence of the patient and maintain clinical responsibility. This would be particularly so where the doctor and patient did not perceive the independent review as adversarial in nature and had confidence in its integrity and the reliability of its decision. It may occur, however, that the doctor is of the opinion that he could not assist the patient therapeutically, either because there was no reasonable medical alternative, or that the patient refused reasonable alternatives. In this case, the therapeutic relationship between doctor and patient would not be viable and could reasonably cease.

The need to dislodge a particular consultant/patient relationship after it has lost its viability is somewhat analogous to that which pertains in general medicine where a patient is referred by his general practitioner to a consultant. If the patient disagrees with a course of treatment proposed by the consultant he is entitled to go back to his general practitioner and seek a referral for a second opinion from an independent consultant. The patient detained under the Mental Health Act, however, has lost the continuing input of his general practitioner and has a unique relationship with his consultant. The general practitioner has legal authority to sign a recommendation for compulsory admission, but does not have standing to intervene at subsequent stages in the therapeutic transaction. The psychiatric patient who is dissatisfied with his consultant or with a particular treatment has limited, if any, recourse to a second opinion and the relationship with one particular consultant is effectively unalterable.

Treatments which are hazardous, irreversible or not fully established

The White Paper is correct to identify certain categories of treatment which are intrusive, produce irreversible psychological or physiological effects, carry risks or are unpredictable in effect, and to distinguish these from other forms of treatment. Under the White Paper formula, treatment which is unusually hazardous, irreversible or not fully established by clinical research and practice could not be given without the patient's consent and with the approval of an independent authority. This would create a virtually unique situation in English law where medical treatment would be subject to review and approval even if it were

to be given with the legal consent of the patient; legal procedures would be interposed in a mutually agreed therapeutic transaction. The justification for this would be the inadvisability of one doctor administering – without further independent examination – particularly intrusive, irreversible or unestablished treatments to patients who, by reason of their confinement and vulnerability, are inherently unlikely to be in a position to effectively examine and question the desirability of receiving the treatment. This principle recognizes that, particularly in respect of detained psychiatric patients, the doctor is serving the interests of society, and has a duty to protect the public, as well as serving the therapeutic interests of the patient. The decision whether to give such treatments is beyond the competence of the medical profession alone, even where the doctor purports to act in accordance with the wishes of a consenting patient.

The White Paper rejected recommendations for a list of treatments in a code of practice or statutory instrument which would warrant special safeguards. Research and clinical practice in psychiatry continually alter professional perceptions of particular treatments. Moreover, treatments could not be rigidly classified even if they were subject to periodic review. Specific treatments may be regarded as hazardous or not fully established when used in one clinical context, but not in another. The case of electroconvulsive therapy has already been used as an illustration: ECT may be regarded as fully established in the treatment of depressive illness; it is less established in the treatment of other psychiatric conditions such as schizophrenia; and it is not a professionally recognized method of controlling behaviour. Electroconvulsive therapy is not normally considered hazardous, except to the extent that any treatment has certain hazards associated with it. It is not unusually hazardous when account is taken of the prospect of benefit to be expected from the treatment in appropriate cases (Fink 1978). However, the anaesthetic which precedes ECT may be unusually hazardous to a patient who has just eaten a large meal or who suffers from a heart condition. Electroconvulsive therapy can be hazardous when administered in an unmodified form (i.e. without muscle relaxant and anaesthetic), where there are significant risks of bodily injury (Adjournment Debate 1981, *Bolam v Friern Hospital Committee* 1957), or when it is used intensively or over a long term, where there is a risk of memory deficit and other adverse effects (Hamilton *et al.* 1979). This argument is applicable to most other treatments; for example, the long-term use of antipsychotic medication carries with it a risk of irreversible neurological damage such as tardive dyskinesia (Kennedy 1980). Accordingly, specific treatments which are used extensively in psychiatry, such as ECT or psychotropic medication, would not necessarily qualify for the more exacting standard of 'hazardous' or 'unestablished'. Nonetheless, it would be wrong to suggest that they could never qualify regardless of the clinical circumstances or manner in which they were administered.

Form of review of individual clinical judgment

The form of review of individual clinical judgment, more than any other matter, divides those who have examined the issue. For the purposes of operating the principles put forward in this paper, the fundamental aspects of a review procedure would be that it is independent of the hospital and the detaining authority; it is multidisciplinary in the sense that it would include a lay element and would not be exclusively or predominantly medical; and it is open and accessible in order to maintain a full sense of patient involvement and to ensure that its procedures and decisions are generally amenable to public scrutiny.

I do not consider that professional review or audit, represented by a second medical opinion or an exclusively or predominantly medical panel, would be a sufficient safeguard or would maintain the confidence of the patient. This is on the grounds that issues of competency and consent cannot be determined solely on the basis of medical or scientific expertise but require a lay, social and commonsense judgment. The decision to impose a treatment on an unwilling patient requires a subjective choice among a number of diverse values including the purpose and importance of the treatment, possible adverse effects and the strength and cogency of the patient's reasons for refusal. That choice and balancing of values lies outside the exclusive

competence of a single doctor and can only partly be the concern of the medical profession.

An additional factor is the understandable reluctance within the medical profession (or, for that matter, within most professions) to interfere with the judgment of a colleague who is responsible for a case. Individual clinical judgment or clinical autonomy is an important part of the thought and training of medicine; a doctor who is not directly responsible for a patient would be faced with formidable professional restraints if he had openly and directly to contradict a colleague, particularly where his second opinion would take precedence over the opinion of the responsible consultant. This form of peer review would be particularly unacceptable if it permitted the doctor to choose a colleague from whom he would seek a concurring opinion. One would expect the doctor to choose an individual with similar clinical training, experience and views and there would be considerable informal pressure toward conformity where the two doctors had to maintain a continuing professional relationship. There would also be questions raised as to whether the doctor could 'canvas' opinion – i.e. seek a second or third opinion if the first did not concur.

Some of these reservations may be partly illusory. However, exclusive professional self regulation is always open to the criticism that it is not sufficiently energetic or dispassionate, that there may be informal pressures to protect a fellow member of the profession and that the views of questioning non-professionals may not be given sufficient weight. Confidence of the patient and public would be maintained only by independent examination and review of individual clinical judgment.

I also do not consider the consent of the nearest relative as a sufficient safeguard for the patient; however, this proposal has been accepted in other jurisdictions such as Ontario and several American states (Gostin 1979) and I do recognize the great importance of closely involving the relative in the decision-making process. It must be observed that the English law does not recognize the validity of a consent given by the nearest relative, except that the consent of a parent or guardian may be given on behalf of incompetent minors or persons formally under guardianship in certain circumstances. Recommendations by government (HM Government 1978) and medical protection societies that the nearest relative's consent should be obtained is as much for the protection of the doctor and hospital as for the patient. Once a nearest relative consents to a treatment it can inhibit certain legal actions he or she may take against the doctor or health authority subsequent to a patient's death.

The nearest relative is not always a detached and competent decision-maker. His or her decision may be influenced, not by the merits of the particular treatment or the competence of the patient to make decisions for himself, but by the nature and quality of the relationship that exists between the patient and his family. Indeed, it is sometimes the nearest relative who has made an application for the patient's involuntary admission to hospital; there is also some evidence that problems relating to mental illness may be associated with the family and its interactions as much as with the patient himself. A patient should not have to rely on the exercise of favourable discretion by a relative (if there is a close relative) in decisions regarding treatment. The person who is to have the rationality of his thinking subjected to outside scrutiny should be entitled to rely on detached and legally accountable decision-making. Nor would consent by the nearest relative necessarily be appropriate from the medical perspective. A nearest relative may have an irrational bias against a particular treatment (for example, electroconvulsive therapy) and may unreasonably withhold consent where the treatment is clearly indicated. It would be preferable, therefore, if the decision were taken by an authority which could objectively assess the medical and social evidence available.

In devising a properly constituted second opinion, it is important to avoid, wherever possible, clumsy, expensive or time-consuming machinery. For this purpose, it might be preferable if the second opinion were associated with a currently existing institutional structure. Mental Health Review Tribunals or independent hospital ethical committees are not currently used for evaluating clinical treatments. (Mental Health Review Tribunals are empowered to examine issues of discharge but not treatment (Gostin & Rassaby 1980) and hospital ethical committees evaluate the clinical and ethical aspects of medical research and

innovative treatments.) Nonetheless, consideration may be given to adapting such institutional structures for use in this context. The use of Mental Health Review Tribunals particularly commends itself because they have existing panels of legal, medical and lay members, they are at present substantially under-used and there is a proposal in the White Paper to increase the size of the Tribunal by adding a social work member. Ethical committees, as currently constituted, have the disadvantage that there is very little public understanding of the way they operate and they do not appear to be publicly accountable for their decisions.

Conclusion

There is an unquestioning acceptance among many legislators, lawyers and doctors that judgments concerning a patient's body may validly be removed from the individual and delegated to experts in the psychiatric, but not the general medical, context. It has been the burden of this paper to illustrate that this is an automatic response to involuntary admission to hospital which is supported more by intuition than by scientific fact or current jurisprudential thought. There is an intuitive medicolegal disposition to hold a psychiatric patient incompetent, irrespective of his clinical condition or capacity for specific rational understanding. This is suggested by a number of factors including the status of the patient as involuntary; the doctor's primary, statutory and moral responsibility to detain and treat the patient rather than to respect his refusal of a treatment which the doctor believes to be medically indicated; and the natural presumption by those who regard themselves as mentally healthy (particularly if they are endowed with specialist knowledge) that they have greater understanding than the mentally infirm. All of these factors may instigate towards paternalism and a predetermination of a patient's competency. Any difference of opinion may be regarded as a question of who is qualified to make a decision. It is within this context that a patient's refusal to consent may be seen, not as a statement of will, but as a symptom of unsoundness of mind. The colloquialisms 'doctor knows best', 'you really don't mean that' and 'you will thank me later' sometimes become the unwritten rules within which the merits of a patient's consent are assessed.

Ethically, a patient should be free to make a decision which may be against his medical interests so long as he is able to understand the implication of that decision; the common law places no legal obstacle to a patient's decision to live in great pain or even to risk his life rather than to accept unwanted medical treatment. The fundamental issue, however, is who should ultimately decide whether the patient is capable of understanding the nature and purpose of the treatment. I have suggested that the doctor – one of the partners in the treatment relationship – should not make the final judgment; nor should the decision be subject solely to professional self-regulation. This was intended not to impugn either the expertise or integrity of the doctor, but to show the importance, from the perspective of the patient and the lay public, of introducing a decision-making process which is independent and in which he could have confidence. This would also serve the interests of the medical profession by effectively protecting the doctor in respect of any subsequent complaint or legal proceedings brought by the patient or his relatives.

It is, of course, fundamental to the therapeutic relationship that the patient who enters the hospital for treatment has trust in the doctor and does not refuse all forms of treatment. The law, moreover, should not normally interfere in a doctor/patient relationship if it is based upon trust and consensual agreement. However, once that trust breaks down, a psychiatric patient, unlike physically ill patients, will find it difficult or impossible to choose another doctor or simply to leave the hospital. It would be wrong in these circumstances if he were compelled in law to accept *any* treatment proposed and where, if he disagreed for whatever reason, his only recourse was to the same doctor who originally recommended the treatment.

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