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Compulsory Treatment in Psychiatry: Some Reflections on Self-Determination, Patient Competency and Professional Expertise

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Compulsory treatment in psychiatry
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The law of trespass purports to effectuate the common law’s regard for personal self-determination; a medically indicated, or indeed life saving, procedure performed with reasonable care may still amount to a battery unless the doctor acts with the consent of the patient.1 The foundation of the concept of self-determination is the competency of the patient to understand the nature and quality of the proposed medical procedure. Accordingly, the right of an individual to self-determination may have to be limited where the individual is incapable of understanding the subject matter or of expressing his will. This may occur in a number of medical and social contexts including cases where patients are of particularly old or young age, where they suffer from certain painful or terminal illnesses, where they are so severely physically disabled as to be unable to express their thoughts, or where they are severely mentally ill or mentally handicapped. The law of medicine is not sufficiently comprehensive or coherent in its expression by the courts to justify a conclusive statement concerning the legal test of competency. Nevertheless one can broadly observe that the test appears to be an individual one relating to the person’s capability for comprehension at a particular time and in respect of a particular decision. There do not appear to be any fixed rules governing consent which are based upon age, legal status, medical condition, diagnosis, or prognosis.2

The one notable exception to this principle is the rigid distinction based upon legal status which is drawn under the Mental Health Act 1959 between informal and compulsorily detained psychiatric patients. The conventional legal view is that the former class of patient is entitled to the same protections under the common law as are afforded to patients in general medicine, while the latter class is not entitled to that protection and can have treatment imposed without consent.3

Legal concern for the right of self-determination of the psychiatric patient has traditionally ceased at the hospital door on the assumption that, while the law could set procedural and substantive standards in respect of compulsory admission, it could not interfere in the clinical relationship which must be established following admission. Further assumptions are that the compulsory admission process itself provides a conclusive determination of a person’s competency to make treatment decisions and that the doctor possesses sufficient scientific and objective medical knowledge to enable him to make reliable and valid choices concerning diagnosis and treatment. The authority of the psychiatric profession to administer treatment against the express wishes of detained patients has no apparent boundary based upon the nature of the treatment, its proven efficacy, its irreversible or adverse effects, or its risks.

In this article I will examine the rationale, in legal and policy terms, of the inextricable association traditionally formed between certification and incompetency. I will argue that forming categories of people in which the law automatically dispenses with the requirement of seeking consent is fraught with conceptual inconsistencies and practical difficulties. I will further

1. See eg, Devlin, Samples of Law Making, 1962.
3. This article is based upon the assumption that compulsory admission under s 26 of the Mental Health Act 1959 does authorise compulsory treatment. This conventional view is accepted by a number of official, medical and legal commentators. See HM Govt, Review of the Mental Health Act 1959, Cmnd 7520 (1978); The Report of the Committee on Hospital Complaints Procedure paras 7.34 – 35, 1973; Medical Defence Union, Consent to Treatment 1972; Clarke, The COHSE Report on the Management of Violent Patients: Counsel’s Opinion, The Bulletin of the Royal College of Psychiatrists
argue that clinical judgments made without the consent of the patient should be made subject to an independent statutory review. Such a review procedure could also be adopted for treatments which are unusually hazardous, irreversible or not fully established even if the doctor purports to proceed with the consent of the patient.

The competency of detained patients to consent to psychiatric treatment

The fixed distinction relating to the right to refuse treatment based upon legal status contained in the 1959 Act could be justified only by demonstrating that detained patients as a class are incapable of making rational treatment decisions. Indeed, in psychiatry and law the entire edifice of forcible treatment is erected upon the presumed incompetence of patients to consent to medical procedures. Any other position would be arbitrary; if a patient has the capability reasonably to understand the nature and purpose of treatment, there is no more justification for disregarding his own conception of his self interest than there is in the case of any other patient — whether physically or psychiatrically disabled. The rationale of mental health law, then, is that admission status provides sufficient information regarding a person’s competency so that further examination of the ability of an individual to comprehend any particular treatment is unnecessary. Informality in the admission process creates a virtually irrefutable presumption of competency throughout hospital residency, while a compulsory status creates the opposite presumption.

The medical and social grounds for the decision to differentiate on the basis of admission status are inadequate for several reasons. First, the medical circumstances necessitating admission are not necessarily the same as those requiring enforced treatment; hospitalisation and legal competence in a variety of contexts are not directly related. Second, 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 of an informal patient were accepted, while the same refusal of an involuntary patient with equal mental faculties were overridden. (Detention itself could not be the conclusive factor for this would cause equal contradiction if the detained psychiatric population were compared to other detained populations who retain the common law right to refuse medical procedures.) Third, unsoundness of mind is usually disabling in limited respects only. Scientific and clinical comparisons of the total range of behaviour exhibited by mentally disordered persons with behaviour exhibited by ‘normal’ individuals show significant overlap in the two populations. 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 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 inescapable 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; they are also highly relevant to the medical and social decision to be taken about his welfare.

If it were possible to draw any firm conclusion 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 consent to psychiatric treatment.


5. For a review of the psychiatric literature see Morse, Crazy Behaviour Morals and Science: An Analysis of Mental Health Law, 51 S Cal L Rev 527-77, 1978.
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 cognitively 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 underlie the concept that the law should, wherever possible, avoid rigid outcomes based upon legal status. The simplistic assumption that compulsory admission status can be regarded as an accurate, and the sole, measure of competency in respect of individual treatments is not in accordance with scientific evidence and clinical observations.

Reliability of medical judgments: fact or illusion?

Legal and medical thought concerning the propriety of allowing mentally ill or mentally handicapped people to exercise judgment in respect of treatment decisions appears to be this. Mental patients are considered to be detained in hospital because they are unable to make reasonably informed judgments concerning the need for treatment. Members of the medical profession are delegated the task of determining those who are lacking competence in this regard and then to substitute their judgment for that of the person concerned. It is the benefit that is said to accrue to the patient which is thought to justify the deprivation of his ordinary right to self-determination. It follows that the law operates on the assumption that psychiatrists can reliably and validly diagnose particular forms of mental disorder, that treatments with reasonably established efficacy exist, and that psychiatrists can make reasonably consistent and objective judgments concerning the need for a treatment response to a particular medical condition. The evidence to support each of these assumptions is highly equivocal.

Diagnoses

One of the most researched areas in psychiatry and social science is the ability of practitioners to make reliable and valid diagnoses of mental illness. Reliability is a term used to describe the frequency of agreement when two or more independent observers answer the same question; that is the ability of psychiatrists to agree upon a diagnosis when viewing the same person or an identical set of symptoms. Research has repeatedly demonstrated that psychiatrists cannot make reliable diagnoses under normal clinical conditions, although refinement of diagnostic skills by experimentally imposed standardisation of interview techniques, nosological nomenclature and psychiatric training tends to improve diagnostic reliability. Further, a diagnosis often does not convey specific and accurate information about how a patient is currently behaving, why he is behaving in that way or how he is likely to behave in the future. Diagnoses do not appear to be reasonably precise; the same behaviour or affect may be indicative of different diagnoses, while a single diagnosis may incorporate a large range of behaviour and affect. The value of diagnoses, therefore, for the purpose of determining, in a reasonably precise way, legally relevant issues such as compulsory admission, competency and forcible treatment is problematic.

Treatment

There is no conclusive evidence in psychiatry concerning the aetiology of most forms of psychiatric illness, nor is there a clear understanding of why many treatments are thought to have a beneficial effect. Nevertheless, there is some evidence that each of the three major somatic treatments — electroconvulsive therapy,7 psychosurgery8 and medication9 — are empirically effective in the treatment of particular psychiatric conditions.

It has to be observed that the therapeutic effect of each treatment is narrowly limited to particular clinical conditions and depends for its effectiveness on the way it is used. Moreover, use of certain treatments intensively or over long periods of time can result in adverse effects which far outweigh any potential.

benefit. The principal difficulty in respect of these treatments and the area of disagreement at the interface of medicine and law is as follows. Psychiatrists properly observe that the major somatic treatments can be beneficial and can have acceptable levels of risk. Accordingly, the medical view is that safeguards are not warranted and that decisions about treatment should be left exclusively to the medical profession. The difficulty with this position is the fact that in psychiatry, as in most professions, there is a wide range of competence and expertise as well as limited time and resources with which to take decisions. The consistent findings of the major hospital enquiries in the last decade have shown that treatments are not necessarily limited to interventions with established efficacy and safety, and that the major somatic treatments are sometimes used far too extensively and can result in severe adverse effects for the patient. It should also be observed that psychiatrists have been shown to exhibit a singular style of treatment response and to categorise patients medically in a relatively fixed way which is independent of the symptoms observed. There appears to be an overall predisposition to diagnose psychopathology and a propensity in individual clinicians to diagnose and administer treatment according to their different experience and clinical orientation.

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 quasi-medical, but are ultimately non-medical, 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. 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, thus undermining his dignity and physical integrity, 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 interests 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 parameters of the argument should therefore be placed in perspective. There should be no interference with individual clinical judgment where, in the usual case, there is consent to an established and safe treatment. A measured safeguard is required only where there are strong indications toward the need for closer examination of a proposed treatment. Accordingly, a review procedure 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 concept of ‘refusal’ is not identical to the lawyers’ traditional understanding of the concept of ‘consent’. The law ordinarily examines only the issue of whether a person has given an effective legal consent. Failure to demonstrate such a consent is treated identically in law, regardless of the decisiveness of the patient. Thus, it does not appear to


12. For a recent discussion of these issues see, Robertson, Informed Consent to Medical Treatment, 97 LQR 102 1981.
matter, for the purposes of the law, whether the patient's response to a proposed treatment is an express refusal or whether, as is more likely, it is indifferent, equivocal, inconsistent, incoherent, inappropriate or entirely absent. In any fresh examination of the law of consent — particularly in psychiatry — there may well be grounds for differentiating among the following categories of response: an effective legal consent, an objection or express withholding of consent, and a non-objection. A non-objection is a situation where a person does not refuse the treatment but where he does not have the desire or understanding to express his will. This is exemplified by the severely depressed or mentally handicapped person who does not, or cannot, respond to a suggestion that a particular treatment should be administered. In such a case, the law might find it appropriate to appoint a guardian or other person who could provide substituted consent.

The only other instance where an independent review would be required is where the treatment was classified as unusually hazardous, irreversible or not fully established. The definitions for these terms are clearly difficult to arrive at. The term "hazardous" refers to the degree of risk or possible adverse effects of the treatment; there would also be a need to balance this against the potential benefit of the treatment and whether it is regarded as "elective" — that is whether other reasonable alternative treatments are available. The phrase "not fully established" refers to the available clinical and empirical evidence which exists to support the treatment, that is whether there is reasonable research evidence of its efficacy. It would also refer to the extent to which the treatment is accepted practice within the medical community, but that factor should not be regarded as in any way conclusive. It is intuitively self-evident to a lay observer that if a treatment fulfills one of these conditions, an independent review would be warranted. This would also be the case in respect of irreversible treatments — notably psychosurgery. Thus, if a treatment poses disproportionate risks, does not conform to any medical orthodoxy or irreversibly and significantly affects physiological or psychological functioning, it would be proper to require the doctor to explain and justify his decision 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.

The question may arise whether there should be a list of special category treatments in a code of practice or statutory instrument which would warrant special safeguards. Research and clinical practice in psychiatry continually alters 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 is illustrative. Electroconvulsive therapy has been shown to be empirically effective in the treatment of severe endogenous depression, although there is some evidence that the electrically induced convulsion is not the critical factor. More importantly, there is no clinical consensus as to its benefit in the treatment of other psychiatric conditions such as schizophrenia and there is no recognised professional body of opinion upholding its use as a method of behaviour control. Electroconvulsive therapy, therefore, may be regarded as fully established in some clinical contexts but not in others.

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. 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 (that is without muscle relaxant and anaesthetic), where there are significant risks of bodily injury, or when it is used intensively or over a long term where there is a risk
of memory deficit and other adverse effects. This argument is applicable to most other treatments; for example, the long term use of anti-psychotic medication carries with it the risk of irreversible neurological damage such as tardive dyskinesia. 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.

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 to suggest 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, most doctors would not wish to impose the treatment without consent. However, if the doctor did wish to proceed, it would be proper to have some independent safeguard; 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 benefit.

Similar illustrations could be envisaged with the other major somatic treatments. The standard pre-frontal lobotomy was observed from its earliest use not to be effective in the treatment of schizophrenia. However, it was estimated that some two-thirds of the 10,000 operations conducted between 1942 and 1954 were on patients who suffered from schizophrenia. Contemporary psychosurgery is also used in the treatment of schizophrenia despite the fact that rarely is there any marked clinical improvement. There is also inconclusive evidence as to the effectiveness of psychosurgery in a number of highly diverse medical and social conditions - for example, psychosurgery has been performed in the cases of anorexia nervosa, sexual deviation, hyper-responsiveness, aggressiveness and anti-social behaviour. Between 1974-76 there were 16 different types of lesions made in a minimum of 14 cerebral sites. Despite the multiplicity of existing surgical interventions, together with their use on almost the entire range of psychiatric and social conditions, psychosurgery is not the subject of specific legal or administrative regulation.

The effectiveness of the final major somatic treatment - medication with anti-depressive or anti-psychotic effects - is now well established. However, it is also well documented that medication has been used in dangerously high amounts and for excessively long periods in long stay hospital patients. Indeed, the use of major tranquillisers in this way can cause irreparable neurological damage which results in uncontrollable shaking of the limbs and other Parkinsonian-type symptoms.

The 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; 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.

Professional review or audit, represented by second medical opinion or an exclusively or predominantly medical panel, would not be a sufficient safeguard and would not 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
care of the medical profession.

An additional factor is the understand-
able reluctance within the medical
profession (or, for that matter, within
most professions) to interfere with the
judgment of a colleague who is respon-
sible 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 contra-
dict 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 col-
league from whom he would seek a
concurring opinion. One would expect
the doctor to choose an individual with
similar clinical orientation, training and
experience and there would be consider-
able 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' an
opinion — ie seek a second or third
opinion if the first did not concur.

Some of these reservations may be partly
illusory. However, exclusive pro-
fessional 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-profession-
als may not be given sufficient weight.
Confidence of the patient and public
would be maintained only by inde-
pendent examination and review of
individual clinical judgment.

In devising a properly constituted
second opinion, it is important to avoid,
wherever possible, cumbersome, expen-
sive or time-consuming machinery. For
this purpose, it may be preferable if the
second opinion were associated with a
currently existing institutional structure.
Mental health review tribunals or inde-
pendent 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
and hospital ethical committees evaluate
the clinical and ethical aspects of
medical research.) Nonetheless, con-
sideration 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 government proposal to
increase the size of the tribunal by
adding a social work member.

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. The assump-
tions are that a person is detained
because he is incompetent to make any
treatment decision; that the doctor can
make reasonably reliable and objective
judgments concerning diagnosis and
treatment; and that the benefit the
patient would accrue from forcible
treatment would outweigh any interest he
may have in self determination. It has
been the burden of this paper to illustr-
ate that these assumptions are automatic
responses to involuntary admission to
hospital which are supported more by
intuition than by scientific fact or
jurisprudential thought. There is an
intuitive medico-legal disposition to
hold a psychiatric patient incompetent,
irrespective of his clinical condition or
capacity for specific rational under-
standing. 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.

25 See, L Gostin and E
Rassaby, Representing
the Mentally Ill and
Handicapped: A Guide
to Mental Health Review
Tribunals, 1981.
of a treatment which the doctor believes
to be medically indicated, and the
natural presumption by those who regard
themselves as mentally healthy (partic-
ularly if they are endowed with special-
ist knowledge) that they have greater
understanding than the mentally infirm.
All of these factors may instigate
towards paternalism and a pre-determi-
nation 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" have 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 and whether the treatment
should be imposed against his wishes.
I have suggested that the doctor — one
of the partners in the therapeutic trans-
action — 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 impor-
tance, from the perspective of the patient
and the lay public, of introducing a
decision-making process which is inde-
pendent and in which he could have
confidence.

It is, of course, fundamental to the
therapeutic relationship that the patient
who enters hospital for treatment has
trust in the doctor and does not refuse
all forms of treatment. The law, more-
over, 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 im-
possible to choose another doctor or
simply to leave the hospital; the
detained psychiatric patient also has
limited access to his general pract-
titioner or to a second medical opinion if
he disagrees with a particular form of
treatment. 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.