

Consent to Treatment: Legal and Ethical Aspects*

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In anticipating the consultative paper *A Review of the Mental Health Act, 1959* the College's Public Policy Committee prepared a report in 1974 (*News and Notes*, October, November 1974). The second of six points covered in the report related to compulsory detention and treatment. It reads:

The Working Party are firmly of the view that compulsory powers should include the power to treat patients compulsorily for any form of mental disorder, but has doubts as to how far certain types of treatment should be applied on the sole authority of the Responsible Medical Officer against the patient's will or when he is incapable of giving consent.

The report went on to describe the 'certain types of treatment' as irreversible, those carrying considerable risk, and those with long-lasting effects. Here the sole authority of the RMO was not enough and a second opinion 'might well' be required from 'an independent consultant'. The Working Party recommended the following code of practice with patients who will not or cannot consent to irreversible or long-lasting treatments:

Consult the next of kin and obtain their approval; Record agreement or otherwise of next of kin and add own observations if next of kin is behaving unreasonably; Obtain an independent consultant psychiatric opinion in writing; The final decision is the RMO's who should record his reasons for not accepting the opinion of the independent consultant if the latter is in disagreement with his proposed course of action.

The unkind might say that discussions with the next of kin had no legal validity, and if relatives did not swallow the RMO's line they were deemed 'unreasonable'—in writing. The independent psychiatrist's view could also be dismissed as long as it was done in writing, although his 'reasonableness' was not questioned. How could such a second opinion be a safeguard if it could be disregarded?

The DHSS inter-departmental committee which published a consultative paper on mental health legislation in 1976 was not persuaded by these arguments. Perhaps Gostin's *A Human Condition* was more in keeping with the political and social climate. The consultative paper read like a eulogy to MIND, although three other parties had made recommendations in the matter: the Davies Committee on Hospital Complaints Procedure in 1973; the College in 1974; and the Committee on Mentally Abnormal Offenders in 1975.

The Royal (Percy) Commission on the Law Relating to Mental Illness and Mental Deficiency clearly took the view that society (through the good offices of the RMO) had the right to impose treatment on a mentally disordered person

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against his will. It is often considered that the Mental Health Act, 1959 empowered an RMO to treat a detained patient without seeking the consent of any other person although until 1976 that 'right' had not been tested in a court of law. The College's proposals in 1974 have been outlined, but what did other interested parties say? The Davies Committee recommended that a second (not necessarily concurring) medical opinion should be obtained in any decision to impose treatment on a detained patient. The Butler Committee's view was more comprehensive:

If a patient is unable to give valid consent to treatment the doctor should only be able to apply it if it is neither irreversible nor hazardous. Irreversible and hazardous are defined by the Committee as entailing significant physical hazard or having unfavourable or irreversible physical or psychological consequences; Where irreversible or hazardous, and whether there is consent or not, a second opinion and consultation with the relatives should take place before deciding to proceed;

A patient who is able to give consent but refuses to do so should only receive the minimum treatment to prevent his being a danger to himself or others, to save life, or to prevent deterioration.

MIND suggested that in every circumstance where there was not informed voluntary consent a Committee on the Rights and Responsibilities of Staff and Residents of Psychiatric Hospitals should have the power to veto the RMO's proposal.

The DHSS consultative paper rightly criticized the rather patent disingenuousness of the College's independent second opinion. Would there not be collusion? And had not the recent sterilization of a mentally backward girl shown that treatment decisions should not always be left to doctors? The consultative paper further argued that it was necessary to improve the protection of the patient. With this in mind the College had suggested that Commissions similar to the Mental Welfare Commission of Scotland should be established in England and Wales. (Note that the Royal Medico-Psychological Association had supported the maintenance of the Board of Control in their evidence to the Percy Commission.) Manpower shortages were seen by the DHSS as a drawback to the idea, and the proposal was also criticized as a 'paternalistic' and 'establishment' solution which denied today's multiprofessional and community policies. In their turn the Butler Committee toyed with the idea of 'guardians' or 'patients' friends' but MIND went the whole hog and proposed an advocacy system. Its purpose was clearly to tilt the balance away from the medical profession towards the general issues of civil liberties and rights. There would be a minimum of one advocate per 500 institution residents; an advocacy co-ordinator at a regional level; and a quasi-judicial system of Committees on the Rights and

Responsibilities of Staff and Residents of Psychiatric Hospitals at both institutional and national levels.

It became evident that once the sacred cow of clinical judgement was challenged, the consent to treatment issue would involve a body other than the RMO. The civil rights movement championed the cause, since it offered amongst other things the prospect of medical iconoclasm. The radical advocate would have wrested some of the power from the reactionary alienist. The College published its comments on these proposals in *News and Notes* (March 1977). The main arguments were that the advocacy system would place an undue emphasis on rights from the legal aspect rather than on humane care. The College also viewed with concern the suggestion that there should be patients' advisors. Were not hospital managements already charged with this function? Surely the solution was to ensure that this responsibility was properly carried out.

The College also suggested, perhaps tongue in cheek, that Community Health Councils should be assigned the task of monitoring hospital management's actions in this area. The College again emphasized that the setting up of Mental Welfare Commissions in England and Wales would make the advocacy and the advisor proposals unnecessary.

In September 1978 the Labour Government published a White Paper *Review of the Mental Health Act, 1959*, and indicated its intention of translating its proposals into an amending Bill. The suggestions regarding the topic of consent to treatment can be briefly summarized:

Nothing in the Act authorises or implies that informal patients can have treatment imposed without consent. The amending act should make it clear that staff can, in an emergency, treat a detained patient for his mental disorder without his consent. Irreversible (and doubtfully irreversible) hazardous, or not fully established treatments should not be imposed without both consent and a concurring second opinion. With detained patients, consent should be sought. If refused, alternative treatment should be offered which may prove acceptable. With a concurring second opinion treatment can only be given against a patient's will to save life, and to prevent violence or deterioration. Second opinions should be sought where ability to give consent is questioned.

The second opinions were to be from multidisciplinary panels established by each Area Health Authority and, furthermore, the hospital managers were to have a duty to inform patients of their rights concerning consent and second opinions.

A Special Committee of the College was set up to consider the White Paper, which presented itself very much as a vindication of the anti-establishment view. The policies were a step away from the Percy Commission's attempt to forge a link between physical and mental illness. The Committee argued that the conditions in which a treatment was hazardous could not be codified in an Act of Parliament but were circumstantial; they should remain a matter of clinical judgement and rely on the proper use of the well-established

practice of seeking colleague's advice. The White Paper broadly followed the lines of the Butler Committee in regard to the criteria for compulsory treatment: it proposed a limitation of the situations in which treatment could be imposed without consent, it distinguished between patients who could give informed consent and those who could not, and it recognized a need for special arrangements for certain types of treatment.

The College reaffirmed the criteria adopted by the Percy Commission, namely that the use of compulsion is necessary for the patient's own welfare or the protection of others. Psychosurgery and the proposed prescription of ECT for patients refusing to give consent were seen as the only forms of psychiatric treatment in which a second opinion might be made mandatory. It was argued that the psychiatrist was trained to judge risks, that it was good psychiatric practice to consult colleagues, and that ethical committees already had jurisdiction over treatments that were not fully established. To the College the least acceptable proposal contained in the White Paper concerned the form of the second opinion. The consultative document had been cautious in discussing, and rejecting, the proposal for Mental Welfare Commissions and in giving guarded support to Butler's advocacy system. In the end it was the multi-disciplinary panel that was championed in the White Paper. The consultative document had hinted that decisions concerning particular medical treatments should not be left to doctors, especially when the treatment was proposed for social reasons or was based, at least in part, on a non-medical prognosis. Psychologists and nurses were identified as future members of the panels, which would

... provide a second opinion whenever it is proposed to carry out treatment which is irreversible, hazardous or which has not yet been fully established, whether the patient has consented or is not capable of giving a valid consent; ... give advice in any other case in which the doctor feels it would be helpful, for example, whether or not a form of treatment should be considered irreversible, hazardous or not fully established.

Both the above are derived from the Butler Committee recommendations, only the form of the second opinion has been radically changed. The third functions for the multi-disciplinary panel would be to '... consider complaints by individual patients that they are not receiving adequate treatment'.

The White Paper stated the Labour Government's belief that the establishment of such panels with a substantial medical involvement would bring positive advantages. Furthermore, it was suggested that once the opinion of the panel had been sought it should not be possible to impose treatment without the panel's endorsement. The College expressed its overwhelming objection to multidisciplinary panels providing second opinions. Despite a medical membership, the panel would not be competent to give a technical opinion, to make a professional judgement, or to

take responsibility for the patient. The College had gained very little, and its members were faced with Government proposals which were anathema to them.

Towards the end of its period in office, the Labour Party depended on a pact with the Liberals, and amending legislation was not put to the House.

When the Conservatives came to power in May 1979 the College was given breathing space and a chance to form an attachment to medicine's ally of old. Would it not be right to see multidisciplinary panels as liberal quangos? Control was the new order of the day in one form or another, and what better time to resurrect the Mental Welfare Commissions proposals? The battle to preserve clinical independence was clearly lost, and psychiatrists now had to face the likelihood of legislation to determine where and when they must seek a second opinion, and from whom.

To influence amending legislation in a major way, policies must be approved at the stage where Government departments issue instructions to counsel. This must be months before the Bill drafters begin work, when decisions are made regarding the content of the following year's legislation in the Queen's Speech. To abandon the concept of multidisciplinary panels and accept the Mental Welfare Commissions proposal would be such a major change, and if mental health legislation is to be contained in the next parliamentary session instructions to counsel, which have already been issued, should have Mental Welfare Commissions as a central concept.

The College has proposed that a Mental Health Commission (replacing 'Welfare') would have two important functions with regard to consent to treatment: the MHC would advise for which treatments and under which circumstances second opinions should be obtained, and arrange for such

opinions to be provided; MHCs would arrange for second opinions to be provided in cases which may be required by legislation. In addition, at the request of the RMO, the MHCs would advise on the care and treatment of patients. The Mental Health Commissions would supplement such bodies as the Court of Protection, the National Development Team, Mental Health Review Tribunals, and the Health Advisory Service—it would not usurp their role. The College envisages that a number of MHCs will be required for England and Wales and that each could serve more than one NHS region. They would include the Special Hospitals. Membership should comprise psychiatrists and members of other health care professions, as well as lay members. The chairman should be an experienced and senior lawyer. Members should be appointed by the Lord Chancellor, and psychiatric members should be selected from nominations made by the Royal College of Psychiatrists. Membership would be for periods of five years. A permanent secretariat would be needed and central co-ordinating machinery would be necessary. MHCs would be concerned with a multi-dimensional problem: one axis would be type of treatment, their concern being the hazardous and irreversible (as defined by legislation and the MHC); the second axis would be the patients' legal status; the third, their status regarding consent. In addition to these powers, duties and responsibilities the MHCs would cover all the other unsavoury areas exposed by the civil rights movement and particularly: reviewing the use of compulsory powers; the care and treatment given to individual patients; protective and advisory roles in relation to patients' rights; monitoring compulsory admission documents; visiting detained patients. If the MHC were to serve these functions properly consent to treatment would not be an issue.

Forthcoming Events

The **Second Symposium of Personal Meanings**, which will be directed at the examination and discussion of issues within the themes of 'Intensive versus extensive designs'; 'Comprehension of ordinary language and structuring understanding'; and 'Values in psychological treatment', will be held at Guy's Hospital on 19 and 20 February 1982. Information: Secretary, Personal Meanings Symposium, Department of Psychiatry, Guy's Hospital Medical School, London Bridge, London SE1 9RT.

The Association of University Teachers of Psychiatry in conjunction with the University of Oxford Department of Psychiatry, is planning a **conference on the teaching of dynamic psychotherapy** which will be held from 17 to 19

March 1982 at University College, Oxford. Information: Dr Sidney Bloch, Organizing Committee, Department of Psychotherapy, Warneford Hospital, Oxford OX3 7JX.

The Psychotherapy Section of the Academic Department of Psychiatry, St George's Hospital Medical School, is offering an **MSc course in clinical psychotherapy (London University)** to start in October 1982. The course will last for three years on a one-day per week basis. All interested medical practitioners should apply to Mrs Court, Psychotherapy Section, Academic Department of Psychiatry, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE.