

Treatment over objection: minds, bodies and beneficence

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“The only freedom which deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily or mental and spiritual”

John Stuart Mill – On Liberty¹

Introduction

This quote from Mill highlights an important distinction for medical ethics: a distinction between bodily and mental health. In this paper, we want to look at the ways that ethics and law have addressed this distinction, especially in relation to involuntary treatment. We will claim that both philosophy and case law appear to address involuntary treatment for physical disorders in very different ways to involuntary treatment for mental disorders; and will relate these differences in analysis to different approaches to understanding the capacity to make autonomous decisions.

Voluntary and involuntary treatment.

The bioethics literature generally has privileged the place of patient autonomy in medical decision making: a position perhaps best summed up by Judge Cardozo in *Schloendorff*:²

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”

There are two key issues here; first, that the privileging of autonomy rests on a finding of ‘soundness of mind’; second, that any intervention by the doctor that does not reflect the patient’s autonomous agreement is an assault. By extension, where there is ‘unsoundness of mind’, the patient’s right to choose for himself may be undermined, and therapeutic interventions may (a) be performed without consent, and (b) will not then constitute an assault in legal terms.

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1 John Stuart Mill, *On Liberty*. London: Pelican Books. 1974 at page 72

2 *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129–30, 105 N.E. 92, 93 (1914).

This extended argument is bourn out by existing legal approaches. Any non-consensual treatment, unless legally sanctioned, will be liable to damages as per existing Tort laws. Changes to the legal concept of 'consent' have led to shifts in the application of judicial sanctions³; including notions such as "informed" consent, proxy consent, best interest, and substituted decision making. Consent is defence to assault; where there has been consent, there can be no injury⁴.

Underpinning the concept of consent lies the concept of capacity or competence. Confusingly these terms may reflect either the legal or the clinical concept, depending on which side of the Atlantic it is being discussed; in this paper we use the term *competence* to refer to the *psychological* construct underpinning a *legal* concept of *capacity*. As suggested above, lack of capacity has been understood as justifying involuntary treatment, or at least undermining a right to consent before treatment. The question of involuntary treatment has been most widely explored in relation to people with mental illness, whose competence to make autonomous decisions may be impaired by that illness. Most countries have legislation that provides a legal measure setting out the conditions under which it is lawful to impose involuntary assessment, detention or treatment for a mental illness.

Such measures frequently cause controversy among jurists, clinicians and academics in mental health law. Most jurisdictions proscribe any prolonged deprivation of liberty of citizens; so that (for example) in the US and Europe, involuntary detention and treatment may contravene both the 14th Constitutional amendment in the USA, and the European Convention on Human Rights.

Some have argued that such involuntary treatment constitutes a paternalistic intervention in the lives of those who are merely socially deviant (^{5,6}cf Kittrie, 1971; Szasz, 1960); or even, that involuntary treatment for mental disorder represents the most severe intrusion by the state into individual civil liberties, short of criminal charge and conviction. Such a view points out the similarities between responses to deviance as a consequence of illness, and criminal deviance, in that both deprive the individual of his or her liberty, usually involve forced residence in an impersonal institution, and subjection to control by others which may entail loss of dignity (⁷Goffman, 1961).

In the case of forced treatment, a person may also be subjected to physical coercion and even intrusion; both of which may be experienced by the individual as humiliation or even punishment. The tremendous power differential between the recipients and providers of mental health care makes freedom to choose an illusion, even when it is ostensibly voluntary⁸. Finally, it has been argued that (a) it is difficult to make mental health diagnoses which would justify any intervention, and (b) that distressing mental experiences do not constitute a health 'disorder' at all; (we will not explore this argument further in this paper, referring the interested reader to Fulford, 1989 for a review⁹).

3 Paul S. Appelbaum. *Almost a Revolution—Mental Health Law and Limits of Change*, Oxford University Press. 1994.

4 Feinberg, J. *Harm to others*. Oxford OUP. 1984

5 Kittrie, N. *Right to be different*. Viking Press 1971.

6 Szasz, T. (1960) *The myth of mental illness*. *American Psychologist*; 15: 113–118

7 Goffman, E. *Asylums*. London, Penguin . 1961

8 McCubbin M., & Cohen D. (1996) *Extremely Unbalanced: Interest divergence and power disparities between clients and psychiatry*. *Int J. of Law and Psychiatry*, 19, 1–25

9 Fulford, K.W. *Moral theory and medical practice*. Cambridge, CUP. 1989

The counterarguments in support of involuntary treatment for mental disorder are briefly:

- (a) that mental competence can be lost for health reasons, and
- (b) that an individual's lack of mental competence to make decisions for himself is a justification for benevolent intervention by others, and
- (c), further, that loss of competence, being a harm in itself, should not result in further harms or the prevention of benefits¹⁰.

Such paternalistic arguments assume that where there is absent or diminished capacity to make decisions, a duty to benefit others takes precedence over autonomy, and that there is only limited over-riding of autonomy. Thus, both the wrong and the harm done to the individual are minor. Further, involuntary treatment is almost always used as a last resort, when there is not only a demonstrated need but also when there is the potential for *harm* without it. Although such weak paternalism does limit autonomy on the grounds of beneficence, the harm or wrong done by denying autonomy is offset by the harm that would have been if the choices of an incompetent person were honoured, or if no choice were made at all. For these reasons, competence underpins legal capacity to consent to health care decisions; absence of competence/capacity is a justification for state intervention on the grounds of *parens patriae*, a legal notion whereby power is exerted by the state on behalf of its citizens.

Perhaps what is most striking about these arguments are the underlying assumptions that mental disorders uniformly render patients incompetent to consent, and that physical disorders do not. Factors that might limit competence have not been explored in the same detail, other than mental illness. Nor has there been the same attention paid to those situations where individuals refuse treatment for *physical* disorders. As a result, there have been several legal cases which have pushed the theoretical debate, in both the USA and England. Before, reviewing those cases, we consider in more detail the legal and philosophical aspects of capacity.

Autonomy, Competence and Capacity

Competence and capacity are legal and psychological concepts, which in turn are closely conceptually related to the philosophical concept of autonomy, which entails (arguably) both a psychological competence to choose for oneself, and the experience of a self that chooses. One requires a competence to be autonomous; to achieve what Berlin describes as 'positive liberty'¹¹.

Autonomy may not have a single coherent meaning; Feinberg¹² suggests that there are four:

- (i) the capacity to govern oneself;
- (ii) the actual condition of self-government;
- (iii) an ideal of autonomy, derived from (ii); and
- (iv) the authority to govern oneself.

Within medical ethics, this fourth aspect arguably underlies both the principle of respect for autonomy and the privileging of that principle¹³. Gillon¹⁴ has suggested that it may be helpful

10 Buchanan, A & Brock, D *Deciding for others: the ethics of surrogate decision making* Cambridge, CUP. 1989

11 Berlin, I *Four essays on Liberty*. Oxford OUP 1971

12 Feinberg, J *Harm to self*. Oxford OUP 1986

13 Beauchamp, T & Childress, J *Principles of biomedical ethics*. Oxford OUP 1994.

14 Gillon, R. *Biomedical ethics*. BMA books. London, 1985

(certainly in the medical domain) to consider autonomy of will, thought and action as separate capacities. Christman¹⁵ distinguishes the psychological capacity for autonomy (P-C autonomy) from the right against actions which undermine P-C autonomy (R autonomy).

Christman's distinction may be a helpful way to think about the distinction between consent to treatment for physical disorders, and consent to treatment for mental disorders. Respect for autonomy in relation to treatment for physical disorders seems to privilege R-autonomy, whereas in relation to mental disorder, it is assumed that P-C autonomy is so compromised that R- autonomy is not a consideration. We will return to discuss this further.

Autonomy and others

Respect for autonomy is reflection of the respect for individual freedom, which Mill believed would produce the greatest happiness for individuals. But Mill's emphasis on liberty is arguably only relevant in isolation and not in the company of others¹⁶. It has been argued that the traditional concept of autonomy is too individualistic and does not take into account normal human experiences of dependence and need for others.¹⁷ Similarly, autonomy is likely to be a developmental capacity that has a lifespan trajectory, and may change over time; there may be different types of autonomy at different stages of the life span. This shifting nature of autonomy is most obvious in relation to children and adolescents where the developing child's autonomy is located in a network of relationships with carers, and only emerges over time^{18,19}. This notion of a nested or located autonomy is similar to that described by Agich as 'interstitial autonomy'. Such N (or network) autonomy is located in the psychological spaces between people in relationships with each other, where their experience of themselves is profoundly affected by those relationships.

A more complex account of autonomy could have significant implications for the ways we look at ethical and legal dilemmas in mental health practice. One of us has argued elsewhere that an approach to ethical reasoning, which locates the actor in a relational context rather than a rights based approach, may offer different and more complex solutions²⁰. In contrast, the law in AngloSaxon jurisdictions such as the US and the UK tends to reflect a traditional individualistic approach to autonomy, as exemplified by the legal notion of capacity to make choices. Such legal capacity is individually based, and is a categorical decision (either one has capacity or one does not²¹). There is some acknowledgement that different decisions require different capacities; e.g. the legal test of competence to make a will (which is a criteria based test) is different from the legal test of competence to get married (which is a status based test).

15 Christman,J(1988) *Constructing the inner citadel: recent work on the concept of autonomy*. *Ethics*, 109-124.

16 " We are not isolated free choosers, monarchs of all we survey, but benighted creatures sunk in a reality whose nature we are constantly and overwhelmingly tempted to deform by fantasy" - Murdoch, "Against dryness", in S. Hauerwas and A. Macintyre (eds.) *Revisions: Changing perspectives in Moral Philosophy*. University of Notre Dame Press 1983 at p. 49.

17 Agich,George A . *Autonomy and longterm care*. Oxford OUP. 1993

18 Josselson,R-E. *The space between us*. Josse-Bass. 1992

19 Sutton,A. (1997) *Autonomy in adolescents*. *Journal of Medical Ethics*. 23: 26-31

20 Adshead,G. *A different voice in psychiatric ethics*. In Parker,M & Dickeson,D (eds.) *The Cambridge medical ethics work book*. Cambridge, CUP. 2000. pp 185-190.

21 Kennedy,I & Grubb,A. *Textbook of Medical Law*. London, Butterworths. 1994.

Autonomy and rationality

Mill's account of autonomy also presupposes rationality, where rationality means the privileging of reason over emotion. Although the descriptive splitting of thinking and feeling as separate psychological functions has a long conceptual history, there is less evidence to support such a split than may be supposed. Affects generate thoughts, and thoughts generate affects; thinking and feeling are processes which need to operate as a psychological matched pair. If either are out of kilter, then the other will be affected; the relationship is symbiotic rather than hierarchical. Rationality therefore presupposes a functioning capacity for both affects and cognitions; it will not be possible to be rational where there is dysfunction of either process.²²

Rationality and autonomy have been closely linked conceptually; hence the general and traditional assumption that the mentally ill lack autonomy, because they lack rationality. Rationality includes the logical capacity to make judgements and decisions, and it is generally assumed that the presence of a mental illness compromises the ability to make decisions of any kind. In fact, it might be argued that one of the symptoms of mental illness is an inability to make decisions for oneself; a loss of an ability to govern oneself is a diagnostic criterion in its own right.

It is however not so clear that all types of mental illness do compromise all types of autonomy, or diminish all capacity to make any decisions²³. There is increasing evidence that people with mental illnesses do retain capacity to make all sorts of decisions, including consent to treatment and research. The problem remains that others may not like their decisions, and this subjective reaction may lead to a questioning of capacity²⁴. What this suggests is that the test of rationality applied is one that relates to the supposed motivations behind the decision²⁵ or the comprehension and acceptance of the reasons given for the decision²⁶.

Many important life decisions for people involve a low threshold for decision making competence. In English law, for example, one need only be 16 to choose to have heterosexual intercourse, or to get married. One has to be aged 18 to vote; this decision, one might argue, is a less complex decision than either of the previous two, which involve judgements about complex interpersonal relationships over time. One need be only 16 to make decisions about health care; later legal modifications to this are discussed below. Given that tests of competence for these decisions are generally set very low, it seems anomalous to set them higher on the basis of an individual's history of mental disorder. It might be argued that the consequences may be potentially very serious, if the wrong decision is made; but this argument would apply also to individuals with physical disorders also.

It could be argued that any type of disorder, physical or mental, compromises autonomy to some degree. Although the distinction between will, thought and action looks attractive, psychologically these are likely to be overlapping domains; and someone with what might be thought to be a purely physical disorder may well find that their sense of themselves as autonomous has been altered or compromised²⁷. Something of this difficulty can be seen in relation to patients' experience of

22 Charland, L. (1998) *Is Mr Spock mentally competent?* *Philosophy, Psychology & Psychiatry*, 5:67–81.

23 Grisso, T & Appelbaum, P. *Assessment of competence*. CUP 1998

24 Roth, L et al. (1982) *The Dilemma of denial in the assessment of competency to refuse treatment*. *American Journal of Psychiatry* 139: 910–913

25 Matthews, E. *Mental and physical illness: an unsustainable separation?* In Eastman, N & Peay, J (eds.) *Law without Enforcement*. Hart Publishing, Oxford. 1999 pp 47–59.

26 Culver, CM & Gert, B. Cited in Buchanan and Brock (*supra*). p 66.

27 Sacks, O. *A leg to stand on*. Simon & Schuster, New York, 1998

giving informed consent in general medical practice, where it is clear that although the procedure of informing patients has taken place, patients do not retain information, and may be hazy about the implications of the consent procedure. Similarly, a study by Appelbaum²⁸ found that a significant proportion of apparently competent people could not distinguish between participation in research and therapy.

Legal approaches to capacity: English and US law

Consent to treatment

We have suggested that both mental and physical disorders may have an impact on the capacity to make good quality decisions about health care. We have emphasised this issue because it appears that the legal approaches to capacity differ in relation to physical and mental disorder. We turn now to review some relevant legal cases.

Consent is defined as the voluntary and continuing permission of patient to receive a particular medical treatment. It is based on knowledge of the nature, purpose, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Consent should be freely given (i.e. in the absence of duress or inducements) and includes the right to refuse treatment.

Valid consent is that which is given by a person with the capacity to make a treatment choice. Right to self-determination in adults with capacity generally prevails over any countervailing state interest²⁹. In relation to the consent of children, a majority decision in the case of *Gillick*³⁰ held that age alone did not make one incapacitated to consent; and parental authority has to give way when capacity is established, based on the maturity of the individual child.

American law has utilised a concept of 'informed consent', which entails competence, disclosure, understanding, voluntariness and consent³¹, all of which must be present for consent to be legally binding. We concentrate here on the legal criteria of competence and understanding, and relate these to more general accounts of tests of capacity to consent. Broadly, these are—

- (a) the ability to make and express a decision
- (b) to actually understand the information presented and alternatives
- (c) to rationally manipulate the information and appreciate the implications of alternative choices and
- (d) to make a reasonable decision.

US and British tests are fairly similar; English law criteria include the ability to understand, retain and believe information.^{32,33} English common law allows a competent individual to decline treatment under the same broad general principles as in the US; the test for capacity to refuse treatment appears to be same as consenting to treatment.

28 Appelbaum PS et al (1987) *False hopes and best data: Consent to research and therapeutic misconception*. Hastings Center Report. Apr.: 20–24

29 *Home Secretary v. Robb* [1995] 1 All ER 677

30 *Gillick v. West Norfolk and Wisbech Area Health Authority and another* [1985] 3 All ER 402

31 *Beauchamp and Childress goes further to add recommendation of a plan in the information part. Authorisation of the chosen plan then becomes similar to*

expression of consent. Similarly, refusal of consent has to be read as decision against a plan. – Principles of Biomedical Ethics – 4th Ed. Oxford University Press. 1994

32 *Re C (Adult) (Refusal of Medical Treatment)* [1994] 1 WLR 290, sub nom *C (Refusal of Medical Treatment)* [1994] 1 FLR 31

33 *Clauses 1 to 5 of a draft of a Bill annexed to the Law Commission report No 231 on Mental Incapacity. 1995.*

Absence of consent: who decides?

Previous cases have highlighted the need to make clear the role of third parties or the state in giving consent to treatment for those who cannot give consent for themselves, either permanently or temporarily. In *re B*,³⁴ the House of Lords found that medical treatment in the absence of consent was not an assault if the treatment were in the patient's best medical interests (as defined with reference to a professional medical standard). However, they noted that there might be some treatments that had such social significance (such as sterilisation) that the treatment decision could not be left to the medical profession, but a court opinion should be sought. Several subsequent cases have further defined 'socially significant' treatments, and the role of the court.

The English courts have therefore favoured a medical justification for proceeding in the absence of consent. In contrast, the American courts have tended to favour the notion of 'substituted judgement' i.e. others make a judgement for the incompetent individual. Yet this is not straightforward. In *Saikewicz*,³⁵ the Massachusetts Supreme Court reviews the concept of substituted judgement; and argues that it involves ascertaining the incompetent person's actual wishes and preferences. However, they also suggest that the decision should be:

'that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would...be part of the decision making process'.

In the case of *Quinlan*³⁶ however, the New Jersey Supreme Court indicated that the views of others close to the individual could substitute for the views of the incompetent patient; which seems to support a less atomistic view of a person's choices.

Various legal measures have been proposed for dealing with cases where there is lack of capacity. A process of substituted decision making was supported by the Law Commission³⁷ and the Expert Committee recently reviewing English mental health legislation³⁸. The Law Commission has also supported advance directives and 'living wills', which express previously given consent as if it were given now, even if currently incapacitated. Lord Goff in *Bland*³⁹, and British medical codes of practice, have clearly stated that advance refusals (directives) are as valid⁴⁰ as the advance statements.⁴¹ Once established as authentic, due respect must be given to such an advance directive. However, such directives are not binding on the professional nor are they effective in the case of treatment refusal for mental disorder if the patient is detained under the Mental Health Act 1983 and is subject to the provisions of Part IV of that Act.

34 *Re B (a minor) (wardship:sterilization)* [1987] 2 All ER 206

35 *Superintendent of Belchertown State school v. Saikewicz*. Supreme Judicial Court of Massachusetts, 1977. 373 Mass.728, 370 N.E.2d 417.

36 *In Re Quinlan*. Supreme Court of New Jersey, 1976. 70 N.J. 10, 355 A.2d 647.

37 Law Commission- *Report on Mental Health Incapacity 1995*

38 Department of Health (1999) *Review of the Mental Health Act 1983: Final Report of the Expert Committee*. Department of Health, London.

39 *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

40 *For an advanced directive to be valid and enforceable, the following has to be satisfied (BMA Code of Practice, infra note 41):*

(a) advance instructions are clear and unambiguous as to what is to be done (or not done) and under what circumstances

(b) at that time he is legally competent to do so

(c) the document should be witnessed

(d) been made fully aware of the risks, alternatives etc.

(e) circumstances are exactly similar, verified by independent health carer(s)

Also see Richard Jones *Mental Health Act Manual (2001)* (Sweet and Maxwell – 7th edition) Para I-630.

41 *BMA Code of Practice on Advance Statements about Medical Treatment – Report of the British Medical Association – BMA 1995*

The capacity to refuse treatment: physical disorders

In most jurisdictions, a competent treatment refusal must be respected by health care teams. This stance reflects not only the respect for autonomy described above, and the privileging of autonomous decisions, it also recognises that there are decisions that are more important than medical ones. Such an approach has been reflected in legal decisions on both sides of the Atlantic. The cases are often tragic ones; for example, the case of AK, a 19 year man with 'locked in syndrome' who refused further treatment, knowing this would result in his death.⁴² Some cases have involved refusal of treatment on religious grounds.⁴³

However, the key issue here is that of how to conceptualise the competence to make such a decision, especially where the foreseeable consequences are risky to the individual concerned. It has been argued that the more serious the consequences, the greater the degree of capacity which needs to be demonstrated. Counterarguments have emphasised the right to make decisions that are unpopular with others, especially in the domain of quality of life and living. Such debates have naturally found most relevance in relation to refusal of treatment that leads to death. Interestingly, the American courts have suggested that the right to privacy includes the right to die.

When treatment refusals have been contested by third parties, the courts have paid close attention to the competence of the patient, and generally assumed that the capacity to consent is the same as the capacity to refuse. In *Yetter*,⁴⁴ the court found that if the refusing patient was aware of the possible consequences of her refusal of treatment then this should be respected, even though it might be considered 'unwise, foolish or ridiculous'. In both *re C* and *re B*, the Courts found that a patient detained in a mental hospital, suffering from a mental disorder, could still make a competent treatment refusal, which must be respected; and in *re T*,⁴⁵ Butler-Sloss LJ stated (at 664),

'the decision to refuse medical treatment by a patient *capable* of making the decision does not have to be sensible, rational or well considered' (emphasis added).

However, this approach has not been consistently supported in relation to one group of competent patients: pregnant women who refuse Caesarean section. Even where the competence of the patient is not in doubt, women have been legally compelled to have surgery in order to save the life of their unborn child.⁴⁶ In *St George's Healthcare NHS Trust v S*,⁴⁷ the mother was compelled to have the surgery; at appeal, Judge LJ said this:

'the autonomy of each individual requires continuing protection even, perhaps particularly when the motive for interfering with it is readily understandable, and indeed to many would appear commendable'.

But as Wicks suggests, it is hard to know if this principle would still have been respected if the patient had not been coerced, and subsequently died. In these cases, one must conclude that the clinicians and the courts have been more influenced by the perceived risky consequences than the principles of respect for autonomy. However, the extent to which professional anxiety may

42 *re AK* [2000] 58 *British Medical Law Review* 151

43 *In re Osborne* District Court of Columbia Ct of Appeals, 1972. 294 A.2d 372

44 *In re Yetter* Court of Common Pleas of Northampton County, Pennsylvania, Orphans Court Division, 1973. 62 Pa.D. & C. 2nd 619.

45 *Re T (Adult refusal of medical treatment)* [1992] 4 All ER 649

46 Wicks, E (2001) *The right to refuse medical treatment under the European Convention on human rights*. *Medical Law Review*, 9: 17–40.

47 *St George's Healthcare NHS Trust v S*. [1998] 3 All ER 688

compromise good quality decision making is not anywhere discussed; just as AK's feelings about his terminal illness are also not discussed. There appears to be a distinction operating about the experience of psychological distress: In relation to a physical condition, it is rational, understandable and does not compromise competence, but in relation to a mental condition, psychological distress is neither rational nor understandable, and does compromise competence.

The capacity to refuse treatment: mental disorders

The situation with regard to treatment refusal is very different if this is in the context of mental disorder. Under current English law, a detained patient may not be legally able to refuse treatment for a mental disorder under certain conditions. There is no requirement to show that the patient lacks capacity to make a treatment decision, (unlike the approach taken above where a determination of capacity is essential); only that they suffer from a 'mental disorder' (a status test).

'Medical treatment' is defined in the English Mental Health Act 1983 as including 'nursing and also includes care, habilitation and rehabilitation under medical supervision'⁴⁸, broadly the range of activities aimed at alleviating or preventing deterioration of the patient's mental disorder. It also includes physical treatment such as Electro-convulsive Therapy (ECT) and the administration of drugs and also Psychotherapy.

Two sections limit the administration of involuntary treatment. There are treatments of a particular kind, administration of which needs special safeguards because of their very nature or effects (such as psychosurgery or hormone implants). Section 57 of the English Mental Health Act requires for these types of treatment both the patient's expressed consent and a second opinion. For ECT or prolonged drug treatment, either consent or a second opinion is required under Section 58.

All other treatment not specifically falling under sections 57 and 58, can be given without the patient's consent, even when capacity is retained. This would include a variety of therapeutic activities with a variety of staff, psychological and social therapies. Only involuntary treatment for mental disorder therefore covers such a wide range of interventions; no such treatments can be given involuntarily for physical disorders.

However, new advances in medicine highlight some of the difficulties there may be in making such a distinct separation between mental and physical disorders. Certain drugs, used for both physical conditions and mental conditions, can have different status under consent provisions. An example would be Propranolol. Originally a drug for heart conditions; it is used for treatment of anxiety. When used as such, it falls under Section 58. When the same drug, in similar dosage is administered for Lithium⁴⁹ induced tremor or akathisia⁵⁰, it is not legally necessary to obtain consent or subject it to Section 58 because the treatment will be for a neurological condition, not a mental illness.

48 *Mental Health Act 1983 Section 145*

49 *a mood stabilizer – used in treatment of manic depressive illness among others*

50 *a condition of motor and psychic restlessness, usually but not exclusively a side effect of certain anti-psychotic medications*

New and controversial interventions have been added to the list of treatments for mental disorder, which can therefore be given in the face of a flat refusal. These include restraint^{51,52}, involuntary Caesarian section⁵³ and tube feeding⁵⁴; all of which have been deemed by courts to be treatment for mental disorder. Treatment has even been extended to include assessment⁵⁵.

Such decisions reveal striking anomalies in the way that the English courts have dealt with treatment refusal in relation to mental disorder and physical disorder. Consider tube feeding as an example. An ordinary person who decides to starve themselves to death (for example, a prisoner), or a terminally ill person who is not eating during the final stages of life, cannot be force fed against their will. It may be that if they become incompetent to take a treatment decision (e.g. when they become unconscious) that treatment may be given in the absence of their consent as described above.

If, however, food-refusing individuals can be deemed to be suffering from a mental disorder, then they can be force fed, even if they are deemed to be competent. The 'not eating' is understood as a symptom, which is secondary to the mental disorder, and forced feeding is the appropriate treatment for that symptom. This was the case in *B v. Croydon Health Authority* where, although B's treatment refusal was deemed to be competent, she could be force fed in the face of her refusal because she was detained for treatment of a mental disorder. Compare this with the stopping of feeding of those with terminal illnesses, where the loss of appetite is secondary to the physical disorder, but a previously expressed wish to forego treatment for the physical disorder can be accepted.

In the case of suspected mental disorder, the judiciary appears to abandon autonomy as the overriding value in relation to consent, and instead favour beneficence, in the form of treatment intervention. In these cases, English courts seem to have favoured a medical 'best-interest' model; consistent with the courts approach to consent in children, where, even if *Gillick* competent, best interests was once again held to be all prevailing⁵⁶.

Mental and physical disorder : autonomy and risk

As described above, courts seem to take a wide definition of treatment for mental disorder, which includes treatment for the physical symptoms of that disorder. The courts have reasoned that to take any treatment interventions out of context will be 'too atomistic a view'⁵⁷. They appear to have taken the view that involuntary treatment may be given for *any* physical condition which is 'integral' to the mental disorder of the patient.

What is then not clear is what 'integral' means in this context. The courts seem to be arguing that where the physical symptoms can be understood as related to the mental disorder, even indirectly, then treatment for the symptoms will be treatment for mental disorder, and thus can be given under current law. However, this position is not consistent with the view (held in both *C* and *B*) that the

51 *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762, (1996) BMLR 93

52 *Herczegfavy v Austria* [1992] 15 EHRR 437

53 *Tameside* supra note 51

54 *B v. Croydon Health Authority* [1995] Fam 133, [1995] 2 WLR 294, [1995] 1 All ER 683, [1995] FLR 470, CA

55 *B v. Barking Havering and Brentwood Community Healthcare NHS Trust, Court of Appeal* [1999] 1 FLR, 106 Lord Woolf MR at 114 E

56 *Re. W (A Minor) (Court Jurisdiction)* [1992] 3 WLR 758 at 769

57 *Tameside* supra note 51

presence of a mental disorder does not necessarily compromise all an individual's decisions. People can apparently split off different aspects of their experience, especially decision making capacity, and possess full competence, even where there is serious physical and/or mental disorder.

The distinction which is being made here seems to rest on the assumption that the presence of any mental disorder globally affects all decision making, so all decisions are rationally suspect and do not reflect a 'true' decision of that person. In addition, physical symptoms arising from treatment refusal in cases of mental disorder are therefore also symptoms of mental disorder; psyche and soma are 'integral' to each other. In contrast, physical disorders are not assumed to affect mental processes in a global way, or indeed in any way. No matter how physically symptomatic the patient is, nor however risky the consequences, his mental capacity to make a treatment refusal can be reliably separated from the effects of his physical disorder; psyche and soma are dis-integrated.

Does it make sense to distinguish mental and physical disorders as different entities in relation to capacity? It might be argued that the chronicity of some mental disorders does affect autonomy in ways that differ from physical disorders which often occur in discrete episodes. As Agich has argued⁵⁸, the ethical issues raised by the delivery of long term care are different from acute care. Agich has argued that "chronic illness involves suffering as a mode of existence" and the definition fits most models of mental illness and certainly personality disorders. Chronic illness is not treated, it is *managed*. Chronic illness thus has to be discussed along a different axis, one which is complementary to liberal theory, not inimical to it⁵⁹. Agich's argument is that, there are differing levels of autonomy, there must be different levels of capacity. But there is no reason why this argument should not also apply to chronic physical disorders. As autonomy shrinks in any sort of chronic illness (mental or physical), so competence to make treatment decisions may be restricted. By implication, legal capacity may also be reduced and *patria potestas* powers become more prominent.

As Winick⁶⁰ suggests, a strong distinction between mental and physical illness in terms of capacity, not only treats those with mental illnesses as lesser citizens in terms of autonomy and consent, but can also have a stigmatising effect on therapeutic relationships for both patients and mental health staff. Research by the MacArthur foundation has found out perceived coercion is common in all forms of psychiatric hospitalisation, and treatment and legal status is not an accurate indicator of perception of coercion.⁶¹ This perception of coercion itself interferes with competence. Valid consent, by most moral and legal definitions has to be free, so that consent obtained under any form of duress is not true consent, but assent. Arguably, a patient who has just been made subject to 'compulsion'⁶² has had a large part of his voluntariness eroded; which in turn must undermine

58 Agich, George A. *Chronic Illness and Freedom*. In Carson R, Barnard D, Toombs K, eds. *Chronic Illness and the Humanities*. Indiana University Press. Indiana. 1992

59 Agich, George A. *Autonomy and Long-term Care*. New York: Oxford University Press. 1993

60 Winick, B. *The Right to Refuse Mental Health Treatment* American Psychological Association, Wash. DC 1994

61 Monahan, J., Lidz, C., Hoge, S., Mulvey, E., Eisenberg, M., Roth, L., Gardner, W., & Bennett, N. (1999). *Coercion in the provision of mental health services: The*

MacArthur studies. In J.Morrissey, and J. Monahan (Eds), *Research in Community and Mental Health*, Vol. 10: *Coercion in Mental Health Services — International Perspectives*. Stamford, Connecticut: JAI Press (pp. 13–30). "Legal status is only a blunt index of whether a patient experienced coercion in being admitted to a mental hospital. A significant minority of legally "voluntary" patients experience coercion, and a significant minority of legally "involuntary" patients believe that they freely chose to be hospitalized".

62 preferred term of the Committee – preferred over detention as it will/can extend to treatment in the community

his competence to make decisions. The very coercive nature of detention⁶³ or compulsion makes any discussion of voluntariness in consent theoretically redundant. If autonomy is all or none, then 'Choice' is all and 'Compulsion', none. Any further negotiation based on capacity merely reinforces Agich's point that autonomy is graded and negotiable.

Legal reasoning

Perhaps legal approaches to capacity reflect a traditional split in Western cultures, which since the 17th century have seen reason as a property of mind, which is distinct from passions or emotions, which are the property of the body⁶⁴. If the mind is disturbed everything is disturbed; if the body alone is disturbed, reason can still prevail over physical sensation and feeling. Unfortunately, there is not much evidence for this traditional view. Instead, there is increasing evidence that physical and mental disorders have similar, but limited effects on capacity in different ways for different people.

It might be argued that if any physical disorder could compromise autonomy and competence, then it might be justifiable to over-ride refusal on paternalistic grounds in the traditional way. Bartlett and Sandland⁶⁵ have expressed legal concerns in relation to overturning treatment refusal, fearing a 'post-modern world where the limits are constantly receding as one approaches it'. Montgomery has gone so far as to suggest that the way is paved by *Tameside* to treat physical disorders without consent as long as they are related to the mental disorder. Such alarm is probably unfounded as there is existing case law^{66,67} preventing medical treatment for physical disorders when capacity is retained, and Montgomery's *related*⁶⁸ is not the same as Goff LJ's *integral*⁶⁹. Nevertheless, the frequency with which these matters appear before the courts suggest that health care professionals are concerned about the extent they will be responsible for the 'risky' decisions of others. This concern reflects a more general question about the responsibility of health care professionals to abolish all medical risks. In relation to mental health, the concept of 'medical risk' appears to have been expanded to include risks to third parties, not just risk to self.

Scotland has recently passed an Incapacity Act⁷⁰ that will provide measures for treatment and care of all those who lack capacity to consent to treatment, whether as a result of physical or mental disorder; it remains to be seen whether English law will follow suit. A similar approach to consent based on capacity was recommended by the Richardson Committee in relation to the treatment of mental disorders. The Committee accepted the need for compulsory treatment but only where there was demonstrated incapacity. Loss of autonomy would be balanced with increased claims to care through the principle of reciprocity⁷¹.

63 American case – *Sex offender in prison consents to trial of anti androgens*. *Kaimowitz v. Michigan DMH*, 1 MDLR 147 (1976)

64 *Matthews*, *supra* Note 25

65 *Bartlett and Sandland: Mental Health Law: Policy and Practice*. Blackstone Press Ltd. 2000.

66 *Re. C (Adult) (Refusal of treatment)* *supra* note 32

67 *Re JT (Adult: Refusal of Medical treatment)* [1998] 1FLR 48

68 “...in a wide range of circumstances. Provided that the physical problems are related to the mental disorder, either in their origin or their effects, consent will not be

strictly necessary” – *Montgomery J. Health Care Law*. Oxford University Press. Oxford. 1998.

69 Goff LJ– “Section 63...may apply to the treatment of any condition which is integral to the mental disorder” *St George's Healthcare NHS Trust v S; R v Collins and Others ex parte S* [1998] 2 FLR 728

70 *Adults with Incapacity (Scotland) Act 2001*. See Lyons *Medical Treatment using the Scottish Incapacity Act: Will it work?* pp197–202 of this issue of the *Journal of Mental Health Law*.

71 *Eastman, N & Hope, RA (1988) The ethics of enforced treatments: the balance model. Journal of Applied Philosophy*, 5: 49–59

However, this proposal was rejected by the current English government⁷². In contrast, the Government's proposal was that loss of autonomy for the mentally disordered was justified with reference not to lack of capacity but *risk* (to self or others). Similarly, American outpatient and inpatient commitment procedures (for compulsory treatment for mental disorder) are judicially determined and dangerousness based. The American system of judicial determination for commitment has at least three models; Exceedingly non-interventionist^{73,74}, minimal intervention⁷⁵ and maximum protection, all dealing with question of risk. In the state of Massachusetts, where the *Rogers*⁷⁶ case was heard, state law has been changed to reflect maximum intervention although as Appelbaum has shown, the theoretical possibility of maximum protection has not matched with the practical outcomes, which still remains deferential to medical advice⁷⁷.

Arguably, the judiciary has been increasingly inclined towards granting the very paternalism which the state seeks⁷⁸. The pendulum has swung back from extreme liberalism to a *parens patriae* model. If that is the case, the liberty interest can be seen in a different light as arguably a type of negative liberty (pace Berlin): the freedom from psychosis⁷⁹ including any risk arising from that illness. It seems that freedom from exposure to any kind of risk is perceived as a medical benefit, which could and should trump claims to autonomy by the mentally ill; an argument which is not applied to the physically ill.

Conclusion

It appears that people with a mental illness diagnosis are still regarded as having limited or no capacity to refuse treatment for mental disorder, (including the physical consequences of that mental disorder) on the grounds of risk. Patients with severe physical disorders are however seen generally as being competent to refuse treatment for their physical condition, even where the outcome is highly risky for them.

Current societal attitudes are towards transparency and respect for persons. In the UK, this has been reflected in the adoption of the Human Rights Act 1998, almost 50 years after the signing of the European Convention on Human Rights. Achieving a delicate balance between the State's

72 Peay, J. *Reform of the Mental Health Act: squandering an opportunity?* *Journal of Mental Health Law*. 2000. 5–15

73 *Youngberg v. Romeo* 457 US 307, 102 S. Ct. 2452 (1982) A decision made by Professionals would be "presumptively valid". Liability may be imposed only when a decision is "such a substantial departure from accepted professional judgement....as to demonstrate that the person responsible actually did not base the decision on such a judgement"— Justice Powell of Supreme Court.

74 *Rennie v. Klein* 720 F. 2d. 266 (3d Cir. 1983) Treatment driven model. It stands for a second physician decision-maker in contrast to *Rogers*. See below

75 *Washington v. Harper* 494 US 210 (1990) The policies and administrative hearing procedures comported with adequate procedural due process. Due process did not require a judicial hearing. State has a legitimate interest in treating inmates for the purpose of reducing danger. Dissent stated that a "mock trial before an

institutionally biased tribunal did not provide due process of law".

76 *Rogers v. Commissioners* 390 Mass. 489, 458 NE 2d. 308 (1983) Also known as the "Rights Driven model". A committed patient is competent until judicially found incompetent. A judge, using full adversarial hearing, determines, using the substituted judgement model, what the incompetent patient (ward) would have wanted if competent. No other state interest supersedes this right save in an emergency, narrowly defined as an "immediate, substantial, and irreversible deterioration of a serious mental illness" or likely harm to self or others. The guardian's role is not as the ward's decision maker, but as a monitor of the treatment plan and the patient's continuing incompetence.

77 Appelbaum PS-Almost a Revolution *supra* note 3

78 Appelbaum PS *supra*

79 anonymous -Quoted in-Appelbaum PS Almost a Revolution *supra* note 3

legitimate interest in preserving life, and the individual's claim to autonomy even in risky situations, is a process which may be best left to the courts. Most of our current legal trends have flown from the other side of Atlantic, albeit very slowly. Only time will tell if Appelbaum's observation on the pendulum swinging back will continue in that tradition.

Perhaps we need a better analysis of what it is to be a person in the company of others. We also need a better conceptual grasp of risk: how it is socially perceived and tolerated, and the management of risk when social anxiety increases. If as a society we are becoming increasingly intolerant of risk, we are likely to be particularly so in relation to mental disorder, where there is a perception that risk can be measured and controlled. However, what this may mean is that patients with mental disorders are not allowed to make the same sort of risky decisions that people without mental disorders are allowed to make: either in relation to their own health or the health of others.