The College

Consent to Psychiatric Treatment for Informal Patients: College Advice to Psychiatrists

Report of the Working Party on the Mental Health Act*

Introduction

The introduction of statutory requirements with respect to consent to treatment for detained patients has highlighted the dilemmas which face the medical practitioner treating non-detained patients. This is a particular problem for psychiatrists treating the elderly and the mentally handicapped, but extends to many other informal psychiatric patients. Similar problems are presented from time to time to physicians, surgeons and other doctors treating the physically ill and for general practitioners managing psychiatric problems. However, this paper is concerned with difficulties which face psychiatrists.

All patients, whether or not they are detained, have the protection of the Common Law. With respect to detained patients, the Common Law is supplemented by Part IV of the Mental Health Act 1983.

Occasions arise where patients need treatment for their own health and safety and sometimes to protect others. Examples are patients suffering from severe depressive illness who have stopped eating and drinking, and insightless patients with a schizophrenic illness who falsely believe others are persecuting them. Doctors have a duty to help such patients with treatment until they are able to decide for themselves in their own best interests.

The Common Law

'Common Law' is not an Act of Parliament but has been described as 'the common sense of the community, crystallized and formulated by our forefathers'. Gostin, the former Legal Director of MIND, has recently written (1983):[1]

> Under the common law, treatment can be given without the consent of the patient in cases of necessity. The doctrine of necessity is not clearly defined in law, but it would obviously encompass the use of a life-saving treatment performed when the patient could not provide consent (e.g. by reasons of unconsciousness), but was not known to object to the treatment. Indeed, the doctrine of necessity might be construed more liberally to embrace treatment or restraint administered in the course of an emergency—for example, a tranquillizer injected to calm a patient during a violent episode. An emergency is taken to mean a circumstance in which immediate action is necessary to preserve life, or to prevent a serious and immediate danger to the patient or other people. In such a case the treatment of physical restraint used would have to be reasonable and sufficient only to the purpose of bringing the emergency to an end. It would be unwise for a nurse or any other medically unqualified person to administer medical treatment except under the specific direction of a registered medical practitioner.

Other management and treatment problems

The recommendations here are only concerned with the treatment of psychiatric disorders. Consent in relation to the treatment of physical disorders suffered by psychiatric patients and involving specialists from other disciplines (e.g. surgery, obstetrics, general medicine) will be considered separately.

Definitions

Treatment

Treatment for mental disorder applies here to medication including depot injections and to ECT when prescribed or recommended by a psychiatrist.

Consent

The notion of 'informed consent' to medical treatment is an American concept derived from the decisions of judges in a series of civil actions in the American courts since 1957. The transatlantic doctrine is based upon a requirement to provide a patient with sufficient information about a proposed treatment, its benefits and risks, to allow him to make a rational choice and to give a true and informed consent to the treatment (or to refuse it). This doctrine has recently been rejected in the Court of Appeal as forming no part of British law.[2] This decision was upheld in the House of Lords (21 February 1985). In Britain, 'a doctor' has a duty to use reasonable care and skill in all his dealings with his patients and the patients have no more, and no less, than the concomitant right. The duty is fulfilled if the doctor acts in accordance with a practice rightly accepted as proper by a body of skilled and experienced medical men. Consent to treatment in Britain is then based upon a medical standard (the way in which a 'reasonable doctor' would behave in similar circumstances) rather than 'the reasonable person' standard (the information necessary to allow a reasonable person in the same circumstances as the patient to make a rational choice). The Court in the case of Sidaway did not remove from the patient the right of self-determination, but gave the British doctor greater responsibility, in the context of each individual case and the doctor–patient relationship to decide how much information to disclose to the patient.

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The Master of the Rolls, Sir John Donaldson, said in the case of Sidaway:

> . . . there is a duty to give sufficient information to enable a patient to reach a rational decision. The nature and extent of the information and the manner and timing of its disclosure are very much matters of professional judgment in the context of the doctor's particular relationship with the particular patient. The general duty of the doctor is to take such action by way of giving or withholding information as is reasonable in all the circumstances of which the doctor knew or ought to have known, including the patient's true wishes, with a view to placing the patient in a position to make a rational choice whether or not to accept the latter's advice.

The Court in this case added that the 'medical standard' was not, in the last analysis, a matter for the doctors: it was a matter for the law, and the courts would not sit idly by if the medical profession 'by an excess of medical paternalism' denied their patients a free choice—'The law would not allow the medical profession to play God'. Lord Justice Dunn in the same case stated that the American doctrine of 'informed consent' formed no part of the British Law. He doubted whether it would offer any major benefit to patients (in Britain), most of whom preferred to put themselves unreservedly in the hands of their doctors. This was not paternalism, but simply an acceptance of the doctor–patient relationship as it had developed in Britain.

In the House of Lords these principles were endorsed. Substantial or material risks should be disclosed to a patient, but (Lord Bridge):

> Whenever the occasion arose for the doctor to tell the patient the results of the doctor's diagnosis, the possible methods of treatment and the advantages and disadvantages of the recommended treatment, the doctor had to decide in the light of his training and experience and the light of his knowledge of the patient what should be said and how it should be said. At the same time, the doctor was not entitled to make the final decision with regard to treatment which might have disadvantages or dangers. Where the patient's health and future were at stake the patient had to make the final decision.

'Real consent'

The term 'real consent' is used in this paper in preference to 'informed consent', which is associated with the North American doctrine.

Real consent must be based on sufficient information given to the patient in terms that he can understand. This should include reference to the nature of the treatment, its intended purpose and likely effects (including any *probable* side effects), and substantial (but not unlikely) risks. The doctor must decide how much information will allow the patient to give real consent, while taking into account the patient's condition. The patient's consent must be real and must be freely given.

A form of treatment involving a physical intervention (for example, an injection) may not be given to a patient without his real consent based upon sufficient information. The amount of information that should be given to the patient depends upon his condition (his ability to comprehend and the effect that information will have upon his condition), the range of alternative treatments available to treat him and the nature, benefits and risks of available treatment.

The Mental Health Act 1983 (England and Wales) has qualified these basic rules with respect to detained patients (Sections 57 and 58). For informal or non-detained patients a qualification has been added by the Act when certain specific treatments are proposed, even though the patient consents (Section 57). (Scottish Law differs in this respect.)

However, some non-detained mentally disordered patients are incapable of giving 'real consent' (because of the degree of mental handicap, for instance, or as a result of mental illness preventing a sufficient degree of comprehension of the nature or risks of the proposed treatment). This is a particular problem in relation to some psychiatric patients. It is good practice in these circumstances to ensure that the patient's rights are protected and that he receives the treatment he needs. The doctor will in such cases wish to discharge his duty of care and to provide necessary treatment. Detention in hospital is not necessarily in the patient's best interests and indeed may not be justified simply to obtain a second opinion.

Consent to psychiatric treatment and non-detained patients

The non-detained psychiatric patient has a right to give or withhold consent to a proposed treatment. 'The consent of an impaired patient is easily obtained but this fact does not rob the consent of its validity' (Glanville Williams). In practice, doctors not infrequently have to decide how to treat non-detained patients who are unable to give real consent. Without treatment the patient may deteriorate or present a danger to himself or to others in the longer term. The protection provided by the Mental Health Act may not be available (e.g. the mentally handicapped patient).

(i) Patient is competent to give real consent

If the patient is capable of providing consent and consents, the treatment may be given (unless Section 57 applies).

(ii) Patient is not competent to give real consent

Patients in this category may be: (a) not unwilling to receive treatment, but their passive (implied) consent cannot be regarded as 'real'; or alternatively the patient may (b) actively refuse or resist treatment.

Detention under Mental Health Act

The doctor should initially consider the alternatives of detention under the Mental Health Act, where grounds exist, as the Act provides the patient with the statutory protections of Section 58 and other safeguards. But this alternative may often not be in the best interests of the patient or the patient may not come within the scope of the Act. The doctor must then consider providing similar protection to the patient while he retains his informal status.

Proposed safeguards for non-detained patients unable to give real consent

The principles to apply are similar to those encompassed formally in the Mental Health Act.

Passive accepter: The passive acceptance of treatment is not sufficient to imply consent (e.g. mentally handicapped, cognitively impaired or psychotic patients). The doctor, depend-

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ing on the circumstances, should consider consulting the nearest relative (or substitute), but ultimately the decision is that of the doctor.

Active refuser: A treatment which the doctor recommends as necessary may be actively physically rejected with struggling resistance. To force the patient to accept treatment would involve the risk of an allegation of assault. In cases of persistent refusal, detention should be considered where practicable. In an emergency, the Common Law qualifications apply (see below). There are some cases where none of these apply but the treatment is in the patient's best interests and the doctor should consult the nearest relative, but, in addition, should obtain an informal second opinion from the patient's family doctor or a local consultant colleague who is not involved in the patient's treatment. (In Scotland, the Mental Welfare Commission has a special responsibility to be involved in these cases.)

Consultation with other professions

When deciding upon treatment, good practice involves consultaton with other appropriate professions, even though the final responsibility rests with the doctor.

Nearest relative

It is suggested that a social worker, friend, family doctor or some other person who can take account of the patient's interests may substitute for the nearest relative if he or she cannot be found or is incapable. The nearest relative contributes to the doctor's decision but cannot consent on the patient's behalf.

Second opinion

It is unrealistic to assume that second opinions which are suggested here may be given by doctors appointed under the Mental Health Act 1983 for this purpose. Second opinions should be obtained as in conventional good medical practice, from a colleague who is not involved in the patient's treatment.

Records

It is important to keep good records of the steps taken to safeguard the patient, to avoid subsequent misunderstanding, to deal with any subsequent challenge, and to protect staff.

Treatments of urgent necessity

The Common Law dictates that the doctor has a duty of care and an obligation to obtain the consent of the patient. However, as Section 62 of the Mental Health Act 1983 states (with respect to detained patients), treatment may be given without consent in cases of urgent necessity, which may include: (a) treatment which is immediately necessary to save the patient's life; (b) treatment which (not being irreversible or hazardous) is immediately necessary to prevent a serious deterioration of his condition; (c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering; and (d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to others; and other situations evaluated according to the circumstances.

A patient may be persuaded or may recover sufficiently to give real consent, then the situations listed above (a–d) must be taken into account, but each case must be considered independently. Section 62 of the Mental Health Act may be taken as a guide to providing urgent treatment for non-detained patients.

Mentally disordered prisoners

It is hoped this advice will be of assistance to doctors who have the responsibility to treat mentally disordered prisoners where the provisions on consent to treatment in the Mental Health Act 1983 do not apply. The principles of Common Law however do apply to prisoners as much as to informal psychiatric patients. Prison medical officers may consider the principles of Common Law given in Section 62 of the Mental Health Act 1983 particularly useful in emergencies.

Good practice

The above recommendations, in the opinion of the Royal College of Psychiatrists, represent good practice and may, in some cases, reduce the need for detention simply to obtain a second opinion from an Approved Doctor. Nevertheless, it should be remembered that in England, while doctors are judged in the Courts by a medical standard, it is the Courts themselves that reserve the right to the last word.

REFERENCES

[1]GOSTIN, L. (1983) *A Practical Guide to the Mental Health Act*. London: MIND.

[2]THE TIMES (1985) Sidaway v. Bethlem Royal Hospital and the Maudsley Hospital Health Authority. Law Report (House of Lords), *The Times*, February 22.

Consent to Treatment: Mental Health Act Commission

In July 1985 the Mental Health Act Commission circulated a long and detailed document to all health authorities dealing with Consent to Treatment. This document was produced without prior consultation with the College and the College would not necessarily agree with its contents. We are concerned that this document from the Mental Health Act Commission may be assumed erroneously to have statutory authority. We would, however, commend this as a discussion document to be considered in the same way as the College's consultative paper which is published in this issue of the *Bulletin*.

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