THE VOLUNTARY MENTAL PATIENT

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Delivered at a Meeting of the Medico-Legal Society held on 27th May, 1978 at 8.30 pm at the Royal Australasian College of Surgeons, Spring Street, Melbourne. The Chairman of the Meeting was the President, Dr. J. J. Billings.

I draw your attention to the excellent paper by Mr. Justice O'Bryan, delivered to this Society on Saturday the 16th of May, 1959, published in Volume eight of the Proceedings and entitled "The Consent of the Patient to Surgical and Medical Procedures". In it, Sir Norman said:

> "The common law protects the ordinary man from the uninvited though well-intentioned and even perhaps beneficial administration of the medical practitioner. The common law does not give any right nor does the statute law of this State, except in special cases, such as a patient under the Mental Hygiene Act to legally qualified medical practitioners, so long as the patient is conscious and capable of making sane decisions, to interfere with a person's body without his consent and *a fortiori* without his consent to remove a limb or an organ even without fee or reward and however desirable, in fact, such an operation may be."

Later, and having dealt with the provisions of the Mental Hygiene Act in force at that time, Sir Norman continued in this way—

> "However, there can still arise in fact, unusual though it may be, the case of a person of enfeebled intellect who is not a patient or mental treatment patient within the provisions of that Act. If one had to consider for treatment the case of a person of enfeebled intellect, who did not fall within the terms of the statute, the first practical question would be the extent of his mental deficiency and the extent of control exercised over his person by any natural or *de facto* guardian. The first question in the case of such a person would be, is he capable of making a sane judgment on the matter in hand? If yea, his consent is necessary and sufficient. If nay, then if he has a natural or *de facto* guardian, the consent of such guardian is necessary and sufficient. It would require a grave emergency to justify action where no consent is available or where such as is available is refused. In such a case, his position, in my opinion, would be equated to that of the unconscious patient which case I now turn to consider."

It can be seen from those passages that Sir Norman was of the view that if the patient was capable of consent you had to get his con-

sent to what you proposed to do. If he were incapable of consent, then, unless he was in a state of dire emergency, in which case an agency of necessity might be said to arise, you would be obliged to obtain the consent of a guardian or person in *loco parentis*.

However, two statements, one a question and the other an assertion, concern me. The question, unanswered by Sir Norman, because it was not part of his purpose to answer it, is "what is consent?" and the assertion contradicts Sir Norman's proposition in the passage last quoted, namely that it is unusual to find a person of enfeebled intellect who is not a "patient" or "mental treatment patient" within the provisions of the Act. On the contrary, such a situation is quite common.

I sought the assistance of medical practitioner friends and, in particular, those who practice in the branch of Psychiatry and I was speedily confronted by what they saw as a very real dilemma of daily occurrence. The dilemma occurs in typical form, when a doctor is confronted by a patient, not necessarily of enfeebled intellect, but suffering from an illness of the mind characterised by episodes which might be described as quiescent and others which might be described as florid, so that at times the patient is merely sick, capable of being treated by drugs or therapy in his own home and whilst he goes about his daily affairs, but at other times he becomes floridly psychotic. When the patient presents with such a florid episode, the doctor has a choice. On the one hand, he can obtain a "consent" from the patient to enter hospital and to undertake such treatment or treatments as the doctor deems desirable. The alternative consists of an election by the doctor to certify the patient under the provisions of the Mental Hygiene Act and thereby to relieve himself of any difficulties arising from the failure of consent of the patient to such treatment as the doctor deems desirable. A typical case is perhaps that of the manic depressive whose illness has temporarily increased as the result of a failure to take adequate lithium, and who presents to the treating doctor in a stage of increasing mania and as a person likely to be dangerous to others and, certainly, in a little while dangerous to himself. "The first question in the case of such a person would be, is he capable of making a sane judgment on the matter in hand?". So said Sir Norman O'Bryan. Let us leave this question aside for the moment. Let us assume that the treating doctor is able to obtain either from the patient or, as proposed by Sir Norman, from his guardian or guardians the magic words "I consent". Let us turn our attention to the way in which that magic statement is obtained and the practical reasons motivating the treating doctor in obtaining it. He knows that he may act under the Mental Hygiene Act, certify the patient and administer such treatment as is deemed desirable.

However, there are cogent reasons that may lead him to believe that that course is not in the best interests of his patient. Those reasons arise partly from the deficiencies of the Mental Hygiene Authorities and partly from the very nature of certification itself. The doctor knows that if he certifies the patient it will mean a confinement of liberty in physical surroundings rather less desirable than those in, for instance, "B" Division at the gaol. He fears that the treatment which he would regard as the best and most desirable in the patient's interest may not be given because of the intervening opinions and authority of those in charge of the institution. He fears also that the very nature of bureaucracy is such that the patient may be kept in the institution for a much longer period than with more individual attention would prove to be necessary.

As an instance of the last fear, one might cite the case of Mr. Trujillo as it appeared in Court who suffered from a difficulty of communication in being a Spaniard who spoke little or no English. On the 21st of October, 1974, he was admitted to the Mont Park Mental Hospital with a history of having been found behaving irrationally and having had some liquor taken. He was released from that institution on the 1st of April, 1975, over six months later. It had taken thus long for it to be discovered that the episode which brought him there in the first place was simply one of acute severe alcoholic intoxication, and that he suffered no illness or abnormality of the mind whatever.

However, even more important than the foreseen physical consequences of certification are the equally foreseeable social consequences. Certification is seen by most people in the community as that step which separates the sane from the mad. Without certification, the expressions "nervous breakdown", "in need of a rest", even "having some psychiatric treatment" or just plain "ill" are euphemisms readily accepted by family, friends and employers as appropriate to describe a fellow citizen who has succumbed temporarily to the strains and rigours imposed by modern society. A "get well" card is the appropriate response. However, once certified, the response changes dramatically. Relatives are ashamed and frightened by a condition that they do not understand and believe infects them by familial association or may be seen by persons outside the family to do so. Friends shun the madman lest their attentions may only increase the severity of his illness. Employers find it their duty to their board, their shareholders, their work force or just themselves to run no risks by employing the madman. The doctor knows that these physical, emotional and social consequences depend upon his decision.

The first ethic of the doctor is the best interest of his patient. Confronted by the dilemma of certification or of obtaining a consent to treatment, it is not surprising that the doctor sees that almost any activ-

ity designed to obtain that consent is in the best interests of his patient.' However, persons suffering from mental illness very frequently deny their own sickness and assert that they are in need of no treatment. Indeed, it might be said that the more insane they are, the harder it is to obtain an admission that they require treatment. Those who have had and resented a particular form of treatment will not uncommonly refuse to consent to its fresh administration or its continuance. Confronted by such a patient, what does a doctor do? He confronts the patient, very frequently, with his own dilemma. He explains that in the absence of voluntarily undertaken treatment it will be necessary to resort to certification. He describes in draconian terms the results of certification, he asserts in forceful terms his belief in the need for the treatment and his determination that it shall be administered one way or the other. The patient or his guardians confronted by this approach almost invariably capitulate and say the magic words. The problem is, do those words represent a true consent?

Before attempting to examine the nature of such a consent, it is convenient to refer to some other doubtful situations. Take the case of the military patient. Found in some conduct which is thought to indicate eccentricity of mind, he is referred by his commanding officer to a Naval, Army or Air Force psychiatrist for examination and assessment. Suppose, as is probably most frequently the case, that he desires to be neither examined nor assessed and that he expresses his disinclination to the psychiatrist, what is the psychiatrist's duty? Further suppose that having made the necessary diagnosis and having formed the belief that the military person would be better for some treatment, is the psychiatrist obliged to seek the personal consent of the soldier? Should he assume in the absence of any expressed unwillingness that consent has been given? To what extent is the doctor justified in taking at face value a submission to treatment which is procured by force of military orders? The workers compensation or common law litigant presents a slightly different problem. Take the patient who has been quite properly advised to wear a brace for his back, but has informed all concerned that he finds it intolerably uncomfortable and does not propose to accept that treatment. To what extent is the doctor justified in supporting the solicitor who says "unless you do what the doctor tells you, the jury will think that you are malingering or otherwise untruthful. I want to see a well-worn brace on the day this case gets to court". In the psychiatric context, the submission to electro-convulsive therapy may also be seen by the patient's legal representative as a most effective way of indicating to a tribunal the extent of the plaintiff's disabilities and the persistence of his determination to be rid of them. A good description of E.C.T.

should add several grand to the verdict. The criminal and quasi-criminal patient is perhaps susceptible of the most immediate duress. The drinking driver who retains his licence and is released upon a bond to be of good behaviour conditional upon his undertaking a course of medical treatment designed to cure his problem with alcohol, and the homosexual, similarly released upon condition that he undertake hormone treatment designed to decrease his libido, both submit to judicial compulsion: either this or no licence, either this or gaol. Is that submission to be taken as consent? If not, to what extent is the doctor responsible for the treatment given without consent? What is a "voluntary" patient?

There exist in the world in which we live various movements antipathetic to those who practise the profession of medicine. We have anti-Doctor Societies, anti-Psychiatrist Societies, anti-Drug Societies, anti-E.C.T. Societies, anti-Therapy Societies, and a horde of other persons in the community who reject, and encourage others to reject, the practice of medicine or various aspects of it. No longer does a doctor operate in a community, for the most part uneducated, and minded to treat his pronouncement as divinely inspired or close to divinely inspired. We may regret the compulsory half-education which provides sufficient knowledge to question and destroy, but insufficient learning to understand and construct but we must resign ourselves, I think, to the continuance of that state of affairs. I mention these matters because they sharpen the need to consider the practices and procedures employed in obtaining the consent of the patient. Some of those practices and procedures may well provide ammunition to those minded to emphasise the deficiencies of the practitioner. Parents, friends and "guardians" who have been induced to consent to the administration, for instance, of E.C.T. to a patient, may well find that despite recurrent administration of the treatment, the patient steadily becomes more ill. In fact, the worsening condition is in the nature of the disease. However, the guardians are apt to think that it is caused by the E.C.T. or that the E.C.T. has failed to stem it. It is but a short step for them to become critical of the means by which they were induced to give their consent to the original administration of that treatment.

There are perhaps four stages of doubtful practice in obtaining "consent":

1. A failure to provide information sufficient for the patient to make a decision.
2. Failing to tell the patient of the intention to administer the treatment.
3. Informing the patient that one is not going to administer treatment which one in fact intends to administer.

4. Outright compulsion either physical or by the application of threats, such as those already instanced.

The difference between consent and submission is one familiar to the criminal lawyer. It frequently arises in considering the state of mind of a woman who alleges that she has been raped. The definition of the *actus reus* of rape is "carnal knowledge without consent". The consent referred to must be, it is said, a "real" consent not a mere "submission". It is probably helpful, though to a limited extent, to define consent for our purposes as a free choice between different available courses of action; a free choice to permit or refuse the proferred treatment. I say that the helpfulness of that definition is limited because it may merely transfer from the word "consent" to the word "free" the problems of definition. Does a strong motivation to avoid some external evil, such as being court martialled or going to gaol or being disbelieved in court, deprive the consent of its reality? To what extent, and at what point, does the performance of the doctor's obligation to direct his patient's attention to the unpleasant alternative of certification become mere blackmail to obtain, under the guise of consent, a mere submission to treatment? Man seeks pleasure and avoids pain. All human activity is motivated consciously or unconsciously. The motivation may be obscure and slight. On the other hand, it may be desperate and urgent. To speak of consent as an intellectual activity divorced from considerations of motive is, in my opinion, to invent an ephemeral, legal, philogistic symbol. It does not help the doctor to determine in a practical situation how far he may go, in imposing his will upon that of the patient.

It is obvious that, if the doctor and the nursing staff behave improperly they would be open to actions by the patient for false imprisonment and assault. To plagiarize Sir Owen Dixon "Wherever one draws the line, this conduct would clearly fall on the wrong side of it". It is the attempt to draw a line which raises the interesting problems.

Having raised them, I find myself unable with any certainty to lay my ruler upon the paper. The only test which occurs to me is that before a patient may be said to have consented to medical treatment, he must have been given by the medical practitioner concerned adequate truthful information; and his will should not have been so overborne by that of the medical practitioner for it to be said that he has been deprived of a freedom to choose between alternatives. Having verbalised the test in that way, it becomes apparent that a high degree of responsibility is invested in the medical practitioner, in his intelligence and integrity and that there is no touchstone, the application of which will dispel all doubt in any particular case. Adequate truthful information may in some cases be very little indeed. In many

cases, a patient does not want to know and places implicit trust in the doctor. In other cases, the patient does desire to know but is so uneducated or the information so arcane that it is almost impossible to convey adequately the desired information. All these matters require *in limine* to be considered by the doctor. The doctor must then proceed to examine his own conscience as to the real need of the treatment. In a case in which the treatment is desirable but not dramatically necessary, the imposition of the doctor's will upon that of the patient would probably be seen by the doctor to be less in the interests of the patient, than in a case in which the doctor was convinced of a dire need to administer the treatment. However, whatever may be the extent of the need to administer the treatment, it will remain necessary for the doctor to remember that the end will not justify the means. His persuasion of the patient must stop short of such duress that he will bring upon himself the wrath of Sir Norman O'Bryan: ". . . to perform that or any other operation upon a patient without his consent, the patient then being capable of giving or withholding such consent, will render the operator and all knowingly concerned with him, liable to a civil claim for damages and to a criminal prosecution for assault and there is no defence that the operation was for the public benefit or the private benefit of the patient."