Black robes and white coats: who will win the new mental health tribunals?

SAMEER P. SARKAR and GWEN ADSHEAD

Under current proposals for new mental health legislation, psychiatrists increasingly will be involved in tribunal processes examining the grounds for compulsory detention and treatment, both in hospitals and in the community. They will lose some authority over admission and discharge, with decision-making instead being given over to legal bodies that will regulate admission and discharge. The proposals for wholesale change in UK mental health law are an opportunity to devise a new type of legal hearing where all 'sides' are properly represented. However, the new mental health tribunals proposed in the draft UK bill sit in a twilight zone of 'quasi-criminal' courts. The use of single joint experts or 'expert panels', consistent with the recent civil law reforms, means that problems of undisputed medical evidence may become even more acute. American experience shows that judicial deference to clinical opinion, even in overtly adversarial commitment hearings, is considerable (Bursztajn *et al*, 1997). In this editorial, we argue that these proposals justify a re-examination of the values of law and psychiatry.

TRADITIONAL MEDICAL VALUES *V.* LEGAL PRINCIPLES

It has been argued that when legal and medical values clash, particularly in the domain of mental health, medical values and objectives should take precedence over legal ones, not least because the legal process can cause 'juridogenic' harm to patients (Obomanu & Kennedy, 2001). Most ethical conflicts are between principles and consequences, with medicine favouring consequences and law favouring principles. There is a need to balance good consequences with the claims of justice and respect for autonomy (Eastman & Hope, 1988). However, when it comes to considering 'good' outcomes, doctors and lawyers have different constructions of the word 'good'. The ethics of law emphasises respect for autonomy and liberty, whereas medical ethics tend to privilege beneficence and healthy paternalism, where a 'good' outcome means 'what is good clinically'.

A lawyer's principal duty is to represent the client's wishes honestly and clearly. Loyalty is a key value for the lawyer in the pursuit of justice. Such representation may necessitate the withholding of unfavourable reports, which some psychiatrists argue is unjust and may do the patient harm by excluding relevant clinical information. But if Article 5 of the Human Rights Act 1998 guarantees a right to protection against self-incrimination, it is hard to see why a patient at a detention or committal hearing can be denied that right. Most people seek to protect their own interests above those of others or society, and the law acts to regulate the tension between the individual and society's interests. Why should people with mental illness be more altruistic?

REINVENTING MEDICAL VALUES OR RETHINKING THEM?

It may seem counter-intuitive but good outcomes and harm prevention cannot take precedence over all other ethical principles (Gillon, 1994, 2003). Theories of bioethics over the past 30 years have followed the civil rights movement in privileging individual autonomy, with the consequent erosion of undue deference to clinicians' assessments. The current emphasis on user involvement in healthcare delivery means that the principle of respect for autonomy of the service user should be paramount. One of the professional challenges in psychiatry is to determine how, and in what way, mental disorders compromise autonomy. There is evidence that mental illness does not always affect decisional capacity (Wong *et al*, 2000; Berg *et al*, 2001) and it cannot be assumed that detained patients lack the capacity to make decisions about their own welfare.

In a society obsessed with harm and risk, what sort of harm might a lawyer do to patients whom they represent at detention hearings? It remains a possibility that potential or existing therapeutic relationships will be challenged and, to some extent, undermined by legal argument. But is this harm a reality? There is no empirical research to support this. Rather, there is evidence to the contrary. When an American court ruled to override the confidentiality between therapist and patient, mental health professionals claimed that this would harm therapeutic relationships; experience and subsequent empirical research showed this not to be true (Appelbaum, 1994).

Doctors tend to generalise, and thus may sometimes confuse, the issue of best interests with best 'medical' interests. A person's 'best interests' means many things and may not be the same as 'best *medical* interest': a point made by the House of Lords in *F v. West Berkshire Health Authority* (1990). Liberty and respect for autonomy may mean more to the patient than their medical health, a point that has been made repeatedly in courts assessing individuals' competence to refuse treatment. But in psychiatry, 'best interests' may be conflated with 'best *social* interests', in terms of the prevention of harm. Even if we agree that it is 'good' for people not to be risky to others, this is not a 'good' that is generally applied to others in the community. It is not clear why this is a 'health' good, beyond the fact that conviction and subsequent incarceration may be detrimental to the mental health of those predisposed to it. When medical interests overlap (or are at odds) with social interests, the courts legitimately have been afforded oversight, if only to curb excesses of professional authority.

THE REAL HARM

In the anxiety about harm to therapeutic relationships by judicial oversight or legal manoeuverings, it is easy to overlook the existence of real ethical conflict for treating psychiatrists testifying in commitment (admission) or discharge processes. Psychiatrists testifying at tribunals currently do act as agents for the health authority and therefore, by extension, the patient.

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But they also act as agents with a responsibility for public safety. These dual functions will be more pronounced in the draft bill. It is possible that legal argument will undermine the therapeutic relationship by explicitly acknowledging the psychiatrist's dual agency, but if the dual agency were made explicit from the start, this particular harm could be minimised. Better still, this harm to the therapeutic alliance could be avoided altogether by separating the therapeutic and legal roles of the psychiatrist. There would be the benefit of increased transparency about the roles of the psychiatrist and the avoidance of bias.

Risk-sensitive psychiatrists may inadvertently bias their testimony by emphasising the risky aspects of the patient's history or condition as opposed to the safer ones. Equally, lawyers may find themselves being encouraged by the client to ignore or minimise issues of risk. This is a particular problem in cases where there has been alleged violence by the patient that is not well described or documented, or followed by any police investigation. Civil commitment and detention hearings fall somewhere between civil and criminal proceedings, and some jurisdictions therefore apply a middle ground of standards of proof called 'preponderance of evidence'. Some states in the USA even apply the 'beyond reasonable doubt' standard in civil commitment, acknowledging the liberty interest that is at stake.

There is a risk that people with mental illness will find themselves 'convicted' of being dangerous to others by a civil standard of proof. Few of us would like to be found guilty of offences of violence on the basis of a standard of proof that was lower than for other citizens. The tribunal is specifically empowered to receive in evidence any document or information, notwithstanding that it would not be admissible in a court of law (Department of Health, 1983). It is not hard to imagine cases where a person's admission or discharge will rest on unsubstantiated and sometimes hearsay evidence about behaviour that will be presented and admitted in tribunals. Where detention is justified on grounds of risk, it is discriminatory to patients to admit evidence that would not normally be admitted in criminal proceedings. This has not been tested as yet but in the recent case of *R v. Mental Health Review Tribunal* (2001) it was held that to ask the patient to bear the reverse burden of proof was incompatible with the Human Rights Act.

SAMEER P. SARKAR, MD, GWEN ADSHEAD, MRCPsych, Broadmoor Hospital, Crowthorne, Berkshire, UK

Correspondence: Sameer P. Sarkar, Broadmoor Hospital, Crowthorne, Berkshire RG45 7EG, UK
E-mail: sameer.sarkar@wlmht.nhs.uk

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RISK, HARM AND BENEFICENCE

The important ethical question becomes: whose duty is it to represent the interests of public safety at psychiatric committal or admission hearings? If it is the treating psychiatrist who assumes this duty from some unclear public mandate, then his or her patients are unlikely to believe that he or she has their interests as a first concern and they will turn to their lawyers. This may or may not be a harm; if it is, it is an 'iatrogenic harm', which cannot be said to be the fault of the legal profession. This mistrust of doctors may explain why many patients are increasingly asking for extra statutory recommendations on discharge or treatment. They use tribunals as a type of case review where the clinical judgment of the consultant psychiatrist is questioned. Similarly, doctors sometimes use the tribunal's recommendation to press the Home Office for a particular desired outcome, usually in collusion with the patient's lawyers.

The contentious issue with the current (and indeed the proposed) tribunal set-up is not that it is adversarial rather than inquisitorial, but that it is not adversarial enough. Medical opinion is seldom challenged on cross-examination, even in cases where the clinical issues are central to the question of detention. In many tribunal hearings the patients are not legally represented and subjective opinion disguised as medical facts are not uncommonly introduced. If clinical opinion on which hinges the decision of discharge (or admission in the new tribunals) is to be presented by either party, it should be able to meet the scientific criteria of admissible evidence (as set out in the American case of *Daubert v. Merrel Dow Pharmaceuticals*, 1993) and be logical in its conclusions (as stated in *Bolitho v. City and Hackney Health Authority*, 1997). Such an approach also would address the concerns about bias that were raised earlier.

The point ought to be what the law is being used for and not how it is being used. Clinicians object when lawyers pursue clinical goals in tribunal settings. By definition, a lawyer is an advocate for his or her client; if there were better advocacy services for patients, there would not be a need for their lawyers to extend their advocacy into the clinical domain. It might be helpful also to consider the psychological meaning of a conflict between a patient and a clinician that is enacted legally. Our experience is that such conflicts contain rich therapeutic material and can be an opportunity for dialogue.

CONCLUSION

When the issue is one of liberty, therapeutic considerations, however laudable, cannot be the overriding consideration for the courts. Although not expressly stated in any statute or bill, there is an accepted principle of reciprocity, which entails that commitment must bear some relevance to the purpose for which it is sought. Currently, bodies such as the Mental Health Act Commission (a statutory body with accountability to the Parliament) are set up for the overseeing role that patients sometimes seek from the tribunals. The new proposed tribunals, however, will have the overseeing role for the overall treatment offered but will balance it against the need for detention and compulsory treatment. Given the enormous power that psychiatry has to detain and forcibly treat capacitous patients on the grounds of risk, it is in all our interests that there is a body that considers liberty interests and not just medical/safety interests. This is a time for stricter procedural safeguards, not less, and certainly is no time to plead for unfettered paternalism.

The law has an interest in the detained patient, not because of a right to treatment but because everyone has a claim to liberty. There is no 'right to treatment' derived either at common law or even from the recently enacted Human Rights Act 1998, but there is a 'right to liberty' from both of these sources. If claims to interests such as justice and freedom are eroded for

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people with mental illness, then how will we argue when others want to erode our own claims? Treating others as we would wish to be treated is an ethical principle that is honoured in nearly every culture. Asking the courts to base their rulings on solely therapeutic considerations in preference to natural laws of justice is asking them to re-invent the wheel.

DECLARATION OF INTEREST

Both of us are members of the Ethics Committee of the Royal College of Psychiatrists which G.A. chairs. S.P.S. is additionally a member of the Law Committee of the College, which has deliberated on the draft bill and will continue to do so on the new draft bill.

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