
The Commentaries

Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law

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When it comes to involuntary interventions, the notion that people with mental disorders should be treated identically to persons with general medical disorders has an undoubted appeal. As Dawson and Szmukler have argued previously, principles of fairness and non-discrimination would appear to be well served by basing involuntary hospitalization and treatment in both contexts on incapacity to provide consent.² In this commentary, I take note of some of the intellectual forebears of the Szmukler, Daw, and Dawson proposal,³ and ask why – despite the formidable intellects that have lined up behind similar approaches in the past – they have not been adopted. I also consider some aspects of the current proposal itself, including the unresolved tensions between equal and differential treatment of persons with mental disorders, and the potential practical consequences, especially for persons with general medical disorders.⁴ I conclude that the rationale for fusing two disparate bodies of law may itself be irremediably flawed, and the undesirable consequences significant.

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2 John Dawson & George Szmukler, 'Fusion of Mental Health and Incapacity Legislation', 188 *Brit. J. Psychiatry* 504 (2006).

3 George Szmukler, Rowena Daw & John Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation', *Journal of Mental Health Law* (this issue).

4 I write, necessarily, from the perspective of a U.S. psychiatrist, and many of my comments will reflect the peculiar legal and clinical context of the United States. I regret my lack of an intimate acquaintance with the situation in the U.K. and New Zealand, whence this proposal derives.

The History and Status of Incapacity-Based Approaches to Mental Health Law

It was not always the case that people being hospitalized for treatment of mental disorders were dealt with differently than people with general medical disorders, at least not in the United States. As I have written elsewhere:

Prior to the 1830s, only a few hospitals of any sort existed in the United States, and these generally made no distinction between the admission of patients for treatment of physical disorders and the admission of patients for treatment of mental disorders. The same doctors cared for both. Private institutions established their own rules for admission, which often required only that a family member or friend guarantee payment of the patient's bill, and that one of the hospital's attending physicians certify the patient for admission. Family members usually requested admission for patients who were too confused or debilitated to speak for themselves, blurring the distinction between voluntary and involuntary hospitalization. The right of family members and friends to act in patients' interests was supported by a number of early court decisions.⁵ [internal citations omitted]

In those early days, hospitals were reserved only for the most seriously ill, whether afflicted by mental or general medical disorders, and the assumption that neither group was in a condition to make decisions for themselves was probably reasonable.

This situation began to change as specialty psychiatric facilities, both public and private, proliferated in the middle of the 19th century, and as general hospitals became more common as well. With larger numbers of general medical beds available, medical and surgical admissions were more likely to involve patients at an earlier stage of illness who might be more capable of making their own treatment decisions, and hence who were given the opportunity to do so. The exception involved patients who lacked capacity, for whom family members continued to provide consent. In contrast, in the separate psychiatric system, even as the numbers grew of those hospitalized, the presumption remained that persons with serious mental disorders – especially those who were subject to involuntary admission – were incompetent, and hence could be treated without their agreement.⁶ These two distinct systems, running in parallel, operated in these disparate ways for more than a century.

Among the earliest signs of an impetus for change was the Draft Act Governing the Hospitalization of the Mentally Ill, produced by the U.S. National Institute of Mental Health in 1952.⁷ Suggesting a marked deviation from the historical criteria for involuntary commitment – need for care and treatment – the Draft Act proposed two alternative grounds for admission: a dangerousness-based criterion that looked to the likelihood of patients harming themselves or other people; and a capacity-based criterion for people who needed hospitalization, but could not make their own decisions.⁸ Although much discussed, the

5 Paul S. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change*, 18–19 (1994).

6 Indeed, in many U.S. jurisdictions, involuntary commitment to a state facility rendered the person incompetent as a matter of law for many purposes, including managing financial affairs, writing a will, voting, and marrying, or produced a presumption in that regard. See Frank T. Lindman & Donald M. McIntyre, Jr., *The Mentally Disordered and the Law* 220–222 (1961). Not all authorities, however, agreed with this approach. See, e.g., the comment of Isaac Ray, the father of American forensic psychiatry, in his major work, *A Treatise on the Medical Jurisprudence of Insanity*

(1838/1983) at 471: “Restraint [i.e., hospitalization] is a measure entirely distinct from that of interdiction [i.e., depriving a person of the power to conduct his or her affairs on grounds of incompetence], and neither should be considered, as they sometimes are, necessarily dependent on the other.”

7 Reprinted in Lindman & McIntyre, *supra* note 6, at 397–424.

8 The specific wording of the capacity criterion was: “[the proposed patient] is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to this hospitalization.” *Id.* at 402.

Draft Act had relatively little impact on commitment law in the (then) 48 states over the next decade.⁹ In particular, its innovative capacity-based criterion, which would have made the process of psychiatric hospitalization for many patients (excluding commitments based on dangerousness) more similar to admission of incompetent patients to general medical hospitals, was not widely adopted.

The 1970s in the U.S. were a time of great ferment in mental health law, with widespread concern that need-for-care-and-treatment standards for commitment were unconstitutionally vague and overbroad.¹⁰ This might have been a time when capacity-based standards, with their promise of treating all patients alike, could have made significant inroads, especially given the precedent of the Draft Act. Indeed, in 1975, Alan Stone, the Professor of Psychiatry and Law at Harvard University, published a proposal to accomplish exactly that. In his model, a necessary criterion for involuntary hospitalization was that “the diagnosable [mental] illness impaired the person’s ability to accept treatment”; going a step beyond the Draft Act, Stone would not have permitted dangerousness-based commitments in the absence of incapacity.¹¹ But in this pure form – much like the approach to involuntary hospitalization and treatment proposed by Szmukler and colleagues – the Stone criteria received little support.

When another leading expert in psychiatry and law, Loren Roth, published his proposal a few years later, he included a capacity-based criterion to “ensure that mental patients would be treated similarly to other medical patients, namely, in the absence of their incompetency to consent or refuse, or absent an emergency, patients may not be treated against their will.”¹² However, Roth limited capacity-based commitments to 12 weeks, and included alternative dangerousness-based criteria for which commitment could be indefinite; for danger to others, incapacity was not required, while for danger to self it was.¹³ In 1982, the American Psychiatric Association (APA) issued its model law on civil commitment, the outcome of a process guided by Stone but subject to the full influence of the diverse views in the Association, that yielded yet another variant on a capacity-based approach. Under the APA’s standard, emergency commitment was based on immediate dangerousness, while longer-term commitment was predicated on both dangerousness to self or others *and* the absence of “capacity to make an informed decision concerning treatment,” arguably the strictest standard of all.¹⁴ Today, a handful of U.S. jurisdictions have models that appear to require incapacity or at least diminished capacity prior to involuntary hospitalization for mental disorders (usually without using those terms).¹⁵ Although the application of the capacity criterion in these jurisdictions to my knowledge has not been studied, my contacts with at least some of these states suggest that incapacity (or the equivalent term) is usually presumed from a refusal of hospitalization, and hence plays a minimal role in the decision to commit.

Experience in the U.K. appears to echo the American reluctance to require incapacity as the basis for hospitalization. Thus, in England and Wales, the recent reform of the *Mental Health Act 1983* did not include a capacity criterion, despite the urging of an expert panel – and even that panel provided an alternative route for commitment based on “a substantial risk of serious harm to the health or safety of

9 *Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Special Information Bulletin No. 1, Psychiatric Points of View Regarding Laws and Procedures Governing Medical Treatment of the Mentally Ill (September 1962).*

10 See the discussion in Appelbaum, *supra* note 5 at 22–28.

11 Alan A. Stone, ‘Mental Health and Law: A System in Transition’ (1975) at 66–70.

12 Loren H. Roth, ‘A Commitment Law for Patients, Doctors,

and Lawyers’, 136 *Am. J. Psychiatry* 1121 (1979) at 1122.

13 *Id.* at 1124–25.

14 American Psychiatric Association, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults* (1982) at 10.

15 See Treatment Advocacy Center, *State Standards for Assisted Treatment: State by State Chart* at http://www.treatmentadvocacycenter.org/storage/tac/documents/new_the_updated_state_standards_chart.pdf.

the patient or to the safety of other persons...¹⁶ Scotland's recent *Mental Health (Care and Treatment) (Scotland) Act 2003* pairs a dangerousness requirement with what appears to be a "soft" incapacity provision, requiring that "the patient's ability to make decisions about the provision of medical treatment is significantly impaired because of his or her mental disorder."¹⁷ How determination of "significantly impaired" capacity compares in practice to a straightforward requirement that capacity be lacking is unclear, though the U.S. experience suggests ample room for leeway with such standards.¹⁸

What accounts for the reluctance of jurisdictions to embrace a capacity-based approach to commitment, and what implications does that have for the current proposal? The concerns seem to run in two directions. First, a shift to a capacity-based model, with simultaneous rejection of dangerousness criteria, may be seen as broadening the scope of commitment to include large numbers of non-dangerous persons with mental illness who are not currently committable. Put differently, the dangerousness criterion may be the limiting factor in the commitment process, the removal of which would open the floodgates.¹⁹ In fact, in the only study to examine the question, Stone's suggested criteria taken as a whole were shown to be markedly more restrictive than the usual U.S. dangerousness-based standard.²⁰ The possibility of widening the net of committability is not likely to be of great concern in England and Wales, where existing criteria are much broader than those in the U.S., and the capacity requirement is likely to have a restrictive effect.

Of greater concern to those making mental health policy is that a capacity-based standard will exclude persons who are dangerous to themselves or (especially) to others, but who may retain decisional capacity with regard to treatment decisions. The spectre of losing a means of detaining mentally ill persons who are thought likely to wreak harm clearly raises anxiety levels among the general public, especially given widespread beliefs that persons with serious mental illnesses are particularly dangerous.²¹ Efforts to persuade the public that, as a group, people with mental disorders present only a small elevation in the risk of violence – and that often due to substance abuse – largely have been unsuccessful.²² Nor have studies indicating that dangerous mentally ill people who otherwise qualify for commitment are unlikely

16 Report of the Expert Committee, *Review of the Mental Health Act 1983* (November 1999) at Sec.5.95(v).

17 *Mental Health (Care and Treatment) (Scotland) Act 2003*, Sec. 44(4).

18 An expert committee report on reform of the *Mental Health Act in Northern Ireland* proposed a capacity-based model that resembles in its general approach the proposal by Dawson and colleagues. See *The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legislative Framework* (August 2007), accessed at <http://www.rmhdni.gov.uk/index/published-reports/cl-framework.htm>. Although the government initially indicated its intent to propose separate reform of mental health and capacity legislation, it later announced a plan to introduce a single bill that would adopt a capacity-based approach. At this writing, the proposal has not yet been filed and its final form remains to be seen. See McGimpsey announces single bill approach for mental health, Northern Ireland Executive, 10 September 2009, accessed at <http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-10092009-mcimpsey-announces-single.htm>.

19 Mary L. Durham & John Q. LaFond, 'The Empirical Consequences and Policy Implications of Broadening the

Statutory Criteria for Civil Commitment. 2 *Yale L. & Pol'y Rev.* 395 (1985).

20 Steven K. Hoge, Paul S. Appelbaum & Alexander Greer, 'An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Commitment', 146 *Am. J. Psychiatry* 170 (1989).

21 See, e.g., Bernice A. Pescosolido, John Monahan, Bruce G. Link, Ann Stueve, & Saeko Kikuzawa, 'The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons With Mental Health Problems', 89 *Am. J. Pub. Health* 1339 (1999).

22 For a brief summary of the data on the relationship between mental disorder and violence, see Paul S. Appelbaum, 'Violence and Mental Disorders: Data and Public Policy', 163 *Am. J. Psychiatry* 1319 (2006). Although not all research findings support the attribution of the excess risk associated with mental disorders exclusively to substance use, for recent confirmatory evidence see Eric B. Elbogen & Sally C. Johnson, 'The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions', 66 *Arch. Gen. Psychiatry* 152 (2009).

to be excluded by an incapacity criterion had much impact on the debate.²³ Thus, capacity-based proposals have been and are likely to continue to be opposed by policymakers who fear that public outrage over a single episode of violence after a dangerous mentally ill person is turned away from the hospital because he or she is deemed decisionally capable would have catastrophic political consequences.

It therefore appears that the core of the Szmukler and colleagues' proposal with regard to mental health law, i.e., altering involuntary hospitalization criteria to comport with the capacity-based approach used in general medical care, is one of those academically attractive notions that – at least until the world is a substantially different place – is unlikely to garner sufficient support from policymakers and the public to be widely adopted.²⁴ One might note that this is not an entirely irrational posture for public policy: society may simply need to have a mechanism for detaining persons thought to be imminently harmful to themselves or other people – even if the risk is exaggerated – and the price, namely inconsistency in legal approaches to mental and medical disorders, may be one that society is willing to pay. Moreover, insofar as people with mental disorders can be treated and effective treatment lowers their risk of subsequent violence, there may be good reason to single them out from the universe of dangerous persons for this kind of intervention.

Differential Treatment of People with Mental Illnesses in the Current Proposal

Given the dedication of Szmukler and colleagues to parity in dealing with mental and general medical disorders, it is of interest to note two ways in which this proposal fails to achieve that goal, and to speculate on why that may be. One example involves the provisions for authorizing “serious medical treatment” (Clause 9). Although primary caregivers, who are most likely to be family members, are given general authority to consent to treatment for persons who lack capacity (Clause 6), they do not have such straightforward authority for a subgroup of those medical treatments deemed “serious.” In such cases, “the agreement of an approved doctor qualified to give a second opinion on the treatment shall be obtained before treatment proceeds.” (Clause 12) One might pose many questions about this process, including who gets to pick the giver of the second opinion, and whether failure by a second physician to agree ends the matter or the opinion of a third physician might be sought.

For our purposes here, though, the interesting issue to note is which treatments are included within that subgroup of “serious medical treatments” that require this special review. One might imagine that they would include major surgical procedures or interventions such as bone marrow transplants with their bimodal outcomes of curing or killing patients. Indeed, perhaps such procedures would be included, as the proposal gives the drafters of the implementing regulations authority to create the list of covered treatments. However, there are two exceptions: electroconvulsive therapy and “medication for mental disorder beyond the period of 3 months” are the only two procedures that are specified in the statute itself as requiring this extra level of review.²⁵ The authors are silent on why they created these two exceptional

23 Hoge, Appelbaum & Greer, *supra* note 20; John Monahan, Mary Ruggiero, & Herbert D. Friedlander, ‘Stone-Roth Model of Civil Commitment and the California Dangerousness Standard’, 39 Arch. Gen. Psychiatry 1267 (1982). Note that the Monahan, et al. study showed a much greater impact of a competence criterion in the emergency setting than when longer-term commitment was at issue.

24 Northern Ireland’s recently announced intention to introduce a capacity-based approach, may change these attitudes, if it is implemented as intended and succeeds in

avoiding the generally feared outcomes, but it is likely to be some years before we can judge the consequences of the Northern Ireland experiment.

25 Clause 12 requires another level of review, by a Tribunal, for a second group of procedures, including withdrawing nutrition or hydration, organ or bone marrow donation, and non-therapeutic sterilization. The latter two traditionally have been deemed beyond the power of substitute decision makers to authorize, requiring court review. I consider withdrawal of nutrition or hydration below.

categories, and why both involve treatments for mental disorders, although it is clear that level of risk alone cannot be the reason.

A second example of continuing disparate treatment of those with mental and general medical disorders deals with the only class of capable persons who, under this proposal, would be treatable against their will. Under Clause 45(2), persons found not guilty by reason of insanity or unfit to plead can be treated involuntarily if such treatment is in their interests or for the protection of others, their disorders were related to their offences, and treatment is likely to reduce the risk of recurrence of their criminal behaviour.²⁶ This group of persons who have committed – but not been convicted of – crimes are thus deprived of the right of a competent person to decide about treatment that otherwise motivates this entire proposal. Ironically, had these people simply been convicted of their offences, regardless of their need for treatment or its likelihood of reducing their recidivism, they could not have been treated against their will (see Clauses 43, 44, and 46). The authors explain the deviation from their principles embodied in this provision as justified “in order to prevent harm to others.”²⁷

What might account for this continued differentiation between mentally ill and medically ill persons? At some level, the authors seem to be acknowledging that traditional public concerns about being protected from persons with mental disorders – no matter how irrational their concerns may be – and avoiding abuse of persons with mental disorders create a different set of issues where psychiatric treatment is concerned, requiring different statutory and regulatory oversight. Perhaps they are wrong in this belief, and the anomalies can be corrected merely by eliminating these two outlying provisions from the proposal. But if they are correct, the exceptions noted here call into question the desirability of merging general health law as it relates to incapacity and mental health law. Looking at the proposal from the perspective of its effect on people with general medical disorders reinforces the concern that perhaps the project overreaches in its goal.

Effects on People with General Medical Disorders Who Lack Decisional Capacity

To this point, I have examined the proposal from the perspective of the impact it would have on the treatment of people with mental disorders. However, there is another – probably even larger – group of people who would be affected by the incorporation of provisions such as these into law: people with general medical disorders who lack capacity to make treatment decisions. As general hospitals admit a patient group that is, on average, sicker than in the past, the proportion of persons lacking capacity in this population is likely to be substantial.²⁸ Hence, we should be sensitive to the possibility that merging the rules governing their treatment with mental health law would work to their disadvantage.

Decisions about hospital admission and general medical treatment for incapable persons (e.g., elderly persons with Alzheimer’s or other dementias) traditionally were made by their loved ones, and that continues to be true in the U.S. today. Indeed, in the early 1980s, urging that this practice continue, the

26 As best I can determine, neither judicial nor Tribunal review is required under this Clause.

27 Note that those defendants found unfit to plead cannot be treated to restore their capacity to proceed to adjudication, unless also incapable of deciding about treatment, raising an additional set of policy issues that I do not have the space to consider here. I note, however, that the group of people who are unfit to plead but still have capacity to make medical treatment decisions may not be small. See Norman G. Poythress, Richard J. Bonnie, John Monahan,

Randy Otto & Steven K. Hoge, ‘Adjudicative Competence: The MacArthur Studies’ (2002) at 104–110.

28 One English study estimated that more than 40% of patient in a general medical hospital lacked decision making capacity. See Vanessa Raymont, William Bingley, Alec Buchanan, Anthony S. David, Peter Hayward, Simon Wessely, Matthew Hotopf, ‘The Prevalence and Associations of Mental Incapacity in Medical Inpatients’, 364 *Lancet* 1421 (2004).

President's Commission for the Study of Ethical Problems in Medicine noted that family members are generally the most concerned about the good of the patient and most knowledgeable about the patient's preferences and values, and that families deserve recognition in this context as important social decision-making units.²⁹ Yet, Szmukler and colleagues' proposal would infringe on the traditional prerogatives of families in a variety of ways.

"Serious medical treatment," however that is ultimately defined, would require the agreement of a second physician before it could be implemented, regardless of the family's desires. Perhaps more significantly, decisions "to withhold or withdraw artificial nutrition or hydration from a person in a permanent vegetative state or a minimally conscious state" – among the most sensitive of decisions with which families have traditionally grappled – will require review by a Tribunal (Clause 12(5)), with all the time, costs to the system, and stress for the already anguished family that this process implies.³⁰ Another clause of the document goes further, specifying that even a substitute decision maker appointed by the patient would not have the power of "giving or refusing consent to life sustaining treatment unless the power expressly so provides" (Clause 49(5)).³¹ That suggests recourse to a Tribunal in these cases as well. The words of the President's Commission almost 3 decades ago, addressed to the possibility of judicial review of families' decisions, are *apropos* here:

Judges may not feel that they are able to add very much to the decisions already reached by those most intimately involved, particularly in cases that are brought simply to obtain judicial sanction for an agreed course of conduct... Since this judgment requires substantial understanding of the patient's medical condition and options, the court may simply defer to the recommendation of the treating physician. The courts' vaunted disinterest may be closer, in practical effect, to lack of interest.³²

Thus, the proposal is likely to complicate and extend the decision-making process at the most difficult period for family members, to no apparent gain.

Other areas where similar effects can be seen are treatment over objection and physical restraint. Given

29 *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, Vol. 1: Report (1982) at 181–184.*

30 *I am grateful to Dr. Szmukler for pointing out to me that both this provision and the provision addressed in the following footnote reflect current law in England and Wales. Recourse to the courts in these cases apparently has been required since the 1993 decision of the House of Lords in Airedale NHS Trust v. Bland ([1992] UKHL 5 (04 February 1993)). Thus, those jurisdictions would experience no change in relevant practices under this proposal. However, given that this statute is aimed at eliminating anomalies and improving the current system, I would commend to the authors the virtues of keeping these cases out of the courts, and would hope that other jurisdictions that might be influenced by this model law would avoid creating these complications for themselves. Moreover, I note that the Law Lords in Bland themselves appeared reluctant to require indefinite application to the courts, with Lord Goff's opinion expressing "the hope that the President of the Family Division... will soon feel able to relax the present requirement so as to limit applications for*

declarations to those cases in which there is a special need for the procedure to be invoked"; and Lord Keith's opinion suggesting judicial review "at least for the time being and until a body of experience and practice has been built up which might obviate the need for application in every case." Has 17 years been sufficient for that body of experience to have been developed?

31 *This limitation is embodied in the Mental Capacity Act, Sec. 11(8)(a). However, perhaps on grounds similar to those offered in the previous footnote, consideration might be given in the model law to removing this restriction on powers of appointed surrogates. Note two other apparent anomalies created by this clause: 1) the preclusion of substitute decision makers appointed by the patient from giving consent to life-sustaining treatment, for which it is difficult to discern a policy justification and which in any event usually occurs in an emergent context and would be covered by the blanket authority provided to treaters under Sec. 11; 2) the application of this limitation to a surrogate decision maker appointed by the patient, but not (as best I can tell) to the primary carer or other person designated to make decisions for the patient, who may be less likely to know or represent the patient's desires than someone selected by the patient.*

32 *Ibid.* at 186–187.

the prevalence of patients with dementia and delirium in general hospitals who often resist treatment – with reactions that range from pulling out intravenous lines or nasogastric tubes, to attempting to get out of bed and leave, to refusing to swallow oral medication – restraint and involuntary treatment are a common and unavoidable aspect of acute medical care.³³ However, under this proposal, a need for compulsory detention and treatment is governed by Part V, and invokes an elaborate set of procedural protections, including assessment and registration with the local health authority (Clause 22), and by the end of 24 hours (during which only emergency treatment can be provided (Clause 28(1)(a)), a “health or social care professional” must examine the patient, report to the appropriate authority, and agree to the continuation of compulsory detention for another 7 days (but again apparently only emergency treatment (Clause 28(1)(a)). Before the end of a week, application must be made for review by a Tribunal, and the procedures go on from there. Similar procedural requirements appear to apply to a demented or delirious patient who needs hospital admission, but is resisting that option.

What is going on here? Routine decisions, most often made by family members and invariably taken in patients’ interests, have been entombed under a pyramid of complex procedures at substantial costs to families, hospitals, and the broader society. I suggest that this outcome may be the result of attempting to deal at the same time with the mental health and general medical systems, with their very different histories of oversight and regulation. Treatment in general medical hospitals is generally consensual, and when it is not, i.e., when patients are incapable of offering consent, family members ordinarily provide consent on behalf of loved ones. Society is generally of the opinion that the system has worked well – that is, to patients’ benefit – and there has been little reason or impetus to suggest radical change.

Regulation of the mental health system, however, has a very different history. Admission and treatment have often been non-consensual, with decisions taken away from both patients and families. Abuse and neglect have been all too common in the past, and periodic exposes have led to repeated calls for tighter regulatory oversight. Hence, an elaborate structure has developed to regulate mental health treatment, with distinct mental health acts. Since neither patients (because of the presumption that their capacities are impaired), families (because of the belief that they often will place their own interests above those of patients), nor treaters (because of the legacy of abuse) are trusted to make admission and treatment decisions, frequent resort is had to judicial or quasi-judicial processes. Despite endless debate over the substantive and procedural detail of mental health law, there appears to be no sentiment in favour of simply removing this legal superstructure.

These may be essentially incompatible bodies of law and regulation. Attempting to fuse them, as in Szmukler and colleagues’ proposal, may inevitably result in overregulation of the general medical care system or under-regulation of the mental health system. Here, applying a model drawn from the mental health law tradition of tight oversight and external review of end-of-life decisions and of treatment involving restraint or compulsory treatment (with elements borrowed directly from the Mental Capacity Act), they create a structure that materially disadvantages the general medical system, patients, and families. The seeming inevitability of this outcome or its converse, namely a mental health system without adequate oversight, leads to the question of whether attempting to fuse mental health law with the law governing general medical treatment of incapable patients is an inherently quixotic endeavor.

33 Paul S. Appelbaum, Loren H. Roth, ‘Patients Who Refuse Treatment in Medical Hospitals’, 250 JAMA 1296 (1983).

Conclusion

Szmukler, Daw and Dawson justify their proposal on the grounds of fairness, and argue that disparate treatment of persons with mental disorders and general medical disorders violates that rule. However, fairness does not require that we treat all people equally, only that those persons who are similarly situated be treated the same. As the discussion above suggests, a case can certainly be made that the two groups in question here are situated quite differently. People with mental disorders evoke (not entirely irrational) concerns about violence and other criminal behavior, as Szmukler and colleagues recognize in proposing an exception to the general rule that competent persons cannot be treated over their objections. In addition, treatment of mental disorders is embedded in a system in which the quality and even the beneficence of the care being provided has been called repeatedly into question, leading to the development of an extensive regulatory structure. This too appears to be acknowledged in the proposal in singling out treatment with psychotropic medication and electroconvulsive therapy for special regulation as “serious medical treatments.”

Fusing legal regulation of such different systems of care, especially when the costs are likely to be substantial (here largely imposed on the general medical system), may simply not make a great deal of sense. The work that would be involved in that effort might better be put to use improving each distinct body of law.