Potentially incapable patients objecting to treatment: doctors’ powers and duties

To the Editor: Sadly, the case of “John”, who perhaps should have been detained earlier, is common. Mental health Acts seem to vary with the times, from the narrowness of legalistically defined “dangerousness” criteria to the vagaries of “care” criteria. Abuses and failures at each end repeatedly swing the pendulum back the other way. Some Australian legislation has been adjusted to bring it in line with United Nations recommendations, but those recommendations themselves have a history, being in part an over-reaction to historical abuses of psychiatry and detention around the world. They may not be quite right for us.

Competence as a criterion is a potential solution to much of this but is problematic because of the level of sophistication required, particularly if the right to detain is extended — as it is in some jurisdictions — to all clinical staff. If in John’s case competence criteria had been legally available to the caseworker, would she have felt comfortable exercising them just because he seemed psychotic, when there didn’t seem to be any immediate danger? It is a big ask of relatively junior staff.

Is it always appropriate to assume competence until proven otherwise — the legal principle? I would have thought that if a person acts in a way sufficiently different to the way most people would in any situation, there should at least be doubt; and the more severe the potential consequences, the lower the threshold for intervention with a view to assessment of competence. It is on this basis that we intervene when the physically injured person places their health at risk by a refusal of treatment. Why would we not extend the same courtesy to the mentally unwell? We would do it with our neighbours or friends, surely!

Eagle and Ryan provide a stepped approach to the management of some of these situations but could elaborate on the meaning of “detain”. If we are physically holding or medicating, against their will, a delirious patient who would otherwise be at risk, do we need to use one of the Acts (mental health, guardianship etc) in the various states, with all the inherent clumsiness that entails? Or is it enough that we document what we did and why, as part of the ordinary business of duty of care?

Paul Dignam
Child and Adolescent Psychiatrist
Child and Adolescent Mental Health Service, Women’s and Children’s Health Network, Adelaide, SA.
paul.dignam@health.sa.gov.au

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In reply: The answer to Dignam’s apparently rhetorical question about using “one of the Acts … with all the inherent clumsiness that entails” is known and relatively straightforward.

The common law and the guardianship legislation of most states and territories allow a doctor to act in an urgent situation involving an incompetent patient to “save their lives, or to ensure improvement or prevent deterioration in their physical or mental health”. Under the common law, this power to provide needed treatment without consent is known as the principle of necessity, or the emergency principle, and is enunciated as acting in the “best interests” of the patient. There is nothing clumsy about using these powers, and if the circumstances demand their use, treatment may be given without any prior third-party approval or documentation. Having dealt with the emergency though, it is important to document what was done and why, including some documentation as to why consent could not be obtained in the normal way.

Kerri Eagle
Forensic Psychiatrist

Christopher J Ryan
Psychiatrist and Clinical Senior Lecturer

1 Department of Psychiatry, Justice Health, Sydney, NSW.
2 Discipline of Psychiatry and Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney, NSW.
keaa30788@bigpond.net.au

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1 Department of Psychiatry, Justice Health, Sydney, NSW.
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Correction

Incorrect Latin plural: In “Dysphagia, regurgitation and weight loss in an elderly man” (Med J Aust 2014; 201: 114) and on the cover and contents page of the 21 July 2014 issue, the correct plural form is “diverticula”. We thank our knowledgeable readers who noted this.

References