

Response to Szasz

Medical incapacity, legal incompetence and psychiatry

George Szumukler and Frank Holloway

Thomas Szasz is justifiably famous for his critique of psychiatry. He was instrumental in focusing an important debate on the status of 'mental illness' and its social implications for which we are all deeply indebted. However times have moved on. Holloway and I seek to cast different "skeletons from the closet" to those of Szasz. We seek to destigmatise mental illness, so it no longer constitutes a secret source of shame or pain to a family or person. We ask that mental illness be treated neither better nor worse than physical illness. Only if a person suffers from mental incapacity, whatever the cause – brain injury, exsanguination, schizophrenia, learning disability, stroke, toxic infection – and it is in that person's 'best interests', carefully defined, should they be treated against their will. Szasz seems oblivious that every day, many more patients with a physical illness (associated with incapacity) are treated non-consensually than those with mental illness. It is just that we don't draw attention to it, and society accepts it is right. A little bit of homework on his part would have told him that in this country, exactly opposite to his assertion, the law does justify the "medical treatment of incompetent persons, say one who has a stroke or is unconscious as a result of an accident" (if it is in the patient's 'best interests'). Again, exactly opposite to his claims, in this country no other person can consent on behalf of an incompetent patient. We argue that all patients in this position should have similar safeguards. Mental illness does not automatically confer incapacity, nor does it raise special issues requiring specific mental health legislation. But of course Szasz does not believe mental illness exists.

Instead of casting out skeletons, Szasz goes on to throw in a 'man of straw'. He links incapacity with dangerousness when we have attempted to separate them as clearly as possible. Capacity bears only on actions taken in the patient's 'best interests'; it is irrelevant to decisions about dealing with dangerousness to others. Szasz also accuses us of "proposing a justification for non-consensual treatment for dangerousness as if dangerousness were a disease and the non-consensual treatment of a competent person

were a *bona fide* medical treatment". This is a travesty of our position. We hoped our paper made it clear that we opposed preventative detention, exercised as it is at present, exclusively for people diagnosed as being mentally ill. Dangerousness should be dealt with in the same way for all persons, whether mentally ill or not. If preventative detention is what our society wants, and there are recent signs that it does, then the decision that someone is too dangerous to live freely should be made without reference to whether the person is mentally ill or not. We argue it should be a judicial decision. Only after a court has ruled that the person should be detained does the question of what should be done, if anything, to render that person less dangerous arise. Some, perhaps very few, may benefit from existing psychiatric treatments; others may benefit from psychosocial rehabilitation programmes which have nothing to do with psychiatry; and the remainder may be deemed to require long-term imprisonment. How then can Szasz say we regard dangerousness as a 'disease'? We agree with Sayce (1998) that dangerousness legislation of this kind raises enormous civil liberties issues and we are not necessarily advocating it. Non-discriminatory treatment for the mentally ill is all we ask; laws that potentially apply to all of us will ensure greater attention to safeguards than those limited to a marginalised minority.

Let us return to Szasz's ghost – 'mental illness'. This, he has long argued, is not a '*bona fide* disease'. Here is not the place to enter into a detailed argument about the meaning of illness or disease. However, we need look no further than the author of one of the commentaries on our paper, Fulford, to find an entirely opposite argument. In both extended (Fulford, 1989) and brief presentations (Fulford, 1999), he has, using the tools of analytical philosophy, argued that illness and, consequentially disease, (since illness is logically prior to disease) are 'fact-plus-value' concepts; that is, they involve value judgements. There is no difference in principle between mental and physical illness; the differences lie in the extent to which judgements of value (e.g. what is disproportionately severe

anxiety) vary between observers, this being greater for the former than the latter. He also shows that illness ascriptions are not based on disturbances of structure or function as Szasz would have it, but on failures of particular kinds of action – of 'ordinary doing', physical or mental, which we 'just get on and do' but which are intentional. Fulford suggests that mental illness is indeed paradigmatic since it shows most clearly the evaluative element, which tends to be overlooked in physical illness. Fulford's analysis is entirely consonant with a moral intuition dating from classical times that the mind may be affected by illnesses and that those so afflicted are not able to behave responsibly.

Indeed Fulford's (1998) reservations about our approach to capacity flow from his concerns that we are attempting to constrain our thinking about mental illness to a simplistic, non-value laden, view of physical illness. Our response to this is that a capacity plus 'best interests' approach to non-consensual treatment would have the merit of making more transparent the value judgements behind decisions to treat. The diagnostic problem identified by Fulford remains. However the test of capacity involves a judgement of the ability of the patient to reason with the information provided to him or her about treatment and its effects. This involves the patient locating that information within his or her system of values; for example, freedom from drug side-effects may have a higher value than preventing relapses and hospitalisation. The 'best interests' judgement proposed by the Law

Commission explicitly considers the patient's values by paying regard to "the ascertainable past and present wishes and feelings of the person concerned, and the factors that person would consider if able to do so"; and "the views of other persons whom it is appropriate and practical to consult about the person's wishes and feelings". This is a considerable advance on current legislation which addresses the decision to admit to hospital in terms of the patient's health or safety or the safety of others. There is much more thinking to be done on these questions, but we are pleased that a debate has commenced.

References

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George Szmukler, *Medical Director*; and Frank Holloway, *Consultant Psychiatrist, Bethlem and Maudsley NHS Trust, Maudsley Hospital, Denmark Hill, London SE5 8AZ*