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Inter-disciplinary teaching strategies for mental health law

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ABSTRACT

The use of an inter-disciplinary teaching strategy in the context of mental health law is explored here as a means of balancing concerns for the patient's best interests and maximizing their autonomy. One law professor and one psychiatrist participated in joint teaching sessions in the Queen's University School of Medicine, and share their strategies for overcoming perceived conflicts between patient's legal rights and the practice of psychiatry.

1. Introduction

Many mental health professionals perceive a 'clash of cultures' between law and medicine, believing that 'law is at best irrelevant to, and at worst an insensitive brake upon, the therapeutic ends of mental health practice".[1] Traditionally, the role of the lawyer is to champion the individual rights of patients, acting on the liberal individualist principle that we are all fully capable and have a right to make our own choices, however suspect those choices may be to others. Lawyers thus fight to maximize patient autonomy by protecting the right to bodily integrity and self-determination. As an advocate, the job of the lawyer is to follow the client's instructions, even when those instructions might seem unwise or contrary to the client's own interests: "the lawyer has a duty to the client to raise fearlessly every issue, advance every argument, and ask every question, however distasteful, which the lawyer thinks will help the client's case and to endeavor to obtain for the client the benefit of every remedy and defense authorized by law."[2]

The role of the physician requires that they act in the patient's best interests, to ensure their well-being and to provide the best care possible. According to the Ontario College of Physicians and Surgeons, "the patient must always be confident that the physician has put the needs of the patient first".[3] The emphasis here is on the needs and best interests of the patient, and these perceived needs may conflict with the patient's own expressed desires and choices in some circumstances. A need for treatment and care may then necessitate intervention where an individual is at risk, as physicians cannot abdicate responsibility where individuals are incapable and therefore unable to care for themselves.

These conflicting values are a reality that must be addressed by lawyers and healthcare providers alike. The battle lines appear to be drawn where patient autonomy is seen as being at odds with health and well-being, and this conflict is often most acute where the state authorizes a forced intervention to assess, restrain or treat, contrary to the patient's own expressed choice.[4] The power imbalance between the doctor and patient is exacerbated in such coercive circumstances, and adequate legal representation is often unavailable.[5] The authors acknowledge that these tensions are often present, especially in situations where involuntary committal or treatment is required. In practice, however, we suggest that there are many shared views that underlie both the practice of medicine and law; ideally, psychiatrists should seek to respect and enhance patient autonomy alongside clinical care, and lawyers should be concerned about their client's health and well-being as well as their legal rights. Thus, both law and psychiatry tread a fine line, struggling to discern and respect patient self-determination while simultaneously respecting the concern for care and treatment.

The goal of this paper is to explore those shared understandings and to describe how they have informed and facilitated our own experience in teaching mental health law to medical students. We describe our own

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[1] Sheila Wildeman, "Law and Mental Health: A Relationship in Crisis?" (2010) 33 Dalhousie L.J. 1 at 1.

[2] Commentary on Rule 4.01 (1), Advocacy: "When acting as an advocate, a lawyer shall represent the client resolutely and honorably within the limits of the law while treating the tribunal with candor, fairness, courtesy, and respect." Law Society of Upper Canada Rules of Professional Conduct, Ontario, Canada, Rule 4.01 THE LAWYER AS ADVOCATE.

[3] CPSO Principles of Practice and Duties of Physicians, at http://www.cpso.on.ca/policies/guide/default.aspx?id=1702.

[4] Law Professor Elyn Saks demonstrates this conflict most eloquently in recounting her own experiences with forced treatment, endorsing techniques that encourage patient co-operation rather than resorting to brute force. E. Saks, *The Center Cannot Hold: My Journey Through Madness* (New York: Hyperion, 2007).

[5] In Ontario, the lack of adequate Legal Aid funding and the reliance on in-house rights advisors rather than independent legal counsel seriously undermines effective advocacy. Aaron Dhir also enumerates a number of the obstacles to effective legal representation, including sanist and paternalistic attitudes on the part of legal counsel, who "can fall into the trap of conflating the presence of mental disability with incapacity." Dhir, A. "Relationships of Force: Reflections on Law, Psychiatry and Human Rights" (2008), 25 W.R.L.S.I. 103.

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efforts to craft a joint teaching session on law and psychiatry, beginning with the historical background and previous problems, followed by a description of the teaching method we used, and finally summarizing our observations and conclusions. We suggest that the struggle to balance these competing concerns may be fruitfully addressed via an inter-disciplinary approach in education. There is some evidence that this approach does help to overcome bias between different disciplines,[6] and this was borne out in our own experiences, documented below, as we found that students were more receptive to both the clinical and legal dimensions of psychiatric practice. Multiple perspectives can also provide a more complete picture of the individual's life situation and concerns, ideally helping us to avoid the pitfalls of a medical model that risks reducing human experience to a clinical diagnosis. Instead, both faculty members utilize a social model that resists rigid diagnostic categories and recognizes the multi-dimensional nature of any finding of mental illness, as resulting from a complex interaction of various social and environmental factors as well as internal psychological states.[7]

2. Background

Medical students in second year at Queen's University take a course in psychiatry prior to clinical clerkship. The medical program is a longiudinal competency based program with the use of a number of teaching modalities. Lectures and assigned readings are used to introduce knowledge. There is a strong emphasis on small group learning to facilitate application of knowledge and exposure to the non-expert competencies in a simulated setting. In terms of their legal knowledge, these students had already learned the basic principles of consent to treatment, capacity assessments, and substitute decision-making, via a review of legislation and case law in a seven-week first year medical school session taught by the law faculty.[8] Prior to 2012, the students had one lecture on suicide risk assessment given by clinical psychiatry teaching faculty, and a second separate lecture on the Ontario Mental Health Act[9] by the Law Faculty, which governs psychiatric assessment and committal. These sessions were relatively isolated from the medical curriculum however; there was minimal communication between the two faculty groups and little understanding of the goals and objectives of each other's teaching sessions. This resulted in some confusion for the medical students, who felt that they were getting different messages and had some anxiety about how the two viewpoints could be balanced.

Prior to the first session, faculty members from law and psychiatry met to discuss the joint session and to prioritize the learning objectives. The clinical faculty wished to portray the assessment of suicide risk and reduce anxiety about the use of involuntary admission when necessary for the safety of the patient. The legal faculty wanted to ensure that students understood the legal rules governing psychiatric treatment and appreciated the importance of compliance with the law. In those discussions, both groups sought to find an approach that would address the legal and clinical dimensions of psychiatric practice.

Faculty members from law and psychiatry ultimately agreed on the following perspective; law could be seen as establishing clear boundaries for clinical practice, so that any acts *outside* of those bounds would attract legal sanction, but anything *within* the bounds of law was both permissible and justified.[10] This approach helped to meet an important clinical goal of the session, as students were assured that intervention was both permissible and warranted in some circumstances, thus reducing anxiety about the decision to admit someone to hospital on an involuntary basis. This approach also met the concerns of law faculty, as knowledge of the law became a critical starting point for knowing whether or not one could intervene. Using this perspective, we hoped that the message delivered to students would become somewhat more clear and less contradictory. Law provided the ground rules, and transformed difficult interventions into legally permissible acts, *provided all the formal legal requirements were met*. In this way, students were empowered to make difficult choices, and at the same time appreciated the critical importance of complying with the rules.

3. Inter-disciplinary teaching sessions

In April of 2012, the first joint teaching session on psychiatric emergencies was given by a law professor and a psychiatrist to second year medical students, using a team based learning model.[11] A number of case scenarios were presented and students worked in small groups to determine a management plan. Discussion was facilitated by the law professor and the psychiatrist, who were able to model decision-making in the same learning event; students were thus able to consolidate the legal requirements for involuntary admission and apply them to the clinical situation.

Since the goal of this session was that the students would learn how to perform a suicide risk assessment, identify level of risk of suicide and identify the legal requirements in the management of the suicidal patient a number of small group learning tasks were assigned. In dyads, students were each given one of two clinical scenarios and had the opportunity to perform a suicide risk assessment on one another while acting these scenarios. This gave them the opportunity to practice asking the questions that had been provided as part of their pre-reading. They were then required to interpret their interview and establish risk of suicide (high, medium or low). In the final tasks, students discussed a number of different case scenarios in small groups. These scenarios were jointly designed by psychiatry and law faculty members to elicit both clinical decision-making and a consideration of the legal constraints that would affect treatment decisions.[12] Clinical teaching staff divided up and observed various groups performing the above tasks, to assess the students' understanding and their application of the various concepts of risk assessment and the Mental Health Act.

The session concluded with a plenary discussion on the scenarios presented. Both faculty members responded to students' questions on the legal and clinical aspects of the problems presented, and this evolved into a dialog between faculty members on the problems and

[6] Baker et al. (2008), Barr et al. (2000), Barrow et al. (2011), Reeves et al. (2002), Salm et al. (2010), and Wakefield et al. (2003), as cited in Kenaszchuk, Rykhoff, Collins, McPhail and van Soeren, "Positive and Null Effects of Interprofessional Education on Attitudes Toward Interprofessional Learning and Collaboration" (2012) 17 Adv. In Health Sci. Educ. 651 at 652.

[7] In their 2012 report on disability and the law, the Law Commission of Ontario employs a social model, stating that "definitions of disability must recognize the diversity of experience that results from the interaction of an individual with his or her environment." Law Commission of Ontario, *A Framework for the Law as It Affects Person with Disabilities: Advancing Substantive Equality for Persons with Disabilities through Law, Policy, and Practice* (Toronto: September 2012) at 19. For additional discussion of the medical and social models, see Johnson and Stewart, "DSM-V: Toward a Gender-Sensitive Approach to Psychiatric Diagnosis" (2010) 13 Arch Women's Mental Health at 18, and Kaiser, H.A., "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139.

[8] Decisions reviewed include A.M. v. Benes (1999), 46 OR (3d) 271 (Ont. C.A.), Fleming v. Reid (1991), 82 D.L.R. (4th) 298 (Ont. C.A.), Re Koch (1997) 33 OR (3d) 485, Malette v. Shulman, [1990] O.J. No. 450 (C.A.), Reibl v. Hughes, [1980] 2 S.C.R. 880, and Starson v. Swayze [2003] 1 S.C.R. 722.

[9] Mental Health Act R.S.O. 1990 c. M. 7.

[10] The authors acknowledge that this approach does not solve the problem of bias *inherent in the legal system itself* toward the validation of physician's determination of best interests at the expense of patient autonomy. This bias is evident in Charter challenges to Ontario legislation that have consistently held that patient's rights are less worthy of Charter protection because doctors are acting in their best interests. See, for example, Justice Karakatsanis' conclusion that "the *Charter* does not extend the same level of procedural protections to people brought to a hospital pursuant to the *MHA* as to those being criminally investigated by police." (C.B. v. Sawadsky, 2006 OJ 4050, ONCA at para. 4, summarizing Justice's Karakatsanis' trial decision.) Our hope is that our approach at minimum offers a robust endorsement of the necessity for physicians' strict compliance with the law.

[11] A second session was given along the same lines in April of 2013, and both of these sessions form the basis for our observations.

[12] See Appendix A for examples of case scenarios that we used.