NOT AS STRAIGHT-FORWARD AS THAT IT'S JUST 'AN ADDED FUSS' - UNTANGLING HOW INDIAN PSYCHIATRISTS CONSTRUE DOMESTIC HUMAN RIGHTS LEGISLATION

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1. INTRODUCTION

After its ratification of the 2006 United Nations Convention on the Rights of People with Disabilities (UNCRPD), the Indian government proceeded to work through a list of laws from various fields – employment, housing, healthcare, personal status – that would need to be amended to guarantee the rights in the UNCRPD. Regarding the healthcare of persons with mental illness, the law-drafters deemed it insufficient to merely amend the existing law and proceeded to draft a new, innovative mental healthcare law. When the Mental Healthcare Act (MHA) was passed in 2017, responses were strongly polarised: On the one hand, it was lauded for staying true to the vision of the UNCRPD (Duffy & Kelly, 2019), while on the other hand, especially psychiatrists heavily criticised that they anticipated the law would adversely affect their ability to treat patients.

A. Aim and Argument of this Paper

As the MHA enters its fourth year, governmental and non-governmental policy experts begin to tentatively evaluate its impact and effect. Through this paper, I seek to untangle the criticism Indian psychiatrists[1] have expressed about the MHA and identify the main factors that inform how they construe the law. I identify 'internal' factors – the priorities and ideology of the psychiatric profession – and 'external' factors – the intentions of the law-drafters and how they are reflected in the law – as critical in shaping how psychiatrists construe the law. I find that psychiatrists criticise the MHA because they feel their priority to deliver health is subverted to priorities they perceive as less thought through and imminent. I also argue this is a direct consequence of the law-drafters wanting to prompt psychiatrists to critically reflect on their professional priorities.

I first summarise the main criticism expressed about the Act and then review existing literature on the regulation of organisations through law to demonstrate that Indian psychiatrists make sense of laws through the perspective of their field. I then highlight shortcomings in existing literature and justify the need to examine a law's specific innovations as a factor that shapes how a law is perceived. Based on my own conversations with psychiatrists, I then lay out the features of their professional culture with consequentialist priority-setting, its emphasis on treating and promoting

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[1] In this paper, I use the term "psychiatrists" to refer both to "Indian psychiatrists" and "the psychiatrists I talked to".

health. Next, I examine the most criticised innovations of the MHA – including advance directives and mental health review boards – and argue that these are considered problematic as they subvert medical and administrative decision-making to the procedures of bodies created by the legal system. I show that many psychiatrists feel unfairly singled out and seek a reason for their own considerations being subverted. I then consider the perspective of the law-drafters, and draw on the concept of communicative laws to argue that the law-drafters prioritised communicating in which situations human rights should be considered more, rather than designing the law to communicate human rights norms themselves. Finally, I discuss how laws are often used by legislators seeking social change in order to level the playing field within society prior to softer approaches. As many of the MHA's law-drafters themselves are psychiatrists, the feeling of provocation perceived by their colleagues is likely part of a larger strategy of human rights socialisation.

B. Background: Criticism of the MHA

The MHA contains prohibitions as well as positive obligations upon service providers. For instance, the MHA provides that electroconvulsive therapy – electro-shock treatment commonly used on cases of treatment-resistant depression – cannot be administered in the healthcare setting without anaesthesia, and that minors can only receive the treatment if permission is granted by a board (Sections 95(2)(a)-(b)). Other provisions of the MHA bestow persons with mental illness (PWMI) with the right to issue "advance directives" (AD), legally binding indications subject to certain exceptions of ways in which a person wishes to be – or not be – treated if they later lack capacity to make decisions (Sections 5-13). The MHA also stipulates that each state shall set up a Mental Health Review Board, to which psychiatrists must apply for permission should they want to administer any treatment that is excluded in the patient's AD, or should they generally want to admit a PWMI to a mental health facility against their will (Sections 11(1)-(2)).

Psychiatrists appear to still identify the same problems about the law after its entry into force as they did when it was first drafted. Several concerns circled in journals and newspapers around issues of feasibility and costs, such as the healthcare system in India not being equipped to implement the ambitious provisions of the MHA (Duffy and Kelly, 2019; Rao et al., 2016; Sachan, 2013; Kohli, 2018, Bada Math et al., 2019). As most such claims are backed by figures laying out concrete budgetary constraints, I do not scrutinise these further, but focus more on those claims regarding the creation of social and legal barriers to providing care. In a 2018 newspaper interview, Dr Nimesh Desai, director of Delhi's largest mental health facility, predicted that the MHA "will make it tough to treat patients", especially in the context of admitting people with mental illness into hospitals (Kohli, 2018; see also McSherry and Weller, 2010; Kala, 2013). An article published in the Indian Journal of Psychiatry describes advance directives and other features as elements of "alien Western law enforced on Indian cohesive family dynamics", without specifying what makes the family "cohesive" (Pavitra et al., 2019, p. 832). Several other articles condemn the MHA as being incompatible with "Indian culture", albeit without specifying what precisely is meant by this (see also Kumar Kar and Tiwari, 2014; Kala, 2013). Psychiatrists, thus, appear to have a clear view of the MHA that they frame as if self-evident: That it cannot be implemented in India.

C. The Regulation of Organisations and Professions

Laws are always received by and filtered through existing social institutions (Edelman and Suchman, 1997). To make human rights principles 'work', they must therefore be translated into terms that make sense to and resonate with different groups of actors (Merry and Levitt, 2017). I approach psychiatrists, as a group of actors, through the lens of "semi-autonomous social fields" (SAF) and professional organisations, each of which I define below.

The concept of a semi-autonomous social field (SAF) was devised by Sally Falk Moore (1973) to highlight that the social world is composed of several networks of actors, each with their own rules. Notably, these networks are not neatly distinct, but are layered and interact in complex manners, with each one being embedded in, overlapping with or containing others. As such, legal obligations may permeate, but never fully transform the rules of a smaller field that is embedded in the larger one dictating the rules. These SAFs are "semi-autonomous" in that they can never be fully regulated from the outside, but are always somewhat influenced by outside rules (Witteveen, 2014). Socio-legal scholar Wibren van der Burg (2009) compares the interactions between an SAF and the field it is embedded in as similar to a "medieval feudal relation between a powerful count and a distant emperor with little more than a nominal claim to sovereignty" (p. 156).

Organisations, such as companies or formal professions, are easily conceptualised as an SAF, as they clearly delimit members from non-members and enforce an (often written) code of conduct, but are nonetheless embedded in a nation state whose legal system they must abide by, and whose legal reforms inevitably impact them. In his analysis of professional organisations, van der Burg (2009, p. 147) introduces the term "centre-periphery perspective" – in which the profession is at the centre – to visualise why professionals primarily focus on their professional practice. Most fundamentally, individuals tend to consider things in relation to themselves. From this follows that a law's target group considers laws from a fundamentally different perspective than law-drafters. Van der Burg (2009) emphasises that "perspectives" are not merely passive; rather, one's perspective is an essential element in constructing and navigating reality, and the primary lens through which actions obtain meaning. When a law permeates into the SAF that is a formal organisation, this often "triggers a response in the affected subsystem which treats it like an external irritation, which leads to a mistranslation of the external message into the language and the ideology of the receiving subsystem" (Witteveen, 2014, p. 498).

SAFs therefore participate actively in socially constructing the meaning of law (Edelman and Suchman, 1997). Importantly, "certain ideas about law tend to become institutionalised within particular professions", such as the perceived reach, purpose and fairness of any legal regulation from outside (Edelman, 2005, p. 348). Several analyses found that professionals exaggerate the threat of the law, and for instance regard any legal regulation as "misguided, or even morally wrong, and as thwarting [their] actions" (van der Burg, 2009, p. 150). Such a collective legal consciousness – that is, the "ways they experience and understand the law and its relevance to their lives" (Merry, 2010 p. 42) – forms part of the so-called "professional culture" (Edelman, 2005, p. 342). Professional culture, in return, is crucial to the idea of SAFs, as it generates norms and rules around how members of the profession should act in general, and also how they should incorporate laws imposed by the SAF they are embedded in.

D. Regulating Psychiatric Professionals Through Human Rights Law

While the *Mental Healthcare Act 2017* (MHA) features some substantive provisions regarding explicit rights of people with mental illness, most provisions oblige psychiatrists to go through specific mandated steps before making any decision regarding the treatment of PWMI and their admission into hospitals. Above paragraphs sketched out the criticism psychiatrists have published about the MHA in journals, on websites, and in editorials; the nature of this criticism suggests that the Indian psychiatrists as a semi-autonomous social field react to the MHA in accordance with the existing literature: The SAF construes the meaning of the law by placing it within the frame of reference of the psychiatric profession.

This professional culture has been scrutinised in the field of medical sociology, although what is mapped out is the professional culture of doctors (not of psychiatrists specifically); a prominent author in this field is Eliot Freidson (1970a; 1970b; 1975), a sociologist who extensively researched the social role of doctors in 1970s' USA and whose findings remain confirmed today. Over the course of several works, he examined the implied entitlements society reserves for doctors as a consequence of their knowledge and prestige (more recent works that reiterate his arguments are Lidz, 2010, Parsons, 2013, Montgomery, 2006). An example of this is the observation that doctors are uniquely allowed to conduct intrusive operations on their patients for the sake of restoring their health (Lidz, 2010; Montgomery, 2006). Kapp and Lo (1986) expand on the sociology of medicine by contrasting the way doctors approach problems with that of lawyers, and discuss the origin of the strong stereotypes each often has of the other (see also Annas, 2008). Notably, this analysis is of *lawyers* and doctors, not law-drafters – while lawyers apply the law, the role of those who draft the law has not been scrutinised.

Additionally, van der Burg (2009) explains that doctors generally do not institutionalise new norms within their framework of reference but rather continuously consider regulatory law an external sanction. He argues that rather than institutionalising the *law*, doctors institutionalise a feeling of antagonism against laws and the legal professional in general. Notably, his and others' conclusions are limited to findings such as that 'doctors do not like being regulated', or that 'doctors do not find that law has a relevant place in medical practice' (Montgomery, 2006; Sivalingam, 2001; Willmott et al., 2016). Not only is the explicit content of 'the law' not specified in these analyses, but what specifically about a law is perceived as overly restrictive is skimmed over as well. This creates an impression that the content of the law is irrelevant – however, the law communicates between law-drafter and law-recipient, and the precise provisions may thus be crucial to understanding each unique case.

E. Research Design

The research question underlying the paper merits an examination of both the psychiatric profession as well as of the legal profession, and a closer look at the function of laws. My findings are based on an analysis of articles psychiatrists published on the MHA in scholarly journals, as well as primary data collected from personal conversations with psychiatrists in Northern India in January 2020, and with a psychiatrist involved in the law-drafting process.[2] Interlocutors were recruited through four main paths: contact details in academic articles, websites of major hospitals in the New Delhi area, LinkedIn, visits to hospitals in person. In total, ten interlocutors were interviewed, eight of which using a semi-structured interview method either in person, on call or via video chat, the other two ethnographically during a visit to IHBAS, the main psychiatric facility in Delhi. Oral consent was taken on the digital interviews; a consent form was provided to sign for the in-person interviews. All interlocutors were explained in detail the purpose of the interview as well as the way in which data are intended to be used. Interlocutors were asked if they preferred to remain anonymous; two requested for their identity to be anonymised. Each interview was concluded with the question whether any quote should be omitted from analysis, and both requests to do so by interlocutors were respected.

Emphasis was placed on interviews being conversations, in which arguments evolved fluidly as we progressed. While focus groups could have proven fruitful for the present research topic, as important new ideas could emerge due to collaborative thinking (Webley, 2010), such focus groups were unfeasible for the research because psychiatrists in India are highly busy, and assembling them in one place would have exceeded the scale of the research. To simulate the interaction sought in focus groups, interlocutors were asked to comment on quotes they and their colleagues had published in articles, and to react to the hypotheses of the researcher. Rather than extracting information from interlocutors, findings were intended as a collaborative effort, in which interlocutors were encouraged to analyse their own background and norms alongside the research. Understanding the perspective of a different discipline and what confinements, preferences and obligations exist within the minds of interlocutors was inherently an empathy exercise, and required stepping into their shoes, imagining what may prompt them to do what they do, and reflecting on how they interpreted the presence of the researcher. This reflects feminist notions of research in which the researcher "favor[s] the role of supplicant, seeking reciprocal relationships based on empathy and mutual respect, and [shares] knowledge with those they research" (England, 1994, p. 243).

Data analysis followed the steps of thematic analysis as best proposed by Braun and Clarke (2006). Their method proposes six steps: First, familiarisation with the data; second, the generating of initial codes; third, the searching for themes; fourth,

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[2] The research design received an official ethics sanction through the Ethics Review Board of Leiden University College on November 20, 2019, and its implementation was supervised by Prof. mr. dr. A.W. Bedner of Leiden University.

reviewing themes; fifth, defining and naming themes; and finally, the usage of the themes and data to construct a report. During the thematic analysis, theories were consulted of how laws are vernacularised and how organisations construe legal obligations. Theories served as "coat hangers" in that they helped connect together "particular pieces of data, which otherwise may seem unconnected or irrelevant" by "draw[ing] attention to particular events or phenomena" (Maxwell, 2005, p. 43).

II. FACTORS THAT SHAPE HOW PSYCHIATRISTS CONSTRUE THE MHA

A. The Professional Culture of India's Psychiatrists

As a semi-autonomous social field, the profession of psychiatry creates and enforces its own normativity while being embedded within the norms of the wider medical community and the legal system of India (Edelman and Suchman, 1997). Indian psychiatrists thus have an internal professional culture with its own professional perspective, through which these professionals navigate reality (Richardson and Asthana, 2006). Sketching out the general features of this professional culture is a fundamental steppingstone to untangle the criticism of the MHA and discover underlying issues. Importantly, the professional culture of Indian psychiatrists is neither static nor harmonious; while there are commonalities regarding norms and conceptualisations of reality, these are constantly renegotiated and refined (see Atkinson et al., 2004). Based on the existing literature on *doctors* and my own conversations with Indian *psychiatrists*, this section examines the professional culture of the latter and demonstrates that it is a major 'internal' factor in how they construe the law.

B. Notions of Harm and Good of the Professional Culture of India's Psychiatrists

In their training phase, Indian psychiatrists are socialised to act in conformity with Hippocratic traditions of medicine. The Hippocratic way of thinking is primarily concerned with a patient's *health*; beneficence is considered above all other considerations (Miola, 2007). The psychiatrists I talked with emphasised that their top priority was making their patient "well" again. A patient dying was described by one interlocutor, Dr Raheja, as the ultimate fear; psychiatrists are not among those who may accept someone's desire to die as legitimate, but rather view life as sanctimonious (confer McSherry and Weller, 2010). A majority of interlocutors brought forward that health can only be achieved by a medical professional, and that the best interest of a patient is thus to be treated. This line of reasoning prioritises any kind of treatment over no treatment, leading to the notion that action is preferable to inaction (Freidson, 1970a). Of course, action should be thought through and contribute to a legitimate purpose; in this regard, psychiatrists orient themselves along medical ethics, which, rather than dictating what behaviour is right and wrong, are "a normative framework that gives guidance on how to ethically come to treatment decisions" (Clouser, 1973, p. 787). In discussion with Dr Ukrani and Dr Sharan, it emerged respectively that neither medical ethics nor the Hippocratic Oath are actively summoned in a decision-making process; rather, both guide thinking subconsciously through prior internalisation and acculturalisation (see also Freidson, 1970b).

The notion that treatment is an absolute good pervades the professional culture and defines what behaviour a psychiatrist should *not* engage in. In all instances, the threshold to something being described as 'harmful' required *physical* harm to occur – a rather high threshold. Dr Kumar Kar, for instance, referred to chaining, beating, seclusion and restraint as harmful acts that patients have been exposed to but should not have been. Regarding the question what "human rights law" ought to cover, Dr Tripathi described his view that it violates a patient's human rights if, for instance, medication is prescribed without a diagnosis, or if a treatment plan is drafted solely based on second-hand reports of the patient's symptoms. When discussing the nature of human rights with the interlocutors, a general trend emerged in which only grave clinical mistakes – such as prescribing without a diagnosis – were considered condemnable, as these can lead to health deteriorating. From this follows that acts are measured by their consequence, and do not amount to condemnable harm if the ends justify the means. Dr Tripathi added that:

> If you allow the family members to take decisions for the patient, probably the chances of him getting cured becomes better. It might appear as an infringement of the human rights of a particular person, but, but, but if you see in totality that family members, if they are allowed to take decisions, the chances of the patient getting better […] are more than if they leave him on his own. […] I understand that this kind of goes against the basic understanding of human rights, that every person knows for him or herself. But if you allow the family to be part of it, to take decisions, the chances of human rights violations are there, but overall, there is more good than harm.

In this quote, Dr Tripathi attempts to expand on his definition of what constitutes harm, but he concludes by emphasising that he is primarily concerned with whether an act will contribute to overall health. Another interlocutor from Northern India described that:

> In some cases – and this is not a very legal thing – I do not tell [patients] about the side effects, because I notice that if they *do* know about the side effects, they do not take the treatment. Sometimes the side effects are as mild as some acidity, so I understand that the benefit is higher than the risk.

In this case, the psychiatrist forewent proper informed consent procedures, knowing that the chances of his patient's health improving were higher if he withheld certain information. Another interlocutor, Dr Sharan, opened up about a practice in which a procedure that promises health improvements is carried out without consent: "For certain anti-psychotics, there are many patients in India who are treated by liquid variants without their knowledge, and they're not in-patients." He described how the treating psychiatrist provides family members with the medication, who then at home "put it in a drink" and administer the medicine to the patient without their knowledge, "sometimes for years and years." Due to the consequentialist nature of their decision-making, neither Dr Tripathi, nor Dr Sharan, nor the third anonymous interlocutor found their acts to be condemnable, despite their awareness that they are not in accordance with law. These aspects of the professional culture form variables internal to the recipient, and are crucial in shaping how the profession receives the MHA.

C. Patient Autonomy in the Professional Culture

Merely upholding human rights for the sake of it does not feature in the line of thinking of any of the interlocutors. This section discusses how patient autonomy features in psychiatrists' professional culture, and thus presents an important factor in how psychiatrists construe the law.

While the idea of human rights was explicitly welcomed by several interlocutors, they never placed it above considerations of health; Dr Kala (2013) for instance stated in an editorial on the MHA that "advance directives have not worked as intended even in the West", and that while "the concept may have a certain kind of popular appeal, it has no scientific evidence to back it" (p. 217). His desire to find evidence of 'usefulness' links to a need to consider everything in relation to health; as he sees no evidence that advance directives lead to an improvement of health he dismisses them. Some interlocutors expanded on this notion by associating 'the human rights approach' itself with constituting harm: In conversation with Dr Sharan, I asked him about his approach to informed consent, and how much time he generally spends per patient to ensure that they understand the procedure. He pointed to the fact that he works at a well-visited government hospital, and that the vast amount of people waiting outside his practice allows him only a few minutes per patient. Notably, he did not consider this to be inherently harmful, and invoked that healthcare is a "social justice" issue:

> It fits the social justice principle: If there are so many people who need services and you are the only one available, then what do you do? Do you say to that: I'm treating 30 people and I'm not treating 370 [others]. […] From an equity perspective, it's a major, major problem.

By invoking the term "social justice", he appropriated the terminology generally associated with human rights activists, and highlighted how it would be absurd to require patients to fully understand the treatment and its risks if this could infringe upon another's right to access healthcare and treatment. Given the scarcity of psychiatrists in India – 43 psychiatric hospitals and approximately 4000 psychiatrists for 100 million PWMI in 2013 (Duffy and Kelly, 2019, p. 169) – psychiatrists balance the right to health of various people with each other, as I noticed through my interlocutors, who thought in terms of whether treating one person might mean not treating another. Dr Tripathi specifically highlighted that any consideration of how to treat one patient is done in light of an overburdened healthcare system:

> The patients taking voluntary admission were earlier just told to sign a paper and they will be admitted. They just signed the form. They didn't really know what exactly they are signing. This is changing now, but, you see, you cannot blame the doctor for it. The first response would be that the doctor is behaving unethically, right? No, he was being *practical*. He has to admit 40 patients a day, he is the only doctor, he has to explain everything and the patient doesn't even understand anything about all those stuff. So what option is he left with?

The priorities and norms of the professional culture are thus finetuned as psychiatrists are confronted with dilemmas in real life. In conversation, psychiatrists emphasised towards me that PWMI do in fact quite frequently try to refuse treatment. Dr Tripathi, for instance, mentioned common myths among the general population about psychiatric practice, such as that every psychiatrist chains their patient and puts them into a mental asylum, which leads to people not seeking help out of their own volition. Another psychiatrist indicated that many of the people who *did* take the leap of faith and came to see him believed that he would force them to take sedatives and felt worried about this. Dr Kumar Kar, who works at a large government hospital, expressed that he felt that he could not reconcile letting individuals with schizophrenia or other illnesses with persecutory delusions decide their treatment, as these often assert they do no need treatment and thus refuse to be admitted in almost all cases. Respecting their autonomy to make decisions, he argued, might lead to a harm to self as well as to society. Overall, interlocutors expressed that they feared allowing patients to make decisions about their own life, as these can be clouded by mental illness and stereotypes about psychiatry.

Given their experiences, psychiatrists have thus constructed an intricate system through which to most effectively uphold their professional norms in their individual context, such as in a hospital or a private clinic. Importantly, my interlocutors indicated that they tap into the individual cultural and social background of their patients to enhance treatment. Dr Tripathi, for instance, explained:

> Indian healthcare follows a paternalistic method of treatment. When I was in the US, I saw doctors doing this: They would sit with the patient and tell them that there are three options, option A is this, etc… And you choose. And I came back to India, and tried to do the same thing here, and the patients were puzzled – they were like, you are the doctor! You tell me, how would I know?

Regarding the same topic, Dr Kumar Kar described that many of his patients fundamentally respect any decision made by a superior given the hierarchical system of decision-making within many Indian families. He asserted that not asking some of his patients about their preferences and wishes is not a violation of their autonomy, but a variant of respecting their autonomy by understanding that they *want* another person to make a decision (see also Donnelly, 1984). Similarly, several psychiatrists indicated that they use family members as assets to help a person achieve health as fast as possible. As the proportion of patients living with their family is over 98 percent in India, psychiatrists can treat people *through* their family members (Singh, 2017, p. 101), as already indicated above. Another interlocutor stated that he makes use of a family's cohesiveness by asking a relative to stay with an admitted patient in the ward. That relative assists with feeding, personal hygiene, and supervision of the patient, and also makes decisions for them. Not tapping into this cultural arrangement would appear to psychiatrists to be a missed opportunity at enhancing the path to health. In order to directly resonate with psychiatrists, the MHA would therefore have to support these practices; otherwise, the professional culture is likely to construe the law as having 'odd' priorities.

D. How the Professional Culture Illuminates the Criticism

This paper seeks to understand not only what factors have shaped how psychiatrists construe the MHA, but also what can be learned from this about the criticism psychiatrists have expressed. Dr Raheja, Dr Pathare, and Dr Desai all asserted that the criticism their colleagues have uttered about the MHA are a pretext through which they express that they felt their power as psychiatrists is being undermined. Their impression is in line with findings by scholars researching compliance with medical law, who suggested that "[a]lthough the rhetoric is phrased in terms of benefiting the patient, an underlying issue may be loss of control and power by physician" (Kapp and Lo, 1986, p. 169). I argue that in the present case this is an oversimplification, given the intricate and complex professional culture of psychiatrists laid out above. The argument that the underlying issue is power, not patient wellbeing, suggests that these two are separate, when actually they go hand in hand – what gives the psychiatrist power is his bestowing the patient with health (confer Freidson, 1970a; 1970b; 1975). When describing the MHA, several interlocutors invoked terminology that accused law-drafters of overlooking how much effort psychiatrists have already put in to strike a balance between making sure people's health improves, and treating them with respect. Dr Tripathi specified:

> See, when you talk to Indian doctors, you might get the feeling that they are not too high on this human rights thing. […] There's a reason behind this, it's not that we are bad people. But, you know, it's all about trying to find what harms less to the population. Let's say there's a schizophrenic patient who has no family support. He himself does not understand stuff. The human right approach is to find out if his capacity to make decisions is there or not; if it is not there, to write a letter to the mental health review board, or to the magistrate, then take a decision… But we do not have resources for that. If you push a doctor to do all this – usually there is a single doctor in the emergency ward – he is short on time, he might simply refuse to admit this patient, rather than going through all the hassles. And the patient may end up being on the streets. […] The patient who could have gotten help is now devoid of this help.

Dr Tripathi understands from the MHA that it does not acknowledge that the Indian healthcare system is overburdened, and feels that it does not allow him to fulfil his sense of obligation towards ill people by treating them efficiently. As I demonstrate in the following, the MHA pushes 'health' as psychiatrists understand it into the background, and thereby increase the distance between psychiatrists and their goal of providing treatment.

E. The Devil in the Details of the MHA's Innovations

When I asked him what "the problem" with the MHA is, a young psychiatrist assessed that "with all of the experience that the older psychiatrists have, they do not want this *fuss* to happen!" As argued above, psychiatrists assert to have found the most efficient way of effectively treating patients given case-specific constraints. The introduction of any law thus requires psychiatrists to recalculate and find a new most efficient way within the new constraints. To understand what exactly constitutes the above-mentioned "fuss", this section demonstrates that psychiatrists I spoke with did not criticise that the MHA poses actual obstacles – rather, the issue seemed to be that the MHA impacts upon this recalculation through implicit messages.

Generally, psychiatrists will likely be able to continue treating as before in most cases. For example, while the MHA requires psychiatrists to explicitly assess the legal capacity of their patient to make healthcare decisions, the MHA only states than an Expert Committee will be appointed to provide guidelines to assist psychiatrists in this assessment. The same provision, Section 81(2), states that "every medical practitioner and mental health professional shall, while assessing capacity of a person to make mental healthcare or treatment decisions, comply with the guidance document" and thus makes compliance with external guidelines mandatory; however, it is unclear how a thought process could be policed, and therefore how this provision can be enforced.

Rather than creating actual obstacles and complications, the issue with this provision appears to be that psychiatrist's existing decision-making procedures, based on medical ethics and professional experience, are not trusted to do the job, wherefore additional guidelines are published. Van der Burg (2009) excellently maps out the thought process by explaining: "For the autonomous professional, this may seem preposterous. Who do these incompetent people in the capital think they are – looking for instruments to guide and control the behaviour of expert professionals?" (pp.156-157)

The criticism of psychiatrists can be traced back to their reading implicit messages from between the lines of individual innovations. For example, if a PWMI has issued an advance directive (AD), a document in which a PWMI can indicate ways in which they wish to be – or not be – treated if they later lack capacity to make decisions, the MHA mandates that a psychiatrist must align his treatment with it (Section 10). Dr Tripathi highlighted that the low level of education, as well as general misconceptions about mental health and psychiatric practices are already constraints that psychiatrists have to accommodate; the MHA, by allowing PWMI to issue ADs, increases the burden that these constraints already pose:

> [ADs are a] beautiful thing, surely, right? But the problem is that most of the people don't even consider mental illness a legitimate illness. […] When people don't even *understand* about mental illness, and a person then can write how they should be treated – this in theory is perfectly fine! The problem is that in India if someone were to write an AD, their preferences will be clouded by misconceptions about what mental illness is. […] In a country where people don't even know what kind of treatment is done for mental illness, how do you expect them to choose what is right and what is wrong for them?

If a psychiatrist finds that the nature of the patient's illness requires him to challenge the AD, or if a relative requests treatment to be done that is not permitted in it, an application must be made to a Mental Health Review Board (MHRB) for review (Sections 11(1)-(2)). ADs can be modified if the person did not intend the AD to apply to the current circumstances, especially if the current circumstances were unforeseeable, "unforeseeable" being a term left up to case-by-case consideration (Section 11(2)(b)). Each state is responsible for setting up its own MHRB and creating the rules of procedure of the respective MHRB. Given the flexibility, being granted permission to overrule an AD may not be a major hurdle. Additionally, ADs are not yet commonly used, and given that how much of a constraint an AD poses depends on the individual specifications, they do not appear to restrict professional practice much. However, the issue at hand seems to be that the choice of treatment is taken out of the hands of the psychiatrist and placed first into the hands of a PWMI whose judgment may be clouded by misconceptions and rumours, and second into the hands of a body set up by the government.

The above-mentioned innovations are major factors in how psychiatrists perceive the MHA, which emphasises the importance of studying the specifics of the law's provisions themselves. A final major innovation of the law are the steps required to carry out a supported admission – viewed from the perspective of the psychiatric profession, they can be taken as a major delay in or barrier to doing good. The first step keeps the centre of control within the profession itself: If a psychiatrist in a hospital wants to admit a patient without his consent, the MHA requires that two professionals – one psychiatrist and another medical professional – independently assess the PWMI and conclude that admission is necessary (Section 89(1)). A compulsory second step, however, is a vetting by a Mental Health Review Board. Importantly, the task of reporting to the MHRB is not that of the psychiatrist, but of the administration, and until the MHRB makes a decision, the psychiatrist can treat the patient as he would otherwise do (Section 89(11)). However, in this second step to a supported admission, the locus of decision-making is outside of the hospital, in a newly created body. Several interlocutors expressed that they did not understand the value of having someone outside of the hospital evaluate the patient's circumstances; Dr Ukrani added that because one member of a MHRB is necessarily a psychiatrist, asking a third psychiatrist to *yet again* determine whether admission is merited is redundant and a waste of time.

From the analysis above, it emerges that psychiatrists consider those parts of the MHA problematic that require them to follow new procedures, such as reporting to a MHRB after admitting a patient without consent. This continues a trend identified in 1997 by Edelman and Suchman, in which health practitioners construct the law as a major threat to healthcare and argue that they have the unique ability to perfect healthcare. However, I argue that this argument is only part of a larger picture in which psychiatrists infer a message from the procedural innovations of the MHA. As stated above, the procedures permit various outcomes – only few things, such as ECT without anaesthesia, are completely ruled out. The problem psychiatrists identify is that these procedures have to be done all the same. The crux of this section is that alongside the internal professional culture of psychiatrists, the specifics of the law – that is, what decision-making it governs and possibly prolongs – is a crucial variable in how psychiatrists view the law as a whole. The MHA is thus an "added fuss" in that decisions are always vetted through intricate review mechanisms, and this vetting cannot be circumvented regardless of any other considerations.

F. Tying it Together: The Message Psychiatrists Read from the Law

The MHA does not codify norms and asks psychiatrists to incorporate them in their practice themselves; rather, it specifies procedures in which psychiatrists have to interact with actors outside of their profession and abide by their standards, forms and terminology. The MHA is not placed within the medical field and left there to work its magic. Instead, psychiatrists are required to communicate with Mental Health Review Boards and actively involve them; they must thus first place the MHA within the reality of their own field and frame of reference, but then also refer back to the frame of reference as law-drafters designed it. This is more than just a cognitive effort – psychiatrists construe the law as a constant reminder that they cannot satisfy themselves with institutionalising the general human rights norms into their own procedures. As a MHRB is a state institution that has official sanction to veto a psychiatrist's decision – even if in practice it does not do so – the priorities of the psychiatrist are subverted, and all his considerations can be, in theory, dismissed as secondary. Notably, as the law was only introduced in 2017, MHRBs have yet to be set up in most states (Dr Kumar Kar, personal communication, January 3, 2020). The issue therefore does not seem to be whether treatment and admissions are *actually* overturned by a MHRB, or whether the procedures of requesting a review indeed take up much time – instead, the mere fact that it *can* do so appears to be problematic. Psychiatrists interpret this possibility itself as signifying that their perspective can be dismissed as wrong, and that the fundamental idea that health outweighs all other considerations is not universally valid.

G. Psychiatrists' Perceptions of Being Unfairly Targeted

How actors construe a law depends on whether they consider that the intentions of the lawmaker vis-à-vis themselves are good. Social psychologist Tom Tyler (2013) has thoroughly discussed the effects that trust plays in encouraging compliance. Fundamentally, he argues that if decision-makers show concern for the well-being of others, subjects will consider them more trustworthy and will be more inclined to cooperate with the decision. Even if the decision-makers make mistakes, what matters most is whether they act in good faith and what their intentions are (Tyler, 2013). Tyler (2013) elaborates:

> When a decision is being presented, authorities should emphasize that it accords with the ideas underlying the rules and procedures of the organization. In particular, they should explain the decision by reference to rules and organizational principles that show that the decision is not based upon personal prejudice or bias. (p. 47)

The MHA, as discussed above, does *not* conform to the perspective psychiatrists have of the world. In contexts such as these, Tyler (2013) advises: "When decisions go against the person, it is important to show that the decision was made by applying rules and using facts." (p. 47) In conversation with me, interlocutors expressed that not only was their perspective on being subverted, they also felt unfairly targeted. Rather than trusting that the MHA had been devised with concern for their interests, many felt that the law-drafter had singled them out.[3] One psychiatrist expressed this by referring to patients:

> So many laws are based on the idea that patients are vulnerable. I get that – but is it that only people with mental illness are vulnerable? People with other illnesses who are on their death bed are much more vulnerable!

Dr Ukrani directly referred to his own profession rather than to patients:

> Psychiatry is the only branch of medicine in India that is governed by [a special] law. They don't have a law for cardiologists, or dentists, or neurologists, that admissions have to be done in a certain way. They don't have to submit certain documents, they don't have to justify everything, there is no review board who then will give the permission. They can practice freely!

Dr Desai, director of IHBAS, the largest mental health facility in Delhi, reported that Dr Ukrani's view is common, as "some psychiatrists feel singled out because they think that it is unfair that only psychiatry is being regulated."[4] When I asked Dr Ukrani whether he felt unfairly treated by legislators, he paused, and nuanced that: "See, it's all about the stigma. Many times, psychiatrists *have* been misused by governments.

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[3] I discuss the actual intentions of the law-drafter that I identified in a subsequent paragraph.

[4] Note that immediately after, he admitted that he himself approved of the MHA; he believed that even if the MHA restricts psychiatry, it is needed to stop psychiatrists from thinking that they are "Gods".

There's a history behind that. […] To a certain extent a law is required." Finally, he exclaimed agitatedly: "But they should listen to what the psychiatrists are saying! We are not trying to harm someone intentionally!" In further conversation, Dr Ukrani explained that he felt the law-drafters of the MHA did not trust his intentions, but rather assumed that his intentions were to harm his patients. This, given the strong normative commitment to treatment and health within the semi-autonomous social field, makes Dr Ukrani feel offended. Another psychiatrist rounded off this argument: "The ways the laws are framed, it's always the doctor's fault if someone dies."

From the paragraphs above and the previous sections, it emerges that psychiatrists feel they are being placed under scrutiny and suspicion for acting in accordance with their professional goals – they attempt to promote what they feel is the patient's best interest (health) in the most efficient and effective way possible given the constraints of the overburdened healthcare system and the culture and preferences of the patient. As a logical consequence, psychiatrists wonder what the reason is for this: Why are the goals of the healthcare sector pushed into the background? In a previous section, this paper already discussed the ways in which the law's provisions themselves are relevant 'external' variables in shaping how psychiatrists view the law as a whole. The next section proceeds to the intentions of the law-drafters as main factors external to the psychiatric professional culture.

III. EXTERNAL FACTORS IN PSYCHIATRISTS' MEANING-MAKING: INTENTIONS OF THE LAW-DRAFTERS

This section examines the priorities of the law's drafters and argues that while the MHA may likely not be enforced, the MHA nonetheless seeks social change – not based on legal coercion, but on communication with a touch of provocation.

The Preamble of the *Mental Healthcare Act 2017* proclaims that its purpose is to "align and harmonise" Indian healthcare law with the United Nations Convention on the Rights of People with Disabilities (UNCRPD). India signed and ratified the UNCRPD in the year it was inscribed, and according to leading authors Duffy and Kelly (2019), the Indian MHA indeed succeeds in adhering to the UNCRPD. The explicit reference to satisfying international requirements in the preamble, however, may be taken as indicating that the law was not passed with the intention that the provisions would be enforced.[5] Whether or not, or to what extent, the MHA is implemented is not fundamental to untangling the criticism; rather, the content of the provisions themselves do not fit into the reality of psychiatrists, and are therefore perceived as subverting medical considerations, which are the essence and pride of psychiatrists. More important than the intentions of the government who decided a law is needed are therefore the intentions of the drafters – that is: those who were tasked with writing the law and decided the wording and content of the provisions in the first place.

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[5] Even if the intention of the legislator – as distinct from the law-drafters – may have been to enforce the law, a recent calculation by Bada Math et al. of the healthcare budget indicates that without serious changes in the overall budget that is available for mental healthcare, the costs for implementing the MHA, especially its MHRBs, are unlikely to be covered (see Bada Math et al., 2019; Ministry of Health and Family Welfare, 2017).

In 2010, three years after India ratified the UNCRPD, the Ministry of Health and Family approached the Indian Law Society and the Centre for Mental Health Law and Policy (CMHLP), both based in Pune, for support in amending a list of laws that were deemed as not conforming to the requirements of the UNCRPD (Kala, 2013). In conversation, Dr Pathare, Director of the CMHLP, stated that the existing Mental Health Act of 1987 fell short in so many aspects that merely amending it would not suffice; instead, a new law had to be drafted. Over the course of three years, the two civil society organisations conducted consultations with various stakeholders, among them PWMI themselves, their relatives, human rights activists, and mental healthcare practitioners ranging from psychologists over ayurvedic doctors to psychiatrists (Kala, 2013). In an otherwise highly critical editorial, psychiatrist Dr Kala (2013) commends that the drafting process of the MHA was overall "inclusive and transparent" (p. 218). In conversation, drafter Dr Pathare clarified that while "all" stakeholders were given space to voice their concerns, this did not at all mean that everyone's wishes would be incorporated. He clarified that the concept of Nominated Representatives (NR), for example, had been requested by several women with mental illness with abusive husbands, as they feared their husbands could control and exploit them if their mental health deteriorated to the extent that they lost their decision-making capacity. As can be seen in the final MHA, the law-drafters included these women's requests. The wishes of psychiatrists, however, were not fully accommodated; Dr Pathare emphasised that "worrying about the needs of the professionals is the last thing you should be doing." More specifically even, Dr Pathare spoke about actively wanting to not let psychiatrists have their way:

> This culture has such a high level of patriarchy. It does not benefit the individual person, but it benefits only the institution of collectivism. […] The law was made to disband privilege. The whole battle around it is about power dynamics!

The law-drafters likely drafted the MHA with these considerations guiding their every pen stroke. Dr Pathare specified:

> [Laws are] a way of saying that this is where society is supposed to be in a few years time. […] The law is a statement. In modern nation states, the law is a statement of intent of the state.

Importantly, he uses the words "intent" and "supposed to be", which indicate a plan to actually accomplish the things stated. Even though the provisions may never be enforced, the law-drafters express that the realisation of human rights can inch a step closer through the law nonetheless. This section argues that the message psychiatrists infer from the MHA's procedures is a direct consequence of the law-drafters' preferences – rather than using the law to communicate *human rights norms* themselves, the law-drafters communicate in what *places*, *decisions,* or *relations* human rights need to be considered, and where psychiatrists need to make space for alternatives.

Generally, when laws are described as "saying that this is where society is supposed to be", the law in question is communicative. In a piece celebrating the effectiveness of communicative laws, van Klink and Witteveen (1999) explain that rather than seeking to regulate behaviour through punishment and enforcement, communicative laws choose persuasion as their strategy. Generally, the process of drafting communicative laws is as follows: First, the drafter pinpoints specific values they consider essential, but which are not yet clearly actionable. Second, the drafter specifies legal norms based on these values that can guide the application of these values in specific cases. The provisions of communicative laws are thus purposely vague, so that the law can promote its norms in a cooperative manner (van Klink and Witteveen, 1999). Communicative laws are specifically useful when trying to get companies, professional organisations or other fields with their own codes of conduct to abide by new norms. As each organisation has its own reference points inherent to its perspective, communicating the priorities and essentials of the law can help organisations identify how to most efficiently comply and incorporate the law's norms into its own procedures.

Communicative laws thus have the potential to direct psychiatrists towards what Dr Pathare described as "where society is supposed to be". Interesting to note in this regard is that Dr Pathare was trained as a psychiatrist; before moving into the field of mental health policy, he worked as a consultant psychiatrist in a private hospital. He therefore himself inhabited the semi-autonomous social field that is Indian psychiatric practice, and undoubtedly has viewed phenomena through its social lens. It is therefore likely that he considered how his colleagues would construe a provision that communicated human rights themselves, and how they would construct compliance. Dr Pathare explicitly referred to this by saying:

> There is this notion that: I am a professional, and because I am a professional, my reality should trump everybody else's reality… I mean we are in 2020, that's just not a sustainable argument! If the law should remain *for* the people, then it should meet the requirements of multiple groups. Worrying about the needs of the professionals is the last thing you should be doing.

From revisiting the specific innovations of the MHA, it emerges that whenever the law presents human rights values, this is already done in association with things that the law-drafters had priorly singled out as problems. In light of the communicative law theory, it seems that psychiatrists are not communicated the *human rights* themselves, but the *place* in which the law-drafters think that human rights considerations should feature prominently: When a person is admitted, when their consent is taken, and when psychiatrists rank priorities in their overburdened daily practice. In fact, from the conversation with Dr Pathare, it emerged that he wanted to prompt psychiatrists to inquire into the essence of their role as a treating doctor:

> The medical community needs to do some reflection on the meaning of "treat". Are we treating the illness, are we treating the person? What are the intended outcomes of the treatment? You can couch it in the language of "duties" and "obligations", but fundamentally you need to examine if it is their self-interest they are actually considering most.

Rather than communicating human rights norms themselves, the MHA is therefore more of a preparatory document to human rights socialisation. From Dr Pathare's quote, its goal rather appears to communicate the foundation that is required *before* human rights can flourish in it. Given that Dr Pathare emphasised psychiatrists' reality cannot "trump" everybody else's reality, the MHA is thus rather a tool to signal to psychiatrists that they should reflect on their role in society.[6] From reviewing the intentions of the law-drafter, the provocation that psychiatrists perceive is arguably exactly what the law-drafters intended to convey.

IV. THE MHA AS PART OF A LARGER STRATEGY

Literature on the regulation of professions generally supports the idea that laws ought to prioritise persuasion and the communication of norms through vague laws if it aims to induce behaviour change from highly autonomous SAFs (see Edelman, 2005). The message conveyed through the MHA, however, is not received by the psychiatric profession as peaceful and collaborative. The crux of why a communicative law provokes antagonism in the present case appears to be, fundamentally, that the MHA is not simply any law. Rather than seeking to regulate the organisation for economic reasons or taxation purposes, it is a human rights document that, as explicitly indicated by Dr Pathare, aims to level the playing field of psychiatrists and PWMI. Given their medical background, Dr Pathare and his colleagues are arguably uniquely positioned to design the specific role of the MHA in the wider process of norm socialisation. In this regard, I asked Dr Pathare whether he thought using laws to initiate social change was the best strategy, to which he responded that the law is a supplementary tool to social movements and nudging. This suggests that the MHA was written as it was in order to contribute to a wider and long-term strategy.

A common model of the process of human rights socialisation is devised by Thomas Risse (1999), who found that actors employ three strategies in the process: First, forced imposition, second, institutionalisation and habitualisation, and third, moral consciousness raising and persuasion. Importantly, "each process is necessary to achieve the internalization of international norms into domestic practices […and…] the question then becomes which mode of action prevails at which stage" (Risse, 1999, p. 530). While Risse's model refers to states and processes at the international level, the three strategies are also applied at the domestic level to reach sub-communities, where "a balance between power and love, or confrontation and cooperation, must be sought rather than aggressively or exclusively pursuing one of the other" when advancing human rights (Parlevliet, 2015 p. 235). Which strategy change-makers pursue depends on the stage of vernacularisation, and the social position of those deemed 'human rights violators'. The greater the imbalance of power between those most at risk and those most likely to infringe upon their human rights, the more need there is to first introduce legal barriers, and to proceed to persuasion and cooperation only later on in the process (Parlevliet, 2015; Risse and Ropp, 1999).

Exactly this order seems to have been adopted in India: The MHA was drafted in 2010, and discussions about it began around the same time. As a sanction-based legal tool, it precedes 'softer' measures, such as initiatives to reduce mental health stigma through general and specific education initiatives. Psychiatrists who are open to changing their practice to promote human rights, among them some of my interlocutors, have started giving presentations at psychiatry conferences to

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[6] My data does not reveal what kind of role this is. While the conversations and a review of the literature suggest tentative themes, I refrain from analysing them here.

emphasise the importance of human rights, and thus work proactively to institutionalise human rights within psychiatry. Similarly, the Medical Council of India (2018) announced changes to the general medical curriculum in that students will forthwith study AETCOM (Attitude, Ethics and Communication) as a separate module.

V. CONCLUSION

This paper has sought to answer why psychiatrists construe the Mental Healthcare Act 2017 as an "added fuss", and to thereby untangle what exactly constitutes the "fuss". It identified that psychiatrists' criticism of the MHA is shaped by external and internal factors, external being the intentions of the law-drafters and how these are reflected in the law's provisions, and internal being the professional culture of psychiatrists. Notable about the MHA is that while it was passed primarily to align India's domestic law with the United Nations Convention on the Rights of People with Disabilities, the law-drafters went beyond this simple ambition and arguably aim to communicate to psychiatrists that practices they consider necessary for promoting health are not justified by default. Rather than aiming to institutionalise human rights within the field straightaway, from conversations with one of the drafters it emerged that they designed concrete procedures as well as innovative decision-making bodies in order to trigger a process of reflection. The psychiatrists I talked to view the MHA from the unique perspective of their professional culture – the internal variable – which emphasises providing effective healthcare over all other considerations. Psychiatrists' professional culture justifies certain paternalistic practices by referring to how they contribute to the realisation of the human right to health, whereas the MHA considers these practices *prima facie* untrustworthy and as always in need of justification. As such, at the core of the criticism that psychiatrists will lose power and that patients will suffer lies an awareness that the drafter does not agree with placing a patient's health as an indisputable top priority. Psychiatrists assert to have found the most efficient way to use local resources, such as cultural beliefs and family members, to treat their patients despite the constraints of an overburdened healthcare system. Whether the MHA will be fully enforced or not therefore matters little for the criticism. Fundamentally, the law appears to have been drafted to emphasise that the human right to health is not superior to other human rights, and psychiatrists have clearly received this message.

The findings of this research should be seen as indicative of a general trend within the sample studied. Limitations that ought to be considered are, for instance, that the only female input comes from an ethnographic interview with a post-graduate psychiatry student. Additionally, half of the interlocutors were active in the private set-up, and were not involved in admitting patients for in-patient treatment. They have therefore not been exposed themselves to many of the procedures mandated by the MHA.

This paper's argument could be read as implying that because of how psychiatrists construe the law – as intrusive, restrictive, and causing more harm than good – the process of implementing human rights is hampered. If the law stood alone, this may be a reasonable argument to make, but it is not what this paper means to imply. Dr Pathare confirmed that he anticipated psychiatrists would react the way they did, but deemed it necessary as part of a larger picture in which the MHA is only one of many approaches to making human rights reality. While the Mental Healthcare Act may appear catastrophic in psychiatrists' current reality – a new reality is on the horizon.

Declaration of Interest

None declared.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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