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Basic Liberties, Consent, and Chemical Restraints

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We thank all the thoughtful authors for their insightful comments. In this response, we try to address some of themes that emerged from the commentaries. We leave aside some of those comments that don't fit into these categories, but only for the sake of brevity.

Our primary aim in the target article (Crutchfield and Redinger, 2024) is to advance a way of thinking about the circumstances in which chemical restraints are permissible. Specifically, we argue that chemical restraints that merely influence the contents of particular conscious states are less intrusive, and thus more permissible, than chemical restraints that sedate. We pull three main themes from the commentaries: comments related to patient perspectives and preferences, comments related to the philosophical distinctions that motivate the recommendation, and comments related to the obligation to obtain informed consent.

Hempeler, et. al. (2024) and Dougherty et. al. (2024) share a common concern that our analysis inadequately engages the experiences and preferences of patients subjected to chemical restraints, especially in the context of patient vulnerability and the perceived harms of chemical restraints from the lens of patients' subjective experience. If our analysis was not clear, we share these concerns. In fact, they substantially motivated our writing of this paper.

Some confusion appears to stem from misunderstandings of our third condition for the ethical administration of any chemical restraint, that informed consent be obtained. Dougherty, et. al. claim that patients who receive chemical restraints are often decisionally impaired. Rather than presuming a lack of decisional capacity, ambiguity about patients' capacity instead requires an attempt at ascertaining the patient's decisional capacity to provide informed consent for restraints specifically. Our experience is that many patients whose agitation is escalating and at risk of becoming a danger to themselves or others are in a position to consent to a sedating medication, and often have an informed and rational preference of sedating agent or prefer physical restraint or seclusion over chemical restraint. This is accounted for by our analysis (p. 12). Moreover, the act of engaging in a respectful consent conversation often decreases the patient's agitation to the point that no restraint is necessary at all. It also reinforces the suggestion of Hempeler, et. al. to encourage the use of psychiatric advanced directives directing restraint preferences in future situations of agitation. Lacking an advanced directive, routinely

discussing restraint preference on admission may suffice. Rather than a criticism of our analysis, we believe this is an excellent example of our analysis in action.

Dougherty et. al. also raise concerns that patients' preferences may not be "authentic" and that patients report that "treatment teams have attempted to alter their mental experiences" (p. 29-30). We don't deny this; we simply note that physical restraints and some chemical restraints violate a patient's basic liberties in a way that other chemical restraints do not necessarily do and that all other things being equal, intrusion on a basic liberty is worse than other types of liberty intrusions. There is a limit to the ability of treatment teams to assess the internal authenticity of patients; after all, patients are free to deceive their doctors and there is no way to consistently determine that they are doing so.

Finally, Hempeler et al. claim that the practical implementation of a chemical restraint necessitates a physical restraint to "hold" the patient. We acknowledge this scenario by stating that when both physical restraint and chemical restraint occur together, "the physical restraint can only be applied for the duration necessary to administer the chemical restraint and, if necessary, until the chemical restraint is able to take effect but no longer." (p. 14). But there are numerous clinical scenarios, psychiatric or otherwise, in which chemical restraints can be delivered without concurrent physical restraints, including when the patient has a capacitated preference for one form of restraint over another. Rather than a criticism, the ability of our analysis to resolve the situation of co-applied chemical and physical restraints demonstrates its versatility.

Several commentators criticized our distinction between basic and non-basic liberties, and how we use this distinction. Birks (2024) and De Marco et al. (2024) argue that some chemical restraints that influence the contents of particular conscious states do intrude on a basic liberty. It is our oversight for not being sufficiently clear: our position is not that interventions upon the contents of particular conscious states necessarily fail to intrude upon a basic liberty. Rather, our position is that such interventions don't necessarily intrude upon a basic liberty. On our view, it is possible that interventions upon the contents of particular conscious states do intrude on a basic liberty. But we also claim that those restraints that undermine being conscious do necessarily intrude upon a basic liberty.

This comparison is important for our recommendation that interventions on particular conscious states be the first line chemical restraint. Any restraint aimed at a person's being conscious will necessarily be more intrusive than a restraint aimed at any particular conscious state, because intervening on one's being conscious implies intervening on one's particular conscious states. Intervening on one's being conscious simultaneously intervenes on every

particular conscious state, not just those states that are being targeted for restraint. So, that some interventions on particular conscious states may intrude on a basic liberty, their doing so doesn't undermine our argument that chemical restraints targeting particular conscious states should be the first line, other things being equal.

Relatedly, Tsu and Sugimoto (2024) and De Marco et al. also criticize our claims on the sufficiency of interventions to intrude upon a basic liberty. De Marco et al. claim that being handcuffed temporarily doesn't prevent one from living a free life, because one won't be handcuffed forever. Tsu and Sugimoto claim that restraints that undermine one's being conscious still don't undermine a basic liberty—for that to happen one must also want to make a decision.

It's hard to see how either claim could be true. Being temporarily handcuffed may be a temporary restraint. But what follows from that is not the conclusion that temporary restraints don't intrude upon a basic liberty. What follows is the conclusion that basic liberty intrusions are also sometimes temporary. Specifically, while one is handcuffed, one's basic liberty is being intruded upon. Tsu and Sugimoto's claim that being conscious is only a basic liberty if it's accompanied by a desire to make a choice is also something that we doubt is true. There are lots of times when a fully conscious person might lack a desire to make a decision. When we are watching a movie, for example, there is no identifiable desire to make any particular decision, especially if the movie is engrossing. Sedating us unto unconsciousness would violate a basic liberty.

This is not to say that we don't appreciate the attitudes that motivate this account of basic liberty intrusion, which is that informed consent is doing the heavy lifting in our framework. Indeed, it is doing the heavy lifting in the moral evaluation, but this is always the case with liberty intrusions, not just restraints. Liberty intrusions are typically morally unproblematic when they are consented. But we never claim in our article that wrongness is tied to liberty intrusion specifically. Instead, we write that "Although degree of restraint is a matter of degree of liberty intrusion, on our view neither of these dimensions is necessarily associated with degree of wrongness" (p. 11). Informed consent is doing some heavy lifting in attributing wrongness, but not in whether or to what degree a given intervention is a liberty intrusion.

Others raise additional doubts about the moral value or disvalue associated with liberty intrusions. Birks recognizes that it's true we lack control over our own thoughts in the way that might be necessary to ground contemporary conceptions of cognitive liberty. But he also claims that we have a right to mental self-determination, which is supposed to be freedom from interference. But here also is a freedom that cannot possibly be protected, for we also ordinarily

lack control over what goes into our minds. Humans have an extremely limited ability to control what the mind represents about the world. If influencing, without consent, how or what one thinks is wrongful interference with mental self-determination, then one couldn't be in public without wrongfully intruding upon one's right to mental self-determination.

There is much more to say about the thoughtful commentary on our target article. Our aim in the article was to advance the thinking around the ethics of chemical restraints. Though we don't see reasons in the commentaries to overturn our original claims, we appreciate that adjustments may be necessary to accommodate the insightful comments and criticism that the commentators offer. We hope that the target article and associated commentaries provide a solid foundation for further advancements in this area.

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