

Autonomy Gone Mad

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Abstract: *Medicine's fundamental moral philosophy is the responsibility of caring for the ill, yet beneficence is not under the province of the law. Indeed, fiduciary responsibilities of doctors are limited. Instead, American law is preoccupied with protecting patient rights under the precept of patient autonomy, and contemporary medical ethics is dominated by these concerns. The extrapolation of autonomy rights from the political and judicial culture to medicine is, under ordinary circumstance, non-problematic. However, in instances of conflict, the dominance of autonomy reveals a hierarchy of values determining patient care. To illustrate the moral calculus of balancing competing principles, the ethical issues of involuntary treatment of psychotic patients are considered, and alternatives to the moral reasoning currently guiding the care of these individuals are offered to better solve the dilemma of respecting patient autonomy while still fulfilling the claims of physician responsibility.*

Introduction

Medical ethics is strung on a taut line between the claims of patient autonomy and physician fiduciary responsibility. Autonomy assumes self-responsibility, which in the ordinary clinical scenario means patients are duly informed and freely consent to their care by physicians who assume delegated responsibility. Simply, autonomy may be exercised by relinquishing

certain choices and maintaining other, more basic ones. This application of autonomy in most cases suffices as a governing ethos of the doctor-patient relationship. But the tremulous balance of patient autonomy and physician responsibility is exposed in certain instances, of which the treatment of the non-consenting psychotic patient will be used here to demonstrate the limits of fiduciary responsibility in the medical context. Indeed, the placement of autonomy rights over this more ancient moral principle of beneficence imposes a tension not easily resolved.

Consider the acutely psychotic person who refuses medical care, and whose psychiatrist has little power to treat unless extreme danger to the patient or others is evident. In this situation, the autonomy rights of the insane leave the physician with little responsibility, and autonomy is placed first among the principles guiding care. The doctor-patient relationship is left as one of independent moral agents sorting out a neutral contractual agreement between them (Veatch 1972). In the more ordinary setting, autonomy is regarded as compromised by illness, and the physician is enjoined to restore the full sense of autonomy a person might have had prior to becoming incapacitated. In this situation, autonomy is relinquished to the physician, and care of the patient assumes a comprehensive orientation. This is the "natural" alignment of the doctor-patient relationship. But what transpires when the "normal" scenario is replaced with one skewed by a patient whose mental function is severely compromised?

The Question of Competence

In the 1960s and 1970s, the insane were bestowed with civil rights hitherto obfuscated by the stigmatization of their illness. The equal protection clause of the 14th Amendment was widely applied to negate the discriminatory practices arising from distinctions made by race, gender, national origin, religion, sexual orientation, and mental illness. In a series of judicial rulings, no criteria to discriminate the mentally ill from their normal fellow citizens have been accepted. Intrusive mental health treatment, violations of due process, and invasions of privacy have repeatedly been asserted as violations of fundamental constitutional rights of the mentally compromised (Winick 1997, 256). Indeed, the hitherto implicit fiduciary responsibilities of psychiatrists were usurped by a widely expanded understanding, and application, of patient autonomy.

Involuntary hospitalization resides at the extreme end of the psychiatric legal continuum. Confinement rests on the police power of the state to protect citizens and the individual against harm, and sometimes on the *parens patrie* interest in promoting the health and welfare of those who cannot care for themselves. Thus the issue of competence is limited to particular kinds of incapacity and is not a general designation when applied to hospitalization. Indeed, modern law presumes competence unless proven otherwise, and in this setting the assessment of competence is restricted to the *potential* of "danger" (specifically violent behavior directed against others or oneself, or more leniently the inability to care for oneself), and cannot be based simply on a diagnosis of insanity. However, there is no general agreement concerning the appropriate standard for determining competency even in this restricted sense (Winick 1997), and when data is sought to determine how well involuntary detention "works," i.e., effectively identifies those truly in danger, studies are beset with design problems that make such information difficult to gather and then assess.

Competence is not a global characteristic, that is, the competent person has several complex mental faculties, and consequently the mentally ill are best understood as possessing some intact rational functions and others which are not. But in practice, such a nuance is not required by current legal practice. Insanity per se is not at issue. Either one is competent or not, and the only criterion of legal standing determining that designation is danger to others or oneself. Note, judges are asked not to measure "competence," but only assess "danger" under the auspices of "competence." A ruse is at play here: The insane are by definition not competent in an ordinary

sense, but they are extended this identification to secure their rights as citizens. The judicial authority thus determines whether to sustain autonomy based on one set of criteria (danger), whereas the medical authority, in securing an assignment of "insane," uses a different set (delusions) to argue that an individual is no longer autonomous, i.e., competent. The latter determination, the one employed to demarcate sane from insane, is superseded by the former in deciding involuntary confinement and treatment. Indeed, while they may overlap, they need not. In short, judges deal with individual rights; psychiatrists and other health care providers deal with insanity and its treatment. The crucial point: *citizen and patient are not necessarily the same social agent governed by the same moral concerns.*

Tapping into a deep reservoir of what has been called "a culture of rights," proponents of a more liberal exercise of rights for the mentally ill have largely prevailed in convincing courts and legislatures that civil commitment had been practiced in a highly selective fashion (and thus violated the Equal Protection Clause); frequently the violation of civil rights was predicated on false premises and defied empirical data; too often commitment failed in achieving its avowed purposes (by making the mentally ill *less* socially adaptable); and finally, hospitalization was wasteful of health care resources (Miller 1976). This latter criticism was particularly appealing in light of the assumption that community-based facilities were more economical than hospitals. Couple these arguments with mainstream psychiatrists' own hope that new medications and out-patient management might in fact be more therapeutic in the long term, and all parties were then aligned to advocate a strong patient rights movement.

Both because of economic choices and advancement in medical therapies, deinstitutionalization has become the norm since the 1970s (Johnson 1990). But the liberation of these patients has not been without deleterious costs. Carrying a variety of diagnoses from substance abuse to psychosis, the mentally ill comprise approximately a third of America's homeless (La Fond and Durham 1992, 104). These unfortunate individuals have been moved from institutions to the streets by expanding their putative claims of autonomy, and despite repeated reassurances of the medical and economic justifications for this movement, the ethical ambiguities remain to perplex physicians entrusted with the care of these patients (Gaylin and Jennings 1996). So where does this leave the psychiatrist? He walks a moral tightrope.

In the end, both judicial ruling and social opinion support the same ends: For the mentally ill,

and for that matter any diseased person, autonomy overrides beneficence as a governing moral principle except under dire conditions. And consequently, physician fiduciary responsibility appears as a faint figure on the ethical horizon of this discussion. To the extent that the physician entrusted with the care of the severely ill asserts control, he or she must do so against a judicial tide that gives the benefit of doubt to the judgment of the mad under the banner of patient autonomy.

The dangerous are adequately dealt with by our legal system, but those who are left to cope with demons they cannot control must appeal to different moral principles than that of their putative autonomy, specifically I refer to physician beneficence. On a primordial level, the fiduciary physician is making a humane response to the cries of the agonized. But that is not enough. The rationale for revoking the psychotic's autonomy rests on a simple assertion: The insane, because they are deranged and radically irrational, are not truly competent and thus not autonomous. Simply, one cannot assume responsibility for choices and actions if those decisions are not based on rational reflection. So a fiduciary's rationale to treat is to offer the insane ultimately more autonomy and control. If this *telos* is accepted, then a path must be found through the thicket of current policy and judicial interpretation to real autonomy, i.e., rational individual choices freed from demonizing fears and oppressions. In short, I seek to end autonomy's feigned and assumed appearance in the care of the mentally ill.

Reconfiguring Autonomy

We begin reconfiguring autonomy among competing moral precepts by more carefully differentiating the moral identities of patient and citizen, which, as previously discussed, overlap, but are not necessarily coincident. Fundamentally, one class of citizens cannot be treated as legally different from another, but we might profitably look elsewhere in the law to deal with the problem of involuntary commitment and still honor our basic moral axioms. So while not advocating the suspension of autonomy, we must probe for its appropriate application. In this light, the role of physician fiduciary responsibility should be reassessed.

Although physicians perform fiduciary-like roles and generally regard themselves as adhering to a fiduciary ethics, American law regards such functions only in narrow contexts (Rodwin 1995). "Fiduciary" is now largely a metaphor, and no longer, at least legally, has much relevance to the doctor-patient relationship. While one might presuppose that physicians act on their client's behalf, fiduciary principles have only

been applied for specific purposes: physicians cannot abandon their patients, they must keep clinical information confidential, and they must disclose to patients any financial interest in clinical research (*ibid.*). That physician fiduciary authority is so limited seems counter-intuitive to our basic notions of health care (one might reasonably assume a wider legal basis for physician responsibility), but aside from professional competence and these specific fiduciary responsibilities, the law makes little demand on beneficence as a governing moral principle in medical practice.

If one embraces a traditional model for the doctor-patient relationship, a broadened fiduciary role of the doctor is assumed and current American law seems anomalous. After all, the oldest tradition in medicine makes physician responsibility to the patient sacrosanct, and, indeed, empowers the physician to act on behalf of the patient. And while some have argued that this relationship remains at the core of medicine (e.g., Pellegrino and Thomasma 1988; Tauber 1999; Pellegrino and Harvey 2001), others regard this classic formulation as naive and "woefully inadequate and inappropriate" to present realities (Wildes 2001). On this view, medical care is a commodity: Patients are clients or consumers, who freely choose their health care options, and physician responsibility then resides solely in providing specific professional services, and no more. Correspondingly, the rise of corporate dominance in health care has redefined fiduciary relationships: Physicians have now assumed a new dual character of responsibility, for they must divide their loyalty between patient and employer. How to resolve this tensioned twofold allegiance is a matter of broad debate as managed health care increasingly challenges the traditional private relationship of doctor and patient (see Jacobson and Cahill 2000 for comprehensive references).

To fill in the moral "lacuna" left by the retreat of an ethics of responsibility, American bioethics has championed patient autonomy. Indeed, within medical ethics proper, the principal axis of discussion has placed patient autonomy at one end of the moral spectrum, and physician responsibility, on the other, with the weight decidedly in favor of autonomy. Autonomy has claimed primacy in medical ethics in no small measure because of its ready extrapolation from our politico-judicial culture to the clinic (Jonsen 1995). This is readily perceived in the master narratives of medical ethics, which are developed from the template of crisis resolution as enacted in case law. This orientation has favored individual autonomy and has effectively defined the basic *legal* structure of the contemporary doctor-patient relationship. Thus the chorus of protective rights dominating contemporary

judiciary debate has seeped into medicine's moral universe to effectively subordinate an ethics of responsibility for one designed to protect patient autonomy.

But autonomy's claims are not necessarily appropriate for medicine's moral praxis. More to the point, the legal guidelines regulating physician actions and the moral underpinnings characterizing medicine's moral structure do not necessarily coincide. This is a crucial distinction and a dilemma not easily resolved: Despite autonomy's contested standing in medical ethics—the complex dynamic governing its balance against beneficence, justice, and non-maleficence—it remains the trump card because of its legal standing. Indeed, because of autonomy's legal primacy, and its sociological investment as a response to the complex economic character of American corporate medicine, physician fiduciary responsibilities correspondingly recede in the moral drama played at the bedside. In general, this does not lead to conflict, but in some instances it does, which highlights how a proper balance between commonsensical ideas of trust and patient autonomy is not always easily achieved.

I argue for two responses, each of which contributes to substituting the hegemony of a single moral principle, autonomy, for a pluralistic approach. Elsewhere, I maintain that autonomy might be re-configured so that a relational ethics is more easily constructed (Tauber 2003). Here I would like to suggest that even within contemporary American law, fiduciary responsibility might be more aggressively asserted: Beneficence is sanctioned as a guiding principle of action in Good Samaritan statutes, which prescribe that physicians provide care to those in jeopardy irrespective of usual patient consent. The basis of such laws is that individuals, if they were competent to give consent, would do so in order to save themselves or relieve their suffering, and physicians, under some vague assertion of responsibility, must respond through the invocation of beneficence. This legal approach is utilitarian in orientation, for it sees that the ends—restored health—justify the means—the suspension of consent, i.e. autonomy. American law has not adopted a uniform enactment of Good Samaritan statutes, and indeed, the philosophical and legal basis of "rescue" is contentious (Menlowe and McCall Smith 1993). But despite the fuzziness of determining the scope of rescue, many states provide protection from liability if the physician

gratuitously and in good faith, renders first aid or emergency care at the scene of an accident... to a person injured therein, he or she shall not be liable for any civil damages

as a result of his or her acts or omissions in rendering first aid or emergency care, nor shall he or she be liable for any civil damages as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person.
(Alabama 2002, §6-5-332)

Are the Good Samaritan laws the conduit for caring for the psychotic who cannot care for herself? I believe so. Plausibly, extrapolation of the Good Samaritan legal approach would better enable psychiatrists to treat patients, who, caught in the grips of acute psychosis, cannot exercise their full autonomy. This strategy assumes that the psychotic's inability to escape from dominating demons has precluded her ability to make rational choices, which she would undoubtedly make if not so afflicted. A quagmire of potentially conflicting values between patient and physician, not to say the abhorrence of unchecked police powers, have hitherto stymied any serious effort to go beyond the present status quo of preserving the psychotic's autonomy rights. Notwithstanding these severe problems, I believe that current sensitivity to these trespasses would serve to offset abuses, especially if penalties for abuses were in place. Accordingly, guardianship should be more freely granted if it might reasonably be supposed that the patient would, in the long term, benefit from such intervention, *and* if that individual, when in a more rational state, would presumably choose such benefits.

Justification

In championing the psychotic as a citizen, i.e., in conferring the same rights of autonomy enjoyed by those who more fully appreciate its appropriate exercise and limits, the courts have too often forgotten that autonomy in its original definition means self-governing according to *rational* understanding, and most modern models endorse, to varying extent the mediating role of rationality. Albeit the designation of rational may be contentious, and one might apply various definitions to determine rational agency, in the legal setting of involuntary commitment the only apparent criterion is self-endangerment or danger to others, per John Stuart Mill in *On Liberty*. In other words, the question of a person's rational capacity is suspended only until pressed by the most utter choice of life and death. But if one begins with the understanding that the severely psychotic is not autonomous as a rational, self-governing person, but is instead a caricature of such an agent, then the protections afforded a normal citizen do not apply. In other words, I agree with those who liberally assume

fiduciary responsibility and advocate that decision-making be temporarily invested in others until the treated psychotic again demonstrates competence to exercise rational choices about his or her own stewardship and thereby regain the key criterion of autonomous agency.

Critics reject this solution as paternalistic, but the paternalistic spectrum is marked by a distinction between "hard," also known as "legal," and "soft" paternalism (Feinberg 1986), a compromised version also called "parentalism" (Klutgen 1995). Joel Feinberg distinguishes the two:

Hard paternalism will accept... that it is necessary to protect competent adults, against their will, from the harmful consequences even of their fully voluntary choices and undertakings... it imposes its own values and judgments on people 'for their own good.' (Feinberg 1986, 12)

In contrast, it is not clear that soft paternalism is paternalistic at all: "Soft paternalism holds that the state has the right to prevent self-regarding harmful conduct... when but only when that conduct is substantially non-voluntary, or when temporary intervention is necessary to establish whether it is voluntary or not" (*ibid.*). In blocking a non-voluntary choice or action, responsible parties are defending an individual against "threats to his autonomous self, which is quite another thing than throttling that autonomous self with external coercion" (*ibid.*, 14).

Obviously, safeguards to prevent paternalistic abuse are crucial to protecting the rights of the psychotic, but how those rights are interpreted requires a "tightened" definition of competence in order to determine whether autonomy even applies. Further, soft paternalism or parentalism seeks to balance the potentially competing interests and desires of the subject in the context of his or her own individual values, and not those of the state, family, or medical authorities. This is a crucial caveat, for it protects the application of some universal standard and instead seeks to protect the values and interests of the incapacitated patient. In rejecting hard paternalism, we need not also disregard protecting citizens from their debilitations over which they have no control. In short, fiduciary responsibility does not necessarily translate into despotic paternalism. Sensitivity to the patient's values and the recognition of individualized goals distinguishes soft paternalism from its harsher rival.

My utilitarian attitude suffers all those criticisms revolving around means/ends justifications, and thus those who favor the current state of affairs will argue that once compromised the principles upon

which a rights-based culture rest cannot withstand the onslaught of even the best-intentioned compromises. Stalwart libertarians maintain that no matter how humane, autonomy is inviolable and, unfortunately perhaps, includes an inevitable price for those who are incapacitated to enjoy the full benefits of such freedom. But if the grounds for comprehending autonomous personhood are defined in terms of relationships, duties, and obligations, as opposed to atomistic individuality, I believe these criticisms may be effectively deflected (Tauber 2003).

Conclusion

On the basis of avowals of autonomy, involuntary hospitalization of the psychotic patient occurs only under very special circumstances, which clearly illustrates how beneficence—more specifically, fiduciary responsibility—has been trumped by patient autonomy as a governing medico-legal principle of medical care. To be sure, "trumped" suggests dominance, whereas it is more judicious, and perhaps more accurate, to describe what is truly a tremulous balance between the two principles. Autonomy, despite its obvious utility and premier standing as a political credo, in medicine must find its place among other moral concerns and demands (Beauchamp and Childress 2001). In dealing with the desperately psychotic patient, revision of current legal practice must be based on a clearer comprehension of the presuppositions under-girding the law. Autonomy assumes moral agency, which in turn is based on *rational* understanding and *rational* choice. It is, from this vantage, at minimum, incongruous to allow severely psychotic individuals to assert their putative free will under circumstances in which they have lost the rational basis for self-assessment. When the irrational mind displaces the rational self, autonomy becomes a tool of the disease under the guise of equal protection.

Patients, like individuals in other social roles, allow themselves to fit into a structure in which they trust that their basic rights will be protected. By and large, they are concerned far less with their political or legal autonomy than with getting better. They prioritize their various definitions of selfhood, and autonomous individuality, at least in this setting, is almost always subordinated to other identifications. Indeed, being a patient alters the fundamental sense of personhood. Patients want to facilitate the process of healing, and to do so they typically admit their dependent status. Here, physician fiduciary responsibility takes hold. In short, autonomy in the medical context is an *aspiration* of the curing process—a goal, not a starting position. The primary distinction between the psychotic and the

normal individual is precisely in this difference to discern "normal" from "abnormal" and the necessary choices that must be made to attain health.

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