

## Patient autonomy on a psychiatric ward

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### Summary

Patient autonomy has been a frequently discussed issue since the 1960s. Nearly all bioethical works stress the necessity of respect for the patient's autonomy. For many years now, a conscious consent of the patient to medical treatment has been fundamental for medical ethics. The patient's acceptance of treatment is a confirmation of their autonomy in this area. From the moment autonomy became a fundamental issue in the doctor–patient relationship, the concept has been given numerous definitions. This article provides a number of suggestions of how to understand the concept of autonomy. However, there is a vital elementary question: does autonomy apply to all patients to the same degree? Are patients on psychiatric wards, patients with alcohol or drug addiction and patients serving a jail sentence entitled to the same extent of autonomy as others? Regardless of whether they are capable of undertaking, with the help of their doctor, a course of medical treatment, or whether they are capable of making conscious decisions relating to their health and needs. Where are the limits of their autonomy? To summarize, the article argues that a paternalistic approach of doctors to their patients is dangerous and that there is a need to reflect on the scope of autonomy of patients on psychiatric wards.

**patient autonomy, bioethics, paternalism**

Among the questions accompanying the development of bioethics, patient autonomy is considered of utmost importance. This rather complex problem is ambiguously interpreted, especially in the case of patients on psychiatric wards.

When investigating the origin of bioethics it was necessary to look back to the 1960s, as it was the time of rapid development and changes in biomedicine (kidney dialysis, transplantation, contraceptive pill, artificial respirator, prenatal diagnosis). Scientific development was accompanied by broad social and cultural changes. Before 1967 universities did not undertake systematic research on the bioethical reflection. However, these problems were recognized in Catholic higher schools and also at papal universities in Rome, within the so-called “pastoral medicine”. In 1967, as one of the first universi-

ties in the USA, the State Pennsylvania University opened the Department of Human Sciences for students of medicine and from then on theoretical and practical medicine has been submitted to ethical assessment, i.e. in view of its conformity with a particular axiological system.

For many years the basis of medical ethics has been the conscious consent of the patient to medical treatment. Without it a great part of medical services would have been neither ethical nor legal [1]. Patient consent is the basis and confirmation of their autonomy. A strong appeal to conscious consent has begun after two fundamental events: the first was the Nuremberg trial in 1946–47 against 20 Nazi physicians and 3 administrative military officers accused of organizing and conducting criminal experiments on prisoners and citizens of conquered countries. In its grounds for the judgments, the Nuremberg Tribunal listed ten basic rules of conducting medical experiments. Article 1 of the code (known as the Nuremberg Code) stressed the need for vol-

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untary consent of potential participants in an experiment. Since then, requirements concerning gaining voluntary consent have become standard. In 1972 that obligation was included on the Patient's Card by the American Hospital Association. Bioethics, especially in America in the sixties and seventies, was dominated by the notion of the patient's autonomy. It may have resulted from the atmosphere of those times: contestation and counterculture, negation of authorities and distrust of the predominant conception of paternalism. Already in 1954 Joseph Fletcher assumed in his book *Medicine and Morals* that the idea of personal choice is the most important moral value. In the writings of this American bioethicist, autonomy was mainly seen as the right to self-determination.

The notion of autonomy already appeared in ancient Greece. An autonomous human being means a person politically and thus legally free (i.e. not a slave). Literally, this notion can be translated as "self-governing". However, that idea gained moral significance in the 19<sup>th</sup> century due to discussions around Immanuel Kant's philosophy. The notion of autonomy appeared in his *Justification of Moral Metaphysics* and *The Critique of Practical Reason*. According to Kant, every violation of a person's autonomy is at the same time violation of their humanity, when a human being is treated as a thing. Kant's view originated from deontological ethics, which holds that the determinant of a deed's morality is a fulfillment of the moral obligation to treat a human being as an autonomic subject. It is in fact an uncompromising view.

Kant's famous text *Answering the Question: What is Enlightenment?* of 1784 that prompted the human race to leave its minority, suggested that the motto of an illuminated so of age and autonomic human being should become the courage to use one's own reason. Since Kant's time, autonomy has almost become synonymous with human dignity and an internal value in any system declaring its serious approach to respect for human beings. However, though the notion of autonomy has considerably grown in importance, it is still at best unclear. According to Joel Feinberg, its ambiguity is connect-

ed with the application of the term "autonomy" in different contexts,<sup>1</sup> though he acknowledged that those applications are closely related when used for individuals. Autonomy may relate to the ability to self-control, which can be developed, or to the actual state of self-governing and its values, or to an independent power to self-governing absolute within our own moral limits. It should be observed that the term "autonomic" corresponds with the term "independent", able to support oneself, to control one's own life and be responsible for one's own decisions. Thus, the central meaning appears to be the self-sufficiency of the subject, and Robert Paul Wolff are of considerable significance for contemporary philosophy debating the notion and position of autonomy of the individual. The first places himself among the continuators of Kant's tradition of rational ethics, based on at least four assumptions: (a) it is reason that describes our moral choices, (b) the existence of reason is a necessary factor for being human, (c) everyone, irrespective of our position, must accept the recommendation of reason under the threat of exclusion from the community of intelligent individuals, (d) free choice means autonomy, that is following one's own rules based on the acceptance of some reasonably justified imperatives. Finally, those imperatives are formulated. With imperatives as the system's main principles Kant's ethics was the ethics of obligation. Rawls does not go so far. His ethics is of a formal shape. Here, the rules of justice form a kind of categorical imperative. They neither choose the aims nor decide on the arrangement of good but not limiting our freedom they can apply to us irrespectively of our aims. However, it is up to us whether we choose to submit to them. Rawls is convinced that in our life we should follow well thought-out plans independent from hazardous circumstances and claims that autonomic individuals should govern their lives in accordance with justice.

Robert Wolf, describing the principles of autonomy, wrote: "An autonomic man does not submit to the will of another man. He can follow the other's orders but not because of being ordered. (p. 14)" [3] Thus, an autonomic activ-

<sup>1</sup> Article 32 Regulation of December 5, 1996. On the profession of medical doctor and dentists (Official Gazette of 2011, number 277, item 1634 with later adjustments).

ity is defined by the subject. So when we are ill and submit to medical treatment we cast away our autonomy, and that is obvious and justified. The problem of autonomy is an example of intellectual self-sufficiency. However, Wolf is right when declaring: "In the contemporary world there exist considerable, maybe even impossible to overcome obstacles to gain the total and rational autonomy. (p. 17)" [3].

The notion of autonomy has been brought up in the political and legal context as well as the medical one. Difficulties connected with that issue were accurately characterized by Gerald Dworkin [4]. He wrote that describing a person as autonomic we state, among other things, that they are not an uncritical conformist who easily adapts to the dominant fashion and, to be accepted by a person or a community, easily adopts their views and behavior. Such an individual's inclinations, opinions and ideas as well as moral models are their own if in any way they influence the person's behavior. Dworkin defines autonomy in the following short formula: autonomy means authenticity and independence. The authenticity of a person is decided by their attitude towards factors shaping their behavior. The list of meanings of the term autonomy is rather long: among others, there is the freedom of acting, sovereignty of individual, independence, responsibility, critical reflection, knowledge of one's affairs.

Respect for patient autonomy is a fundamental justification of obtaining their assent to medical treatment. Tom L. Beauchamp and James F. Childress in *Principles of Medical Ethics*, a book that in the 1970s was regarded as a classic and compulsory reading for all bioethicists – indicated four principles on which medical ethics should be based. Among them is respect towards the patient. In the very beginning, when discussing autonomy, the authors recall examples connected with the difficulty of its application. They write about patients addicted to alcohol and those on psychiatric wards: "The patients of psychiatric wards requiring care and acknowledged legally incompetent are entitled to such autonomic activities as for example choice of a particular dish, resignation form a medication, a telephone talk with acquaintances. (p. 132)" [5]. According to the authors, an autonomic activity is an activity that can be un-

dertaken by everybody who acts intentionally, with understanding and without outside influence determining their deeds. The first condition is constant: acting either is or is not intentional. The next two conditions, understanding and nonexistence of outside influence determining an act, can be fulfilled to a greater or lesser degree (for example, the independence of children or elderly). So, finally, "an action can be considered autonomic if we are satisfied that its performer understood its meaning in a sufficient degree and that he/she did not act under outside influence. (p. 134)" [5]. To have some autonomy does not mean to be accorded respect as an autonomic person. The obligation of respect towards a patient's autonomy does not include those obviously not autonomic, and such is the case of many patients on psychiatric wards. Here another term should be recalled: competence.

A competent decision is a decision we are responsible for. However, it should be added that a patient is competent to make a decision if they can understand the content of information transferred to them, can assess it and are able to communicate with the community. When the patient does not have those abilities lack of competence may be presumed. Those tested as incompetent should be treated paternalistically. Decisions on behalf of those lacking autonomy or only partly autonomic patients are made by their attorneys. Immanuel Kant did not see that paternalistic issue towards non-autonomic or partly non-autonomic patients.

If a patient's actions are not a result of their autonomic choice, the interference of medical staff should be regarded as paternalism (according to the definition of the term "paternalism" in the Oxford Dictionary). In spite of his reluctant attitude to paternalism, J.S. Mill thought that interference into the life of another human being is sometimes justified. In his essay "About Freedom" he wrote that the right to freedom is being taken away from "children, the insane and individuals in state of preoccupation not allowing them for consideration. (p. 257)" [6]. Thus only a person of reasonable behavior and ability to choose can be regarded autonomic. According to Mill, limiting the activities of people with mental illness would not constitute paternalism.

Bioethicists Beauchamp and Childress wrote about two forms of paternalism: strong and

weak (Feinberg labelled it as hard and soft paternalism) [7]. The first relies on limiting the autonomy of a person who has the ability to self-decide (that form is unacceptable). The second bases on others deciding for a person lacking autonomy. Where there is no autonomy, there is no violation. However, the autonomy of a particular person (as well as their competence) is not a permanent factor. It deteriorates in final phases of sickness and then returns. Beauchamp and Childress recall the example of Catherine Lake, suffering from hardening of arteries, who partly lost her understanding and memory. That state was not permanent. There were periods when she was mentally able and behaved rationally. Still, she was placed in a psychiatric institution as mentally unwell and not able to self-defend. The patient did not consent to her stay in the psychiatric hospital. When in court she explained her reasons rationally. Still, the American court of appeal decided to place her in a psychiatric institution, reasoning that “she could be a danger to herself”. She was treated as a person without autonomy.

John Rawls, an American philosopher drawing to a great extent on Kant’s as well on Dworkin’s philosophy, propagated a form of limited paternalism. Persons of incomplete autonomy are not able to make rational decisions. Patients with serious psychotic conditions cannot decide on their medical treatment. In such cases the soft form of paternalism applies. However, some form of harder paternalism (compulsory hospitalization, compulsory treatment) may also be considered.

American bioethics has been shaped by the liberal and individualistic tradition, hence its focus on a person’s autonomy. Renee C. Fox stated that it was the American way of perceiving the world, the stress on the individualistic values and the rights of an individual that inspired bioethics, first of all declaring the absolute value of a patient’s autonomy. According to Fox, the principle of autonomy obtained such a great importance thanks to the Anglo-American analytic philosophy that paved the way to the American model of bioethics [8].

The model presented here assumes the competence equality of the doctor and the patient able to decide for themselves and independently establish moral priorities. Thanks to doctor–

patient cooperation, the unanimity of aims is facilitated. However, some critics comment on the differences appearing between the subjects: the patient needs help and has only a limited amount of knowledge that the doctor possesses. The dynamics of the patient’s decision-making abilities may change (especially in the case of psychiatric patients). Such abilities are sometimes selective. The patient is able to decide in one matter and not in another. Thus, there appeared a group of bioethicists who concentrate not on the patient’s autonomy and his movements but on another task: the patient’s well-being. The concept of Edmund D. Pellegrino and David C. Thomasma presented in their joined work *For the Patient’s Good* [9] is based on the declaration that the patient–doctor relationship relies on a kind of covenant agreement and has one aim only: the needs of the patient. That is why the doctor should be first of all led by the principle of doing good – acting in the best assumed interest of the patient. The absolute dictate of patient autonomy has been questioned. The authors declare that the patient’s autonomy is already sufficiently limited by their sickness. It would be worth developing this train of thought since it appears to be of special interest for doctors in psychiatric institutions. Of course, the method of fulfilling the patient’s needs has been assumed in advance by the doctor deciding what is good for the patient. The principle of the doctor’s good will (virtue of benevolence) results from the standards accepted in a particular community bound by the same tradition and the same vision of a good life.

In 1984, Mark Siegler founded the MacLean Center for Clinical Medical Ethics at the University of Chicago. It was the first American program (practical everyday problems in medicine) teaching ethics to medical doctors on real cases. This conception criticized the bioethics for its remoteness from medical practice. According to Siegler, it is the reality that has the first-rate meaning in understanding the ethical aspects of medical decisions. When looking at a collection of cases and explicit opinions concerning them, one can apply understanding *per analogiam*.

There are a great many bioethical theories. As it can be seen in this very short summary, the term “patient autonomy” has been accepted neither unanimously nor in all cases. In 1995

Poland passed an act of psychical health protection, which does not however exclude the breaches of patient autonomy. Exact tests determining the level of the patient's competence are necessary. Still, as Marta Lang writes: "according to the Polish act on psychical health protection in the case of admittance of an unwilling patient to a psychiatric institution the test of his competence is not the most important. What appears fundamental are the utilitarian factors – minimization of harm to self or others in case of the patient's refusal of medical treatment (p. 118)" [10]. This act definitely prefers strong "paternalism", since the most important conditions are those concerning health and life protection. Neither autonomy nor consciousness of the patient are really included, and nor is respect for patient's privacy considered. On May 21, 2009 regulations including the Ombudsman for Patients' Rights were introduced and only in those can one find the following statement: "patient's rights for his privacy must be respected". We could widely analyze what the patient is and is not entitled to in the psychiatric institutions, but respect is most needed by patients everywhere. Everyday experience both commands and bans resulting from legal regulations. A patient who is not informed about their rights and is not explained the reasons of treatment, who is not asked for consent, is aware of some limitation of their autonomy. Such a situation often causes frustration, which sometimes turns into aggression. By informing the patient on the reasons and procedures undertaken the medical staff emphasizes that they are still due respect.

The ancient maxim "the most important for a medical doctor is his duty to act for the patient's benevolence (*salus aegroti suprema lex esto*)" has been embedded in the Medical Code of Ethics concerning the doctor–patient relationship.

## DISCLAIMER

I am a philosopher who is interested in bioethical issues, therefore the article focused on philosophical literature. I am familiar with it and I use it in my work with students. I have no access to research with patients exposed to paternalistic treatment or patients whose autonomy was attempted to be respected.

A philosopher most often will not give unequivocal answers, but will only suggest the direction of reflections to be inspired. I hope this is what this article has achieved.

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