Informed Consent in Psychiatric Practice: The Primacy of Ethics Over Law

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ABSTRACT

In recent years, concern with informed consent in psychiatry has led to an overemphasis on legal formulations of the problem and a heated debate about when physician paternalism can be justified. This paper proposes that the principle of respect for persons provides better guidance for treatment decisions than do legal guidelines based on a questionable standard of competency.

It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation.[1]

Over the past twenty years, many professionals involved in law and medicine have shown an interest just short of obsession with the doctrine of informed consent. In the past ten years, this preoccupation has expanded to include significant debate about the applicability of informed consent to psychiatric and psychotherapeutic practice.[2] Although it is difficult to formulate clear guidelines, it is generally agreed that some type of informed consent requirement exists whenever voluntary psychiatric or psychological services are provided. Recent litigation has raised the question of whether and, if so, under what circumstances not only voluntarily, but also involuntarily committed patients must give informed consent to the administration of medication.[3]

Because the concern with informed consent in therapy was generated largely by attorneys, the debate has been cast almost entirely in terms of legal values and legal perspectives. Even when ethical issues are acknowledged, preoccupa-

1. Lord Chief Justice Coleridge, in *R.* v. *Instan* (1893) 1 QB at 453.

2. For a good review of informed consent doctrine, see Meisel (1977).

3. The major cases in this area are *Mills* v. *Rogers*, 102 S.Ct. 2442 (1982); *Rennie* v. *Klein*, 476, F.Supp. 1294 (D.N.J. 1979), *affirmed in part* 653 F.2d 836 (3rd Cir. 1981), S.Ct. *remand* (1982), *cert. denied* 101 S.Ct. 3059, 1981; *Jamison* v. *Farabee*, U.S. District Court, Northern District of California, No. C 78 0445 WHO.

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tion with laws, cases, regulations, and policies dominates conferences, committees, professional organizations and even conversations among colleagues. As a result, those who speak, write, and legislate on this topic frequently concern themselves only with the threshold questions that define minimum legal requirements. If the law provides only a minimum moral standard, then a minimum *legal* standard does not give us much guidance about ethical conduct in professional practice.

This paper shifts the emphasis away from law toward the admittedly more elusive but perhaps more important ethical issues. It is argued that the doctrine of informed consent does not and cannot fully resolve the inevitable tension between patient autonomy and professional paternalism in health care. Instead one must turn to and take seriously the ethical principle of respect for persons. This paper attempts to clarify and illustrate in clinical contexts the significance, as well as the usefulness, of respect for persons.

PATERNALISM VS. AUTONOMY

Informed consent doctrine attempts to resolve the tension between physicians and attorneys, but has not been very effective in doing so because, at least on one level, law and medicine have significantly different assumptions about the ethical principles that govern conduct between parties. The doctrine of informed consent purports to resolve the tension between medical paternalism and personal autonomy, but in fact merely embodies it.

Legal regulation of health care is frequently interpreted by physicians as the abandonment of the caring and protective values of medicine to a sterile legal concern with rigid rules and bureaucratic procedures. On the other hand, lawyers often seem to believe that physicians' insistence upon their right to judge what is in their patients' best interests is nothing less than the sacrifice of human liberty to authoritarian control by doctors.

From a philosophical perspective, autonomy and paternalism are not equal, competing values. Personal autonomy is a liberty interest and needs no justification, although it may require limitation.[4] Paternalism, on the other hand, requires justification. It may, for example, require that the harm being prevented be greater than the harm of overriding the person's preferences, and that the person's preferences be irrational.[5] However, in the context of the debate between physicians and lawyers as to whether patients should be allowed to refuse treatment or physicians should be allowed to impose treatment, this hierarchy of autonomy and paternalism is lost. If it were clear that the harms prevented were greater than the harms incurred or that the patient's preferences were clearly irrational, then the justification for paternalism could

4. John Stuart Mill's formulation of autonomy permits no paternalism: "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant."
5. Gert and Culver (1979) define paternalism in such a way as to make clear why it needs justification: "because it involves doing that which requires one to violate a moral rule." The justifications which they propose for paternalism would probably not satisfy Mill, however.

be easily made. However, most frequently, there is no clarity, let alone certainty, about any such judgment. In such cases, the physician's paternalistic practices rise to the level of an equal competitor with the individual's liberty rights since they presume to substitute for autonomy when the patient's ability to act autonomously is impaired. The subject is further confused by the fact that paternalism is often characterized as authoritarianism. Unlike paternalism, authoritarianism has no justification. Authoritarianism is simply the imposition of one's will upon another without concern for the best interests or rationality of the other. In the heat of debate, actions which appear to be paternalistic are often referred to or treated as if they were authoritarian, and vice versa.

Clearly, the same behavior can be described differently: when a physician imposes treatment on an unwilling or nonconsenting mental patient, is it unjustifiable authoritarianism resulting from indifference or pride, or justifiable paternalism born of compassion and concern? After spending several years providing legal and ethical consultation services to patient care staff at the UCLA Neuropsychiatric Institute, it is my opinion that we cannot give a general answer to that question. Sometimes when treatment is imposed upon an unwilling patient, it is a thoughtless or inappropriate act. At other times, it is the kindest and most appropriate act. Although all of us (physicians as well as lawyers) yearn for the clarity of black and white categories, and for the sharpness of precise boundaries, the fact is that life—and clinical practice—is never that simple.

The legal/psychiatric community has endlessly debated the right to refuse treatment and the need for informed consent to treatment. However, the grounds of the debate have been generally ill-conceived because they have insisted upon ethical principles and legal analogies that do not fit the problems of clinical practice in psychiatry. For example, police power justifications for imposing treatment[6] depend entirely upon reliable predictions of dangerousness, which psychiatrists are unable to provide. Similarly, autonomy-based arguments ignore the *clinical problem* of the involuntarily hospitalized patient who refuses all treatment. Such a patient may be legally held—indeed, in some instances, must be held—but to what therapeutic purpose if all treatment is refused?

Our understanding of the moral right to refuse treatment and the legal requirement of informed consent is drawn from our experience with traditional medical practice. Lawyers, philosophers, and physicians still disagree about whether truly informed consent is ever possible in very serious illnesses. There is a genuine question about whether patients who have only just been informed that they have life-threatening illnesses or are facing very risky treatment procedures may be in such a stressed state that they are unable to comprehend and weigh the risks and benefits of treatment decisions. Many still dispute whether a patient should ever be allowed to refuse treatment that is life-saving—either

6. The police-power limitation would satisfy Mill's conceptualization of the limits of autonomy.

because life should always be valued or because the very fact of refusing life-saving treatment (especially in the absence of religious or conscientious objections) indicates a failure of rationality. But, in spite of these continuing disagreements in restricted areas, there is a general consensus (1) that physicians must give patients (who are presumed to be competent) enough information to permit the patient to make rational decisions, and (2) that the patient who has that information has the right to refuse treatment. This consensus reflects both legal and moral standards.[7]

An insistence upon maximizing patient autonomy, minimizing physician paternalism and eliminating authoritarianism makes sense in traditional medical practice (or at least in many parts of it). Autonomy and independence are highly valued in our society and, at a time when health care costs are increasing at a disastrous rate and a significant amount of patient care is thought to be either useless or counterproductive, we would do well not to encourage patients to become excessively dependent upon their physicians. Physicians themselves are often very vocal about the disagreeableness of handling extremely dependent patients. We frequently hear anecdotal or research reports that health improves when patients feel a sense of responsibility for their own physical well-being. The high stress level in physicians' professional lives is sometimes accounted for, at least in part, by their having the burden of "being in charge," and of having to take on such serious decisions for their patients. These are only a few of the practical concerns that augment the moral and legal endorsement of patient autonomy.[8]

However, valuing patient autonomy presupposes a reasonable degree of patient competence. In the typical encounter between psychiatrist and patient in the acute care psychiatric hospital, patient competence is likely to be compromised.[9] A patient may meet a legal definition of competence, such as being aware of time, place and purpose, of the psychiatrist's diagnosis and even of having a problematic mental state. Yet, his or her competence—in the sense of a capacity for informed and rational choice—is likely to be more impaired than that of the typical medical patient as a result of, for example, well-delineated and well-defended delusional thinking, conflicted emotions, or selective repression. Thus, the doctor-patient relationship in psychiatry is likely to involve a patient whose ability to act autonomously is limited and a physician whose inclination to act paternalistically is considerable. Psychiatrists, like all physicians, are trained to intervene, to act, to cure, to ameliorate conditions, and to reduce symptomology. Many are not, either by training or perhaps even by temperament, inclined to wait for someone else to make a decision, especially if that someone else seems already to be in serious difficulties with respect to the ability to make decisions.

7. See, for example, Jonsen, Siegler, & Winslade (1982), especially pages 67-92.
8. For an excellent discussion of the role of the patient in the doctor-patient relationship, see generally, Siegler & Osmond (1979).
9. See Roth, Meisel, & Lidz (1977); and Jonsen et al. (1982), pages 56-67.

An analysis of such an encounter is likely to produce a deadlock: the physician who is too quick to be paternalistic; the patient who is too impaired—if only for a brief period of time—to make autonomous choices. It seems to me that such a deadlock provides us with little to say either about informed consent or about the right to refuse treatment. The tension between autonomy and paternalism in psychiatry is often inevitable and neither a subtle and sophisticated rephrasing of the problem nor an intricately designed decision-making matrix can completely eliminate that tension. If we are persuaded that there is some way through or around this tension, it is only to find that further down the road, the conflict will resurface and we will once again have to confront our inability to justify paternalism or confirm autonomy as the correct or even preferable basis for decision making.

The autonomy-paternalism conflict appears to be intractable and irresolvable in those cases where risks and benefits are unknown or unquantifiable in any meaningful way, and patient competence cannot be well determined. However, we might find a much greater consensus about the troubling informed consent cases in psychiatry if we were to alter the grounds of the query. Very often, when psychiatrists come up against a difficult problem in their practice in an area where there is some kind of legal regulation, they perceive it as a legal problem. In just that way, many of the informed consent cases are thought to be legal problems. But if, instead, we think of them as ethical problems of clinical practice, they begin to look different. By focusing on the ethical aspect of clinical decision making, the legal issues of informed consent and the right to refuse treatment may be encompassed without exclusive reliance upon either paternalism or autonomy.

ETHICS & CLINICAL DECISION MAKING

It is respect for persons that constitutes the primary ethical value of the patient-psychiatrist relationship. Both paternalism and autonomy depend for their own justifications upon respect for persons and, if we look to that underlying value in these encounters where paternalism and autonomy are deadlocked, we may find some light.

What might "respect for persons" mean in psychiatric practice and how would it relate to the need for consent and to the autonomy-paternalism problem? Consent is not a necessary condition for expressing, establishing or sustaining the principle of respect for persons.[10] A physician has a duty to treat patients as persons even if they do not or cannot consent to treatment. The very fact that a physician may refrain from treating a patient who will not consent exemplifies respect for the person's autonomy. Suppose a person lacks the capacity, temporarily or permanently, to consent to treatment. A physician who treats such a person need not invoke the fiction of implied consent. Instead, the physician can appeal to the duty to care for a person who is in need

10. Although Ramsey (1970) provides an excellent analysis of the importance of respect for persons in medical care, he overvalues the importance of consent as an element of demonstrating respect.

of help. This duty stems from the principle of respect for persons; caring for those in need is one way in which respect is made manifest. A person who is ill or injured is in danger of losing the capacity to think and act as a free and responsible person. The task of the physician is to help restore the person.

Nor is the presence of consent sufficient either for establishing or for sustaining respect for persons. Even if a patient has consented to treatment, a physician may treat the patient in a disrespectful manner. This may occur in contexts in which consent is not even a prominent feature of the situation. When a voluntary mental patient submits to examination, the question of consent does not arise; the very presence of the patient in the doctor's office is taken to be a sign of consent. Yet the doctor may or may not treat this patient with respect. It all depends upon the manner in which the doctor behaves—showing, or failing to show, kindness, compassion, patience, or concern. Consent is only one element of a complex set of attitudinal and behavioral factors which are relevant to a person-oriented medical morality.

Nonetheless, if consent is not always a necessary condition in demonstrating respect for the person, it can play an important role. In a doctor-patient relationship where the patient is fully competent, respect for the person would necessitate providing necessary information and encouraging rational choice, but allowing the patient to make the decision. In a doctor-patient relationship where the patient is incompetent, respect for the patient would require the physician to recommend, urge, and perhaps even fight for that course of action that the physician sincerely believes to be in the patient's best interests. In what is more likely to be the paradigmatic case for hospital-based psychiatrists, the patients will have competence that is impaired or spotty or transitory. For these patients, decisions about treatment may have to proceed more slowly and less directly as the physician tries to assess the nature and import of the patient's objections or preferences. When psychiatrists base treatment decisions upon respect for persons as well as upon medical indications, the choices are sometimes paternalistic and sometimes autonomous, depending upon the quality of the patient's preferences. When, in clinical practice, psychiatrists focus their attention on respect for the individual patient rather than on abstract ideas about whether autonomous or paternalistic decisions are "correct," or who "ought" to make decisions, or even what the law requires or permits, the decision-making process becomes more subtle and decisions more tentative as well as more individualized.

CASE EXAMPLES

Three recent cases demonstrate this orientation. The first was a young man in his early twenties with no history of mental illness. Although brought up in a family with little interest in religion, the young man became intensely involved in religious study in his late teens. The family essentially ignored his religious involvement, perhaps especially because he did not join a cult or even regularly attend church. However, they began to be much more concerned when he

became preoccupied with his ideas about God's absolute insistence that each person suffer for his sins. He dropped out of college and refused first to go out of the family home, and then refused to go out of his bedroom. His parents were able to convince him to see a therapist, but the therapist was unable to make any progress. He believed that the young man was probably suicidal, and the family feared that he might be homicidal. Finally, after an intense confrontation between the young man and his father, the police were called and the young man was taken to the hospital for evaluation.

During the evaluation, the young man was extremely agitated and delusional. He refused to enter the hospital voluntarily and was held on grounds of dangerousness. Antipsychotic medication was the obvious next step. However, the patient vigorously protested the administration of any medication claiming that it violated his personal and religious beliefs. The treating physician talked with him at considerable length, discussing both the patient's mental state and his religious objections toward receiving medication, sincerely trying to persuade the patient to accept medication. The effort was unsuccessful and the physician then explained to him that she did not really need the patient's consent to give medications but that she thought they would be far more effective if the patient accepted the idea. She also pointed out that without medication the young man's condition was very likely to get a good deal worse. Although she did not specifically say so to the patient, she believed that treatment in this case would be a long-term effort and that if there were to be any chance of success, the patient would need to cooperate.

Time passed and no medication was given. The physician saw the patient regularly and the patient's condition deteriorated as the physician had predicted. Then, on the tenth day after admission, the patient told the psychiatrist that perhaps it might be a good idea to try the medication since he was in the hospital anyway. Within a week, the patient had converted to voluntary status; he received long-term inpatient care. After the patient was discharged from the hospital, the psychiatrist continued to see him as an outpatient for several years. The young man returned to school and appears to be doing well with psychotherapy supplemented by small doses of medication.

The second case was that of a voluntary patient who had had no prior hospitalization. This thirty-year old man was currently unemployed but had worked as a paralegal for several years. After losing his job, he became convinced that the termination was part of a well-orchestrated plot conducted by the parents of a former girl friend. In addition to getting him fired, they were training machines on his apartment to make loud noises that made it impossible for him to sleep, which then made it impossible for him to get a new job. Using his paralegal skills, he filed a lawsuit against the couple. A friend convinced him to come to the hospital to talk about his sleep problems and the psychiatrist who saw him felt that the patient had some serious problems and suggested that he spend some time in the hospital. The man agreed to enter the hospital. He mentioned the impending lawsuit and commented that if it didn't work he would be obliged to take more drastic action against the couple. At the very

least, he thought the purchase of a gun to protect himself would be required.

This patient was extremely lucid except for his delusional system, and the psychiatrist decided to keep medication minimal, even though a higher dose would probably have substantially reduced his interest in the lawsuit. However, the psychiatrist was concerned about the indirect threat against the couple and was unsure whether he should allow the patient to pursue the suit. In particular, he was concerned about the lawsuit's aggravating the patient's mental state so severely that the patient might physically attack the couple should a meeting with them be required. After an unsuccessful attempt to persuade his patient to drop the suit, he decided to accede to the patient's desires. The patient did conduct the litigation, from the hospital, up to the deposition stage. At that point, the patient had to reveal to the defendants and their lawyer that he was a patient in a mental hospital. After the deposition, the lawyer convinced the patient that the suit could not be successful and the patient decided to drop it. He continued for some months as a voluntary patient at the hospital, was discharged, and has continued outpatient treatment with the psychiatrist who had treated him as an inpatient.

The third case is that of a young man with a long history of mental health problems and numerous hospitalizations. He is stable if he takes lithium, but dislikes the side effects of the drug and severely resents the burden that his mental condition has placed on his life. Although competent and lucid in most respects, he believes and hopes that he will be able to get along without the medication and, as a result, frequently stops taking it. Inevitably, he deteriorates into a manic phase with paranoid delusions and a resulting potential for dangerousness that results in arrests or involuntary hospitalization. When hospitalized, he invariably refuses antipsychotic medication even while acknowledging that it has been helpful in the past and that the medication's primary effects would enable him to be released from the hospital. In one instance, the treating psychiatrist, who had seen the patient on a number of admissions, was unable to convince the patient to accept medication and administered it without consent, because he believed that this patient equated consenting to treatment with consenting to being mentally ill. By acting paternalistically on the patient's behalf, the therapist allowed the patient to hold on to his own hope and belief that he was larger than his problem.

In all three of these cases, the psychiatrists had every "professional" reason to move forward with what they thought would be best for the patient, even in the face of the patient's disagreement. In the first case, the medication would have been prompt in its effect. In the second, heavy medication would have eliminated concern with the suit and the potential for dangerousness. In addition, allowing the patient to conduct his lawsuit from the hospital placed considerable strain on several staff members because the patient's condition was certainly aggravated (at least temporarily) by the litigation process and because there were a number of confidentiality problems with regard to the patient and his status in the hospital. But both held back (although with considerable trepidation), believing that in the long run, it would not only be bet-

ter but absolutely necessary for these particular patients to make certain decisions for themselves. In the third case, the doctor felt quite uncomfortable imposing treatment upon a patient who so clearly understood his situation and yet remained adamant in his refusal of treatment. Nonetheless, he felt that he might better serve the patient by helping him to gain release from the hospital with his hopes for his future intact. In all three instances, the psychiatrists approached the situation as an ethical problem, not as a legal problem. This permitted them to consider how best to work with the particular patient in a framework that was not simply "what does the law say we have to do?" or "how can we get around the law?" They took their discretionary responsibilities seriously and tailored their decisions to the person before them, attempting to treat their patients as fully as possible, as responsible persons who had preferences and priorities.

DISCUSSION

Respect for persons can be demonstrated in many ways in the psychiatrist-patient relationship. Some patients need to be led; some patients need repeated explanations; some patients need to feel a sense of personal involvement in treatment decisions; and some want no sense of responsibility at all for what is being done. Patients need to be listened to and taken seriously. But some need jokes, some need reassurance, and some need the firm authority of a parental figure. The psychiatrist who uses hospital policies or legal rules as the major determinant in treatment decisions will be much more likely to make mistakes in individual cases. If, for example, the hospital or state law says that involuntarily hospitalized patients need not give consent to treatment, that does not mean that treatment without consent is always morally acceptable or clinically desirable. It means that the physician will be obliged to take each patient individually and determine how best to offer respect to this particular patient, including consideration of whether treatment can or should be given without the patient's consent. The law or hospital policy sets minimum moral standards, but it allows for and should encourage higher ones. American law permits substantial discretion to psychiatrists with respect to treatment of the mentally ill because there are no clear and fast rules that always or even almost always apply. Discretion exists in order to permit the physician to make decisions that fit the patient, not "the law." But if professionals accept the minimum standards of the law as being all that is required of them, instead of seeing such law as a method of providing opportunities to make finely tuned decisions, then litigation and further regulation will inevitably plague the profession.

The law is as uncertain as medicine, and the physician who thinks about treatment decisions only in terms of rules, legal or medical, will have failed in his professional responsibility. A psychiatrist who takes the patient seriously as a person, who respects his patient's personhood, is unlikely to suffer legal consequences regardless of whether the outcome supports the values of patient autonomy or those of physician paternalism. Decisions that are driven by a

continuing concern for respect for persons are not as easy to come by and do not have the comfortable consistency of decisions that always honor patient autonomy or always express medical paternalism. Neither in law nor in psychiatry can rules and standard procedures provide more than necessary minimum guidelines; only unrelenting attention to detail and sensitivity to the nuances of the clinical situation are sufficient for sound professional judgment.

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