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Proceeding Without Consent: The Ethics of Disregarding Patient Preference for Paternalistic Reasons

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Proceeding Without Consent: The Ethics of Disregarding Patient
Preference for Paternalistic Reasons

Nicholas J. Munsey

Senior Research Project

Submitted in partial fulfillment of the graduation requirements
of the Westover Honors College.

Westover Honors College

May 1st, 2020

Nicolas Frank Ph.D.

Laura Kicklighter Ph.D.

David Freier Ph.D.

Edward DeClair Ph.D.

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Acknowledgments

I must begin this piece by acknowledging those who have assisted me in the research, writing, and presentation of this project. The guidance of Dr. Nicolas Frank was imperative in the development of this topic, as well as crafting its organization and structure. The expertise and specialization of Dr. Laura Kicklighter as a Bioethicist was essential to content review, and her generosity in time and patience with me when I was in need of someone with whom I could brainstorm is deeply appreciated. Dr. David Freier was a member of my thesis committee and served very well in the final review of the work in considering coherence, readability, and cogency. The aid of Dr. Freier, whose polymathic knowledge of literature, scientific background, and extensive experience with the medical community proved invaluable to ensuring the interdisciplinary accessibility of the project, is also deeply appreciated. I must also thank Dr. Ed DeClair for his meticulous attention to my progress, in addition to ensuring that I had access to the tools necessary to complete this project. Lastly, I must thank the University of Lynchburg and the Westover Honors College for their support in my creation of what is the largest and most advanced project I have produced to date, and thank them both for their dedication to maintaining a rigorous and sophisticated academic experience that so well equipped me to complete this research.

Abstract

Within the last few decades, modern medical regulations have brought the practicing medical community to an unprecedented level of accountability. Laws and regulations governing the practice of medicine were once, at best, loosely enforced guidelines; practices such as experimental surgeries, dangerous health testing, end of life care, and treatment of mental illness were left comparatively unregulated. The introduction of patient rights and new standards for practicing have left the medical community with a novel dilemma: how might one approach a patient who, according to medical advice, is in need of treatment if that patient is unable to express preference or give valid consent? The intent of this thesis is to evaluate the ethical nature of forced treatment under such circumstances, specifically in cases of psychological impairment. This will require a comprehensive review and consideration of 'autonomy'; a determination of what is required for a person to be considered 'autonomous' and a discussion of whether and when it might be morally permissible to violate an individual's 'autonomy.' This is required so that a solid foundation may be formed in deciding what is and is not a transgression of an individual's rights. Furthermore, an evaluation of ethical theory is required, particularly Rights Theory and three ethical principles that are often considered in bioethical determination: beneficence, non-maleficence, and justice. Neglecting to establish rules or guidelines for the administration of healthcare for differently abled individuals or those with other cognitive impairments leaves open the potential that doctors practicing excessive, experimental, or unhelpful medical treatments would be addressed with inappropriate arbitrariness or leniency. After a review of autonomy is complete, followed by the critiques of the preferred ethical devices, I will then consider the nature of forced treatment and form a

conclusion regarding its moral status. The latter half of this thesis presented a proposal for appropriate uses of forced treatment, and a defense will be presented regarding when and on what grounds forced treatment may be deemed a permissible practice despite its arguably non-moral status.

Introduction

The field of medicine is presented with very serious concerns for individual rights and patient autonomy. No doubt this has been brought forth with the considerable advancement in social issues of personal choice, freedom, and identity, such as gains in marriage equality, gender equality, and most saliently, a more gracious acceptance of different mental abilities and illnesses. Until roughly 1960, little research had been conducted in exploring specific moral concerns found in medicine, such as considerations for patients' rights or the complexities of experimental surgeries.¹ Wider social acceptance of mental illness has been relatively recent; progress made in the understanding and acceptance of certain conditions such as autism (and its subsequent degrees) and schizophrenia has developed most significantly in the last three decades,² and the defeat of stigmas associated with mental treatment is still being combatted. Previous to this activism, those suffering from such conditions were even more vulnerable to severe disenfranchisement, including the limitation of job opportunities, insufficient community support, and often excessive medical treatment, especially in cases of forced institutionalization. This was most evident in the lack of limited job opportunities, little community assistance, and often excessive medical treatment. I concern myself with the last item, as an in-depth review of simple moral ideals such as 'rights' does little to address the complexities of mental illness and the level of moral permissibility of its corresponding treatments. In other words, it seems as though some prima facie moral ideals, such as autonomy, struggle to be fully and adequately applied to cases of mental illness. Thus, one is left with the arduous task of determining what is

¹ Jonsen, Albert. *The Birth of Bioethics*. Oxford University Press, 2003.

² See John M. Kane, MD and Christopher U. Correll's, MD piece *Past and Present Progress in the Pharmacologic Treatment of Schizophrenia*.

and is not permissible when considering type, method, and extent of medical treatment for a patient with psychological impairment. Presented below are sections evaluating many of the facets of medical treatment that require consideration when determining moral permissibility. The primary question of concern is whether forced treatment can ever be a morally grounded act. This evaluation includes determining an adequate definition of autonomy and a consideration of moral theory that is often used and accepted by medical professionals. From these determinations, I will finalize some reasonable standard(s) of permissibility that may be used if and/or when forced treatment is being considered as an option.

Part I: Considering the differences between Forced Treatment and Treatment Without Consent

For the purposes of this review, a distinction between forced treatment generally, and other forms of treatment without consent must be established. Anything that one would call ‘forced treatment’ *is* by definition ‘treatment without consent’; the meaningful difference is, when simply using the term ‘forced treatment’, one is specifically describing a time when, despite the patient’s expression of a preferred treatment, or their withholding of consent, they are treated anyway “for their own good.” Although the same feature exists necessarily for treatment without consent, these instances occur when treating patients whose condition *literally* prohibits them from giving or withholding consent, for example, if the patient was unconscious. This differentiation is important as it is the preliminary determination of an individual’s capacity to consent that influences the actions of medical staff when they decide to provide treatment to someone who is physically unable to express any preference. This presents the primary concern of forced treatment in instances where psychiatric conditions are present. Cases in which patients

suffer from psychological disorders prove particularly challenging. In such cases, patients are often able to clearly express a preference. However, healthcare providers ought to take great caution in the assessment of whether or not any feature of the psychiatric illness prevents the patient from being able to make choices in their own best interest.

Suppose an individual enters a hospital in pursuit of treatment for their symptoms. Unbeknownst to them, they are suffering from an illness that has a high transmission potential, and a very high likelihood of causing death. They are then immediately quarantined in an effort to minimize the contagion, and despite their pleas to be let go, they are forced to undergo the required treatment and quarantine. The ethical ramifications abound; there exists a disregard for the patient's withheld consent; the nature of the illness suggests that one must also consider the rights of others, specifically, the right to not be infected with a potentially fatal disease. A question is posed: whose rights are supreme? It would seem here, as is generally accepted by society, that a consideration of 'the greater good' in an instance such as this is enough to proceed despite the patient's expressed, contrary preference.

More commonly, this dilemma is witnessed in the case of children who often, by means of shouts and tears, express their preference against being administered an injection, despite that injection being very beneficial to them. Rarely is this preference ever taken into consideration over the wishes of the parent or guardian; it is typically *assumed* that minors are unable to give or withhold any valid consent. Thus, as in the case of the diseased and quarantined individual, their preference may be overridden. In such a case, it seems as if some degree of paternalism is acceptable for disregarding preference. The reason for treating minors in this fashion is the generally undisputed belief that they are simply incapable of rational choice. Clearly this is not

always the case, as it is reasonable to assume that someone who is a day short of turning eighteen bears the same decisional capacity as the person the day following. Of course, there are certainly instances when younger children *are not* able to rationally decide what is best for themselves, just as there are likely cases when someone who is over eighteen might not realistically be able to produce a decision that will encourage the greatest benefit for himself. This case of the minor then introduces an interesting and sometimes conflicting consideration of legal permissibility over moral permissibility. The law is the justification and defense for the disregard of the moral complexity, though, this is hardly universalizable. The general maxim in such a situation would have to read, “it is permissible to violate a moral ideal when a legal ideal excuses it.” If the situation was changed slightly to include an individual not bound by the same restrictions as a case concerning a minor, then the imposition of a treatment they have not consented to, even if the law permitted it, would not be morally justified.

In the case of the minor, the moral conflict that exists between overriding autonomy and the paternalistic actions of their guardian(s) and healthcare providers is easily mitigated by its legal justification. The law asserts that minors are irrational, and thus *need* someone to act in their best interest even if they do not consent³ The validity of this notion stems from society’s general acceptance of that rule. This standard is limited in scope and cannot easily be applied beyond individuals under the legal age of consent. If the same reasoning were applied to other cases in which there is a supposed inability for the patient to provide or withhold consent, such as when the patient is mentally handicapped, then those individuals would be at risk of never being able to have their preference, expressed through their withholding consent, respected.

³ This issue is mitigated presumably by the understanding that non-autonomous beings cannot have their autonomy violated. See Part II for more detail.

There are cases in which the court grants individuals close to the age of consent the authority to give or withhold consent despite their guardians' desires to maintain the right to act on behalf of the minor. In such instances it is recognized that the criteria for autonomous functioning are hardly dependent on the empirical value of age.⁴ Applying the same level of consideration to adults, simply 'assuming' that an individual cannot make rational decisions, despite their clearly articulated withholding of consent, would be impractical, if not entirely morally unjustified.⁵

To acknowledge the validity of the previously asserted conclusions implicates a glaring inconsistency in the application of its reasoning: the expressed 'consent' or 'preference' of adults is treated with far greater authority by the medical community than the 'consent' of minors. I argue that this is not because the consent of adults is inherently more valuable, but because there exists a conflation of law and moral reasoning in determining its permissibility. In ambiguous cases, the law is used as a scapegoat for potentially immoral actions, such as the violation of withheld consent. Additionally, the law spares healthcare providers the arduous task of determining how to ethically proceed in such cases by making the decision for them.

The final example I will present is that of an individual who endures a permanent vegetative state (PVS) and is also undergoing some sort of treatment. Because a patient enduring a PVS is unable to communicate, all treatment administered is, technically, performed without consent. However, there is a feature of this example that differs substantially from the former two: in the previous examples, patients were experiencing treatment forced upon them despite their active withholding of consent whereas this patient, in the most literal sense, is *unable to*

⁴ Rather, cognitive development, which is not standard across the board, thus requires some general standard be applied.

⁵ It is generally assumed that adults are capable of rational thought and autonomous function. Exceptions are usually in the face of serious and clear cognitive or psychological incapacities.

give consent. Even more important in this instance, the patient enduring a PVS is *unable to withhold consent*. When treating patients in a PVS, healthcare providers must rely on the preferences of the patient's closest responsible party for consent to treatment, but when even this party is absent, they must rely on procedural policy. Of course, there may be the instruction of an advance directive, in which case it may be assumed that consent has been given accordingly, provided one does not dwell on the possibility that the patient's preferences might have changed. Even so, such a case invites consideration of the nature of treatment without consent in regard to psychiatric cases. Treatment without consent in psychiatric cases differs from forced treatment generally in that it requires an *assumption* that, like a patient in a PVS, an individual is, for some psychiatric reason, *incapable of rational thought, and therefore unable to give or withhold valid consent*.

Previously reviewed are three scenarios in which treatment without consent was justified primarily by reasons of paternalism, with an explanation of what makes each case different. In this paper, I am primarily concerned with instances of treatment without consent in cases involving supposed psychological disorder. These cases differ from the other two presented scenarios in that greater ambiguity exists in determining criteria precluding an individual from the ability to validly give or withhold consent. Therefore, in such cases it is more difficult to justify paternalistic action that may be contrary to the patient's expressed preference. Furthermore, these instances are differentiated from the case of the minor because there is no baseline criteria defining rationality⁶; Jillian Craigie and Lisa Bortolotti write, "[I]n the academic literature as well as in an everyday sense— questions of rationality concern the normative

⁶ Whereas, in the case of the minor, the baseline is set by the law and not a moral determination.

constraints on decision-making: what we should believe, or what we should do.” This presents a clear philosophical problem: if considerations of rationality, even those presented in the DSM (Diagnostic and Statistical Manual of Mental Disorders), are normative, then it becomes near impossible to assert an objective criterion for the way a person “ought to act.” The case of the minor is differentiated from the case of the diseased patient who is being detained for the benefit of *others*;⁷ and differentiated from the individual who is in a PVS who more importantly is unable to *withhold consent* given their condition. The cases I am concerned with in this paper are those in which there are no easily identifiable features of a condition that would prevent individual choice, no legal definitions that are accepted in practice (such as in the case of the minor), no instances in which the wellbeing of others is being questioned (such as in the case of the diseased individual), withheld consent is clear, and individual preference is effectively communicated.

When discussing the moral permissibility of paternalistic treatment, the primary concern is consideration for patient autonomy and their ability to consent. It is widely assumed by healthcare professionals that the patient’s ability to act on their own accord is not only valuable, but also should be respected by those providing treatment. Neglecting to establish rules or guidelines for how we manage the administration of healthcare for individuals who have special needs or other cognitive impairments could result in addressing doctors who use excessive, experimental, or unhelpful medical treatments with inappropriate leniency. Thus, undesired treatment that is imposed upon a patient, even in pursuit of what the healthcare provider thinks is best for the patient, is in stark conflict with the healthcare provider’s responsibility to protect the

⁷ Which is an instance protected under law, in the same sort of way that there are laws governing day to day conduct in order to protect members of society.

patient's autonomy. It is then vital for the discussion to form some sort of understanding of what makes an individual 'autonomous', and what gives them their ability to offer valid consent.

Part II: Autonomy and Consent

A consideration of autonomy, in addition to a determination of the essential features of 'consent', is necessary to address concerns regarding the supposed necessity of forced treatment. The definitions of these terms are arguably the primary concern of doctors who are faced with the challenge of navigating the treatment options for patients whose preferences seem contrary to what is thought to be best for their health. The primary justification for disregarding patient preference is the assumption that an individual is unable to act in their own best interest. Paternalism is used to justify the disregard for a patient's clearly expressed preference because it is determined that an individual is unable to act in their own best interest. Special attention ought to be paid to the separation of those two aforementioned ideas: preference is disregarded *because* of paternalistic goals; that decision is *justified* and deemed *excusable* by the claim that they cannot (or will not) make the best decision themselves.

Another issue in such cases is the inconsistency in deciding *when* an individual will 'need' treatment, despite their withholding consent. "There is a seeming double standard between a healthcare provider's obligation to support a patient's ability to choose, and their willingness to suggest that they are incapable of choice when their preferences do not agree with the healthcare provider's idea of what is in their best interest." (Leo, 1999). Because the primary concern of medical professionals lies in restoring or maintaining patient health via treatment, a unique conflict arises between fulfilling that endeavor and respecting the patient's preference in cases in which that preference opposes the recommended treatment. As long as the patient's

desired means of treatment coincides with that of the healthcare provider, there is little time spent deliberating that patient's capacity, except in the most extreme cases of clear delusion or unconsciousness.⁸ However, when the patient withholds consent, this thwarts the healthcare providers from administering treatment, thus compelling them to examine whether the patient actually has the capacity to withhold consent. This is especially prevalent in instances of psychiatric impairment; it may be difficult to identify evidence of what causes an individual's inability to choose, subsequently requiring that their desire to forgo treatment be the only thing considered when evaluating their decisional capacity. If an individual is, for some reason, lacking in the capacities necessary to make a rational choice, then *any* choice they make may not be a true expression of what they feel is in their best interest. It is inconsistent for healthcare professionals to only question this capacity when a patient's preferences contradict the providers.

Thus, when considering the complex cases of individuals who wish to refuse treatment but do not seem rational enough to act in their own best interest, the question arises of what is required to be considered functionally autonomous and able to give or withhold valid consent. Considering the concerns above of a double standard, it is crucial to develop a working framework for the features of valid consent that may be applied broadly and used to mitigate the problem of questioning an individual's rationality only when their preference contradicts that of their healthcare provider.

To evaluate the nature of autonomy in respect to the many definitions and interpretations that have been published is, without a doubt, ambitious. I am personally inclined to agree with Bruce Jennings, who explains how one of the primary differences between bioethical

⁸ Such as the case of Mary Northern presented in part 2.3.

deliberation and traditional philosophical academic deliberation is the audience one is trying to appeal to (Jennings, p.75). The abstract concern of autonomy that the academic philosopher might ponder makes it very difficult to determine a clear definition that can be reasonably applied by the clinical bioethicist. Ultimately, the aim of this review is to avoid a construction of autonomy that is either too narrow or too broad to be reasonably applied to a case concerning abstract details, and to avoid the construction of a definition that is so abstract it cannot be reasonably applied to an ethical case.

2.1 The Conceptions of Autonomy

While there are various conceptions of ‘autonomy,’ their shared essence lies in the notion of self-governance (Beauchamp, p.61). The general philosophical notion of “autonomy” is often, but not always, synonymous with “autonomy” as understood in applied medical ethics. Tom Beauchamp emphasizes intentionality, information, and voluntariness (i.e., “without controlling influences”); O’Neill discusses heavily the requirements of informed consent (Jennings, p.76); Frankfurt seems to pose some notion of an individual’s autonomy meaning that they can achieve their desired ends (Dworkin, p.3); and Gerald Dworkin asserts an idea of an individual being free to consider the value of their first order preferences (Dworkin, p.15). Feinberg simply suggests a right for one to make their own decisions, namely, how they treat their own body (Feinberg, p.54). Raz posits that autonomy is one’s ability to “make their own lives” (Raz, 2009). For the sake of brevity, I will refrain from dissecting the different conceptions of autonomy, however all of the conceptions (e.g., those of Dworkin, Raz, and Feinberg) do share a few commonalities crucial to developing a definition that I apply here.

Firstly, they all share a requirement for an ability to *act freely* in pursuit of any consequence. Secondly, they all require some *understanding* of consequentiality. O'Neill's proposed definition puts a focused interest on the understanding of what exactly one is consenting to and what their options are before consenting. I intend to maintain these basic ideas of autonomy and contribute them to a definition that will best suit the formulation of a definition of autonomy that may be generalizable for other areas of medical ethics. Considering that all of these definitions are very similar, I will assert another definition intended specifically for use in medical deliberation: "autonomy" may be defined as an ability of self-governance free from outside influence, especially with respect to the individual's own body, and in pursuit of the patient's desired future life.

Combining the essential features of 'capacity', we are left with a definition that consists of many individual bits of theory, specific enough to be useful for the purpose of ethical medicine, and expansive enough to hold generalizability. The definition of autonomy outlined above can be determined by addressing the patient's decisional capacity. Because autonomy may be minimally defined as an ability for self-governance, there next needs to be a standard method of determining whether an individual is actually capable of self-governance free from outside influences that would prevent them from achieving their desired quality of life. I will look primarily at the practical features of decisional capacity required to conclude what is necessary for an individual to make rational choices, and what criteria must be met to justify choices being made on their behalf.

The first requirement is that the patient has some baseline level of cognitive ability. With only the broad requirement of "cognitive ability" alone, one may already disqualify individuals

in a coma, persistent vegetative states, and brain-dead individuals. If one offers further stipulations for cognitive ability, such as reaching primary developmental milestones, then that description may also exclude individuals with severely impaired cognitive development, such as adults who never pass primary points of mental development. Requiring the ability to maintain awareness of surroundings and situations eliminates people with late stage neurodegenerative disease. All of what has been mentioned thus far seems practical enough to apply to the features of cognition. An individual must have the capacity to be aware of and understand the details of their medical situation and make decisions accordingly to be considered cognitively capable of exercising valid autonomy.

In consideration of psychological impairment specifically, the following requirements for decisional capacity are to be utilized to measure whether the patient is able to act in accordance with the aforementioned definition of autonomy: a baseline level of cognitive ability, which includes (but may not be limited to) an awareness of present circumstances (otherwise stated ‘seriousness of the condition’); an understanding of treatment options and the possible effects of that treatment; and an understanding of the (presumably) severe consequences of forgoing treatment. I argue that this definition is sufficient for deliberation in cases where the autonomous status of an individual is questionable. Henceforth, the use of the word “autonomy” is understood to be in reference to the asserted definition, and it is understood that the measure of whether a person’s autonomous choices must be respected is the criteria for deciding if they have decisional capacity. With this having been established, a consideration for the requirements of valid consent may now be offered.

2.2 Consent and its Requirements

It is imperative that one establishes an operational definition of autonomy because to be ‘autonomous’ is arguably the most important feature of an individual’s ability to consent. Standard medical practice would require that an individual consent to medical procedures, if capable, before treatment is provided. Thus far, I have used the term “preference” in phrases like “disregarding patient preference.” The use of the word “preference” refers specifically to an individual’s giving or withholding consent. The reason for why the word “consent” was avoided until now is that, in cases of psychiatric impairment, there is a question of what makes for *valid* consent. However, that does not take away from whether the “preferences” expressed by the patient exist. An individual may be suggesting that they do not want treatment via withholding consent. Their desire to forgo the treatment may be legitimate and it may also be the result of a condition preventing them from choosing otherwise.

The requirements for valid consent per basic consent theory are as follows: 1) the consequences of withholding consent cannot be detrimental to the individual,^{9,10} 2) the consentor must be fully informed of what they are consenting to, 3) consent must be free of any undue influence or coercive forces, 4) must be able to be withdrawn at any time (Miller and Wertheimer, 2010). It would be reasonable to add that, for the purposes of applied medical ethics, 5) the consenting individual must be autonomous. If any of these criteria are not met, then any consent offered is *not valid*. Withholding consent is simply the inverse of consenting and does not need any special features added to this list. The intent of this section is to address issues

⁹ This may be determined simply by evaluating notions of harm, and whether the consequences of withholding treatment may make them worse off than they were before.

¹⁰ This poses an interesting conflicts for Do Not Resuscitate (DNR) orders; I am an inclined to suggest that these issues would be mitigated by the thought that in most cases DNR’s are in place when resuscitation would be considered a greater consequence than death.

of consent situationally, not to assert a list of requirements for broad use (however, there is nothing necessarily preventing these requirements from being used in other instances).

There are two rationales in support of imposing treatment upon an individual who cannot consent that makes the above sections significant. An initial review of consent theory would lead to the conclusion that because one is unable to give or withhold consent, it is not permissible to administer treatment. Generally, consent theory would require one to refrain from imposing treatment on a patient unable or unwilling to give consent, and any sort of general principle of respecting patient autonomy would require that patient preference not be violated. However, complexity arises in situations involving individuals who can benefit from treatment but cannot give consent due to a non-autonomous state. If an individual is, because of their age, assumed to be unable to give consent, then medical professionals would be permitted to continue with treatment accordingly. However, because such an assumption would be wildly disenfranchising to individuals who might actually be autonomous, we require some sort of system to guide the decision of whether an individual does or does not have decisional capacity.

Initially, this problem seems easy to mitigate in simple instances of individual incapacity, such as a PVS or mental impairment. An argument could be made that if an individual is non-autonomous, then logically it would not be possible to violate their autonomy. However, the same reasoning is much harder to apply to instances of psychological impairment, as it is much more difficult to identify the meaningful feature of a person's psychological state that would reasonably invalidate their judgment, preference, and ability to make rational choices. In instances of, for example, attempted suicide, the identified 'cause' of the individual's mental state is considered indicative of an 'unusual' or 'abnormal' state that would cause someone to

behave in such a characteristically ‘irrational’ manner. The feature of a psychiatric condition that impacts decisional capacity is often identified using third-party interpretation of action, and making corresponding judgments on recognized norms and thoughts of how *things ought to be*. It seems far more difficult to experience a sentiment for one struggling with a psychological condition compared to what one may be able to sympathize when considering a more physical condition, such as the fear of a surgery or the pain of a broken bone. Clearly, an individual in surgery is not capable of expressing preference at the time, and their willingness to undergo the surgery is evidence that they want to live. Thus, it is more difficult to sympathize with an individual who does not want to live and has no apparent condition that may suggest a reason for them to not want to live.

Considering the details of autonomy and consent discussed in earlier sections, I am left to conclude that forcing treatment in instances of supposed psychological impairment deserves a much different level of consideration than instances of a PVS or mental impairment. It is much more difficult to identify the meaningful features of the condition that would realistically suggest that an individual is not autonomous, and it then requires one to make a bold claim: that, despite their clearly expressed preference, this preference is not valid, the patient is not autonomous, and thus cannot have their autonomy violated. Therefore, when considering the requirements for autonomous function and valid consent discussed throughout section two, forced treatment for reasons of psychological impairment must be deemed *not* morally permissible. Given the complexities of psychological impairment, I would say that it is, at best, ‘amoral’, in that because the treatment is intended to ‘help’ the patient, it could be considered good in nature, but it is left

to fight a strong battle against the means required to achieve it. In later sections I will begin to offer my argument on the requirements of forced treatment to be considered ‘helpful’.

Instances of impairment include such conditions as being in a coma, PVS, or suffering from a debilitating mental illness, all of which prevent an individual from being able to communicate any preference or understanding of the present circumstances of their condition.¹¹ Because these individuals are non-autonomous, any treatment provided cannot be a violation of their autonomy. Other instances may include individuals who *are* able to express a preference, but for some reason this preference is not conducive to supporting their own healthcare needs. Suppose an individual is living with mid-stage Alzheimer’s disease. It is likely that this individual is capable of communication and retains some or most of their motor function, however, they may lack total cognitive awareness. In the event that they refuse their medication because they feel they do not need it, their refusal is an accurate representation of their preference, though it is not a preference made with an understanding of the consequences of not taking their medication. In cases such as this, where patient preferences need to be disregarded and treatment be given without their consent, the meaningful identifiers of their cognitive ability are much harder to identify, making it much more difficult to proceed without a possible violation of their autonomy. The definition of autonomy that has been provided addresses this problem by identifying the essential features of an autonomous person. This may now be demonstrated in its application to the case of Mary Northern.

¹¹ In some instances, these individuals will *never* be able to communicate this.

2.3 Mrs. Mary C. Northern

Mary C. Northern was a 72-year-old woman who was living in conditions not suitable for survival. Upon review of her living conditions, she was taken to the hospital to be treated for malnutrition and severe frostbite and necrosis of the feet. Doctors estimated that, given the severity of the rot and the infection, Northern had a roughly 5%-10% chance of survival, and recommended the amputation of both of her feet. Northern was either unable or unwilling to appreciate the severity of her condition, and she was adamant that she would heal without the need for surgery. In an effort to save her life, the doctors filed with the court a question of competency in hopes to be granted permission to amputate her feet to save her life. Before the court she explained her feet were only such color because, “they need to be washed, as they are covered in dirt and soot. In the presence of this court, the patient looked at her feet and refused to recognize the obvious fact that the flesh was dead, black, shriveled, rotting, and stinking. It was by this that she was deemed partially insane, unable to appreciate the gravity of her condition, and a guardian ad litem was assigned to act on her behalf on the matter. She died not many days later from a blood clot coming from the gangrenous tissue.

Mrs. Northern is an unfortunate, but appropriate, example of an individual who did not meet the requirements of autonomy as defined here. Northern was able to clearly express a preference, but clearly she was not aware of her present condition, and was unable to appreciate its severity. She did not want to undergo surgery, and when asked if death was preferable she responded “probably”, never giving any sign that she truly could comprehend the either-or nature of her condition. Because of this, Northern did not meet the requirements for an autonomous individual because she did not demonstrate a baseline level of cognitive ability with an

understanding of present circumstances, treatment options, the possible effects of that treatment, and an understanding of what would be the severe consequences of forgoing treatment.

2.4 Concerns for the Rationality of the Desire to Die

‘Rationality’, as it pertains to one’s ability to consent and their autonomous capacity, desperately needs to be addressed, specifically the desires to die and to avoid life sustaining treatment. It is generally assumed by the medical community that a desire to die is ‘irrational’ in nature, and therefore must be indicative of some psychological impairment that prohibits one’s ability to make ‘rational’ choices that are really in one’s own ‘best interest.’¹² This idea is the most common justification for the hospital practice of restraining and medicating those who enter the facility because of a suicide attempt. However, some find the varying arguments that the desire to die is irrational very unconvincing.¹³ Certainly such stances might be conceded in instances when both suffering and death are guaranteed (such as the case of a terminally ill patient), therefore making the desire to avoid suffering by achieving the seemingly imminent and inevitable death much more ‘reasonable’. Though, I am inclined to question, is it actually more ‘reasonable’ for one to wish to avoid suffering in the aforementioned instance of a terminal illness as opposed to the instance of emotional or psychological suffering? My determination is ‘no’; there is not a meaningful difference between those circumstances.

¹² Outside of instances such as terminal illness, where death is imminent, unavoidable, and will likely cause a great deal of suffering.

¹³ A study conducted by David Owens suggests that some ninety percent of people who commit suicide and survive *do not* go on to die by suicide at a later date. Although, of those ninety percent, roughly thirty percent of those individuals do re-attempt suicide.

2.5 Mrs. Boomsma

The case of Mrs. Boomsma (as she is known in the Netherlands) is a prime example of rationality, preference, and a psychological ‘condition’ that has prompted a desire to die. Mrs. Boomsma was a very unhappy woman who expressed multiple times that her personal reason for living emanated solely from the satisfaction she derived from motherhood. Her oldest son committed suicide, causing her significant distress, ultimately requiring hospitalization. Later, her husband became physically abusive, which led her to initiate a divorce and move away to work and care for her remaining son. Tragedy then struck again when her youngest son was hit by a truck, and despite surviving, died soon after from late stage cancer.¹⁴ Not long after, she contacted a psychiatrist by the name of Chabot, to whom she told that the emotional and psychological pain she was experiencing as a result of her twin tragedies amounted to a level of suffering so severe that to her, death was *preferable*. After twenty-four hours of psychiatric sessions with Boomsma, and an agreement made in consultation with multiple other professionals (including an ethicist), Chabot complied with Boomsma’s requests and supplied her with the medications necessary to end her life in her pursuit to end the suffering.

Such suffering in many instances¹⁵ would not qualify an individual for physician assisted suicide or euthanasia. The complexity of cases such as that of Mrs. Boomsma lies in judging the desire for death subsequent to such suffering to be irrational or arise from a characteristically ‘abnormal’ psychological state that if otherwise treated, would allow the patient to ‘regain

¹⁴ Wijsbek, Henri. “Case Study ‘to Thine Own Self Be True’: On The Loss of Integrity as a Kind of Suffering.” *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 462–467.

¹⁵ Some places, such as the Netherlands, *do* consider emotional/psychological suffering when determining whether a case is suitable for euthanasia (Tuffrey-Winje, 2018). However, even in the case of Mrs. Boomsma, her desire to die was in the end considered to not be compliant with the requirements of Dutch law.⁷

rationality'. Symptoms like Mrs. Boomsma's, specifically in the United States, would have been addressed with psychiatric treatment in the hope of trying to 'fix' whatever the 'problem' was that prompted such an 'irrational' desire.

There are bioethicists who consider certain psychological conditions to impair autonomous capacity. Beauchamp suggests that "autonomous persons sometimes fail, in particular circumstances, to act autonomously because of temporary constraints caused by illness or depression..." (Beauchamp, p.61). It may be that such is believed because people are often unable to empathize with suffering they themselves have not experienced, and because few people are as familiar with the suffering brought by psychological pain than physical pain, they are better able to empathize with people suffering from the latter. Thus, it is my conclusion that due to limitations in one's ability to fully empathize with psychological concerns, it is too difficult for many people to understand a psychological pain so great that death is preferable. It is with that conclusion I refute the general notion that a 'desire to die' is 'irrational' in nature. Difficulty comes in deciding whether, in a particular instance, a mental health issue *is* present, and it is *actually* debilitating to a person's autonomous capacity. Thus, I am led to conclude that the desire to die is not inherently irrational and it therefore cannot be used as an identifying feature of an individual's rational state or their capacity for autonomy.

I would be remiss if I did not address the instances of those who have a desire to die that might arguably *not* be rational. As not to discredit anyone's personal sufferings, I will refrain from attempting to offer examples. However, I must concede that there are in fact some instances when a desire to die might not be a reasonable corollary to the circumstance that urges such a desire. The distinctions to be made on this front are rather expansive and likely outside the scope

of this paper, so I will encourage thorough deliberation in discerning what instances meet such criteria. This concession does not conflict with my previous conclusion, as the validity of the claim that ‘there are instances when a desire to die is not indicative of irrationality’ is general enough to achieve my purpose without stepping beyond its own boundaries.

There are of course instances of questionable rationality that likely do not need to be addressed, as the details of those cases are straightforward enough and argued enough already. Examples of these include but are not limited to individuals with severe intellectual disabilities (i.e., delayed cognition), existing in PVS, suffering from trauma-induced reduced cognitive ability, and an extremely progressed neurodegenerative disease. In all of these cases, there is a clear inability to express preference, and so those caring for them are left with no opportunity to substitute their own judgment for the wellbeing of the individual (Kuflik, 2010).

If one is to be considered ‘autonomous’, and that decision is to be grounded on the healthcare provider’s interpretation of the patient’s decisional capacity, there still exists a need to address why anyone ought to care about the patient’s autonomy. The widely accepted answer is that patients have a right to have their autonomy respected. This system of patient rights and the correlative duties of healthcare providers will be discussed thoroughly in Part III, as it is this relationship that suggests why patient autonomy ought to be considered at all.

Part III: Considering the Nature of Rights

Having come to some final interpretation of autonomy, its definition and requirements, I now find it necessary to address what I notice to be a common principle in the bioethical community: the acceptance of certain ideas of “rights”. The intention of this section is to address the philosophical nature of rights and how that affects its applicability to medical ethics,

specifically in cases of forced psychiatric treatment. For the sake of brevity I have only included what is necessary to support my final conclusions on the moral permissibility of forced treatment.

3.1 What are 'Rights' and Where Do They Come From?

Generally speaking, rights are thought of as governing principles that promote the action or preference of one individual over another individual. Occasionally, these “rights” might be further reduced to ‘liberties’ or ‘licenses’ that promote some sort of action or preference of an individual, (however, such distinctions are far beyond the scope of what I hope to achieve here). Often rights are expressed in terms of an individual, henceforth “X”, having a claim over something (e.g., property rights). This proclamation of ‘right’ suggests a *requirement* of others to refrain from acting in a way that would infringe upon that right. Assuming that it is correct that there is some standard of action that is required of all, or most, individuals in respect to individual X who possesses a right, then this standard would be designated by most as a ‘duty’ to X. It is this understanding of rights that is applied to the practice of medical ethics: patient X has a right of some sort, and it is the correlative duty of others to respect that right. Rights are either ‘positive’, meaning that they exist out of an obligation of others towards an individual (they must be granted), or they are ‘negative’ (also called rights of non-interference) where the obligation of others is to simply not violate that right.

The primary question often raised in general philosophy addresses the origin of these ‘rights.’ Some philosophers argue that they are naturally derived, others that they are contractual, and still others that they do not exist at all. This is an important question because in the medical community it is generally accepted that physicians and other health care providers do possess

some duty to their patients, whether it be to act, protect, save, or simply treat. It has been suggested by rights theorists such as Wesley Hohfeld that if one asserts that a duty exists, then it must exist as a product of some other individual's right. Otherwise said, if Y has a duty to X, then that duty must exist because X is the owner of some right which *imposes that correlative duty onto Y*. Because it is widely accepted by the medical community that patients are the owners of rights, and healthcare providers hold the burden of maintaining the correlative duties to those rights, then to fully assert this claim it must be understood where these patient rights come from.

I am inclined to argue that patients *do* have rights, and healthcare providers do possess correlative duties to these rights, but these rights do not exist in full form 'naturally'; rather, they are the product of one right that normally goes undisputed by rights theorists: the right to freedom. This 'freedom' refers broadly to a right to existence, and to exist in some way that is of one's own preference. Of course, if this is a right that all people possess, then it further stands to argue that all people possess a duty not to infringe on another's 'freedom.' This manifests in the world of medicine with greater complexity, as individuals who assume the role of healthcare providers have assumed a positional duty to help their patients. In order for individuals to act in their right to 'freedom,' more 'rights' must be subsequently defined to frame which behaviors are permissible to others in the pursuit of not interfering with an individual's right to freedom. This is the origin of many of the patient rights that are assumed in medicine, such as the right to refuse treatment, the right to information, and the right to not be harmed. If medical professionals are going to act in the best interest of a patient (as they have agreed to do by holding their position) and they are to respect an individual's right to freedom, then there must be some specific rights that function as guidelines for healthcare providers who are assisting patients

while maintaining the patient's right to freedom. Thus, the complex system of patient rights occasionally creates conflict between a healthcare provider's commitment to help patients and their duty to respect the patient's right to freedom.

Similar to the difficulties faced when evaluating the nature of autonomy; problems arise in cases where there is conflict between a medical professional's duty to help a patient yet must violate the patient's right to refuse treatment in order to provide that help. This would violate the doctrine of double effect, which holds that an action with foreseeable harms may be permissible provided that those harms not be used as the means to achieve the good. Harms may only be foreseen and unintended *consequences* of action, not the means by which one reaches the preferred outcome (Beauchamp & Childress, p.165). Thus, it becomes very difficult to use forced treatment to treat an individual without clearly violating them in some way to achieve the end goal. The remainder of Part III is dedicated to reviewing the cases of patients that supersede an individual initial right to freedom.

3.2 Concerning 'Rights'

Of the numerous rights derived from an individual's right to freedom, this evaluation of treatment without consent treatment is concerned foremostly with a patient's *right to refuse treatment*. This right is the result of an understanding and acceptance of the idea that healthcare providers ought to promote and respect patient autonomy, which rises from the standard acceptance of a right to bodily integrity. Most would agree that, in the name of preserving autonomy, individuals who are capable of autonomous action and rational thinking have the right to refuse or forgo treatment despite the fact that the consequences of doing so could result in

death or some other unpreferable outcome.¹⁶ This extends further than just the singular individual as well. This right to refuse treatment is also one that is bestowed on the supplemental decision makers in the event that the patient is incapable, whether it be for physical, mental, or legal reasons, of making their own decisions. Parents who wish to refuse standard treatments for children, such as vaccinations, are permitted to do so. This of course poses serious questions as to whether or not this right of the supplemental decision maker actually is the foundation for the correlative duty of the actor in respect to their actions towards the patient.¹⁷ Most important to understand is that the right to refuse treatment is dependent on a patient's ability to act autonomously. This understanding becomes a litmus test for deciding the permissibility of treatment.

The discussion of autonomy offered in Section II becomes incredibly useful here in deciding whether this right ought to be maintained by the holder of its correlative duty. When applying treatment in an instance where someone is terminally ill, is aware of their terminal status, and is aware that no matter the treatment they are very likely to succumb to death because of their illness, the urgency of any action to 'help' is nullified by an acceptance of the outcome. In an instance when someone is incapable of expressing preference because they are in, for example, a PVS, disregarding the thought that they can neither consent nor withhold consent, seems more justified for the sake of trying to act in their best interests. In the instance when treatment is forced on someone whose preferences are the opposite of what may be in their best interests, a new conflict arises between a healthcare provider's being able to help, and having to

¹⁶ This is displayed by Joseph Raz when he asserts that an individual ought to retain the right to pursue their own desires, even if they are self-destructive.

¹⁷ Hohfeld, 1913

fulfill a duty to respect individual rights that seems contradictory to help.¹⁸ Of course, that duty vanishes if it is reasoned that, because of a psychological impairment, they are incapable of representing what is in their own best interest, thus mitigating the conflict between ‘helping’ the individual and violating their rights.

A second issue arises here aside from the conflict between helping an individual and violating their rights. I frequently use ‘best interests’ in reference to a patient’s rational capacity, however, ‘best interests’ is entirely subjective, and it is not uncommon for patient preference to contradict the opinion of the doctor as to what they believe will be best for promoting individual health. It is important to recognize that, while it is not realistic for a healthcare provider to know what is objectively in “the best interests” of their patient, it *is* reasonable to assume that they are *trying* to act in the best interest of their patient; whatever “best interest” may actually mean is irrelevant, as whether they happen to know exactly what the patient “needs” or “ought to have” or not, the conflict arises between the patient’s desires and the healthcare provider’s idea of how treatment should be administered. If one is to hold the position that a healthcare provider can never know what is best for a patient, then it would be reasonable to then argue under *no* circumstance may a healthcare provider transgress upon a patient’s expressed preference. This does not seem conducive to a wide promotion of patient health. Therefore, some sort of determination must be made as to what is absolutely critical for the well-being of the patient.

Looking again at the case of Mrs. Mary Northern, the doctors felt that given her condition of living, combined with her cognitive state and the seriousness of her infected lower extremities, it was *necessary* to have her feet amputated, and her unwillingness was taken as a sign that she

¹⁸ Leo, 1999

was clearly unable to know what was best for herself and act from that knowledge. It is certainly possible that she may have preferred death to amputation. However, because she was not able to appreciate her condition, the doctors were left to try to do what they would to contribute to her wellbeing, and it was reasonable for the medical professionals to conclude that it must have been whatever was going to allow for her best life in terms of longevity and quality

While this seems to be a reasonable conclusion, it poses serious potential implications. The potential misuse of this ‘psychologically impaired’ designation, which also acts as a justification for violating the patient’s rights, is quite possible. The population of individuals who can be treated despite their clear refusal to consent has been broadened to anyone who can be deemed irrational because they did not act in accordance to a specific standard. This could produce severe disenfranchisement for vulnerable populations, including but not limited to people with intellectual disabilities, people with emotional disorders, people who struggle in social situations, and people who try to commit suicide or those who have tried in the past.

Given the concern of violating patients’ rights, and the inadequacies of using autonomous capacity as the sole justifying factor, I am left to conclude that it is unlikely that forced treatment can ever be conducted in a way that respects the rights of patients. The above sections have addressed ‘autonomy’, ‘consent’, and ‘rights’. This has established the necessary for the following sections on bioethical principles and the total application of this evaluation to the selected cases.

Section IV: The Primary Principles used in Bioethical Deliberation

The area of applied ethics in medicine considers many moral frameworks when assessing different cases. Of those frameworks, their suitability is often concerned with four primary

principles. In *The Four Principles of Biomedical Ethics*, Beauchamp and Childress use the culmination of these principles to create an independent framework that can be used to assess certain types of cases that are relatively simple. While the framework they propose is very effective, I am not generally concerned with it in its entirety, but the individual principles they use to construct it.

The principles outlined by Beauchamp and Childress are beneficence, nonmaleficence, justice, and respect for autonomy. Given that the entirety of Section II is dedicated to different conceptions of autonomy, I do not find it necessary to address them again here in Section IV. In the following subsections there are analyses of the three other principles, many of which are defined using the definitions and explanations offered by Beauchamp and Childress, as their ideas seem sufficient to reference here.

4.1 Nonmaleficence - The Intent to Avoid Harm

‘Nonmaleficence’ is intended to mean a specific intent to avoid causing harm. ‘Nonmaleficence’ is differentiated from ‘beneficence’ in that ‘nonmaleficence’ holds that “one ought not to inflict, promote, or allow evil or harm” while beneficence suggests that, “one ought to do or promote good”.¹⁹ While harm may manifest in different forms, the general nature of harm that this paper is concerned with is baseline-harm, or any instance of making an individual worse off than they were before. In conjunction with patient rights discussed in Part III, the principle of ‘nonmaleficence’ at its root exists from a healthcare provider’s duty to respect a patient's right to not be harmed.²⁰ When considering again the discussion of individual rights,

¹⁹ Beauchamp & Childress p.151

²⁰ The idea of harm that is to be avoided by Beauchamp and Childress’ explanation of nonmaleficence would be any “thwarting, defeating, or setting back of some party’s interests, [even though it] is not always ‘wrong’ or unjustified.”

patients own the right to *not be harmed*. This right is one of non-interference; the only thing that an individual has to do in order to respect that right is simply not harm the patient. In the thinking of Wesley Hohfeld, the rights of the patients are the foundation for the correlative duties of others to not harm them.²¹

To adequately conclude this section, it is critical to give appropriate consideration to the doctrine of double effect. In regard to instances of psychiatric impairment, treatment that is in violation of the doctrine of double effect would look like the following: an individual who appears to be suffering from a psychiatric impairment is in ‘need’ of some level of treatment. Because of this impairment, they are restrained, medicated, and committed in an effort to make them better off than they would have been otherwise. This action would qualify as harm to the patient, and it would violate the doctrine of double effect because the harm inflicted was done so intentionally to achieve the positive outcome. This creates an obvious issue, for if treatment such as this is not permissible, it makes it very difficult for healthcare providers to adequately help their patients in their efforts to do good.

4.2 The Intent to Do Good

‘Beneficence’ requires agents, in this case health care providers, to provide benefits to others and act in their best interests.²² The general principle of ‘beneficence’ is founded on prima facie obligations of the medical field, such as defending patient rights, preventing harm, preventing conditions that will cause harm, helping people with disabilities, and rescuing people in danger.²³ Using forced treatment in instances where there are concerns of patient rationality

²¹ Hohfeld, Wesley Newcomb. *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*. The Yale Law Journal Company, 1913.

²² Beauchamp & Childress p.202

²³ Beauchamp & Childress p.204

could be in the best interest of the patient, and the intended purpose of the treatment and its providers could be genuinely *good*. The issue then is not one of ethics but an odd dynamic in which a group of individuals providing treatment are acting in both a maleficent and beneficent manner, in that, they are intending to do a harmful thing for the good of the patient (assuming that the forced treatment is a violation of patient autonomy and contradicts their expressed preferences). If such is in fact the case, then despite the healthcare provider's attempt to do good, they are again in violation of the doctrine of double effect mentioned in Part 3.1.

It might seem trivial to discuss 'beneficence', as it seems clear that doctors ought to act in the best interest of their patients. However, the foremost concern that arises when considering beneficence is that beneficence is the grounding feature of paternalism. The principle of acting in the best interest of the patient (which seems to be an indisputable 'good') is also the primary feature that seems to permit instances of acting in the best interest of an individual *especially if they cannot do it for themselves*. It has been established already that "the best interest" of the patient is subjective, and simply suggesting that individuals have to act in the best interest of their patients seems to be excessively permissive to all sorts of acts, such as forced commitment, vaccinations, mental health treatments, and other things of the sort. Utilizing all of these concerns when caring for patients is essential to maintaining a level of justice for patients.

4.3 Justice

The last principle this paper is concerned with is that of justice, which is a rather complex and expansive idea. The term 'justice', according to Beauchamp and Childress, follows an Aristotelian vein and suggests that equals be treated equally, and unequals must be treated

unequally.²⁴ This is what is known as “formal justice”, or the baseline of justice. This is because it identifies no particular facets in which equals ought to be treated equally and no criteria for determining whether or not two individuals are in fact equals.²⁵ The reason they leave this definition so simple is so that little debate may arise from its applicability.²⁶ Unfortunately, such a basic claim leaves a great deal of room in determining where ‘equality’ extends and where it ends. It also does not do very well in the protection of disenfranchised individuals; anyone who might be considered ‘unequal’, such as the mentally or emotionally ill, could be forced to undergo undesired treatment and it be ‘justified’. There are other conceptions of justice that might be used, such as a Rawlsian type idea of justice as fairness, in which the deciding feature is largely concerned with the evaluation of whether or not someone would *want* to live in a world where people could be forced to undergo any treatment that healthcare providers think is “in their best interests.” While such a conception of justice is reasonable, it holds a similar issue as the Aristotelian conception, in that they often lack ease in their application to real world cases.

Given this conflict in vagueness and usability, I am inclined to step further away from ‘baseline justice’ and instead argue that ‘justice’, in regard to individuals acting in a just manner, is the support of any situation or action that respects and promotes individual autonomy. This claim is also simple enough to be applied universally in medicine, and it better navigates the issues of possible disenfranchisement of vulnerable populations that could be considered ‘unequal’ or abnormal, and it is done so by requiring that an actor be entirely certain in their conclusions than an individual is incapable of making autonomous decisions. If an individual is

²⁴ Beauchamp & Childress p.250

²⁵ Beauchamp & Childress p.251

²⁶ Although, it would seem that the success of their use of this theory depends on the mutual understanding that every agent involved is in fact *equal*.

truly incapable of rational thought and acting in their own best interest, then it becomes much more difficult to say that their autonomy and subsequent right to refuse treatment was violated. However, if they are capable of making those decisions, then it becomes more difficult for instances to arise when the actor forcing treatment could not be held responsible for their transgressions.

Given that the line of permissibility is so unclear, it would be beneficial to identify some instances when infringement on one's autonomy is clearly unjust. Allowing cognition to be a standard for permissible forced treatment endangers a significant number of already disenfranchised groups such as homeless individuals, those suffering from mental illness, people of low economic status, or people who face harsh prejudice about their nature or ability. Any individual who does not meet a social standard of what many would consider 'normal' could be at risk of being deemed 'impaired'. The actions which are being judged as "abnormal," and are being used to make a determination about their rational capacity, are really just minor consequences of a condition which is not at all debilitation to rational or autonomous function. To remedy this, a qualitative standard of someone to be considered an 'equal', or not abnormal, would have to be rational, stable, and secure- statuses that many individuals in the aforementioned groups do not meet.

With this review of justice I am led to conclude that more often than not, the practice of forced treatment is not just, as it may, and often does, exploit the vulnerabilities of certain disenfranchised groups, and any benefit that may result is rarely achieved through means that respect individual autonomy.

Part V: Concluding Remarks on the Ethical Nature of Forced Treatment

The purpose of this section is to aggregate all of the conclusions in sections I-IV to reach a final assessment on the general nature of forced treatment. Doing so will provide a baseline argument for why forced psychiatric treatment does not fall within the moral parameters necessary to be deemed a permissible course of action for treating patients who might benefit from the treatment, however, withhold consent because they do not want it. In instances when a patient's psychology prevents them from pursuing beneficial treatment, healthcare providers are led to question whether or not their psychiatric condition warrants a dismissal of their expressed preference. Given the previous remarks on autonomy, patient rights, beneficence, nonmaleficence, and justice, I am led to conclude that forced treatment is not an act that respects neither individual autonomy nor individual rights.

5.1 Conclusions on Rights

In evaluating the origin of patient rights and their correlative duties, one is left with the general understanding that patients *do* in fact have rights in regard to their healthcare. This paper is primarily concerned with the right to refuse treatment. This is the right that is most concerned with a patient's ability to choose, which is dependent upon their ability to act in their own best interest, or, their ability to fully understand the consequences resulting from acting otherwise.

In evaluating what criteria must be met for a patient to be considered autonomous, there has been a standard outlined for which individuals may be assessed to determine to what lengths their healthcare providers may go in efforts to help the individual regardless of their expressed preference. The ability to refuse treatment would seem to require the ability to do or act

autonomously. If this is correct, which I suspect it is, then it would follow that a person capable of autonomous action as it has been discussed above should under no circumstance have their right to refuse treatment violated for some paternalistic attempt at doing what that will not do for themselves.

Such a claim has serious implications in dealing with our specific issue, which is not nearly as simple as a case in which someone is unable to *offer* preference. An individual with a debilitating psychiatric condition *is* often able to express preference, and they often do feel that said preference is in their best interest. Deciding to ignore that preference is far more complicated than navigating a case in which preference is never expressed. Cases of attempted suicide are often considered to be indicative of an irrational, non-autonomous state, and such a conclusion is often the primary feature in deciding whether or not that individual will be required to undergo some sort of treatment. However, an attempted suicide or an expressed desire for death is not always an entirely accurate tool for deciding an individual's rational capacity. Such a case may be found in that of Elizabeth Bouvia, who, a non-terminally ill patient desiring to die, was held in a hospital and force fed with a nasal feeding tube (at the directive of a court order) despite both her verbal and physical attempts to refuse that treatment. The goal of the treatment was to benefit Bouvia's biological state of being. However, she was able to clearly express her preference, and considering that her suffering seemed to equal that of a terminally ill patient, the only thing separating her from what would be considered a "rational" desire to die *is a terminal illness*. Even so, her case and that of a terminally ill individual would have been handled much differently, because of the predetermination that a desire to die was irrational.

In considering the tandem relationship between autonomy and a patient's right to refuse, it would be reasonable to conclude that individuals who are not autonomous are not endowed with such a right, as they, for whatever reason, are able to neither consent nor withhold consent. This determination is simple in the case of an individual in a PVS, however, it is much more complex in instances when a person must be ruled unable to consent even though they are able to express their preference. I find it reasonable to then claim that forced treatment in those complex cases would not be a justified means of treatment, as it directly contradicts considerations of preference and subsequent rights to choose, without having a reasonable system in place to make accurate determinations regarding patient ability nor a guide to ensure that patient autonomy is supported to the fullest extent.

5.2 Applying the Principle of Nonmaleficence

The general principle of nonmaleficence would not support the act of forced treatment in any instance because such treatment is in conflict with the doctrine of double effect. The harm experienced during the process of forced treatment is not a foreseen yet not desired consequence of treatment, rather, it is a means to achieve the desired result of the treatment; this would be no better in principle than cutting off the hand of a person who is experiencing pain from a broken finger. To permit such practices could potentially endanger anyone who suffers from a cognitive impairment, special need, or is simply in some way atypical.

5.3 The Healthcare Provider's Intent to do Good

Compelling arguments have been made defending the intent of a healthcare provider to do good, and the necessity of forced treatment to achieve that. In any instance, it would be

difficult to argue that violating a person's autonomy is promoting the true wellbeing of the patient. It would seem that the only time one could argue that such treatment is benevolent is when that treatment is specifically intended to revive the autonomous capacity of the patient. If such is the case, then it might seem permissible to force treatment. However, in the instance of someone who has tried to commit suicide, the goal of the healthcare providers would have to be to relieve the patient of the circumstances that incited such a response. Otherwise, forced treatment would not be supported.

5.4 Concerns for Justice

Lastly, in respect to justice, it would be reasonable to uphold the aforementioned definition that defines it as any state of affairs that respects autonomy. As such, forced treatment would not be permissible insofar as it is used for some paternalistic means of making a patient 'better off' than they were before. Instead, it must be intended to promote the autonomy of the individual. Otherwise, forced medical treatment is hardly, if ever, morally just, and thus hardly ever morally permissible.

****This concludes the portion of this research project intended to satisfy the requirement for PHIL 400.****

Part VI: Final Conclusions on the Ethical Nature of Forced Treatment in Psychiatric Impairment

In the context which this paper is concerned, forced treatment must be separated from treatment without consent via the primary distinguishing feature: forced treatment describes administering treatment against the expressed preference of the patient. The same feature necessarily exists to define treatment without consent; however, those instances exist when a patient's condition literally prohibits them from giving or withholding consent. When evaluating

the permissibility of this treatment, an actor should be concerned with a few things, namely the autonomous state of the individual and the individual's rights.

It is critical to have a working definition of the essential features of an autonomous individual. This is required because the primary problem in addressing the permissibility of forced treatment is the concern for the violation of individual autonomy. If an individual is non-autonomous, then it would not be possible to violate their autonomy. This is why cases of PVS are easier to address than cases of psychiatric impairment, for it is much more difficult to identify the features of someone who is psychologically impaired. I argue that a reasonable definition of autonomy is as follows: a baseline level of cognitive ability, which includes (but may not be limited to) an awareness of present circumstances (otherwise stated 'seriousness of the condition'); an understanding of treatment options and the possible effects of that treatment; and an understanding of the (presumably) severe consequences of forgoing treatment. Autonomy is arguably the most forefront part of an individual's ability to consent, and the definition provided is broad enough to apply to many different instances, while still narrow enough to be relevant to cases of forced treatment involving psychological impairment.

It is argued that if there are any natural rights, then they can generally be referred to as the individual right to freedom.²⁷ From this right comes the correlative duty of others not to encroach upon others' freedom. This basic idea manifests itself in the world of medicine as a right to refuse treatment, the right to information, and a right to not be harmed. I argue that these rights exist as guiding points to healthcare professionals who are also owners of positional

²⁷ As presented by HLA Hart in his piece *Are There Any Natural Rights?*

obligations to help people. With this, there must be lines for demonstrating to what extent this ‘help’ can be given before violating individual freedoms of their patients.

Lastly, this paper is primarily concerned with the principle of beneficence, otherwise said “the intent to do good.” This intent to do good is the underlying feature of paternalism, which is the justifying argument for forced treatment. With such, it requires that things be broken down to what extent forced treatment is being provided and actually helping the patient or doing other than violating their right to freedom and their individual autonomy.

I am led to conclude this review by holding the position that forced treatment in cases of psychological impairment is not categorically ‘moral’ in nature. It is often too difficult to identify the meaningful features of an individual that would deem them actually incapable of autonomous function. Because of this, any treatment offered is a violation of individual autonomy and a breach of individual duty to maintain the patient’s right to refuse treatment and to not be harmed. However, given the complex nature of psychological impairment, I would be willing to concede that there may at least be instances where forced treatment may not satisfy the requirements of ‘moral’ treatment, however, it may at least be in some instances justified. These instances would exist when individuals are a danger to themselves or others or are genuinely incapable of doing for themselves as needed.

Part VII: Paradigm Cases in Determining the Legal Requirements for Forced Treatment

Parts I through Part VI are dedicated to the philosophical review of forced treatment in regard to its moral features and permissibility. While those parts are diagnostic, the following are intended to be prescriptive in nature, examining the practical concerns of forced treatment, such as its effectiveness, legal requirements, and historical use. The paradigm legal cases will be

introduced and reviewed, and later parts of the paper will offer a defended solution to the question and implementation of forced treatment.

7.1 *O'Conner v. Donaldson*

The first historical case is *O'Conner v. Donaldson*, in which Kenneth Donaldson was placed in a mental institution for fifteen years without opportunity to defend his sanity. Prior to that, his parents petitioned to have him committed for insanity because he got into a bar fight.²⁸ The judge agreed, forcing Donaldson to eleven weeks of shock therapy before being released. Twenty years later, his father again brought forth a sanity hearing saying that Donaldson had a persecution complex. The judge remanded Donaldson to Florida State Mental Hospital, where he remained for fifteen more years.²⁹ The time he was in there, Kenneth Donaldson petitioned numerous times for a new hearing, none of which were indulged, nor was he given regular access to a physician.³⁰ In 1971, the time came for his case to be heard, but the facility quickly released him before the hearing. The Supreme Court then established two necessary conditions for involuntary commitment: 1) suffering from mental illness and 2) being dangerous to others or to oneself.³¹ Both conditions must be met for an individual to be involuntarily committed. Later, judges interpreted the condition of “danger” to be imminent, meaning within days or hours, and it included “attempted suicide, threats of suicide, and gross neglect of basic needs” as dangerous.³² Some states in the 1990s further added a third requirement: that the individual must be placed in the least restrictive environment for their condition. These conditions were used in the next historical court hearing.

²⁸ Pence p.304

²⁹ Pence p.305

³⁰ Pence p.306

³¹ Pence p.305-6

³² Pence p.305

7.2 Joyce Brown

The second paradigm case used in this review is the 1987 case of Joyce Brown, a woman who was subjected to forced psychiatric treatment because of the claims that she, being schizophrenic, was unstable and displayed aggressive behaviors that endangered herself and those she might come in contact with.³³ After receiving numerous reports of strange behaviors of Brown, who was homeless and seen burning money and eating garbage, she was picked up by New York's "Project Help", an organization established to "assist needy, homeless people".³⁴ Accompanying their attempts to "assist" these homeless individuals was a policy granting them the ability to involuntarily commit individuals for psychiatric evaluation on the legal standards of mental illness, and also on two of their own criteria, "self-neglect" and "need for treatment of mental illness".³⁵ Project Help forced Brown to the local hospital where she was involuntarily injected with 5mg of Haloperidol, which "provides long-term antipsychotic therapy... (2011 *Nurse's Drug Handbook* p.498)", and 2mg of Lorazepam, used "to treat anxiety..."³⁶ In Brown's release hearing presiding Judge Robert Lippman decided that the state did not make a sufficient case of mental instability and likelihood to cause harm to herself or to others.³⁷ An appellate court overturned Lippman's ruling and remanded her back to hospital custody. The hospital then could not get a court order allowing them to have her forcibly medicated, therefore Brown was released again. Her story became famous; she lectured to Harvard students and had time on the television. Not long after that, she was seen back on the street begging and wearing stained clothing, and some reports suggested she was in and out of psychiatric facilities before dying at

³³ "Though Homeless..."

³⁴ "Though Homeless..."

³⁵ Pence p.299

³⁶ 2011 *Nurse's Drug Handbook* p.606

³⁷ Pence p.300

the age of 58. Joyce Brown's rather unconventional means of living in society was enough to have her considered irrational by the New York Appellate Court that heard her case for the second time; and a compelling argument could be made that she might have benefited from, or maybe even "needed", psychiatric care.

Part VIII: Prescriptive Solutions to the Concerns for Paternalism and Forced Treatment

Thus far, this paper has only presented the grounds on which forcing treatment is unethical. It is important to establish this in order to understand the differences between "ethical" and "appropriate" so that the following argument may address these issues. I propose four conditions that, when met, support forced treatment as an appropriate practice: 1) The individual must lack decisional capacity, 2) treatment will not intentionally bring evident harm or destruction to the patient, 3) the individual must be placed in the least restrictive environment for their condition, and 4) the intent of the treatment must be to promote the highest possible level of autonomous capability.

8.1 Considering Condition One

Concerning condition one, the patient must lack decisional capacity otherwise the treatment provided is in clear violation of their autonomy. This requirement saves patients from potential healthcare providers who disagree with the patient's preferred treatment (or lack thereof) and do what is required for them to pursue what they consider to be in the patient's best interests.

8.2 Considering Condition Two

Intending to help an individual does not fully support forced treatment as an appropriate method. The second condition to be met for forced treatment to be deemed permissible is

treatment will not intentionally bring evident harm or destruction to the patient. Harm in this case is defined as baseline harm, in which someone is made worse off than they were before, namely as a lower level of autonomous capacity. There are also crucial considerations for the physical harm experienced; the use of chemical restraints, physical altercation, and the emotional/psychological harm that can come as a result of being forcibly treated. These concerns for harm require respect for the doctrine of double effect, which is used to evaluate intended effects and quantify the good over the bad. According to the doctrine of double effect, the harm may not be used as a means to achieve the good, it may only be foreseen and unintended.³⁸ This is especially relevant in cases of treatment that may extend beyond what is considered useful. The doctrine of double effect could be applied to the example of the initiative to reduce homelessness. It has already been established that forced psychiatric treatment walks the line between ethical and unethical, and violating patient rights is also harmful; however, with the sole intent to make the patient better off than they were before, it may be appropriate. Furthermore, an individual suffering from schizophrenia cannot be forced to take huge amounts of medication that would have a grave impact on their ability to do or act in pursuit of their desired life.

8.3 Considering Condition Three

The third condition that must be met in order to forcefully treat an individual is that the individual must be placed in the least restrictive environment for their condition. This condition requires healthcare professionals to only use restrictive environments if they are absolutely necessary to giving the patient the required treatments. Individuals cannot be restrained unless

³⁸ Beauchamp & Childress p.165

showing aggressive tendencies; they cannot be institutionalized only because they have certain conditions; and they may not be chemically subdued.

8.4 Considering Condition Four

Lastly, the intent of the treatment must be to promote the highest possible level of autonomous capability. Treatments that will not promote individual autonomy are not permissible. Looking again at the case of Mary Northern, if the circumstances of the case were altered so that Northern displayed all of the necessary features of an individual with decisional capacity, and she still would rather die than undergo surgery, factors such as her advanced age and already-limited mobility must be taken into account before the healthcare providers decide that she will be ‘better off’ if given treatment.

One might argue against this point and suggest that an individual could not be ‘better-off’ if they were dead. To that I rebuttal by suggesting that, while in some cases it may be true that death does not contribute to an individual’s being ‘better-off’, and argue that in some cases, *it is*. In the instance of Northern, who already was at an advanced age, it might be reasonable to suggest that, to her, death was preferable. The only contradicting feature would be a presupposition on the part of the medical staff that believes life is always better than death.

8.5 Synthesis and Defense of Prescriptive Solution

By adhering to the four above criteria, a few things are established. First, the focus is on intent. One must ask if a treatment or commitment is being done for any reason other than to make the patient better off than they were before and promote autonomous ability. If the answer is “no,” then the criteria has not been met and forcing treatment would cross the line from appropriate to unethical. Second, it must be considered whether there is any intent to cause harm

or make the individual worse off than they were before. If the answer is “yes,” then the criteria has not been met and forcing treatment would be unethical. Lastly, it must be determined whether the patient is experiencing a condition which might impact decisional capacity, and whether they are an imminent danger to themselves or those around them. If the answer to this is “no,” then the criteria are not met and forcing treatment would be unethical. If the answer is yes, then forcing treatment would be appropriate under the requirement that it be as least restrictive as possible. The following case is hypothetical and can be used as an example to apply this method.

8.6 Application of Solution to a Hypothetical Case

Deborah Johnston was a middle-aged woman with two kids, a husband, and a job, and also suffered from an alcohol addiction. One evening, while Johnston was very intoxicated, she became very angry. While her family tried to calm her, she began throwing things, including kitchen knives. Johnston later explained that it was just a temporary lapse in judgment and that she apologized and is now fine. Her husband decided to have her involuntarily committed to a rehabilitation program at a local hospital psychiatric unit, where she was kept on the grounds, under supervision, and on stabilizing medication.

When evaluating this scenario, the same criteria as above should be applied in the same order. Deborah’s husband had her involuntarily committed for her own benefit, arguably to promote her wellbeing. There is no intent of harm by those initiating, supporting, or performing the treatment, including her family and healthcare providers. Johnston has been suffering from depression and addiction, both of which are mental illnesses, and recent events have proven Johnston to be an immediate threat to herself and those around her. As long she is kept in the

least restrictive manner possible in her rehabilitation, then according to the above criteria, forced treatment would be appropriate.

Part VIII: Concessions

Like most theories, the argument present here is still susceptible to medical cases that have confounding variables. This argument is not intended to address *all* scenarios in which forced treatment might be a considered option. Ultimately, one of the largest issues with this argument are justice concerns, in that, how people with mental conditions might lose all ability to forgo undesired treatment. Issues arise in cases such as a brain tumor, which may have an effect on an individual's rationality and behaviors. It would be unreasonable to forcibly perform brain surgery, even if the goal is to support the patient's wellbeing. In response to this complex scenario, arguably, brain surgery would not be considered psychiatric treatment, rather, it would be neurological treatment, distinguished by the physical properties of the brain rather than its function. This is still unclear, so the best course is for the outcome of these complex scenarios not to hinge on the application of this argument. In order to protect the integrity of patients, it is best to further evaluate their case beyond the argument that is presented here.

Part X: Concluding Remarks

Forced psychiatric treatment has been an area of concern for decades, and though the medical community has made great strides in protecting patient interests, it will continue to be a concern. The dialogue between needing treatment and wanting it is subjective, and the apparent violation of patient rights makes it very hard to justify. Using the argument presented here, forced psychiatric treatment may be deemed appropriate on grounds that the patient *is* lacking in decisional capacity, the treatment *will* make them better off than they were before (by supporting

autonomous function), and does not cause harm or use harm as a means for treatment. While this still is a violation of autonomy and patient rights, it may be defended on grounds of paternalism and acting for the patient in a way their circumstances prevent them from doing on their own.

Reference Page

- 2011 Nurse's Drug Handbook*. Jones & Bartlett Learning, 2011.
- Beauchamp, Tom L. "Autonomy and Consent." *The Ethics of Consent Theory and Practice*, by Franklin G. Miller and Alan Wertheimer, Oxford University Press, 2010, pp. 55–78.
- Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. Oxford U.P., 1983.
- Buchanan, Allen, and Dan W. Brock. "Deciding for Others: Competency." *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 332–342.
- Cantor, Norman L. "Testing the Limits of Prospective Autonomy: Five Scenarios." *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 366–367.
- Craigie, Jillian, and Lisa Bortolotti. "Rationality, Diagnosis, and Patient Autonomy in Psychiatry." *The Oxford Handbook of Psychiatric Ethics, Volume 1*, Oxford University Press, 2014.
- Dworkin, Gerald. *The Theory and Practice of Autonomy*. Univ. Press, 2008.
- Fagerlin, Angela, and Carl E. Schneider. "Enough: Failure of the Living Will." *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 355–365.
- Feinberg, Joel. *Harm to Self*. Oxford University Press, 1989.
- Frankfurt, Harry. "Freedom of the Will and the Concept of a Person." *The Importance of What We Care about Philosophical Essays*, by Harry Frankfurt, Cambridge University Press, 2009.
- Gold, Jake, and Kate Bellows. "Patient Sues U.Va. Health System Employees for Alleged Due Process Violations." *The Cavalier Daily*, 15 June 2018, www.cavalierdaily.com/article/2018/06/patient-sues-uva-health-system-employees-for-alleged-due-process-violations.
- Hart, H. L. A. "Are There Any Natural Rights?" *The Philosophical Review*, vol. 64, no. 2, 1955, pp. 175–191. *JSTOR*, www.jstor.org/stable/2182586.

- Hausman, Sandy. "UVA Hospital Sued Over Forced Treatment." *WVTF*, 15 June 2018, www.wvtf.org/post/uva-hospital-sued-over-forced-treatment#stream/0.
- Hohfeld, Wesley Newcomb. *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*. The Yale Law Journal Company, 1913.
- Husak, Douglas N. "Liberal Neutrality, Autonomy, and Drug Prohibitions." *Philosophy & Public Affairs*, vol. 29, no. 1, 2000, pp. 43–80., doi:10.1111/j.1088-4963.2000.00043.x.
- "Involuntary Commitment of People with Mental Illnesses: Should states revise laws to make it easier to commit people with mental illnesses involuntarily?" *Issues & Controversies*, Infobase, 18 Apr. 2011, <https://icof-infobaselearning-com.ezproxy.lynchburg.edu/recordurl.aspx?ID=2323>. Accessed 20 Dec. 2019.
- Jonsen, Albert R. *The Birth of Bioethics*. Oxford University Press, 2010.
- Jennings, Bruce. "Autonomy." *The Oxford Handbook of Bioethics*, by Bonnie Steinbock, Oxford University Press, 2013, pp. 72–89.
- Kant, Immanuel. *Grounding for the Metaphysics of Morals: with on a Supposed Right to Lie Because of Philanthropic Concerns*. Hackett, 1996.
- Kennett, Jeanette. "Mental Disorder, Moral Agency, and The Self." *The Oxford Handbook of Bioethics*, by Bonnie Steinbock, Oxford University Press, 2013, pp. 90–113.
- Kuflik, Arthur. "Hypothetical Consent." *The Ethics of Consent Theory and Practice*, by Franklin G. Miller and Alan Wertheimer, Oxford University Press, 2010, pp. 131–161.
- Leo, Raphael J. "Competency and the Capacity to Make Treatment Decisions." *The Primary Care Companion to The Journal of Clinical Psychiatry*, vol. 01, no. 05, 1999, pp. 131–141., doi:10.4088/pcc.v01n0501.
- Locke, John. *Two Treatises on Government*. Pubmix, 2013.
- May, Thomas. "The Concept of Autonomy." *American Philosophical Quarterly*, vol. 31, no. 2, 1994, pp. 133–144.
- Miller, Franklin G., and Alan Wertheimer. *The Ethics of Consent: Theory and Practice*. Oxford University Press, 2010.

- Owens, David, et al. "Fatal and Non-Fatal Repetition of Self-Harm." *British Journal of Psychiatry*, vol. 181, no. 3, 2002, pp. 193–199., doi:10.1192/bjp.181.3.193.
- Pence, Gregory E. *Medical Ethics: Accounts of Ground-Breaking Cases*. McGraw Hill Education, 2017.
- Raz, Joseph. *The Morality of Freedom*. Clarendon Press, 2009.
- Rosenbaum, Lisa. "Liberty versus Need — Our Struggle to Care for People with Serious Mental Illness." *New England Journal of Medicine*, vol. 375, no. 15, 2016, pp. 1490–1495., doi:10.1056/nejmms1610124.
- Schmidt, Jennifer, et al. "Emma, Carrie, Vivian: How A Family Became A Test Case For Forced Sterilizations." *NPR*, NPR, 24 Apr. 2018, www.npr.org/2018/04/23/604926914/emma-carrie-vivian-how-a-family-became-a-test-case-for-forced-sterilizations.
- Sklar, Ronald. "Book Review: Refusing Care: Forced Treatment and the Rights of the Mentally Ill." *Transcultural Psychiatry*, vol. 43, no. 2, 1 June 2006, pp. 326–328., doi:10.1177/1363461506064884.
- "State of Tennessee Department of Human Services v. Mary C. Northern. Court of Appeals of Tennessee, Middle Section, Feb. 7, 1978." *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 325–332.
- "Though Homeless, She Copes, She Is Fit, She Survives." *The New York Times*, 13 Nov. 1987, pp. B00002–B00002.
- Tuffrey-Wijne, Irene et al. "Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012-2016)." *BMC medical ethics* vol. 19,1 17. 5 Mar. 2018, doi:10.1186/s12910-018-0257-6
- Wijsbek, Henri. "Case Study 'to Thine Own Self Be True': On The Loss of Integrity as a Kind of Suffering." *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 462–467.
- Wolfson, Jay. "Case Study Erring on the Side of Theresa Schiavo: Reflections of the Special Guardian Ad Litem." *Ethical Issues in Modern Medicine: Contemporary Readings in Bioethics*, by Bonnie Steinbock et al., McGraw-Hill, 2013, pp. 369–373.

