Comment on Giordano's "In Defence of Autonomy in Psychiatric Healthcare"

GIORDANO'NUN "PSİKİYATRİK BAKIMDA ÖZERKLİĞİN SAVUNMASI" YAZISINA YORUM

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Conventional notion of respect for autonomy suggest that patients should generally be able to make decisions for themselves, consistent with their own view of the world and themselves.

The concept of autonomy itself is an area of ethical debate in mental illness, precisely because, whatever incapacity mental illness causes, it surely has a direct impact on both the patient's capacity to be autonomous, and his or her experience of being autonomous. Further, in cases where mental illness is chronic (which is perhaps the more common situation), the patient's experience and capacity for autonomy will be bound up with his dependency relationships with his carers, both professional and personal.

It would be bizarre to suggest that patients' autonomy is respected in all conditions in psychiatry. First of all psychiatric diseases are not homogenous. Insight and reality testing is very important to decide whether we would respect the patient's autonomy in all conditions or not. Giordano did not make any distinction in her article (1) in mental diseases whether they are psychotic or not. As the author suggests paternalism is not always unethical, and sometimes may be an obligation, especially in treating conditions such as psychosis. As Giordano mentions some psychiatric illnesses destroys the patients decision making capacity, therefore it is hard to say psychiatric patients totally have right to decide themselves or about their treatment modalities.

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There is a misperception about conditions of mental patients; the author gives an example - a schizophrenic woman- who washes her hands because of hearing voices commanding to do this. The author says "she does not know why she has those disorders, and that is the only truth". I think this type of argumentation has some problems. We know really few things about "the exact causes or etiopathogenesis" of the diseases but this does not mean that we cannot conclude anything about the patients autonomy. Assume a patient which is in emergency service who is in coma or in delirium, and some measures are done to treat, and understand the pathology. And during these procedures we do not catch the real pathology yet. What should we think at that time? Is it possible to claim, "to assess the autonomy we should know the etiology of delirium"? Whatever the cause or etiology is the patient cannot be accepted as autonomous because of the clinical state which he or she is in.

The main part of the article is about "diagnosis of psychiatric disorders is descriptive and not casual so they are nonsense in deciding the autonomy". It is really hard to say so. That's true that psychiatric diagnosis are mainly "descriptive" but we are also descriptive in defining the patients autonomy.

And author says, "we do not know the real cause of schizophrenia. So we made some logical faults." Is it really important to now the real cause of the clinical condition in deciding the degree of the patient's autonomy? I think the autonomy of the patient is independent of the factors that cause the disease. Although psychiatric diagnoses are in de-

scriptive nature, this does not mean that we cannot make any comment about their autonomy. Because decision making capacity, reality testing, insight and judgement are also clinical data which we evaluate the patients disease and putting the diagnosis and in making treatment plan. And these are factors that have to consider in making a decision about patients autonomy. Would it be more easy to choose the patients if we know the real causes of the diseases? For example in the etiology of the schizophrenia mostly accused phenomena is the hyperdopaminergic states in the brain. So what? Does it say anything about the state of autonomy of the patient? This is absolutely independent from the cause of the disease. Whatever the cause the important thing is the clinical symptoms and the signs of the patient. If the reality testing, decision-making capacity, memory, orientation, intellectual functioning are impaired autonomy of the patient is also impaired. Nothing to do till the disease resolves or being treated. And during this acute phase of the disease the autonomy may be totally absent. And this is not against the patient's individual rights. This is on the behalf of patients to restore his or her autonomy in a possible short time.

So the type of the psychiatric disorder is very important to determine the borders of the patients' autonomy.

Can we ask the treatment choice of the patient in order to respect her or his autonomy? As clinical psychiatrists do not frequently find themselves in an ethical dilemma about patients' autonomy or paternalism, this is especially true in psychotic patients. About the treatment modalities, I thing the final decision should belong to the clinician. But patient should be listened carefully and asked about the side effects of the treatment for not to harm the patient.

But for the respect to patient's autonomy, if we change our clinical treatment decisions against current modern concepts of treatment modalities this should be accepted as malpractice. One of my patients had psychotic depression. He was a clever young man. And when I met him he was in a very bad clinical condition. For more than 6 months he had not had a bath. He had not gone out his bedroom. And had not attended the school. And we hospitalised him and than applied ECT. So after the second application of ECT he was dramatically being good. After we discharged him, although we had informed his family, they did not continue his medical treatments. And after 6 months we saw him in a position that we had seen him previously. When we ask his family why they did not give the drugs, they said he resisted, and not to make him sad they did not give the pills. In this condition, is the family respecting their son's autonomy or committing a crime?

In anxiety disorders, somatoform disorders etc. decision making capacity of the patient is conserved so we only make treatments in patient's demand. I think since the motivation of the patients is very important in treatment of non-psychotic patients coercive treatments could not be used in non-psychotic patients, i.e. in pathological gambling and in addiction of heroin or alcohol. The treatment should not be done coercively, but we can help to patient not to attend the drug or the matter. By giving some pharmaceuticals as disulphram (antabus) patient would not take alcohol. If he wishes he may not get because he is informed about dangerous side effects of the drug-alcohol interactions. So we make him more autonomous to resist the alcohol. So this does not mean we are reducing his autonomy. They admit us by their own desire and then we treat them. If at any point he wants to give up the drug and treatment we cannot do anything. And that time we cannot behave coercively.

It is difficult to imagine any situation in clinical decision analysis in which a conflict between utilitarian and deontological thinking in psychiatry does not operate. As medical doctors, we are trained to make some kind of cost-benefit analysis on behalf of the patient when, for instance, advocating for drug treatment psychotherapy. Very often, we consider our decision to be good (both technically and ethically) if the benefit outweighs the side effects. At the same time, we have deeply rooted ethical intuitions that we must respect the decisions of the individual patients, with the grand exception of the person being frankly psychotic. Towards psychotic patients we accept a kind of solicited paternalism, but it is the society-as reflected by the legislation or involuntary admission and treatment of psychotic ill patients- and not the patient who has given the consent to suspend the prin-

ciple of autonomy, at least for a limited period of time (2).

Persons are committed as a result of a mental disorder that significantly impairs their judgement, or are released if found not to have one. When insanity is an issue, persons will or will not held responsible for their actions because of a mental disorder. With great difficulty and appreciable limitations, psychiatrists have developed standards for recognizing and categorizing these disorders. Although acceptance of the standards is not unanimous, they are at least consensual (3).

"We advocate a consumer-oriented approach to the clinician-patient relationship. Thus a therapist should be an educator and advisor, rather than dictate treatment. Since patients must live with their disease, as well as tolerate the prescribed treatments, they should play an active part in related decisions"(3).

Namely in anxiety disorders, somatoform disorders etc. decision making capacity of the patient is conserved so we only make treatments if patient demands. So the type of the psychiatric disorder is very important to determine the borders of the patient's autonomy.

Author made some innovative contributions about autonomy of psychiatric patients but the argumentation that he used have some problems.

KAYNAKLAR

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