A Response to Savas's Comments on My "In Defence of Autonomy in Psychiatric Health Care"

"PSİKİYATRİK SAĞLIK BAKIMINDA ÖZERKLİĞİN SAVUNMASI" ADLI YAZIM ÜZERİNDE SAVAS'IN YORUMLARINA BİR YANIT

Simona GIORDANO*

* Ph.D., Centre for Social Ethics and Policy, The University of Manchester

Summary

According to a widespread belief, mental illness may impair autonomy and may lead people to behave in certain ways. On the basis of similar arguments, the diagnosis of mental illness is sometimes considered one of the criteria that justify paternalism. On my "In Defence of Autonomy in Psychiatric Health Care", I have argued that paternalism cannot even partly be based on grounds such as these. Savas has moved some objections to my arguments: psychiatric patients' autonomy is diminished by their dependence upon carers; I should have distinguished between psychoses and neuroses; mental illness may destroy people's decision-making capacity; people with mental illnesses cannot have the same right as anyone else to refuse psychiatric treatment. Here, I shall respond to Savas's objections. This will allow me to clarify some of my arguments and to strengthen my claim that the people with psychiatric diagnoses should be treated as anyone else.

Key Words: Decision-making capacity, Autonomy in psychiatric health care, Right to refuse psychiatric treatment, Mental health care law

T Klin J Med Ethics, Law and History 2002, 10:178-185

Özet

Yaygın bir inanışa göre akıl hastalıkları insanların özerkliğini bozar ve belli şekilde davranmasına yol açar. Aynı iddialara göre, akıl hastalıklarının teşhisi paternalist yaklaşımı meşrulaştıran bir kriterdir. "Psikiyatri de Özerkliğin Bir Savunması" yazımda paternelismin bu nedenlerle kısmen bile olsa meşrulaştırılamayacağını iddia etmiştim. Savaş, benim iddialarıma bazı itirazlarda bulundu.; psikiyatrik hastaların kendilerine bakanlara bağımlılıkları nedeniyle özerkliği bozulur; psikoz ve nöroz arasında ayrım yapmak zorunda olduğum; akıl hastalıklarının insanların karar verme kapasitesini yok ettiği; akıl hastaları diğer insanların sahip olduğu psikiyatrik tedaviyi reddetme hakkı olmadığı. Bu yazıda ben Savaş'ın itirazlarına cevap vermeye çalışacağım. Bu bana, bazı iddialarımı açığa kavuşturma ve psikiyatrik hastalarında diğer insanlar gibi tedavi edilmesi konusundaki görüşümü kuvvetlendirme şansı verecektir.

Anahtar Kelimeler: Karar verme kapasitesi, Psikiyatride özerklik, Psikiyatrik tedaviyi reddetme hakkı, Akıl sağlığı kanunu

T Klin Tıp Etiği-Hukuku-Tarihi 2002, 10:178-185

Dr. Haluk A. Savas has commented on my "In Defence of Autonomy in Psychiatric Health Care"(2,3). I am sincerely grateful for the interest that he has shown in my paper. Savas's critique also gives me the chance to make some clarifications.

First of all, I have to admit that my conclusions may appear somewhat harsh toward psychiatrists and other health carers. I write in my paper:

> Finally, it should be acknowledged that the value of autonomy should not only be understood and respected, but also protected and promoted. For this reason, it is morally important that paternalistic interventions be not only based on the careful study of the conduct at stake, but also aimed at improving the individuals' capacity to act and choose autonomously…(p.66)

Savas remarks that, normally, interventions are directed at restoring patient autonomy. Of course, I did not mean to suggest that health carers are not concerned with patient autonomy. I only wanted to stress that the appeal to the value of autonomy should not be taken as a rhetorical refer-

ence to a widely accepted moral concept, but as a task of the utmost importance and difficulty for all those involved. However, I think I should apologise both to Savas and to all psychiatrists and carers who may have felt that I was underestimating the importance of their work.

Having said this, I wish to respond to a point, raised by Savas and left unexplored in his commentary. To my claim that mental patients' autonomy should be respected, Savas objects that people with mental illnesses, especially chronic mental illnesses, are often influenced by carers in their decision-making. He argues that the relation of dependence from carers and practitioners diminishes their autonomy. I shall analyse this point in the section.

"…The patient's experience and capacity for autonomy will be bound up with his dependency relationships with his carers, both professionals and personal" (p.67)

Savas argues that mental patients are not fully autonomous because they have a relationship of dependence upon their carers. Is he right? Does the dependence upon professional and general carers diminishes patient autonomy?

I believe that it does not. We are all dependent upon carers, when we are ill, and if the argument against the patient's right to make medical decision is based on the dependence upon carers, none of us should be acknowledged this right. In cases of illness, especially long-term illness, we may be particularly dependent on others. If we trust our carers, we will always need their advice. They often have a competence that we lack, and we may feel that they have a clearer view about the best action to take. For this reason, we may even decide to delegate our decisions to them. From this, however, it does not follow that we are denied the right to participate in medical decision.

Others always influence our decisions, in a way that is often difficult to recognise or to conceptualise. What others wish, suggest, fear is often highly influential to our decisions. This does not mean that we are incapable of autonomous actions and decisions. Instead, this means that, in order to exercise our autonomy, we need to ponder many things, and we need information (often given by others) and help.

The dependence that we especially manifest during illness is only an aspect of a more general dependence upon relations that characterises human beings, such as other animal species. "Yerkes once said that *one* chimpanzee is not a chimpanzee at all" (4). Paraphrasing Yerkes's epigram, Konrad Lorenz argued that one human being is not a human being at all (5).

One may object that people with mental disorders, especially if they are institutionalised, are particularly dependent upon professional and general carers. It may be argued that making medical decisions could be a very difficult task for many of these patients. It should be noticed that people with chronic mental disorders who are institutionalised represent a partly different case. It is true that they look much more dependent than any other group. This *peculiar* dependence, however, is not due to the mental illness, but to the institutionalisation. It has been demonstrated, a long time ago, that institutionalisation produces a dramatic increase of dependence; the condition of deprivation that is typical of asylums produces similar effects both on healthy and unhealthy subjects (6). Thus, the effects of institutionalisation may be confused with the effects of mental illness. What produces the abnormal dependence is not mental illness, but institutionalisation.

Even acknowledging that institutionalised patients are strongly dependent on professional and general carers, we should not conclude that they cannot be entitled to participate in the therapeutic process. Instead, we should conclude that they may need special help to become more independent and to feel confident to participate in medical decisions.

I cannot deepen the discussion on the relation between autonomy and dependence upon carers. This is an interesting topic, which would deserve separate discussion. We should now see other objections raised by Savas's.

"It would be bizarre to suggest that patients' autonomy is respected in all condition in psychiatry" (p.67)

Savas probably wanted to say that it is bizarre to suggest that all people with psychiatric problems are autonomous.

In my paper, I have not argued that all psychiatric patients are autonomous. Instead, I have stressed that that virtually all of us (including those with psychiatric disorders) are autonomous, to a variable extent. People's autonomy may be manifested in a wide range of actions and choices. Some people may be able to make complex decisions (for example, about their job, their education, their holidays, their finances, and so on). Other people may only be able to make simple decisions (for example, about what to wear, what to do in the afternoon, which song to play, and other similar things). Autonomy that people manifest in the simple tasks of everyday life is still valuable and deserves the utmost respect. As even the most isolated and apparently inaccessible people sometimes show autonomy, their autonomy should be respected, independently of the scope or the importance of its object. In this sense, it is not bizarre to claim that everybody's autonomy should be respected, even if the person has severe mental illness.

"Giordano did not make any distinction in her article in mental diseases whether they are psychotic or not" (p.67)

There are two reasons why I did not make any distinction between psychotic and neurotic disorders. One is that the traditional distinction between neurosis and psychosis has been substituted, in the most recent diagnostic manuals with a different classification, based on the symptoms (7). In the past, the term "psychosis" was used to refer to illnesses that seemed to cause serious functional impairments (8). The term was opposed to neurosis, which was used within the psychodynamic system to describe a pattern of problems. For example, a person who manifested symptoms that caused psychological suffering, but who was in touch with the reality and who was able to manage with her life, might be diagnosed as suffering from a *neurosis* (9). Neuroses were also considered less serious than psychoses. Nowadays, the distinction is no longer used (10). There are several reasons why this distinction has been surpassed (one is that some disorders – for example, Alzheimer's, Depression, Anorexia - may be considered both psychotic and neurotic). I cannot explore the issue further in this paper, and I refer to the bibliographic notes (11).

The second reason why I did not make any distinction between psychotic and neurotic disorders is that I have argued that, in most cases, believing that the diagnosis of mental illness, whatever the illness may be, renders the person incompetent, is incurring in a logical fallacy. In my paper, I have argued that the psychiatric diagnosis should have no relevance whatsoever in deciding whether paternalism is justified. What is important is not the kind of illness people suffer from, but whether their actions and choices are autonomous or not:

> Whether or not I am justified in preventing you from behaving in a certain way (except the case of harm to others) depends on whether or not your conduct is autonomous. As Mill argued, if I saw you attempting to cross a bridge which had been ascertained to be unsafe being unaware of the danger, but I had no time to warn you, I may seize you and turn your back without any real infringement of your autonomy.... [W]hat matters is.... whether that particular conduct is significantly autonomous (p.64).

What matters is whether people are acting or choosing autonomously. They may lack autonomy if they have a psychotic disorder, if they have a neurotic disorder, if they have some other illness, or if they have no illness at all (like the person who, in Mill's example, was about to cross the unsafe bridge).

It may be objected that this argument cannot stand for those with a mental disorder, because mental disorders impair autonomy. In fact, it is sometimes believed that mental illness may com-

promise people's autonomy. Unfortunately, this belief is also expressed in law, as we shall shortly see. In my original paper, I have shown that this belief is false, as it is based on a logical fallacy, and most of that paper was about explaining this fallacy. However, Savas writes: "As Giordano mentions some psychiatric illnesses destroy the patients decision-making capacity" (p.67). I need to make some clarifications, because this is precisely opposite to what I meant.

May mental illness "destroy" the patient's decision-making capacity?

In my original paper, I have argued that mental illness does not (cannot) have any effect on people's decision-making capacity. Mental illness is a name, which is given to some experiences, and not the cause of these experiences. Agoraphobia, for example, is the name which is given to people's fear of open spaces. Agoraphobia, in fact, means fear of open spaces. Agoraphobia is not the cause of the fear of open spaces, but the fear itself. Claiming that agoraphobia is the cause of the fear of open spaces is as nonsensical as claiming that the fear of open spaces is the cause of the fear of open spaces (12).

The names that have been chosen to call people's abnormal experience, do not of course *destroy* people's decision-making capacity.

One may object that those who have a mental illness will lack autonomy sooner or later. Of course, those who make this objection may be right. If I am told, for example, that a person has received a diagnosis of paranoid schizophrenia, I may expect this person to have, let us say, ideas of reference, or delusions, or false beliefs of other sorts. I may also expect that her decision-making capacity will be compromised, at the time she has these experiences.

In fact, in my paper (p.60), I have clearly said that the psychiatric diagnosis has an important <u>predictive value</u>. However, we need to avoid a logical fallacy.

Whereas it is sensible and correct to believe that a person with a mental disorder (e.g. agoraphobia, or paranoid schizophrenia), at some point will have abnormal experiences (e.g. fear of leaving home, or ideas of references), and therefore will probably lack decision-making capacity at that time, it is logically fallacious to believe that a person may be made incompetent by the mental illness. The statements are different:

(1) A person with a diagnosis of, let us say, paranoid schizophrenia will have abnormal experiences at some point. At that time, she will probably be unable to make medical decisions; and

(2) Paranoid schizophrenia causes abnormal experiences, and may compromise a person's decision-making capacity. A person with paranoid schizophrenia may be rendered incompetent to make medical decisions by her mental illness.

These two statements should be clearly distinguished. Whereas the first is correct, the second is incorrect and should be dismissed. The reason why it should be dismissed is that it makes people believe that there is something inside the person, which, as an effect, compromises the person's decision-making capacity. Instead, there is nothing inside the person that has the capacity to destroy her decision-making capacity. Most psychiatric categories are not something that lies somewhere in a person's mind and that produces some effects (exception is made for a few mental illness, such as Alzheimer's Disease, Parkinson's Disease, Dementia, and, in part (13), Addiction, which are the names of *objective and observable anomalies* that *cause* and *explain* abnormal experiences and behaviour). In most other cases, the diagnosis only provides the name of that experience, and no explanation for it. For example "paranoid schizophrenia", "depression", "anxiety", "anorexia", "agoraphobia", are only names that have been chosen for patterns of abnormal experiences. Nobody has ever found anything inside the person, which is able to explain, or may be held responsible, for her abnormal experiences. They have only seen *the experience,* and have chosen to give it a name (paranoid schizophrenia, depression, agoraphobia, etc.). Thus, the diagnosis of mental illness has a *descriptive value and a predictive value*, but not an *explicative value*.

In my paper, after having widely explained this point, I wrote:

> Acknowledging that in the majority of cases the diagnosis of mental illness merely has descriptive character has important consequences. It implies that the fact that someone has (been diagnosed as having) a mental disorder does not necessarily say something conclusive, and often says nothing about the individual's capability to make their own decision, even relating to their own mental health. It follows that non-consensual interventions cannot be justified (even partly) on the grounds that the individual has been diagnosed as having mental illness or mental disorder. Therefore, we should accord to people with mental disorders the same respect we accord to everybody else (p.61)

I also wrote: "This does not imply that paternalism is always unethical" (p.60); and "This of course does not mean that we should be indifferent to the individuals' destiny. Some forms of paternalism may be ethical…" (p.61). Thus, I could not avoid astonishment when I read, in Savas's paper: "therefore it is hard to say psychiatric patients totally have right to decide themselves about their treatment modalities" (p.67). I shall dedicate the next section to this point.

Would it be "hard to say that psychiatric patients totally have the right to decide themselves about their treatment modalities"? (p.67)

The answer is: no, it would not be "hard", it would be senseless, and even discriminatory. Why should one give psychiatric patients a right which others do not have? Nobody has a "total right" to make medical decision. People normally have the (*prima facie*) right to participate in the therapeutic process, if they are competent to do so, and to competently refuse medical treatment. I have argued that psychiatric patients should be treated like everybody else, that is, they should normally have the (*prima facie*) right to participate in the therapeutic process, if they are competent to do so, and to competently refuse medical treatment, including treatment for their mental health.

It is clear that sometimes people lack decision-making capacity. Savas quotes the case of a patient who is in a coma or in a delirium, in an emergency ward. It is evident that whether the patient is in a coma or in a delirium she is unable to make medical decisions.

However, it should be noticed that, with this example, Savas proves that he agrees with me, despite his objections. The patient in a coma is probably in a coma for reasons unrelated with her eventual mental illness. The patient in the middle of a delirium, instead, may well be mentally ill. Although the former has no mental illness, whereas the latter probably has it, both lack decision-making capacity in a similar way. The one in a delirium does not lack decision-making capacity *more* than the one in a coma, just because she is mentally ill. Both patients need to be protected in the same way, since both are unable to make medical decisions, and the both are at risk. Savas is thus implicitly allowing for the fact that what is important is not the kind of illness people suffer from, but their capacity to make decisions.

One of the main points of my paper was: we should be concerned with people's autonomy and decision-making capacity. Insofar as their actions an choices are autonomous, they should be respected. Since I have also demonstrated that "mental illness" does not impair autonomy or decision-making capacity (as there is nothing like "a mental illness" which lies somewhere in the person's mind and compromises her autonomy; there are only *names* which have been given to patterns of experiences), I have claimed that people with a psychiatric diagnosis should be treated equally to all others. Insofar as their actions and choices are autonomous, they should be respected.

When, in my original paper, I argued that people with a psychiatric diagnosis should be normally accorded the (*prima facie)* right to make competent medical decisions, including decisions relating to their mental health, my target was the Mental Health Act 1983, in force in England and Wales.

The diagnosis of mental illness or mental disorder is considered as the first criterion for coercive detention for assessment and treatment under the Act (14). Moreover, s.63 of the Act states that the patient's consent will not be required for treatment of their mental condition (15). One may contend that these are measures, which are necessary to make sure that the vulnerable is protected. I believe, however, that it may only be in a bad faith that one could say that such a discrimination is necessary to protect the vulnerable.

In fact, it should be noticed that, in order to protect the vulnerable, we do not need to lie about the nature of "mental illness". We do not need to pretend that mental illness is an entity that *causes* impairments of people's autonomy, or decision-making capacity. People may lack autonomy, or decision-making capacity, for a number of reasons, and we may legitimately protect them, if they are about to adopt a self-harming conduct (see again the person in Mill's example of the bridge). This is all we need to say, if we really want to protect people, not only from unwanted harm, but also from long-standing discriminations.

Moreover, sometimes it is necessary to compare legal provisions in force in our own country with provisions in force in other countries, to evaluate their defensibility. Legislators should be aware that other types of legislation guarantee protection to the person with a mental disorder, without denying their entitlement to make competent decisions about their mental health. We may mention the law 833/78, in force in Italy (16). The law was designed to avoid any discrimination toward the mentally ill, and is, in fact, addressed to everybody, not only to people with a psychiatric condition. This law regulates compulsory detention and treatment of people who may be in danger and unable at the time to consent to medical interventions. This law provides that people in this situation may be forcibly detained and treated, for a period up to a week (renewable) until danger is removed or autonomy is restored. A person may be in this *state of necessity* (17) for various reasons (drug or alcohol abuse, for example). It is sensible to believe that people appeal to compulsory detention and treatment mainly in cases of mental disorders, but this fact does not make the law "a mental health law". I am not claiming that this law is perfect and that it should become the model for all legislation. However it demonstrates that it is not necessary to lie about the nature of their condition, in order to protect people who have mental illness, and to have a law which stands for them only, with the result to legalise unjust treatment, and also to reinforce a stigma, which is as unnecessary as unpleasant. The law may be the same for everybody, without people with mental disorders being abandoned at the time they need help.

Etiology of illnesses and determination of autonomy

Savas rightly points out that knowing the etiology of a disorder is not essential to determination of autonomy. As we have seen above (section 6), Savas argues that, although we may not know why a person is in a coma or in delirium, we may reasonably say that a patient in such states lacks autonomy. Fortunately, this is so, as this makes it possible to protect people, whose disorders are not understood, but who evidently need help.

However, we should not believe that the search for the causes of people's abnormal experiences and behaviour would tell us nothing about the autonomy of conduct. On the contrary, there are cases in which knowing the cause of experiences and behaviour is important in order to determine the autonomy of conduct.

For example, we know that some people experience craving toward substances (for example drugs). We have also seen that, unfortunately, people in need for the substance are ready to do virtually everything to obtain it, even things they know to be wrong. Thus, by observation, we see a behaviour, or patterns of behaviour. Some researchers have investigated on *the causes* of this behaviour. They have discovered that human body has receptor points, which are specialised for opioids, in various areas, such as brain, intestine, etc (18). Opioids operate on a person through their impact on these receptor points. Our organism spontaneously produces opioids (encephalines and endor-

phins). Encephalines and endorphins help us to control pain and stress. When narcotics are taken for the first time, they lower the pain and give a strong emotional stimulus, saturating those receptors that have not been filled in by naturally produced encephalines and endorphins. If a person takes narcotics too often, the receptors are overwhelmed, and the internal production of encephalines and endorphins is decreased or interrupted, since the organism no longer requires them. At this point, artificial opioid substances are necessary because of the decrease in the natural production.

This neurophysiological process explains the experience of addicts. It explains why they crave toward the substance, and, at least in part, also explains why they are ready to do things they know to be wrong in order to obtain the substance of addiction (19). In these cases, we know that abnormal behaviour has a cause, namely addiction. "Addiction" is not only *the name* that is given to those experiences, but also the *cause* that, at least in part, explains those experiences and related behaviour. We may therefore claim that typical behaviour (craving, and the conduct adopted to satisfy the irresistible need for the substance of abuse) lacks autonomy, in a significant way. Knowing the etiology of addiction, in this case, tells us something important about the autonomy of conduct.

At the state of our current knowledge, we cannot claim that there is a similar process, which *causes or produces* abnormal experiences and behaviour, in most mental illnesses. We only know that some people, at some point of their life, have abnormal experiences, or adopt abnormal conduct, or experience a strong and unspecified suffering. We do not know why they have these experiences.

Of course, having abnormal experiences, for example having delusions, may compromise the individual's capacity to make decisions, or may lead the individual to actions that she would not do otherwise. However, the *diagnosis* (we cannot say the "presence") of psychological or psychiatric disorders does not *cause* a particular behaviour, and does not compromises autonomy. Thus, we cannot claim that a behaviour lacks autonomy *because of the mental illness*, in the same way we say that craving toward drugs lacks autonomy *because of the addiction.*

To conclude, we should not believe that people with (a diagnosis of) mental illness are victims of some mysterious entity within themselves which makes them incompetent to make medical decisions, even relating to their mental health. Although at the time of their crisis they may be unable to deal with their condition, they may be helped to become aware of their condition, and thus become decision-makers for what concerns their mental health.

These arguments, which I have explained in my paper, were not meant to minimise the scope and importance of psychiatrists' work. I am sure (and I have seen) that most psychiatrists work in the direction of improving patient autonomy, and this is perhaps the most difficult part of their job. My arguments were, and are, meant to point out logical fallacies that underlie common views, sometimes clinical approaches, and sometimes legislation, and that may lead to accept and even to legalise, disrespect for the autonomy of those who, unfortunately, have been diagnosed as having a mental illness.

REFERENCES

1. In this paper, I shall use the adjectives "autonomous" and "competent" as equivalent. Thus, the sentences "autonomous choices/decisions", and "competent choices/ decisions" have the same meaning. However, I ascribe to "autonomy" a broader scope. "Autonomy" refers both to actions and choices, whereas "competence" only refers to choices. Thus, I will say that a person's choice is autonomous, that a person's conduct is autonomous, but I will not say that a person's conduct is "competent". I will rather say that the decision to adopt that conduct is competent.
2. Simona Giordano, 'In Defence of Autonomy in Psychiatric Health Care", Tip Etigi, 9, 2, 2001, pp.59-66.
3. Haluk A. Savas, "Comment on Giordano's 'In Defence of Autonomy in Psychiatric Health Care", Tip Etigi, 9, 2, 2001, pp.67-69.
4. R. M. Yerkes, Chimpanzees, a Laboratory Colony, New Haven, Yale University Press, 1945. Quot. in Konrad Lorenz, On Aggression, University Paperback, Norfolk, 1967, p.177.
5. Konrad Lorenz, On Aggression, University Paperback, Norfolk, 1967, p.177.

6. Erving Goffman, Asylums, essays on the social situation of mental patients and other inmates, Anchor Books, New York, 1961.
7. K. W. M. Fulford, "Mental Illness, concept of", in Encyclopedia of Applied Ethics, Academy Press, London, 1998, Vol. III, pp.213-33.
8. American Psychiatric Association, Guida al Manuale diagnostico e statistico dei disturbi mentali DSM-IV, Masson, Milano, 1996, p.166. Original version, American Psychiatric Association, DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., APA, Washington DC, 1994.
9. John M. Darley, Sam Glucksberg, Leon J. Kamin, Ronald A. Kinchia, Psicologia, Il Mulino, Bologna, 1986, part II, p.141. Original edition, Psychology, Englewood Cliffs, Prentice-Hall, 1984.
10. See, for example, A. Baily, "Neurosis: a conceptual examination", International Journal of Applied Philosophy, 11, 2, 1997, pp.51-61.
11. American Psychiatric Association, Manuale diagnostico e statistico dei disturbi mentali DSM-IV, Masson, Milano, 1996, p.305. American Psychiatric Association, Guida al DSM-IV, cit., p. 97, p.166, and p.237. See also notes 7, 8, 9, 10.
12. I cannot repeat here the whole argument of my original paper. Therefore, I invite the reader who is interested in the topic to see Simona Giordano, op. cit.
13. The reason why Addiction is only in part an "explicative" category are explained in note 19.
14. Department of Health and Welsh Office, Code of Practice: Mental Health Act 1983, 3rd ed., The Stationery Office, London, 1999, http://www.hyperguide.co.uk/shpo/mh9901.htm
15. Exception made for psychosurgery (s. 57) and electroconvulsive therapy and long-term medical treatment (s. 58). However, treatments mentioned in s. 58 may be enforced with either consent or a second medical opinion. According to the Mental Health Act Review Expert Group, this section has received most powerful criticisms. See Draft Proposals for the New Mental Health Act, published on 15th April 1999 by the Mental Health Act Review Expert Group, para. 138, at www.hyperguide.co.uk/mha/rev-prop.htm
16. Ugo Fornari, "Accertamenti e trattamenti sanitari volontari e obbligatori sotto il profilo del rapporto medico-paziente: il problema della scelta", in S. Jourdan, and U. Fornari (eds.), La responsabilità del medico in psichiatria, Centro Scientifico Editore, Torino, 1997, p.61.
17. To proceed to compulsory treatment, the State of Necessity may also be invoked (art. 54 of the Penal Code). See U. Fornari, Trattato di psichiatria forense, UTET, Torino, 1997, pp.576-77.
18. John M. Darley, Sam Glucksberg, Leon J. Kamin, Ronald A. Kinchia, op. cit., pp. 168-69.
19. It should be recognised that addiction is a very complex phenomenon, which can only in part be explained by neurophysiological mechanisms. Important psychological aspects are also involved in addiction. However, the neurophysiological processes to a significant extent explain what addicts experience and their behaviour, and, in the light of these processes, we may claim that the autonomy of conduct is significantly impaired.

Geliş Tarihi: 21.06.2002

Yazışma Adresi: Simona GIORDANO
Centre for Social Ethics and Policy
The University of Manchester
giordanosimona@libero.it