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Has the Care in Psychiatry Other Characteristics than those it has in the Other Fields of Medicine?

Jean-Pierre CLÉRO[1]

> "How is it that a lame man does not annoy us while a lame mind does? Because a lame man recognizes that we are walking straight, while a lame mind says that it is we who are limping. But for that we should feel sorry rather than angry".
>
> Pascal B. (1995). Pensées, Laf. 98,
> Penguin Books, London.

Abstract: Everybody knows that Beauchamp and Childress have tried to define four principles in the domain of care ethics. Their definitions are rather rhetorical; but, on the whole, they satisfy the contemporaries in most of medicine fields. On the contrary, in psychiatry, it seems often difficult and sometimes impossible to apply them. The patient who does not know his illness and that is cured against his consent is not autonomous. He cannot understand the cure that imposes upon him while it is brought out as benevolent. Moreover, the question of justice does not raise as elsewhere in medicine. Specifically, the questions of security are put forward so that the cure is partly jeopardized.
Conversely, the notions used to think ethics in psychiatry are not without any repercussion on the whole of care ethics. They point to the necessity of changing the ethical notions in view to match with the situations as they are everywhere in care ethics.

Keywords: autonomy, care, consent, dangerousness ("dangerosité"), decision, ethical principles, freedom, isolation, justice, language, law, locking, paternalism, patient, person, pleasure, psychiatry, psychological treatment, psychotropic drugs, punishment, refusal of care ("refus de soins"), seclusion, security, society, waiver, will.

I. A definition of the care. The four principles of Beauchamp and Childress

Every time the researcher in medical ethics wants to define *care*, in view to distinguish it from maintenance of an instrument, of a machine, of a

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good able to be appropriated, of the environment, or in view to differentiate between it and the repairs of any object that has sustained damages, and putting aside mere hygiene, he comes upon one or the other following propositions which he can vary from every angle. Care is help that, when it is given to a person who asked for it, aims to make a state of pain stop or to restore well-being or a state of pleasure that were considered lost; in certain cases of particular weakness, from which the matter is no longer for the patient to recover, care is help that aims to avoid a foreseeable state of pain (avoiding that somebody finds himself in a dangerous position, and preventing the events that may be perilous for him). In that case, care takes into account the vulnerability of the person. I must add that, when we speak of caring human beings, the renewal of pleasure and the loss that preceded it deal with vital matter, although, through the settlement of that matter, what is searched for leads to ascertain the best relation life, thus attaching the greatest value to symbolic (language, gestures –whatever they may be reduced to nearly nothing–, decisions, freedom to decide). I add further, at the risk of lengthening the definition, that care may concern somebody whose state of ill health is prevented (illness, difficulty, suffering, disablement), whether the patient is conscious of it or not.

We may recognize in that definition, even if it is in a somewhat rhetorical way, the interweaving of the four famous principles, on which, after Beauchamp and Childress (2007), every ethicist seems to agree; beginning with *the respect and preservation of the patient's autonomy*: through that principle (essentially expressed by the consent with which the care may begin but also cease at any stage of the treatment), care should not be imposed. To that principle of autonomy, it must be added a *non-maleficence principle* (following which painful or more or less incapacitating treatments may be inflicted provided they were in view to patient's good and recovery); this non-maleficence principle may be completed with the *principle of beneficence*, an essential value that consists on willing and doing the ill person's good at every stage of the care. The latter principle is so important that we are used to see regularly its primacy in a conception that considers the true foundation of care in the other's suffering rather than in the personality of the individual that would need the care. Lastly, the principle of justice may be distinguished from the three preceding principles: following the *principle of justice*, everybody must be treated with the same attention, with the same treatments when needed, even if they are expensive and beyond the buying power of those who need them, respecting rules of sharing that are, if not

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always egalitarian, at least proportionate. We agree, incidentally because it is not our subject, that this equality and this proportionality are extremely vague and fall within the field of good intentions rather than they come under the principle of effectiveness.

Our subject begins with the statement that, with such a level of generality, everybody may agree with the principles above. However, as soon as we get into details through the psychiatry's door, our attempt to define care threatens to fall apart. Nearly all the points that seemed strong become doubtful and take another meaning in psychiatric ethics.

Let us examine some ways in which psychiatric care displays itself when considered from the four points of view of the canonical principles to which they are used to, without arising any question.

II. To cure without consent. A denial of the principle of autonomy

What right do we have to cure a patient without his consent, as it happens in involuntary psychiatric treatment more often than in any other treatment of the other medical branches? May we say that we cure when we neglect or circumvent what we call in French "refus de soin" –in English: "refusal of care" or waiver– considering it as one mere symptom among others of the illness that must be cured as any other? What is the idea that we must have of *cure* and *care* when we authorize ourselves to impose a care or to continue caring while the individual under care has clearly said and repeated he did not want or he wanted no more to be cured? Everybody knows that such a behaviour would be considered as a noticeable offence committed by the doctor (or by the nursing staff) in any context other than that of mental illness situation; so is it a sinister characteristic of the mental illness that authorizes it?

If, on the one hand, the *person* is thought as a mere fiction, and if this fiction is, most often, ill-founded as having no other existence than verbal (Hobbes, 2010), if, on the other hand, illness or pain does not affect fundamentally one person but a being whose limits spread beyond those of an individual who is nothing but a player in those circumstances, neither it cannot be very important to set great store by the *individual consent*, nor it is useful to make difficult to cure a voluntary patient who does not necessarily happen to coincide with such or such individual. I do not suggest that such a doctrine is false; there are, in our codes, outside the medical domain, in spite of the unconditional assertion of consent in our law, many points where consent is disregarded and where rules concern more the act than the actor

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that suffers the effect of it, even with his assent. It may be the legitimacy of rights and of ethics to defend people against themselves. It may be thought that the same is true for some medical branches: the defence of values other than person –for example security of society– demands, in some cases, to disregard the patient's consent.

But it is also possible, with the same result, to promote the value of the person, while taking the opposite position to his care's refusal, with the view that the person can be –even though: must be– defended against himself, or that, through the person, humanity can be –even though: must be– defended against the use he does himself of it. So the *person* is, in some way, split, cleaved –as it is the case, for instance, with Kant (1911; 1913)–; society or the state or any depository of pure duty, appropriating the right side of the person, and leaving to the individual the government of the bad side of the person, giving to it just the opportunity to attempt an adjustment with what is reasonable –at least not contradictory– to will. It may be that a person did not give any rational arguments defended by society, by the state or by himself if she / he was fully reasonable: so it is necessary she / he was defended against herself (or himself); in this view, it is not always contradictory to impose involuntary treatment if I owe to myself a certain well-being I am not able to ascertain by myself, or if I must present myself to the others in a certain state of health (at least devoid from some illnesses that could be dangerous for them) whereas I am not able to ascertain this state by myself; of course the better will be that this person imposes the duty to himself, but if she / he cannot reach this level, we do not infringe upon his liberty by imposing on him / on her to do what he / she refuses to do by himself (/herself). So, by this fine dialectics, personal liberty entitles us to impose a treatment, in spite of his refusal. The argument is not only contradictory, but the matter is to know what may be the quality of an involuntary treatment applied to an individual that refuses it: it must be hoped that care does not target quite the same individual than the one who consents or does not consent.

We have the right to find this rhetoric tricky, *first* because it amounts to deprive the individual of his freedom –whose consent is a capital act– in the name of freedom; *secondly* because it brings back to the same position that was taken up by the opponents of autonomy. Of course, we fancy attaching great importance to autonomy of which we believe to hold as the main line of education; and the medical world was revolutionized twenty years ago in pretending to place the patient at the centre of its concerns and

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perhaps to place effectively the patient at the centre of the care system. But what importance should be given to "refusal of care" or to "refusal of treatment" in a mental hospital, when the person that refuses expresses he will commit suicide or assault against others, or that he will unsettle people's lives to the point of threatening to kill them, without exterior intervention to help them calm down? The risk of dangerous behaviour may be the matter (at least partially) in psychiatry. Everybody understands that security, when it is not backed by autonomous action made by the individual himself, must be defended against autonomy.

Certainly, it is possible to impede the autonomy of a person without humiliating him and depriving him of dignity: the patient may be informed of the nursing staff's decision to take no account of his refusal of care or waiver, in giving reasons for bypassing his will and in explaining clearly that the decision was made with a view to enable him to gain a larger autonomy later. On the one hand, that is not a difficulty for those who promote security as a fundamental ethical and juridical value; on the other hand, that is a difficulty for those who are convinced of the meaning and value of the *person* and of his *autonomy*, and who are furthering –as those that we believed to be their adversaries– the value of *security*. There must be a middle of the road principle or an overriding principle that allows to jump from autonomy to security; in changing the lexical order –as Rawls (2005) would say- or in reviewing the compositions of the strengths of principles such as they help secure the goals of security after they have been neglected.

We shall come back, with a twist and turn, to this question we are unable to solve, because of our want of a category that could replace *autonomy*; however, we must inspect now a second principle that instead of tending to split categories into benevolence and non-maleficence in most of illnesses, tends to unite all, in the case of psychiatric diseases.

III. The particular meaning of the principle of justice in psychiatry

It is easy to understand why the second principle does not split in psychiatry. In all the other illnesses, the patient is cured by focusing medical interest on his pain, from which it is possible, up to a point, to separate him and from which he can be distinguished by himself. So it is possible to shut up a patient for a long time in view to cure him from the after-effects of a surgical operation that needs a long immobilization or some continuity of care at hospital. This seclusion is care's collateral effect that is tolerated by the patient as a contingent consequence of the operation or treatment to

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which he has consented. Now, in psychiatry, seclusion is used as a care; and it would be absurd to claim curing a part of a patient, because it is this patient as a whole who cannot –on account of his illness– be conscious of his illness with the benefit of hindsight. Psychiatric patients have sometimes the characteristic to be ignorant of their own illness; it is precisely this ignorance or *anosognosy* (among other characteristics) that it is the matter to cure. However how is it possible to dare thinking that involuntary seclusions respect the person? Certainly it is possible to project oneself in the future when we believe that the patient will feel better and there is no reason not to believe the psychiatrist when he tells us that a number of psychiatric diseases are cured by involuntary admission in an isolation bedroom, in view to rarefy artificially the innumerable sensations and the extraordinary number of situations they give rise to. Nevertheless, constraining somebody, even for his future good, to a seclusion, runs against the illegality of sequestration in all the other cases.

Once again, for accepting such a treatment, that has many appearances of maleficence, even if it is legal and right, it is necessary to operate a dichotomy in the person, to think that the part that does not give its consent depends on the illness of the person, to separate the other part of the person from his illness, though –at the utmost of the alienation– the function of the former person be carried out by others who claim to know better than the patient what he must become and what is good for him. The present of the patient's decision is devoid of all value and authority and the doctor bets that, later perhaps, the patient will be grateful to him for having momentarily taken his place and having managed his own interests better than he could do. But that is only a wager because, from an ethical point of view, it is not sure that the negative face of isolation, settled by the inquiries on the matter, may balance the health benefit it is possible to draw from this seclusion. The difficulty is that it is impossible to shut up one part of somebody without shutting up the other part, exactly as in the case of penal locking up which concerns the whole person without making distinctions, when the judge is convinced that an offence was committed. The nursing staff may have the feeling to safeguard one part of the person, the most rational part: but this part is not invested by the patient. It may be asked, from this point of view, the refusal of care being worthless, why the consent would have more value, except because it serves the interest of the staff. Moreover, when the decisions made by the patient are now discredited in the name of a future supposed better, another fundamental right of the

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patient is infringed: the power to stop treatment or to withdraw from a research's procedure at any time. By so constraining a psychiatric patient, a right is of course withdrawn.

It is difficult to avoid insinuating, by this constraint or by restraining movement, at least in the mind of some patients, the idea of an offence they might have committed and they must pay in advance by means of their locking up; so arises, in such a way, a confusion between treatment and punishment. Particularly when law, so far to prevent this interpretation, encourages it, because it may happen that it forces the user, in several circumstances, to think the treatment as an alternative to the punishment. However does all sexual crime, for example, imply necessarily the existence of an illness of the player? And, conversely, is it because somebody is a mental ill –even seriously–, that all punishment must be rescinded when he has infringed the rule and that his infringement must be entirely considered as a mere effect of his illness? Is it because a man is a psychiatric patient that he must be held utterly irresponsible and that, following a principle of all-or-nothing, he may escape the trial, though it would possible to the judge to apply the law, taking account of the illness? Rather than to use psychiatry for preventing, in certain cases, all possibility that some patients may be judged, would it not be preferable, when psychiatry is implied, to pay the greatest attention to the individuality to the patient to be judged?

IV. The question of psychotropic drugs versus psychotherapy

Up to now, we have mostly underlined one form of treatment which relies on isolation; but psychiatry experiences another sort of treatments that poses similar ethical problems, though they seem to be less impressive. Drugs may deeply alter the behaviour of a patient: the difference and perhaps the incompatibility between the action of a medicine on the brain and the dialogue of the carer with the patient has often been highlighted in view to be denounced. The effects of drugs are criticized for being blind in respect to sense and to the uniqueness of the person; while language is, in the relationship doctor / patient, the elaboration of a meaning. Quite naturally, it has been forwarded that ethics preferred the most meaningful procedures centred on what, in the care relationship, is more specifically human: speech. But, recognizing the primacy of language to locate human, everybody must admit that the intensity of symptoms, the emergency that it implies, the patient's denial of his own illness and of the reality, demand often resorting to drugs.

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Nevertheless, apart from the intensity of symptom, emergency and denial, here raises a conflict between two antinomic positions in the treatment of psychiatric diseases: one of them is the use of psychotropic drugs and the other is psychotherapy. These two positions are not necessarily mutually exclusive, but, even so, they face two different directions that does not stem from a mere difference of quickness. They are two different modalities that, probably, whatever the choice made when it is possible, do not let the patient unscathed. One deals with the history or with the biography of the subject, whose alteration is the aim, whereas the other aims directly changes without passing through personal history and its symbols. But one must not be considered more ethical or less ethical than the other. Attempting to be cured by the construction of what we fancy to be our own history may be defective and, moreover, is not necessarily a benefit for the patient; sometimes, it may be less beneficial than the more direct change yielded on the brain. The two sorts of treatments carry the patient and his illness in a spiral move that changes the illness and the relation of the patient to it, knowing neither how nor in which end except to cure him; but it is not necessary easy to decide which is the best cure.

Very few people would state that somatic or physiologic diseases (if it is possible to distinguish them from psychiatric diseases) could be cured by a mere psychological treatment; even though the latter could not be exclusive of the former. The cure by means of psychotropic drugs is not –from this point of view– very different from the cure of the other serious diseases with heavy treatments that change the initial situation, displace the illness and give on it to the patient different new holds. A psychotropic drug does not act very differently from an anticancer drug or any other powerful medicine; the only thing that SEEMS to distinguish one from the other being that the subject, whose the situation has changed, SEEMS directly more steady, more respected from the point of view of continuity and history, than the subject that takes psychotropic drugs. However that is often a pure appearance, because the medicine whose effects are heavy have mental consequences: they have no less such effects than psychotropic drugs. But we must take care, on the other hand, that we have no reason to think that the locking in the nests of language would have more worth and would be more innocent than the chemical effect of a medicine.

So the interpretation of the antinomy by A. Bismuth, for example, is doubtful when she allows to say –without perhaps taking up this idea– that the difference between the drug option and the psychotherapeutic option is

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that the latter leaves more freedom to the patient than the other (Bismuth, 2009): it would be easy to reverse the word order of freedom and determination. The difference seems more clearly to be between an option essentially (or totally) linguistic and the other option, which is chemical and not symbolic in all its parts.

V. Isolation as a risk of confusion between treatment and punishment

Without going into details, we have entered largely in the domain of justice by means of non-malevolence and benevolence. But we must now gather our preliminary remarks and ask a question, akin to them but more serious.

We are troubled because of the very closeness of the treatment of some psychiatric patients to the treatment of offenders: their voluntary consent is ignored in the same way; locking up is resorted to in both cases, with, sometimes, the same uncertainty as to the end of isolation. The individual is, in one case as in the other, submitted to the same heavy effect, without any distinction: the individual is put under lock and key without any possibility to separate what should be separated in view to be held captive from the rest that should not have to be enclosed but that cannot be detached for a specific treatment; in other terms, locking is destined to an individual as if he was a substance, but as he is a system of relations and not a substance, he is at the centre of immeasurable and consequently uncontrolled relations. If the likeness of treatment between delinquency and psychiatric illness appeared only contingent and merely attached to the phenomenon of isolation that yields associated consequences, so unfortunate as unavoidable, it would be necessary to highlight, on the one hand, some resorts of the law to similar proceedings than those used in psychiatry, not only after the locking but before it. I should want to come back to the matter of dangerousness, which implies potential danger.

One of the main principles of justice, when the law is not arbitrary, consists in judging the person liable only on grounds of acts, eventually criminal, that he is suspected to have really committed, and not on grounds of presumptions or suspicions that he would have been able to commit them, given his filiation, his ethnic membership, his social class of what is supposed of his idiosyncrasy. Now dangerousness has made a worrying apparition in penal codes; and it is possible for a psychiatric hospital, if the medical staff does not take care on this point, to share, with prisons, the

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burden of this dangerousness that is, if not quite a law perversion, at least a contradiction with one of the principles that law asserts itself. It allows – though a fictitious scientific coloration of probabilisation that is not really possible to give to it– to claim protecting the social body against some persons that have not committed any crime, as if they had not "yet" committed it but were getting ready to commit it, and to "cure" preventively those men (by isolation or locking) in view to obtain –without saying it- the effect of a preventive punishment. The shift of the treatment to disguised punishment would not be very difficult if, at hospital, the decisions were not made collective, in such a way that discernment might always raise and make a bulwark against this sort of easy option. Certainly, it may be legitimate that psychiatry allows itself to be the first to notice the forewarning of an aggravation of illness; and it would be wrong if it neglected it. The worsening of an illness in psychiatry may give rise to fears that it will make it more difficult to cure and, in a second time, the apparition of behaviours damaging to the subject himself and to the other; what launches the notion of postponed risk opposed to imminent risk. I am neither saying hat psychiatry may be criticized for doing this work, nor that it is astonishing that psychiatry be concerned with the prisoners it attempts to cure; it is doing its job when it appears before a court to explain behaviours if necessary. But it is particularly inappropriate to get security in using of psychiatric scheme to infringe great principles of justice, when Law has settled them and as if it were possible to anticipate a man's behaviour with so great a degree of certainty that there be no more risk to be mistaken.

VI. Meaning and limits of the philosophy of "care"

To conclude, it seems important, nowadays when we live yet in the situation that Stuart Mill would regret in the years 1850 –I mean: in a time when the categories proper to think and to bring a valuable ethics into play are not yet present– that ethics is particularly looking for domains in which the limits are difficult to be thought in terms of autonomy. The regions of psychiatry are, most often, directly concerned in them. It is not surprising that the same Stuart Mill, on the one hand, was complaining of loss of invention in ethics and, in the other hand, was working to a new conception of causality; though, prima facie, that complaint has no connection with this work. In his *System of Logic*, Stuart Mill (1996) shows how causality may become more acute in penetrating by degrees the details of the events that are in relation of *cause* and *effect*. The research does not cease to associate the

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new events that lay under the old things and that are very different from them. New terms would be necessary to name new events. So, the ethical words of *person*, *personality*, *dignity*, *autonomy* and some others may apply to situations roughly thought; but, as soon as the relations become sharper and when events newly associated by the mind have been substituted to rough old things, need arose to change the ethical terms that are not made for the new world. Of course, it is possible, for a long time, up to a point and for want of imagination, to continue to be content, in view to conceptualise and govern the new world, to use by-gone terminology –it is exactly the *fictio juris*'s proceedings–, but so doing, we are heading for serious disappointment, bound to the discrepancy of words that are used in circumstances that have completely changed. Perhaps we have reached the breaking point that will demand the inventions that could not be done spontaneously whereas we are still preferring to resort to fallacious fictions rather than to true creations. When we think ethically, for a too long time, with a by-gone labelling, one world that has become so different by our own moulding, we yield nothing but haughty denunciations which denote merely we are no more connected with reality.

In the end, I do not believe that the ethics of psychiatry be more or less the same as the ethics of the other branches of medicine. Of course, because psychiatry is medicine, some common characteristics may be found; but, on the one hand, from an ethical point of view, it is too deeply distinguishable from the other branches of medicine for being treated as one of them. On the other hand, every ethical innovation in this domain allows in return modifications in the ethics of the other fields. It is not impossible that the recent philosophies of "care" allowed all the ethics to keep distance from the all-pervading "personalism" whose inflation spreads nowadays over the law. This new concept has allowed changing some points of view, but it not yet equivalent to a creation of categories. However, it must be at least considered because our ability to set to work depends on it. Moreover this change in perspective allows denouncing the universality of principles of which French people make a habit when they are working in law or in ethics. They begin to cast grandiloquent sentences supposed to have an universal import and then the generality gradually loses the advantage of claiming its validity in all cases. Perhaps, instead of using too general principles, it would be better to issue rules that match with cases and gather them in a consistent order. The exceptions weaken the system of principles whereas the principles make the exceptions loathsome.

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