

**Annals Bioethics Column**  
***Butting Heads Over Autonomy***

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***“Consent must be voluntary and free - the product of deliberative reflection on all possible courses of action.”*** Arthur L. Caplan

***“The law and ethics of medicine are today dominated by one paradigm – the autonomy of the patient. Patients want more from doctors than autonomy; they want competence and kindness.”*** Carl E. Schneider

Since Bioethics developed in the 1960s, ethicists have increasingly emphasized one aspect of client autonomy: informed consent. Some have called this trend “the triumph of autonomy in bioethics.” Such autonomy assumes that the client has cognitive and emotional maturity as well as a willingness to assimilate information and engage with caregivers in making medical decisions.

One group of ethicists, the *optional autonomists*, holds that clients should be given all necessary information and that all obstacles to their participation in decision-making should be demolished. They believe that clients are entitled to this involvement, but for reasons of their own, may draw back and not be required to take an active role in medical decisions. The other group, the *mandatory autonomists*, holds that clients need to exercise their autonomy as agents in medical decision-making and therefore should do so. This absolutist view holds that it is unwise and morally objectionable for the client to avoid participation in medical decision-making. Mandatory autonomists seem to have an aversion to all forms of passivity.

Research studies have demonstrated that the degree to which clients want to participate in medical decisions covers a broad spectrum between optional and mandatory views of autonomy. In a Canadian study of early cancer patients, 63 percent wanted the physician to take the primary responsibility in decision making, 27 percent felt that it should be an equally shared process, and only 10 percent felt that they, as the patient, should take a major role. Unfortunately, we have no comparable data for psychotherapy clients.

In psychotherapy the issues of informed consent and client autonomy become more problematic than in any other health discipline, because objective studies show that to

varying degrees mental impairment can jeopardize individuals' abilities to assimilate and process medical information.

It is clearly faulty to assume that every client making choices is functioning at some ideal optimal level. For example, even the validity of informed consent research studies involving mentally ill clients is perennially suspect, since the mental dysfunction and medications of such volunteers may alter their reasoning ability. As another example, some individuals in treatment may be fully informed and advised by their therapists and then exercise their rights by refusing drug therapy or procedures that the therapists judge to be essential to their recovery. In both of these examples the possibility clearly looms that either the too-easy granting (optional autonomy) or imprudent refusal of medical consent (mandatory autonomy) may actually be more a matter of client emotional or mental dysfunction or resistance than of the clients' exercising of free, informed and rational decisions in their own best interest.

How then ought therapists approach this ethical dilemma? What do patients really want for themselves? What do patients want from their therapists? How much participation or "empowerment" do they want, and are they willing to exercise, in their own treatment? Perhaps we should start by reexamining the paradigm of mandatory autonomists that states that every client should want to know all relevant facts and medical literature about their illness, and that they should want to rationally and deliberately participate in treatment decisions. According to this approach, the therapist's responsibility is to impartially provide the client with data about the illness and prognosis, along with various treatment options, and the clients' responsibility is to provide his or her values and select the treatment alternative that seems best for him or her.

Most interestingly, client-response questionnaires such as the Brief Psychiatric Rating Scale (BPRS) can prospectively identify a small subset of patients who are likely to refuse treatment, who have negative attitudes toward treatment, who exhibit disruptive behavior, and who suffer more morbidity than compliant patients. This research tends to support the observation that mental or emotional dysfunction affects the competent exercise of medical autonomy in mental health patients.

Other studies conclude that individuals may refuse psychotropic medications for a range of reasons. Examples include inadequate therapist-patient communication, fear of

medication side-effects, distrust of their psychotherapist or treatment team, the client's need to gain attention, client aversion to regaining mental health and independence, prior unhappy experiences in the current treatment facility, paranoid belief systems, denial of illness, or social factors such as peer or family pressure or influence. So refusal is not a single static phenomenon, but a variety of behaviors whose meaning and course vary with each patient.

Studies during the past twenty years can help therapists identifying clients at risk for not cooperating with mental health treatment, and can propose skills in working proactively to resolve the issues underlying client refusal. Lessons include exploring the discrepancy between the client's experience and understanding of the medications and the therapist's treatment intentions. Medical anthropologists remind us to pay attention to many other cultural and social factors that figure into our multicultural society and affect clients' apparently idiosyncratic attitudes toward the experience of illness and treatment. Some unexpected cultural and social attitudes may be erroneously interpreted as resistance. When conflicts about treatment do occur in the case of hospitalized mental health clients, several studies show that tactful and respectful negotiations usually succeed in bringing about a clinically acceptable compromise that preserves as much patient autonomy as possible. As our clients are increasingly seen in outpatient settings in which compliance with medications seems often taken for granted, our sensitivity and skills grow ever more important.

Those we are trying to help certainly require much more from their therapist than a sterile listing of their treatment options with the assumption that the clients will make reasoned decisions in their own best interest. In the real complexity of practice, such a mandatory autonomist paradigm seldom works. In addition to information and education, a skillful psychotherapist will first discuss the degree of involvement the client wishes to have in decisions, and will then explore the client's concerns about possibly problematic treatment options and their potential social and cultural significance, always evaluating the type and degree of mental dysfunction the client is experiencing. The therapist may also need to include the client's significant others in the discussions.

Thus we can avoid crises of client refusal and noncompliance. Instead we can set the stage for our clients to exercise a comfortable and perhaps over time a progressively more mature level of authentic autonomy.

### **About the Authors**

Dr. Spees and Ms. Boyer are on the faculty of the Center for Bioethics and Humanities, University of Colorado Health Sciences Center, Denver, Colorado. Dr. Spees is a Diplomate of the American Psychotherapy Association and has been a member since 1999. He is physician and chaplain at Devereux Cleo Wallace in Westminster, Colorado, a nonprofit behavioral health facility, and a Clinical Professor of Surgery at the University of Colorado Health Sciences Center. Ms. Boyer is a social worker and writer in Boulder, Colorado.