Special article

Ethical issues surrounding forced, mandated, or coerced treatment

Arthur L. Caplan, (Ph.D.)*

Department of Medical Ethics, Center for Bioethics, University of Pennsylvania, Philadelphia, PA 19104-3308, USA

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1. The centrality of autonomy in bioethics and health law

In my field, bioethics, caution about new drugs and their use is a given. It is one of the obstacles that this drug has to overcome. Bioethics produced the ethical protections that have already been referred to—informed consent, IRB review for new drugs, and the disclosure of conflicts of interest (Lemmens & Waring, 2006). It has been especially concerned with the rights of prisoners because they belong to a population that has been much abused if not neglected in the past and because they are continuously at risk due to lack of advocacy.

Those familiar with bioethical writings over the past three decades know the emphasis that has been placed in American bioethics on the values of personal autonomy and respect for patient self-determination (Beauchamp & Childress, 2001). One of the great achievements that people in bioethics claim for the field is that it shifted medical practice away from a paternalistic model to one respectful of self-determination. Today, you cannot find a stronger value in the ethics of American medicine than respect for self-determination. It is why it is possible to not force a blood transfusion upon an unwilling Jehovah’s Witness or to take away feeding tubes from someone like a Terri Schiavo (Caplan, McCartney & Sisti, 2006). Respect for self-determination is why people expect to be told about their diagnoses, whereas 50 years ago, this often did not happen.

Thus, there is a very strong emphasis both in research ethics and in thinking about the ethics that should govern the provision of therapy for respecting autonomy. This is not a value that is easily overcome.

Most physicians, when confronted with an intervention that might do enormous good for a person or a family or even for society, think that autonomy must yield, but that is not so. Autonomy is given much more weight than that.

When a Jehovah’s Witness refuses blood, that refusal is binding even if it means that the person leaves behind many children without a parent. When a patient wants to follow nontraditional medicine and chooses not to enter the hospital, no one can force him or her to do so even if it means the loss of his or her life and much grief for his or her spouse and family. Even in areas such as vaccination where there are tremendous benefits from “herd immunity,” state mandates requiring vaccination permit individual exemptions based upon personal, religious, or philosophical belief.

Thus, when someone argues in favor of mandatory treatment of drug-addicted individuals on the grounds that they will greatly benefit from a new drug or vaccine or that society will greatly benefit, such arguments are working up a very steep ethical hill. Regardless of the benefit, the notion of overriding a person’s autonomy and forcing any type of treatment upon him or her is going to fall on the value of autonomy. A person has the fundamental right, well established in medical ethics and in American law, to refuse beneficial and helpful care even if such a refusal shorts his or her own life and has detrimental consequences for others (Dworkin, 1998). Hence, although many proponents of mandatory treatments for drug-addicted prisoners are inclined to point to the benefits both for prisoners and for society, it is exceedingly unlikely that any form of treatment that is forced, coerced, or mandated upon a vulnerable population such as prisoners is going to find any traction in American ethics, law, or public policy.

There is, however, a way in which self-determination may not conflict so strongly with the compulsory use of drugs for prisoners. The argument that I am going to make is that respect for self-determination sometimes requires mandatory treatment as a way to create or enable autonomy.

2. Infringing autonomy to create autonomy

Some proponents of mandatory treatment think that mandatory treatment may be justified if it is for the good
of the general public. They say that treating prisoners for drug addiction is morally akin to quarantine. Some argue that it is like forcing treatment on a mother when she refuses a cesarean section or a Jehovah’s Witness’ child whose parents refuse a blood transfusion.

However, it is very tough to make the argument from public health stick. The analogies are not apt.

The justification for quarantine involves the protection of third parties. The moral justification of mandatory quarantines has nothing to do with benefit for the individual. It is forced confinement to protect others.

Similarly, most of the mandatory treatment cases that arise in medicine involve those who do not have the capacity to consent at all or the protection of third parties who cannot protect themselves, such as a near-term fetus or a baby. Mandatory treatment almost always involves protecting either third parties from extreme health risks or those incapable of autonomy and, thus, consent (Barbera et al., 2001). Those who argue for the forced treatment of prisoners by analogy to other public health situations or care for children are not going to get far trying to overcome the presumption of respect for self-determination by travelling these moral paths. There is another neglected but far more promising moral rationale for compelling the treatment of prisoners who are addicted.

People who are addicted really do not have the full capacity to be self-determining or autonomous because their addiction literally coerces their behavior. They cannot be autonomous agents precisely because they are caught up in the behavioral vice that is addiction. If that is so, then it may be possible to justify compulsory treatment for finite periods of time that could rectify this situation and restore the capacity for autonomy.

If a drug can break the power of addiction sufficiently to restore or reestablish personal autonomy or to markedly increase the capacity for autonomy, then mandating its use might be justifiable. In other words you might force treatment in the name of autonomy. If, through the use of naltrexone, the capacity for self-determination comes into existence or rather, returns, that is, if the medication is enhancing the ability to be autonomous, then I think that could serve as an ethical argument that would allow mandating treatment at least for a short period. If naltrexone or any other drug can permit persons to make choices that are free from the compulsions or cravings that would otherwise completely control their behavior, then it would seem morally sound to permit someone who is in the throes of addiction and who cannot choose anything to have the ability to choose restored through a course of treatment albeit temporary.

A form of this argument, temporary coercion in order to create autonomy, was actually made by the father of the importance of respecting individual liberty and choice—John Stewart Mill. Mill used the example of forcibly restraining a man who is walking toward a place where a bridge has collapsed as a case where coercion is morally justified. You are allowed to hold him back even if he protests because he will lose his autonomy if he goes where he does not realize danger lurks (Mill, 1985).

3. Breaking the back of addiction is a better moral choice than maintaining addiction at a lower cost!

The relapse rate for heroin-addicted individuals is very high. So are the costs associated with drug-addicted individuals maintaining this habit: crime, poor impact on families because they cannot be good parents to their kids, policing cost, jails, insurance cost, costs of HIV and hepatitis C, public anxiety, and fear. Hence, many believe that it is better to use substitute drugs that are not as expensive as heroin to restrain the drive to use this drug.

Methadone seems to be a drug that might work. However, methadone may not break the addictive spell that a person is under—it only substitutes a more socially acceptable form of addiction. There are some treatment models out there involving giving out free heroin and trying to make that form of drug use safer. Such programs exist in the UK, Switzerland, Holland, and Australia. But again, these programs, while reducing social cost, do nothing for the drug-addicted individual who has lost some or much capacity for self-determination.

Then there is naltrexone. It looks safe and effective for heroin and it may work against alcohol. The mechanisms behind the drug are well understood. It has been used in some populations safely and effectively for a long time. Thus, doesn’t it make sense to use the drug that both reduces the social cost of addiction and removes the barrier that addiction creates to self-determination?

4. What is autonomy?

Individuals do have the right to consent to treatment. This is our ethical foundation for medical care. We even extend this principle to people who have known mental illnesses so they still can refuse some treatments. If you want to bring someone in for alcohol problems, they must, if they are an adult, consent. They cannot be drunk. They have to sign up for treatment. There are many people who have different types of mental illnesses who are still asked to give their consent before medical or surgical intervention is undertaken.

Americans go very far trying to capture even the embers or the sparks of autonomy. Medicine and the law are looking all the time to try and allow people to consent. You can argue that respect for autonomy is overblown in our society—that we go too far in this direction, but we need to put this aside for now. Consider this question, “Can drug-addicted individuals be autonomous when they are addicted, when they are detoxing, or when they have been addicted and are clean and sober for a sustained period of time?”
someone going to be competent to choose, to make his or her own choices—to refuse treatment, to accept treatment—that he or she needs to understand his or her options, to be able to find reason for these options, to communicate a choice to someone else in a coherent way, to appreciate the consequences of their choices? This is what autonomy means.

If you make a choice, it has to reflect something that matters to you and that you care about. It has to be something that is a part of your value system whatever that might be. Thus, it is not so easy to be competent. It is not so easy to have informed choice. I often joke around our Bioethics Center and ask people how many times in a year they think they have actually made choices that fit this, and most of us just kind of schlep along doing things. We are not computing our options and deciding our consequences. There are a few people with neurosis in the field of decision theory who live their lives that way, but outside of that, most of us are not sitting down and making the hard choices, very often thinking about what it is we want even if it is against our values.

Medical treatment is probably one instance where this does happen. We decide, “Okay, I’ve got to take the pill, I got to have an operation, I’m going to spend some time getting counseled or treated. That’s going to take away other things I could do. I’m going to think about whether I want to do this or not.” One of the things that has not been recognized widely in the bioethics literature is that addiction can in fact be a form of coercion, and thus, the person who is driven by cravings and desires, which absolutely determine his or her behavior, and who cannot really get away from them is coerced. A drug-addicted individual, while not manifestly incompetent, is certainly fighting internal coercion all the time, often associated with having a drug or alcohol habit or whatever the addiction is. These cravings and habits can set up powerful psychological forces in an overwhelmed person who is a drug or alcohol user. If medicine could create more competency by blocking the coercion that results from these addictive, nearly irresistible cravings and physiological forces that, in fact, completely shape behavior, then this would be restoring autonomy and not interfering with it.

I am not saying that a drug-addicted individual, even a heroin-addicted individual, is completely incompetent. I bet many people can ride the bus, decide what they want to listen to on the radio, and make all kinds of routine decisions. They may know who the president is. They can seriously be able to question their competency. They know where they are. They know what is going on. They understand. However, when these patients are transferred over to rehabilitation units after their initial injuries are treated, staff in such units always ignore these demands! Patient autonomy is not respected. Why?

Rehabilitation experts say that they want to allow adaptation to the new state of affairs—to loss of speech, facial disfigurement, or paralysis. They know from experience that if they do certain things with people (train them, counsel them, try to work with them), then they can get them to start to “adjust.” There are, admittedly, still people who say at the end of a run of rehabilitation “I don’t want to live like this.” The suicide rate is higher in these populations, but, initially, rehabilitation specialists will say that they have to force treatment on patients because they know from experience that they can often get them to accept their new state of affairs. The normal practice of rehabilitation right after a severe injury is to mandate the treatment, ignore what patients have to say, and then see what happens. If they still do not want treatment after that, then it is fine, or they may decide to end their lives. However, in the short run, they can build more autonomy back by mandating interventions.

This is precisely my point of argument: Which is the appropriate model to follow in considering the ethics of using naltrexone? Is it not plausible to infringe on autonomy or force treatment in the name of public health or patient benefit when we rarely do so in other contexts. Nor are such arguments oriented toward the best interest of the person being forced to take treatment. However, if the research on naltrexone is sound, if it is possible to say that treatment can

5. Precedents for mandating treatment in the name of autonomy

Interestingly enough, we already know that the answer to the ethical acceptability of this rationale for mandatory treatment in our society is positive. We justify education in exactly this way. We force certain interventions upon people in the name of learning in the military, in medical residency, and in on-the-job training in nearly every company in the world. At the university, we force people to go to class, do certain tasks, talk in class, or sit for examinations because the professors are trying to build autonomy in their students. Ironically, by restricting freedom or forcing them to do certain things, live in certain ways, or acquire certain skills, they can become more autonomous.

Consider what goes on in rehabilitation medicine as an example of a part of medicine where short-term infringement of autonomy is tolerated in the name of long-term creation or restoration of autonomy (Caplan, 1997). Patients, after a terrible stroke and becoming paralyzed, often demand that they be allowed to die. They say, “Don’t treat me.” This is true of people with severe burns as well. They simply say, “I can’t live like this.” No one would seriously be able to question their competency. They know where they are. They know what is going on. They understand. However, when these patients are transferred over to rehabilitation units after their initial injuries are treated, staff in such units always ignore these demands! Patient autonomy is not respected. Why?
enhance, restore, build up, and add to the autonomy that drug-addicted individuals have by letting them be free from cravings, drives, and habits that inhibit their capacity to make choices, then doctors and prison officials can mandate treatment in the short run. The moral basis for this intervention is for the good of the patient and their autonomy. How long and whether someone ought to be able at some point say, “I’ve done this for six months, I’m finished, I want to get high again” are problems. But that is not the problem that has to be addressed first. The moral challenge is to open the door to mandatory treatment. That can be done, ironically, on the grounds of autonomy. Moreover, we can put this argument to an empirical test. If, at the end of a mandatory treatment period, prisoners or former prisoners feel that their autonomy and their self-determination are increased and enhanced following a run of naltrexone, then this justifies temporarily ignoring their autonomy. It may press current ethical thinking to the limit, but mandating treatment in the name of autonomy is not as immoral as many might otherwise deem forced treatment to be.

References