**Patient Autonomy & Informed Consent**

In the context of health care in the United States, the value on autonomy and liberty was cogently expressed by Justice Benjamin Cardozo in *Schloendorff v. Society of New York Hospitals* (1914), when he wrote, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” This case established the principle of informed consent and has become central to modern medical practice ethics. However, a number of events since 1914 have illustrated how the autonomy of patients may be overridden. In *Buck v. Bell* (1927), Justice Oliver Wendell Holmes wrote that the involuntary sterilization of “mental defectives,” then a widespread practice in the U.S., was justified, stating, “Three generations of imbeciles are enough.” Another example, the Tuskegee Syphilis Study, in which African-American males were denied life-saving treatment for syphilis as part of a scientific study of the natural course of the disease, began in 1932 and was not stopped until 1972.

Providing advice related to topics of bioethics, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated, “Informed consent is rooted in the fundamental recognition—reflected in the legal presumption of competency—that adults are entitled to accept or reject health care interventions on the basis of their own personal values and in furtherance of their own personal goals.” But what of circumstances where patients are deemed incompe**tent** through judicial proceedings, and where someone else is designated to make decisions on behalf of a mentally incompetent individual?

Consider the following case:

A middle aged man was involuntarily committed to a state psychiatric hospital because he was considered dangerous to others due to severe paranoid thinking. His violent behavior was controlled only by injectable medications, which were initially administered against his will. He had been declared mentally incompetent, and the decisions to approve the use of psychotropic medications were made by his adult son who had been awarded guardianship and who held medical power of attorney.

While the medications suppressed the patient’s violent agitation, they made little impact on his paranoid symptoms. His chances of being able to return to his home community appeared remote. However, a new drug was introduced into the hospital formulary which, if used with this patient, offered the strong possibility that he could return home. The drug, however, was only available in a pill form, and the patient’s paranoia included fears that others would try to poison him. The suggestion was made to grind up the pill and surreptitiously administer the drug by mixing it in pudding.

Hospital staff checked with the patient’s son and obtained informed consent from him. The “personal values and...personal goals” of the son and other family members were seen to substitute for those of the mentally incompetent patient—and these goals included the desire for the patient to live outside of an institution and close to loved ones in the community. This was the explicitly stated
rationale for the son’s agreeing to the proposal to hide the medication in food. However, staff were uncomfortable about deceiving the patient, despite having obtained informed consent from the patient’s guardian.

Discussion Questions:

1. In the case study above, do you think the ends justify the means? In other words, does the goal of discharging the patient from an institutional setting into normal community living justify deceiving him? Explain your reasoning.

2. Do you think it is ever ethically permissible to deceive clients? Under what circumstances? Why or why not?

3. To what degree should family members or legal guardians have full capacity to make decisions or give consent on behalf of those under their care? Explain.

4. Do you think severely mentally ill people retain any rights “to determine what shall be done with [their] own [bodies]?” Why or why not?

5. Are there risks in surreptitiously medicating a paranoid patient? Would this confirm the patient’s delusions of being “poisoned” by others or escalate his resistance to treatment? Are these risks worth taking in view of the potential to dramatically improve his mental functioning and reduce his suffering?

6. Since psychiatric patients have the right to treatment, does the strategy to surreptitiously administer medications serve this goal? Do you think this is ethically justifiable? Why or why not?

7. Does the history of the forcible treatments of persons with disabilities and other powerless populations affect how you view this case? Explain
CASE STUDY

Resources:
The Nazi Doctors: Medical Killing and the Psychology of Genocide

Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present

Imbeciles: The Supreme Court, American Eugenics, and the Sterilization of Carrie Buck

Texas Administrative Code, Chapter 404, Subchapter E: Rights of persons receiving mental health services

A history and a theory of informed consent

Enduring and emerging challenges of informed consent

Chapter “Consent to medical care: the importance of fiduciary context” in The ethics of consent: theory and practice

CASES; Advice rejoins consent

Making health care decisions: The ethical and legal implications of informed consent in the patient-practitioner relationship

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