Addiction
EDITORIAL
doi:10.1111/j.1360-0443.2008.02369.x

Denying autonomy in order to create it: the paradox of forcing treatment upon addicts

THE PRIMACY OF AUTONOMY IN PROVIDER–PATIENT RELATIONSHIPS

American bioethics affords extraordinary respect to the values of personal autonomy and patient self-determination [1]. Many would argue that the most significant achievement deriving from bioethics in the past 40 years has been to replace a paternalistic model of health provider–patient relationships with one that sees patient self-determination as the normative foundation for practice. This shift away from paternalism towards respect for self-determination has been ongoing in behavioral and mental health as well, especially as it is reflected in the 'recovery movement' [2–4].

As a result of the emphasis placed on patient autonomy, arguments in favor of mandatory treatment are rare and often half-hearted. Restrictions on autonomy are usually grounded in the benefits that will accrue to others from reining in dangerous behavior [5]. However, anyone who wishes to argue for forced or mandated treatment on the grounds that society will greatly benefit is working up a very steep ethical hill.

A person has the fundamental right, well established in medical ethics and in Anglo-American law, to refuse care even if such a refusal shortens their own life or has detrimental consequences for others. Therefore, while the few proponents of mandatory treatment for those afflicted with mental disorders or addictions are inclined to point to the benefit such treatment could have for society, it is exceedingly unlikely that any form of treatment that is forced or mandated is going to find any traction in American public policy on the basis of a consequentialist argument, great as those benefits might be.

However, is benefit for the greater good the only basis for arguing for mandatory treatment? Can a case be made which acknowledges the centrality and importance of autonomy but which would still deem ethical mandatory treatment for addicts? I think it can.

INFRINGING AUTONOMY TO CREATE AUTONOMY

People who are truly addicted to alcohol or drugs really do not have the full capacity to be self-determining or autonomous. Standard definitions of addiction cite loss of control, powerlessness and unmanageability [6]. An addiction literally coerces behavior. An addict cannot be a fully free, autonomous agent precisely because they are caught up in the behavioral compulsion that is addiction. If this is so, at least for some addicts, then it may be possible to justify compulsory treatment involving medication or other forms of therapy, if only for finite periods of time, on the grounds that treatment may remove the coercion causing the powerlessness and loss of control.

Addicts, just as many others with mental illnesses and disabilities, are not incompetent. Indeed, to function as an alcoholic or cocaine addict one must be able to reason, remember complex information, set goals and be orientated to time, place and personal identity; but competency by itself is not sufficient for autonomy. Being competent is a part of autonomy, but autonomy also requires freedom from coercion [7]. Those who criticize mandatory treatment on the grounds that an addict is not incompetent and thus ought not be forced to endure treatment are ignoring this crucial fact. Addiction, bringing in its wake as it does loss of will and control, does not permit the freedom requisite for autonomy or self-determination.

If a drug can break the power of addiction sufficiently to restore or re-establish personal autonomy then mandating its use might be ethically justifiable. Government, families or health providers might force treatment in the name of autonomy. If a drug such as naltrexone is capable of blocking the ability to become high from alcohol, heroin or cocaine [8,9], then it may release the addict from the compulsive and coercive dimensions of addiction, thereby enhancing the individual's ability to be autonomous. If a drug or therapy can remove powerlessness and loss of control from the addict's life, then that fact can serve as an ethical argument allowing the mandating of treatment. If naltrexone or any other drug can permit people to make choices freed from the compulsions or cravings that would otherwise control their behavior completely, then it would seem morally sound to permit someone who is in the throes of addiction to regain the ability to choose, to be self-governing, even if the only way to accomplish this restoration is through a course of mandated treatment.

Of course, it would not be ethical to force treatment upon anyone if there were significant risks involved with the treatment but new drugs, such as naltrexone, appear safe and effective for those addicted to heroin and perhaps cocaine, and should also prove so for alcoholics. The mechanisms behind the drug are well understood [8,9], and in some populations this drug has been used for a long time to reduce the cravings of addiction safely and

effectively. Mandating treatment requires that the intervention carry minimal risk as the patient cannot consent, but some interventions may be able to meet this admittedly difficult standard.

Nor would it make moral sense to force treatment upon someone, restore their autonomy successfully and then continue to force treatment upon them in their fully autonomous state. The restoration of autonomy is the end of any moral argument for mandatory treatment.

Similarly, efforts to restore autonomy would not justify continuous, open-ended use of drugs or therapy in addicts. There must be some agreed-upon interval, after which treatment must be acknowledged to have failed and other avenues of coping with addiction to alcohol or drugs pursued.

PRECEDENTS FOR MANDATING TREATMENT IN THE NAME OF AUTONOMY

Interestingly enough, despite the emphasis on autonomy in law and ethics in American health care there are situations where the ethical acceptability of the rationale of autonomy restoration in permitting mandatory treatment is already accepted. Consider what occurs in rehabilitation medicine. The short-term infringement of autonomy is tolerated in the name of long-term creation or restoration of autonomy.

Patients, after devastating injuries or severely disfiguring burns, often demand that they be allowed to die. They say: 'Don't treat me', or they may insist that: 'I can't live like this'. In evaluating their requests, no one would be able to question seriously their competency. They know where they are. They know what is going on. However, staff in rehabilitation and burn units almost always ignore these initial demands. Patient autonomy is not respected. Why?

What rehabilitation experts say is that they want to allow an adaptation to the new state of affairs: to the loss of speech, amputation, facial disfigurement or paralysis. They know from experience that if they do certain things with people—train them, counsel them, teach them adaptive skills—they can encourage them to start to 'adjust' [10].

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. Nevertheless, at least initially, rehabilitation specialists will say that they have to force treatment on patients because they know from experience that they can often encourage them to accept their new state of affairs. The normal practice of rehabilitation immediately after a severe injury is to mandate treatment, ignore what patients have to say, and then see what happens. If they still do not want treatment after a course of rehabilitation then their wishes will be respected [10].

The rehabilitation model is precisely the model to follow in thinking about the mandatory use of a drug such as naltrexone for the treatment of addiction. The moral basis for mandating treatment is for the good of the patient by rebirthing their autonomy. How long and whether someone ought to be able at some point say: 'I've done this for 6 months, I'm finished, I want to get high again' is a challenging problem, but it is not the key one. The key moral challenge is to open the door to temporary mandatory treatment. That can be achieved, ironically, on the grounds of 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 [7]. Once competency and coercion are distinguished, it is clear that both are requisite for autonomy. Mandatory treatment which relieves the coercive effects of addiction and permits the recreation or re-emergence of true autonomy in the patient can be the right thing to do.

Acknowledgement

The author is grateful for the support of the Scattergood Foundation in writing this essay.

Declaration of interest

None.

Keywords Addiction, autonomy, mandatory treatment, naltrexone, paternalism, right-to-refuse treatment.

ARTHUR CAPLAN
Emanuel and Robert Hart Professor of Bioethics, Chair, Department of Medical Ethics, and Director for Center for Bioethics, University of Pennsylvania, PA, USA.
E-mail: caplan@mail.med.upenn.edu

References

1. Beauchamp T. L., Childress J. *Principles of Biomedical Ethics*, 5th edn. Oxford: Oxford University Press; 2008.
2. Sheldon K., Williams G., Joiner T. *Self-Determination Theory in the Clinic*. New Haven, CT: Yale University Press; 2003.
3. Cook J. A., Jonikas J. A. Self-determination among mental health consumers/survivors: using lessons from the past to guide the future. *J Disabil Policy Stud* 2002; **13**: 87–96.
4. The White House. *The President's New Freedom Initiative; The 2007 Progress Report*. Available at: http://www.whitehouse.gov/infocus/newfreedom/newfreedom-report-2007.html (accessed 14 September 2008).
5. Silber T.J. Justified paternalism in adolescent health care. Cases of anorexia nervosa and substance abuse. *J Adolesc Health Care* 1989; **10**: 449–53.

6. Goodman A. Addiction: definition and implications. *Br J Addict* 1990; **85**: 1403–8.
7. Caplan A. L. Ethical issues surrounding forced, mandated or coerced treatment. *J Subst Abuse Treat* 2006; **31**: 117–20.
8. Comer S., Sullivan M. A., Yu E., Rothenberg J. L., Kleber H. D., Kampman K. *et al.* Injectable, sustained release naltrexone for the treatment of opioid dependence. *Arch Gen Psychiatry* 2006; **63**: 210–18.
9. Krystal J. H., Cramer J. A., Krol W. E., Kirk G. F., Rosenheck R. A. Naltrexone in the treatment of alcohol dependence. *New Engl J Med* 2001; **345**: 1734–9.
10. Caplan A. L., Haas J., Callahan D. Ethical and policy issues in rehabilitation medicine. In: Duncan B., Woods D., editors. *Ethical Issues in Disability and Rehabilitation*. New York: World Institute on Disability; 1990, 135–54.