CIVIL LIBERTIES AND THE ELDERLY PATIENT

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Every year in North America thousands, perhaps tens of thousands, of elderly patients are subjected to involuntary restrictions on their liberty. The restrictions may be physical (for example, locked rooms, jackets, wristlets or bands) or pharmacological (for example, psychotropic drugs), but in either case they are often experienced as deprivations of liberty.

The justifications usually offered for imposing restraints appeal to the safety of those restrained; they are thought to be "at risk" and require protection from self-inflicted harm. An additional or alternative justification appeals to the need to protect others (patients or medical staff) from harm.

These justifications for restraining elderly patients are sometimes compelling. Nevertheless, the danger of abuse and misuse of restraints is significant and the cost, in terms of individual liberty, is high. It is the principal thesis of this paper that elderly patients are frequently deprived of their liberty illegitimately as a result of the wrong questions being asked, the wrong conceptual model being employed by medical staff and family members. An illustration may help.

THE CASE OF MR. JONES

Mr. Jones is sixty-eight years old and a widower, He is being treated in hospital for a broken hip, sustained as a result of an accident. His injury has healed, and he is ready to be discharged. Mr. Jones lives by himself in an apartment, with occasional assistance from a cleaning woman and a friendly neighbour.

Unfortunately, however, he also suffers from arteriosclerosis, which causes him to undergo periods of confusion. During such periods, he has been found wandering downtown without purpose and at some risk to himself. His children believe that he should not be discharged from hospital to live again on his own. They wish him kept under supervision, either in hospital or in a nursing home.

Mr. Jones, during periods of apparent rationality, indicates that he is aware of his problem and the risks it poses to his health and well-being, but he prefers to accept these risks rather than be confined to institutional care. The medical team has decided, in consultation with the family. that Mr. Jones will be confined to hospital until a suitable nursing home place becomes available. They refuse his request to be discharged. When he protests aggressively against their decision, they sedate him to a level that ensures his compliance.

DISCUSSION MR. JONES'S CASE

It is important to stress in this case that those who have deprived Mr. Jones of his liberty are motivated by concern for his best interests. Indeed, they do not perceive themselves as depriving him of his liberty. They do not see this because they apply to his case the often paternalistic medical model rather than the civil liberties model. Family and physicians see themselves acting as *parens patriae* They feel morally justified in sedating Mr. Jones to the point where he loses his freedom of action because they are acting in what they believe to he his best interests, protecting him from the risk of self-inflicted harm at a time when he is presumed to be no longer competent to care for himself

In the medical model, Mr. Jones is viewed as ill ("demented"). Because' he is ill, those who care for him are justified in responding with whatever treatment or therapy seems most likely to promote his welfare. If Mr. Jones is viewed as incompetent, then his protests against this treatment will be dismissed as simply one more symptom confirming his illness. Because the restraints imposed on the patient are regarded as being for his benefit, those who impose these restraints quite naturally feel less inhibition than if they were deliberately imposing some punishment.[1] For example, in a recent case in Quebec, *Institut Philippe Pinel de Montreal v. Dion*,. the court seems to have assumed incompetence on the basis of Dion's refusal to accept treatment: "The court feels that the respondent's refusal to accept the recommended treatment condemns him to detention in perpetuity and the eventual loss of contact with reality. The court does not believe that a man of healthy mind would do this voluntarily.''[2]

The medical model encourages its adherents to take action at the earliest possible moment in order to minimize the possibility of harmful effects. In contrast, the civil liberties model requires its adherents to follow a variety of procedural safeguards when they propose to deprive someone of his freedom. The onus of proof rests with those who would restrict liberty rather than upon the person who is to be deprived of liberty, Insistence upon strict rules of evidence or "proof beyond a reasonable doubt" would, in the medical model be regarded as erecting unnecessarily cumbersome barriers to the delivery of help to those in need.

The medical model is founded upon compassion and a desire to help, but in practice it may be experienced by the elderly patient as controlling and demeaning, The essence of being a mature adult person is to have others respect one's choice. When an elderly patient is labelled as incapable of rational choice, those who apply the label, as well as others, come to view the patient as not fully a person and, frequently the patient comes to view himself as less than worthy of respect. In other words, there is a stigma associated with restraints, and the stigma tends to become internalized and so produces a diminution of the patient sense of self-worth.

MENTAL COMPETENCE

The courts have, in general, established the legal right of a competent patient, to refuse treatment, even when the result of such refusal may involve risk of injury or death, The victim of a massive coronary attack for example, who refuses to take medication or even

alter his work and diet in the face of warnings that such behaviour may be fatal, is recognized as having a right to autonomy which forbids our coercive interference.

In our culture, considerable value is assigned to individual autonomy. We wish to be able to regulate our lives in accordance with principles we have ourselves chosen to accept. We attempt to develop our own conception of “the good life’’ or “self-fulfillment" and we claim the right to regulate our behaviour with reference to this overall plan so long as this does not involve illegitimate interferences with the plans of others.

Undeniably, the life plans adopted by some people will appear imprudent or foolish to others. Nevertheless, even those who favour a range of paternalistic legislation to protect individuals from self-inflicted harm or foolish decisions concede that a competent adult is entitled to take some risks with his or her life, and even to Follow a course of action which may produce serious injury to self. Recognizing someone as a mature adult n that we respect their right to make mistakes, even serious mistakes which may put their very lives at risk.

Important as respect for the value of individual autonomy may be, it is not an absolute value even with regard to competent adults. Moreover, we often feel justified in interfering paternalistically[3] with the liberty of children on the grounds that they do not yet possess the capacities - intellectual and emotional - required in order to make fully rational and voluntary decisions. Children, especially young children, lack the capacity to formulate life plans and they lack the knowledge and experience of the world necessary to discern and act upon their own rational self-interest. Thus, restrictions upon the liberty of children are justified by the need to assist them in developing the competence necessary lot the rational exercise of autonomy.

Paternalistic interference with elderly patients is typically justified by ex tending the argument as it applies to children: for it is sometimes the case that chronologically mature individuals may lose, either temporarily or permanently, the ability to formulate and carry out life plans or to take rational decisions. If paternalism is permitted or required for children then, by the same reasoning, it must sometimes be permitted or required for adults

THE CENTRAL ETHICAL DILEMMA

At this point, one is confronted with a serious ethical dilemma for geriatric medicine: in what circumstances is it morally permissible and/or obligatory to restrict the liberty of the elderly patient on paternalistic grounds? When there is a clash between the sometimes competing principles of respect for individual liberty and that of preventing patients from coming to harm, which principle should have priority? What criteria ought to be employed by physicians, nurses, and family members in order to resolve this clash of values?

Many of those who would be horrified by a proposal to use coercion against cardiac patients in order to ensure their compliance with medical recommendations re willing to

accept coercion of at-risk elderly patients. The mental confusion experienced periodically by patients such as Mr. Jones will seem a sufficient reason for benevolent compulsion.

One difficulty with this line of reasoning is that caretakers of the elderly may too readily make the leap from at-risk" behaviour to the conclusion of global mental incompetence, without properly considering all aspects of the situation. Doubtless there are many elderly patients who are completely lacking insight into their condition and who are, in consequence, unable to weigh for themselves the risks and benefits of alternative courses of action. At the same time, however, many other elderly patients have sufficient insight into their condition and sufficient appreciation of their own best interests to be able to decide autonomously which risks are worth taking for which benefits. When medical staff and family ignore the wishes of this second group, thereby depriving them of the right to exercise their autonomy, this constitutes all unwarranted usurpation of civil liberties.

The point which needs stressing in cases such as that of Mr. Jones is that periodic mental confusion, memory lapses, temporary disorientation and other similar mental deficits are not automatic and decisive proof of global mental incompetence. When an elderly patient suffers from some mild degree of dementia this is not automatic and decisive proof of global mental incompetent.[4] Elderly patients suffering from some mild degree of dementia are not ipso facto incompetent. When a choice has to be made between paternalistic coercion on the one hand and liberty with its attendant risks on the other, those who possess the power to abridge the liberty of the elderly patient have a strong moral obligation to investigate carefully the issue of mental competence.

IDENTIFYING THE MORALLY RELEVANT CRITERIA

Elderly patients are frequently deprived of their liberty illegitimately as a result of failure on the part of family and medical staff to pose the right questions. All too frequently the key normative questions are never explicitly raised because the issue is perceived as a medical rather than a moral problem.

Several important questions need to be explicitly asked and answered before any patient is subjected to benevolent compulsion on paternalistic grounds. Let us consider again the case or Mr. Jones. In his case, some of the relevant questions are: How likely is it that he will come to harm? How likely must it be that he will come to harm in order to justify infringing upon his liberty? How serious must be the predicted harm? How oppressive to the patient is the restriction of his liberty likely to be? How long is it anticipated that the deprivation of liberty will continue? Is there any alternative means available to achieve the desired goal without depriving him of his liberty or without infringing to such an extent upon his autonomy.[5]

Once such questions are raised and openly discussed, a number of guidelines suggest themselves. The less likely the harm, the less serious the harm, the more oppressive the restriction of liberty, and the longer the period of liberty deprivation, the less justified would be the imposition of restrictions. Conversely, the paradigm case for justified use of restrictions would be one in which the risk was very likely, the harm severe, the

restrictions necessary for protection of the patient minimal and temporary. The paradigm case of unwarranted restrictions would be one in which the risk of harm was slight, the harm anticipated was trivial, and tile restrictions necessary to pre vent the harm from occurring were maximally oppressive and long-term.

Moreover, the greater the insight of the patient the less justified would be paternalistic interference. In our case study involving Mr. Jones, one could make a strong argument that Jones's demonstrated rational insight into his condition makes it ethically improper to override his value judgment, even though the risk and the stake may both be significant.

Assessing all the relevant factors in each particular case and factoring in all the morally relevant criteria is a subtle and complex task. Difficult as the task may be, however, it is one which we are ethically and, it can be argued, legally obliged to undertake. It is not adequate to ask simply "is the patient 'at risk'?" or even "does the patient pose a risk of harm to others?"

HARM TO OTHERS

The discussion has to this point been anchored to a case study in which the harm anticipated is to self. Where an elderly patient poses a threat to others (patients or staff), it may be that involuntary confinement will be morally justified by a lower risk and lesser stake than when the risk is only to oneself. Nevertheless, the questions required by the proposed guidelines are still relevant. The decisions to be made are still fundamentally ethical and value decisions, although they have a medical component, What degree of risk of what degree of harm to others justifies what severity and length of liberty restriction? Simply labelling a situation as one in which there exists a risk of some harm to others is not an automatic warrant to intervene. The risk may be slight. Or the harm to others may be no more serious than a slight violation of privacy (from a patient who occasionally wanders into the room of other patients or takes off his clothes), or it may consist of verbal abuse directed towards the medical staff. Such disruptive behaviour does pose a problem and should be dealt with, but can it possibly justify heavy sedation or severe incarceration a permanent basis? The results reported by Dr. Colin Powell et al.[6] confirm strongly the danger of overprediction of danger to self and to others on the part of medical and nursing staff. Since the cost of overprediction is measured in terms of lost liberty and diminished dignity, the burden of proof should rest with those who propose to restrict the liberty of the elderly patient.

Misuse of restraints is most likely to occur when the issues of freedom and :coercion are disguised as medical issues. When we employ the civil liberties model we are compelled to deal explicitly with the relevant moral and values. This approach, taken in conjunction with ongoing empirical research into the least restrictive measures available to cope with the problems of harm to self and to others, should lead to a significant reduction in the employment of restraints for elderly patients.

NOTES

1. Morris. H. (1968). Persons and Punishment. *The Monist*. 52, .475-501

2 *Institut Philippe Pinel de Montréal v. Dion*. cs 438 (1093) 2 DLR (4th) 241, 1983 (transl)

3 'Paternalism" may be defined as an interference with a persons liberty undertaken primarily with the goal of promoting the welfare of the person being coerced.

4 In the recent landmark case of *Rennie v. Klein* (462 F. Suppl. 1131, 1145 [1978]) Judge Brotman of the United States District Court of New Jersey stresses the point that one cannot automatically assume that insane patients ipso facto cease to be competent to give or withhold consent for medication in mental hospitals. *A fortiori*, one ought not to assume that a patient who exhibits symptoms of dementia is necessarily incompetent to give or withhold informed consent to restriction on liberty. (This case is under appeal.)

5 Dershowitz Alan (1968) Psychiatry in the legal process: A knife that cuts both ways. *Judicature*. 51, 370—77

6 Powell, C.. Mitchell-Pederson, F L, Edmund, L, & Fingerote, E. *Freedom from restraint: The consequence of reducing physical restraints in the treatment of elderly persons*, unpublished paper. The proclivity shared by physicians, nurses and family members of geriatric patients to overpredict danger (to self and to others) doubtless arises in part. from the fear that if harm does occur, those who failed to take preventative action may be held morally and/or legally culpable, By contrast, when a patient is unnecessarily restrained because of apprehended risk, the erroneous prediction is never vulnerable to falsification.