

Involuntary outpatient treatment: the ethical implications

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Medicine takes the form of an interpersonal relationship between the doctor and patient which is characterised by inequality: the doctor, with his/her knowledge and the power to make decisions occupies a superior position in his/her role of “accompanying the sick on the road of pain” in the words of Miguel Torga; the patient, meanwhile, suffers, lives in a state of dependence and waits with trust. This inequality has driven doctors, from the time of the Hippocratic oath onwards, to impose requirements that would impose greater respect for patients.

In the society of rights in which we now live, any medical act should pass three successive judgements: 1, the clinical, based on scientific criteria (knowledge, tests, diagnosis and medical recommendation). 2, the medical-legal judgement, governed by general and specific laws that recognise and respect patients’ rights and 3, the ethical, which is more demanding, since once the general rules are complied with, it imposes the duty to seek excellence of the medical act through personalisation, seeking the best for this particular patient, with respect for the patient’s wishes about what they want for themselves, and without forgetting the principles of social justice, fairness and equality.

In such a framework, the doctor-patient relationship is governed by the patient’s right to decide, after receiving enough of the necessary information (autonomy). The requirement in this case is that the patient should be biologically mature enough (from 16 years and always from 18) and that his/her and that his capacity to understand, judge and reason, and from there, decide, should be intact.

The above comments are essential to the issue we are debating here: involuntary outpatient treatment or (IOT), because when the patient’s illness affects their mental functions, a doctor is facing a patient that lacks full autonomy, since they do not understand what is

best for them, or they are in no condition to choose and decide what it is. Once the ethical pillar is lost, which is essential to the doctor-patient relationship, the doctor’s duty is to bring the obligation of welfare to the forefront of the relationship as a guarantee of the patient’s rights, using his/her skills, indications, available resources, etc. to evaluate what may be the best thing to do, as if he/she were in fact the patient. An added feature of this analytical process is justice (quality of treatment, proven efficacy, efficient use of resources, etc.).

In practice, when the medical recommendation for treatment is accepted by the patient (although they suffer from a mental disorder), and by their legal representative or family members, the treatment may be applied without further conflict. But problems arise when the patient rejects the medical recommendation, because that is when we are obliged to discuss “involuntary treatment”.

The Civil Code and the Civil Proceedings Act¹ guarantee that treatment for mental health of a hospitalised patient should be carried out under judicial supervision and with its authorisation, precisely in order to provide treatment for the patient’s welfare until he/she is well enough to give consent. This sort of situation is very well regulated, covering situations ranging from where the internment must be an urgent one, in which case the judge subsequently approves it, or the patient’s clinical situation allows for sufficient delay for the judge to give prior authorisation.

Another type of “involuntary treatment”, in the field of criminal law, applies to the need for a court order to impose internment (or not), and the administration of treatment. This takes place when the person has committed an offence under the influence of a mental disorder or because of an addiction to alcohol or drugs. The judge in cases such as these can

impose the measure of obligatory treatment, either as an outpatient, or as an internee, always under medical control and court supervision, for the purposes of detoxification or remission of the mental disorder. In such cases the time of treatment is calculated as time served in a sentence².

The circumstances surrounding Involuntary outpatient treatment make it different from involuntary internment, but they have other similarities that allow us to consider this issue in greater depth. The fundamental difference is that involuntary outpatient treatment is not coercive in terms of the place, where the patient may live while receiving treatment, since they shall continue to live their lives where they normally reside (city, family, etc). On the other hand, a feature common to them both is that they do not respect the patient's rejection of the treatment, and impose it as obligatory and compulsory, although, in outpatient treatment, when it has been administered, the patient can return home and continue with his/her daily life.

For this measure to be legally and ethically justifiable it is absolutely essential for its scientific efficacy to be proven and the expectations of improvement/cure to be evident. When this is so, the duty of doing what is best for the patient takes precedence over leaving treatment to his/her own judgement and the functioning of a mind affected by the mental disorder he/she suffers from; in fact if a doctor were to act like that it could well fit the criminal definition of a "failure to render aid".

We are therefore totally in favour of applying treatment to a person who suffers from a mental disorder and who needs treatment that is effective and available. The ethics of the situation make it obligatory to personalise the case, which in turn leads to a kind and friendly relationship with the patient, with communication adapted to his/her personal capacities to understand, and to the family and social environment; the information should include the benefits that the treatment may provide (reduced likelihood of admission, recovery of activities, social and family integration, etc.). There is, despite all the efforts made, the likelihood that the patient rejects the treatment. Immediate contact should be made with the family (trustee, legal representative, or de facto representative, etc.) whose consent will be necessary. Once these stages are complied with (clinical opinion, medical-legal and ethical) the time comes to make the decision. The situations would be: a) There is a medical recommendation of treatment and the family accepts it (welfare), the patient, despite suffering from a disorder

that temporarily or permanently affects their mental functions, accepts it (autonomy), the drug is effective, available and safe (justice), the treatment is applied with no evident problems. b) There is a medical recommendation of treatment and the family accepts it (welfare), but the patient rejects it as a result of the effects of the mental disorder has on his/her mental functions (autonomy is cancelled out), we therefore have to resort to justice, represented by the judge who, from civil jurisdiction and protecting the patient's right to be cured, authorises application of the treatment.

After considering the current circumstance of the issue, we should now ask ourselves if it is necessary to regulate involuntary outpatient treatment. The above analysis shows that the doctor, with the family's agreement, can act, by requesting judicial authorisation, when complying with the treatment means going so far as to need support to take the patient to the clinic or wherever the treatment is applied. This situation is very similar to the one provided for in civil law for non urgent internment, already mentioned above; the difference resides in the fact that the situation considered in this article does not require internment (deprivation of liberty) since the treatment is applied under an outpatient regime.

It could be said that in the first case the right of the injured party (patient) is to reject treatment, while in the second two rights are infringed, rejection of treatment and the deprivation of liberty imposed by internment in a hospital. However, in the absence of any specific regulations for involuntary outpatient treatment, the existing ones enable doctors to act similarly in both situations, thus safeguarding the patient's safety. However, very authoritative figures have made excellent proposals on a systematic protocol for dealing with patients for whom involuntary outpatient treatment³ would be recommendable.

Specific regulation of involuntary outpatient treatment would have the following advantages: guarantees to the patient that the treatment imposed has been sufficiently appraised from a scientific viewpoint and therefore personalised treatment can be established. For doctors, having a precise protocol to act on gives them security and simplifies the processes. For the legal system itself, the proceedings are simplified and streamlined, especially if a specific court with a medical/legal approach is given powers to act while taking into account the medical factors and the need to guarantee these patients' rights.

The drawback is the growing presence of the courts in medicine and healthcare, which may go

against the much wished for humanisation of medicine. This question requires further ethical consideration⁴.

By way of conclusion, we consider that regulation of involuntary outpatient treatment would provide major advantages to all those affected: patients, physicians and the legal system.

However, it is necessary to insist that if regulations are accepted that provide procedures to ensure a patient's welfare, which would be governed by the legal system, such regulations should not release doctors from the higher and intrinsic duties of their profession, such as passing a well balanced clinical-scientific judgement that assesses the risks and benefits of the treatment, and which would give firm indications of the treatment to be followed. The medical-legal judgement would rigorously apply the regulations indicating the steps to take to ensure that the patient takes the treatment, and thirdly, the ethical judgement would enable the doctor to comply with the noblest of duties, already mentioned above, of making the patient participate in the process as far as possible, via adequate medical explanations and all the information that the patient can understand about the matter. The decision will be made to opt for the treatment and type of application that provides each patient with the greatest benefits and least risks and drawbacks.

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