

Room for a view

Am I my brother's keeper? Two perspectives on consent

Sophie arrived at our door unexpectedly on the evening of Yom Kippur. There was a sound of sobbing from the front hall, and immediately the telephone began to ring. A neighbour was calling to warn us that an unwanted visitor was walking up our path.

Sophie, with a bruised eye, and a bloody gap where a tooth had been, implored us to help her. She wanted \$40 to buy food. Her ex-husband had left town without giving her money to feed her teenage boys. They were hungry and cold. She said she was desperate and had no one to ask for help. She added that, having seen the mezuzah beside our door, she knew we would do the right thing.

Her battered right eye clenched convulsively while the left bulged in an unnatural stare. A white crocheted sweater, twisted over her lumpy torso, was her only protection against an unseasonal frost. Through nonstop pleading and crying, her tongue kept pushing through her lips, making a smacking sound that punctuated her sobs. Tardive dyskinesia and her dishevelled, frantic state blew Sophie's cover as someone whose misery could be relieved with \$40. She needed a psychiatric assessment and some basic necessities until help and treatment could be arranged. At 10 p.m. on a weekend, the emergency department was the only option.

As if reading my mind, Sophie got

down on her knees beside my kids' shoes and begged me not to call the police. I offered her a bag of groceries, but she refused, saying a pinched nerve prevented her from carrying anything. The idea of driving her to the grocery store was also rejected. She was fixed on \$40. Finally she accepted some money and the proffered bag of food. With extravagant thanks she attempted to kiss my hand, and left.

My neighbour had called the police before I could reach the telephone. A cruiser was idling in front of our house, lights flashing. Two officers attempted to cajole a resisting Sophie into the back seat. Thrashing, her face contorted with distress, Sophie glanced up long enough to see us looking at her through the window. With the bills crushed in the palm of her hand, she angrily made a rude gesture in our direction.

I imagined the ethical dilemma that would soon confront the emergency physician asked to assess Sophie. I doubted that she would readily agree to a psychiatric evaluation. And I figured that she had been in this situation before. Perhaps medication had been prescribed at one time but was lost. Or perhaps she had simply stopped taking it. Since she was not obviously a mortal danger to herself or an explicit threat to

others, it is hard to imagine how the physician could justify overriding the legal obligation to obtain Sophie's consent to an evaluation. Any assessment, medical care and even community follow-up would require her explicit agreement. Respecting Sophie's right to autonomy and self-determination, the physician would have to let her go.

Should a society that considers itself to be humane and compassionate leave those who are chronically ill and unable to care for themselves and their children to fend for themselves? This dilemma is one of the primary legacies of antipsychotic drugs

and deinstitutionalization. Treatments for the symptoms of mental illness exist but are often refused by patients or followed inconsistently. A shift away from paternalism toward individualism has left many people with mental illness relatively autonomous but stranded without care, drifting in an era of scarce resources.

In *The Ethical Canary* Margaret Somerville refers to the ethical and legal responsibilities of the physician to obtain informed consent to treatment. Although she maintains that it is the primary responsibility of the physician



to “act as the patient’s advocate in obtaining the treatment that the physician considers therapeutically most appropriate,” she is unequivocal in her view that failure to obtain consent is medical negligence.¹

But what if the patient is not competent? For example, we can conjecture that chronic mental illness may have had an impact on Sophie’s cognitive abilities: her attention, memory and ability to think clearly. The question of whether she is sufficiently competent to understand and appreciate her illness is central to the question of whether she can grant informed consent. Somerville distinguishes between the ability to understand information given by the doctor and the ability to appreciate, from an emotional standpoint, the implications of this information for the course of one’s illness. When there is a conflict between these two standards for determining competence — one based on factual understanding, the other based on the ability to contextualize those facts — the law weighs in on simply comprehending the facts. This is the less stringent test, and one that allows more people to be deemed competent. Somerville writes:

Under the latter [personal liberty-favouring] type of test, people would be considered competent if they had the mental capacity to understand the required disclosure of information, regardless of how they viewed this information in relation to their illness. Under this test, adults would be competent even if they did not believe that they suffered from the illness with which they had been diagnosed, or that the consequences of refusing treatment might be serious or fatal.²

Somerville concludes that, unless the patient’s emotional state makes her completely incapable of understanding, she must be deemed competent to make decisions. In this context, a physician would have no option but to offer the patient, even a psychotic patient, all the relevant information about her disease and to allow her to make her own choices.

Somerville’s view is a secular and legal one. But Sophie’s reference to my

obligation as a Jew to “do the right thing” prompted me to examine the issue of consent from a Jewish perspective. In contrast to contemporary mainstream bioethics, in which competence and informed consent form part of the basic vocabulary of the discipline, these notions are rarely discussed in Jewish texts. In his collection of essays, *Duty and Healing*, the late clinical ethicist Benjamin Freedman wrote that the principle of autonomy, which underlies the concept of informed consent, is not a persuasive factor within Jewish law (Halakha).³ In this context, a person is viewed as the temporary custodian of her body, rather than as owning that body and having the right to decide what happens to it. Each person is charged with the duty of safeguarding and preserving her health, as well as the health of others, as if these were precious, borrowed entities that require nurturing and maintenance:

In the halakhic understanding, there is a duty upon the physician to heal, and a duty upon the ill person to be healed, and therefore the entire value foundation underlying the principle of informed consent is almost totally nullified. According to halakha, the mode of treatment is frequently not established according to the will of the patient and his consent, but rather according to the objective situation.⁴

This rather dogmatic understanding of medical choices presupposes that there is one objective solution to medical problems. Although Freedman does agree that the Jewish view of bioethics hinges on the duty to heal others as well as to preserve one’s own health, he asserts that there is a more nuanced interpretation of consent, one that extends beyond the obligation to simply choose life over death. He argues that decisions about individual medical treatments cannot be divorced from their context of diagnosis, prognosis and care — nor, indeed, from the way in which a medical choice fits within, or distorts, a patient’s life-plans.

The notion of informed consent should therefore not refer to a single

discrete event, like choosing or refusing a specific treatment, but to the ongoing relationship between a doctor and patient, one characterized by mutual respect and the give-and-take of information that will permit the patient to decide what is in her best interest, if she is capable of doing so.

What does this mean for Sophie, spotted one week after her visit weaving between 4 lanes of traffic? The more traditional, legalistic view would place the responsibility for making a decision about treatment squarely on Sophie’s shoulders, especially if her behaviour was not overtly dangerous to herself or others. Somerville’s interpretation of this view is that the freedom to determine one’s medical fate takes priority over more stringent conditions for consent, such as insisting that the patient demonstrate a comprehensive understanding of what is happening to her. But there is not much point to knowing the facts without being able to put them in context. When a person suffers from a mental illness that results in confused thinking and a wanton disregard for health and well-being, Freedman argues that others in society must assume the responsibility of caring. This is an ongoing social commitment between physician and patient, one predicated on an individualized approach to safeguarding the health of those who cannot safeguard it for themselves.

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References

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