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GRADE / DEGREE

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Human Rights and the Involuntary Psychiatric Patient:
Scientific, Legal and Philosophical Issues in the Scott Starson Case

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Human Rights and the Involuntary Psychiatric Patient:

Scientific, Legal and Philosophical Issues in the Scott Starson Case

Thesis submitted to the

Faculty of Graduate and Postdoctoral Studies

In partial fulfillment of the requirements

For the MA degree in Public Ethics

Faculty of Philosophy

Saint Paul University

C. Ineke Neutel, Ottawa, Canada, 2009

Your file Votre référence
ISBN: 978-0-494-65990-8
Our file Notre référence
ISBN: 978-0-494-65990-8

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ABSTRACT

Two options to human right protection for involuntary schizophrenic inpatients refusing treatment are compared: First, forced treatment until improvement in the illness makes commitment unnecessary, thus, emphasizing dispositional freedom; second, allowing treatment refusal even if it means long-term commitment, thus, emphasizing occurrent freedom. Reviews of relevant issues in psychiatry, Canadian legislation, neuroscience and mind-body issues prepare the ground for an analysis of the two approaches in the light of Gewirth's human rights philosophy. Gewirth examines the dilemma of capable agents using their occurrent freedom to limit their dispositional freedom. Appealing to the responsibility of community agents, he suggests a three-step process in which the second step involves a trial period of treatment. The process suggested by Gewirth resembles the first of the two options, and has the advantages of the treatment preventing irreversible deterioration, and the potential for earlier release with its increase in both personal and situational freedom.

ACKNOWLEDGEMENTS

The Scott Starson case concerned me a great deal when it was in the news, and I have much appreciated the opportunity to engage this topic in some depth. I have found this a very interesting project with many interesting facets, from the history of psychiatry, to the neurosciences, as well as the legal aspects and the philosophical analysis.

This project has been made possible, as well as much enhanced, by my thesis supervisor - Dr Walters. Dr Walters was an amazing advisor. He was always there when I needed help, and gave many valuable comments on the various drafts that came across his desk. His comments were not only insightful and cut to the essence of the project, but he also challenged me on my arguments. Altogether, working with him was a pleasure and increased the quality of the thesis immensely.

I would also like to thank St Paul University for providing many interesting courses, an excellent learning environment, as well as a master's program in Public Ethics that suited my needs. I would like to thanks Dr Chantal Beauvais not only for being instrumental in developing the Public Ethics Program, and also for always being ready to answer my questions. She was also the first to provide encouragement on engaging this topic even before I started the Master's Program.

Closer to home I would like to thank my husband Walter for ongoing encouragement and support. Also I would like to thank my friends, especially Margaret Love, for their encouragement and the opportunity to discuss the issues with them.

INTRODUCTION

In 2002 and 2003, a case made its way through the Canadian court system that made the front pages of major Canadian news papers - the case of Scott Starson's refusal of treatment for his schizo-affective disorder. His psychiatric and legal history started in 1985, when, at the age of 29, he exhibited strange behaviour and was first admitted to a psychiatric hospital. During the next decade, he was in and out of the court system and psychiatric hospitals, because of offences such as threatening behaviour, causing a disturbance, uttering death threats and stalking, in both the United States and Canada. In 1998, he was again arrested for making death threats, this time against his psychiatrists, and he was ordered detained indefinitely. He continued to refuse treatment, in spite of his involuntarily detainment. His psychiatrists appealed to the Ontario Capacity and Consent Board and from there through the legal system all the way up to Supreme Court. Supreme Court eventually upheld his refusal of treatment in a six to three split decision. His mother was devastated saying that he would still not get the treatment that he so desperately needed, the treatment that would almost certainly lead to improvement, and possibly eventually to discharge from hospital. The future that Starson now faces has considerable potential for further deterioration, with little hope of discharge from hospital. By all accounts, he was a brilliant person, now doomed to indefinite confinement by his own choice. Or was it truly his own choice? Should one's own choice always be paramount?

This thesis will be built around human rights issues in the situation when an already involuntary, psychiatric patient makes a decision which has such profound consequences for himself and for society. This thesis will not deal with ethical issues of involuntary commitment as such, but will confine itself to the human rights of a person already committed. The involuntary patient status will be assumed as a given, i.e., a constant background factor. The treatment decisions that need to be made and that are discussed herein will be limited to those relating to the illness that led to involuntary commitment in the first place.

This thesis will consist of a multi-disciplinary analysis of issues contained in the Starson case. Before presenting an analysis of the human rights issues involved in refusing treatment, we will need to have an understanding of the many facets of this type of mental illness that can lead to behavioural consequences with such profound personal and social implications. What are the internal and external forces in the behaviour of persons with such illness? Is a person with that type of strange behaviour really ill, or just different? Is mental illness a social construct? What are the legal ramifications? Within what contexts are the courts operating? Are there measurable differences in a person's brain relating to their behaviour, particularly in people suffering from schizophrenia? What is the relation between brain and mind, anyway? All this is pertinent to the discussion of human rights of a person who is involuntarily committed to a psychiatric institute because of unacceptable behaviour.

The term mental illness in this thesis will be used as it is used in the contexts of the

courts - referring to persons with conditions with bizarre symptoms and impaired judgement that lead to unacceptable social behaviour. It should be remembered that this type of mental illness, in fact, is only a very small proportion of persons with conditions that could be called a mental illness. The vast majority of people who have what are more commonly called mental illnesses are people who have judgement and behaviour of the same quality as all of us.

In order to deal with the many sides of the mental illness under discussion, this thesis will have five main chapters. Chapter One identifies past and present issues in understanding and defining mental illness and psychiatry. Of special importance is the development of classification of mental illnesses. The process of developing the classification was as important as the final product because it was here that the discussion took place that led to the verbal expressions of what is mental illness and who are the mental ill. Verbalizing mental illness in precise scientific language affected development of scientific issues such as pharmacological treatment, as well as non-scientific issues such as societal attitudes toward the mentally ill. Another important development was the anti-psychiatry movement in the middle of the twentieth century, important because of its influence on alterations to the Mental Health Acts being made across North America.

Chapter Two identifies both scientific and philosophical aspects of brain functioning. The scientific discussion includes developing a very cursory understanding of mental illness from a neurosciences perspective, e.g., the potential involvement of neurotransmitters. The philosophical discussion includes a brief introduction to issues, such as the body-mind

problem, free will and treatment refusal.

Chapter Three introduces the legal aspects of the Starson case. This will include a short summary of relevant parts of the various Mental Health acts across Canada and a discussion of the determination of capability from a legal perspective and the difficulties this entails.

Chapter Four present a brief introduction to Gewirth's ethical rationalism and his theory of human rights based on the capability of the agent to act. This chapter will culminate with two practical applications of special relevance to the Starson case: How ought we to deal with persons who cannot act as full agents? How ought we to handle capable agents who use their immediate freedom to make decisions that have detrimental implications for their long-term freedom to act.

Chapter Five applies the human rights theory developed by Gewirth to the Starson case and will do so by examining the following hypothesis:

> That with regards to treatment refusal for the condition that led to involuntary commitment, the Saskatchewan standard of involuntary commitment to provide the person with the care and treatment as a result of which the detention of the person in the facility is no longer required is an option more in line with Gewirth's philosophy of human rights, than is the Ontario standard of involuntary commitment to prevent physical dangerousness to society or the patient themselves, with treatment to be decided by capable wishes.
>
> Saskatchewan emphasizes the return to freedom of movement as soon as possible,

while Ontario emphasizes the personal freedom inherent in consenting to treatment by capable persons. Ontario does so despite the difficulty in determining capability for involuntarily committed patients, who, in effect, have already been deemed incapable in some parts of their lives, and despite foreseeable consequences of the decision for that patient.

The approach of this thesis will be to build the analysis around a specific case study - the Starson case. In-depth analyses of specific situations are important in making advances in providing optimal justice for the mentally ill. This allows a concrete basis for the analysis, avoiding the need to include every possible scenario. In the conclusion, we will revisit the case history approach, and discuss to what extent this case has broader applications.

CHAPTER 1. WHAT IS MENTAL ILLNESS?

In many societies, including our own, the general public is still apprehensive about mental illness, showing little empathy for those afflicted, nor understanding of their affliction. The attitude toward, and treatment of, mental illness has a long and varied history. In this chapter, we will examine how our present concept of mental illness developed. We need to go many years back, since the development of religion and philosophy thousands of years ago still influences our attitudes today. Describing and defining mental illness is not as easy as it sounds, and developing a classification of mental illness, as classifications have been developed in other sciences, e.g., Linnaeus's work in biology, has been difficult. The objective of this chapter is to set the stage for the discussions of various aspects of mental illness in subsequent chapters. This background discussion will be presented under the headings: history of mental illness, treatment of mental illness, classification of mental illness, defining mental illness, the anti-psychiatry movement. The term mental illness here will be used mostly to refer to what is, in fact, only a very small proportion of persons with mental illness, and that is to conditions with bizarre symptoms and impaired judgement. We need to emphasize strongly that the vast majority of people who may be called mentally ill in society today, will be suffering from conditions such as anxiety and depression, and, on the whole, will have judgement and behaviour similar to most people.

1.1 History Of Mental Illness

For the ancient Hebrews, mental health was spiritual health, and mental illness a problem with the relationship between the individual and God as described in the Bible. For example, Nebucadnezzar was punished with madness for disobedience to God (Daniel 4:28-37). The New Testament talks about demon possession which likely included neurological diseases, such as epilepsy, as well as psychiatric diseases, such as psychosis. Because of the importance of the Bible in Christianity, these perspectives have, and continue to influence western society today.

Egyptian psychiatric theory was very much tied up with the Egyptian view of the self and its concern about the health of the soul. While mental illness was often regarded as something supernatural, the Egyptians also started to view it as a physical illness (Carlsson, 2005), and began to develop treatments, including the use of opium and sleep therapy. The earliest known psychiatric text, the first known hospital and the first physician dedicated to mental illness were all found in historical evidence of ancient Egypt at around 2000 BC (Carlsson, 2005). Later in Greece, Hippocrates (400BC) developed the idea of an aberration in the physiologic functioning of the body as a basis for all illness, including mental illness (Bollinger, 2003; Porter, 2002, 37). He developed the notion of 'humours,' body fluids which could be the source of various imbalances in the body.

Medieval Islamic thinking picked up on Hippocrates' idea of mental illness as physiological illness and moved away from the idea of mental illness as demon possession

(Porter, 2002, 49). Many advances were made in the understanding of health in general and mental health in particular during this golden age of Arab science, including the beginning of an understanding of the relation between mental disorders and brain dysfunction (Stone, 2006, 6). The earliest psychiatric hospitals and insane asylums in Europe were built in the Islamic world and many texts were written by famous Arab physicians (Ahmed et al., 2005, 310-317).

In Christian Medieval Europe the attitude became less benevolent, and mental illness was often associated with witchcraft - a resurgence of the idea of demonic possession. Those so afflicted were often ostracized, ridiculed or even killed (Porter, 2002, 25-27). Later asylums were established to house the insane, ranging from the small, luxurious ones for the rich and large, minimal ones for the poor (Porter, 2002, 96). Bedlam for a long time was the only psychiatric institution in Britain, and in the seventeenth century became quite a tourist attraction in London (Torrey, 2001; Scull, 2004, 420). Not until the nineteenth century were the mentally ill treated more humanely.

Toward the end of the nineteenth century, major changes in treatment of mental illness were in the works. Influential European neurologists, such as Freud and Kraepelin, changed the understanding of mental illness drastically (Bollinger, 2003). Freud considered psychological states as energy systems where blockages of the flow of thought resulted in mental illness which had to be unblocked by a 'talking cure.' Subsequently psychiatry split into two directions, one that followed Freud and treated psychiatry as caused by psychological factors, and another that looked to aberrations in the tissues of the brain. Emil

Kraepelin (1856-1926) was one of the latter group, and many consider him to be the founder of modern psychiatry. He believed that psychiatric disease is mainly due to biological and genetic causes (Porter, 2002, 184-186).

Many new developments and breakthroughs in neuroscience occurred in the twentieth century. As part of these developments, schizophrenia was shown to involve brain dysfunctions that interfere with the ability to respond appropriately to the natural and social environment (Glannon, 2007a). New work in the neurosciences and neuroimaging is giving a much better understanding of how the brain works and how it affects people with conditions such schizophrenia. This better understanding has a great influence on the development of new treatments for mental illness.

1.2 Modern Treatment of Mental Illness

In the twentieth century increased emphasis was placed on treatment, which in addition to (or, perhaps, instead of) the 'talking cure,' increasingly relied on shock treatment, psychosurgery and, eventually, psychoactive drugs. The main pharmacological treatments for schizophrenia are the antipsychotics which are used to treat delusions, hallucinations and disorganized speech and behaviour, social withdrawal, etc. (Stroup et al., 2006, 303ff). Although these medications tend to be at least partially effective for the majority of patients, they do have significant side effects. These side effects can be debilitating, especially the sedative effect, the involuntary movements of tardive dyskinesia, the weight gain. Mood stabilizers, such as lithium and some anticonvulsants, anxiolytics and antidepressants are

often used to treat the mood symptoms. Lithium dosage needs to be adjusted carefully as it has a narrow therapeutic range, meaning that there is a narrow gap between too little or too much. The most common side effects are a somewhat groggy feeling and a hand tremor which can be quite annoying, or even disabling in fine work. Many different types of antidepressants have been developed over the years and they have become one of the most commonly prescribed drug classes. They have had their ups and downs over the years. Kramer's book, *Listening to Prozac*, was very popular and very influential in the 1990's, increasing the use of antidepressants, especially the then new class of SSRIs (selective serotonin reuptake inhibitors) that includes Prozac, greatly (Kramer, 1993). More recently there has been controversy about the effectiveness of antidepressants, leading to intensive debate among psychiatrists (Moncrieff et al., 2007).

Psychotropic medications remain the mainstays of treatment for any type of mental illness today. There is still a controversy about how effective they are, although there is little doubt that they decrease psychotic symptoms in many, if not most, afflicted persons. Still there are unpleasant side effects, including: sluggishness, too much or too little sleep, weight gain, tremors, dry mouth, and difficulty urinating. There is also increased risk of hip fracture - a case-control study showed a doubling with prolactin-raising antipsychotics possibly due to an increase in osteoporosis resulting from these drugs (Howard et al., 2007; O'Keane et al., 2007). Not taking medication when needed has its own risk, e.g., a potentially irreversible deterioration, continuing erratic behaviour which could be dangerous to self and/or staff or fellow patients, risk of long-term detention, and the substantial cost to the

health care system when psychiatric hospitals are used for detainment rather than treatment.

1.3 Classifying and Defining Mental Illness

An important part of Western scientific development has been and continues to be classification. Classifying anything is not only important in communication but has a profound influence on the future meaning of a concept and how it will be regarded. Mental illness is no exception. "In classifying disorders, we hope to gain control over them" (Cooper, 2007, 66). Classification is power. Cooper suggests a potential association between the existence of a classification and the emergence of treatment for mental illness (Cooper, 2007, 66). When drug treatments are found, it is hoped that they will work for all patients with a certain classification. This is not only altruistic - this also means money for pharmaceutical and other companies. In developing a classification system of mental illness not only scientific or medical influence and philosophical issues were considered, but also political, financial and other self-serving influences were brought to bear.

Kraepelin was the first to classify mental illness and establish it as a scientific entity with boundaries and divisions (Porter, 2002, 184-186). After studying many case histories in detail, he developed a new way of looking at mental illness. He suggested a classification of mental illness by pattern of symptoms, i.e., syndromes, and by the course of the disease. He is especially well known for separating what he called "manic depression," now called bipolar mood disorder, and what he called "dementia praecox," now called schizophrenia. In describing the course of these diseases, he thought that dementia praecox always had a

continuously deteriorating course. When later this was found not to be true, this led to a name change - schizophrenia. During his life, his work was marginalised largely because he could not compete with the charisma and popularity of Freud. However, after his death his work became more universally recognized and later in the twentieth century his classification was used as a basis for the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the World Health Organization's *International Classification of Diseases* (Stone, 2006, 12-13).

In 1942 the American Psychiatric Association published the first edition of the DSM. The impetus for its development came from the census for which consistent statistics about patients of psychiatric institutions were needed. The first edition of the DSM was adapted from several pre-existing classifications systems, and Kraepelin's system was especially influential. The first edition listed 106 categories, while by the second edition, published in1962, the number of categories already increased to 180. A third edition, the DSM-III, appeared in 1987. The now 292 diagnoses had often been based on serious soul searching and controversy about what should be included. The DSM-III was considered a revolutionary change in psychiatry, and was soon used internationally. Hospital records, insurance claims, etc. now demanded DSM codes. A fourth edition, 1994, now 297 disorders, has fewer changes, and remains in use today, although DSM-V is in the works.

The DSM organizes each diagnosis along five axes as shown in the chart:

Axes	Aspects of disorder	Examples
I	clinical disorders, incl. major mental disorders and developmental and learning disorders	depression, anxiety, learning disorders, bipolar, ADHD, schizophrenia
II	underlying pervasive or personality conditions, mental retardation	borderline personality disorder, schizoid personality disorder, paranoid personality
III	acute medical and physical disorders	brain injuries and physical disorders with mental symptoms
IV	psychosocial or environmental contributing factors	
V	global assessment of functioning	e.g., the Children's Global Assessment Scale for children under the age of 18

There continues to be a debate about the validity and practicality of the diagnostic categories and whether the system makes unwarranted distinction between disorders, and between normal and abnormal, etc.

Cooper mentions a number of issues that needed to be dealt with to develop the DSM, one of which was providing a definition of mental illness (Cooper, 2005, 1-3).

Defining mental illness also includes determining who and what is normal. Determining what is normal is not always easy. For this classification, as is often the case, the concept of 'normal' was determined with reference to what was not considered to be normal, i.e., abnormality as a deviation from the norm. In this way, classifying becomes a value judgement, in that it decides what is normal and what is not normal. As a result whatever is included in the DSM soon becomes recognized as a problem, or as disturbed behaviour, whether that was the intention of those compiling the DSM or not (Cooper, 2005, 1-2). Once a "problem" is included, it affects the way people with that problem are regarded. This is clear from the way DSM codes are used by insurances. To get a claim processed, one needs a code; but having a code means you are no longer 'normal.' Insurance is not the only big business with an interest in classification - pharmaceutical companies are also interested in what is included in the DSM, and what condition needs treatment. Cooper devotes many pages to the interrelation between the development of the DSM and the needs of these companies (Cooper, 2005, 105-128).

The importance of what is in the DSM, and the issue of value judgements, is exemplified by the controversy on whether or not homosexuality should be a category in the DSM classification (Cooper, 2005, 8, 17-18). The gay movement felt that since homosexuality was not a disease, keeping it as an item in the classification would give the wrong impression. Others felt strongly that homosexuality was an aberration and, therefore, should be a category in the DSM. Interestingly, the final decision was made by means of a referendum of the members of the American Psychiatric Association (APA) which publishes

the DSM. The result was that homosexuality was removed. This controversy even affected the definition of mental illness as a definition of mental illness was now needed which would not automatically include homosexuality as a condition to be classified.

A major issue in producing the DSM was as basic as deciding what is a mental illness. A definition of mental disease, developed after discussion and controversy, is provided in the introduction of the DSM III:

> ". . . each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioural, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society" (as quoted by Cooper, 2005, 18).

As can be seen, the American Psychiatric Association did not insist on a totally biological account of mental illness, and one reason was to ensure that homosexuality is not included. Although the DSM only relates to mental illnesses, the DSM-IV included a note indicating that there is no meaningful distinction between mental and physical illnesses, indicating that there is much that is physical in mental illnesses and much that is mental in physical illnesses. Arguments on less or more distinction between mental and physical illnesses have been made by special interest groups, some of whom are interested in a greater distinction, (e.g., psychologists who want to be able to treat the mental illness to a greater

extent), and others in less distinction (e.g., forcing insurances to reimburse treatment of mental illness as they do physical illnesses) (Cooper, 2005, 10).

Cooper is not entirely happy with the DSM definition of mental illness but allows that what she terms a "tidy definition" cannot be achieved (Cooper, 2005, 22). As part of developing her definition, she argues that a disease is a condition that 1) is a bad thing to have, ***and*** 2) the afflicted person is unlucky to have it, ***and*** 3) the condition can potentially be medically treated (Cooper, 2005, 22).

Cooper's definition is not entirely convincing as a conclusive definition either, and one of Cooper's examples is rather worrisome. She suggested that an elderly person having difficulty walking should not be considered as a disease, because one would expect an elderly person to have difficulty walking, and therefore, the person cannot be considered unlucky. To me, that is a very problematic situation, and clearly shows the danger of definitions, or labelling. If difficulty in walking is considered 'normal' for an elderly person, then a physician might not think of looking any further and not bother to treat it. In fact, difficulty with walking may be due to a treatable condition, such as poorly fitting shoes, arthritis, a corn on the toes, or poor circulation, in which case, treatment may improve walking and quality of life for the elderly person. This example illustrates the power of definitions.

The diagnosis of schizophrenia remains difficult. In spite of improved classification and the increasing knowledge of physical changes with schizophrenia, no concrete test is available to diagnose schizophrenia (Beers and Berkow, 1999, 1566). Neuroimaging has not

yet developed to the stage where it has sufficient, predictive reliability - possibly, it never will. As a result, the diagnosis of schizophrenia is based on the self-reported experiences of the potential patient, as well as abnormalities in behaviour reported by family members, friends, or co-workers. This would be followed by secondary signs observed by health professionals such as psychiatrists, social workers, clinical psychologists or other clinicians involved in the clinical assessment. To be diagnosed as schizophrenic, a person will show symptoms such as delusions, hallucinations, change in social functioning and self-care. Schizo-affective disorder goes beyond schizophrenia in that it also incorporates mood disorder, which, in Starson's case, consisted of manic episodes.

1.4 The Anti-Psychiatry Movement

Still, some people remain mistrustful of psychiatry. Confinement in an institution has been a major part of treatment for a long time and confinement had a potential for abuse. Stories are told about commitment of perfectly normal people to hospital for the sake of control by others, e.g., wives who were in the way of their husbands' aspirations. It was also well known that in some countries psychiatric institutions were used to detain dissidents, e.g., in cold war USSR. As professional psychiatry became more established in the twentieth century, distrust did not necessarily disappear. Anti-psychiatry movements became especially prominent in the 1960's and the 1970's. The critics of psychiatry were a diverse group with people such as Szasz, Rosenhan, Foucault, Breggin, Laing, each giving different reasons for distrusting psychiatry.

The title of Szasz's controversial article and book, *The Myth of Mental Illness*, became a rallying cry by members of the movement (Szsaz, 1960). Szasz himself was a trained psychiatrist, so no one can claim that he would personally benefit from proclaiming the non-existence of mental illness. Szasz claimed that most psychiatric patients were unconventional rather than ill, even if the behaviour made others uncomfortable (Szasz, 1960). Although some may consider schizophrenia the "sacred symbol' of psychiatry, according to Szasz, it does not exist, and psychiatry is used for social control. Szasz was quite vocal about the insanity defence, and called it a legal tactic. Testimony about the mental competency of defendants should not be admissible in trials, and no one should be committed to hospital involuntarily unless he or she is guilty of a criminal offense. Psychiatric patients should be able refuse treatment just like any other patients. In spite of this rhetoric, Cooper thinks that Szasz is not as radical as he claims (Cooper, 2005, 39; 2007, 17). Szasz would accept brain diseases but not mental disease, and if a mental illness such as schizophrenia could be shown to have a physical basis then he would accept it as a real disease. Presumably with all the advances in the neurosciences, Szasz may well rethink some of his stands on specific illnesses. Still, Szasz's types of views have been influential both philosophically, for thinkers such as Popper, Foucault, as well legally, in the revision of mental health acts in the 1960's and 1970's (Gray et al., 2000, 97).

Other approaches to opposing psychiatry have been advanced by Foucault, Laing, Rosenhan and others. Foucault argues that the concept of mental illness depends on our particular historical development. If the historical development had been different, this

concept might never have emerged (Cooper, 2007, 14). Foucault concluded that madness is not the kind of illness best treated by doctors (Foucault, 1971). A somewhat different side of a similar idea is that of Laing who claims that conversation with the mentally ill makes sense if their social context is considered (as quoted by Cooper, 2007, 25). In a different environment, they would not be considered ill. Later Laing went so far as to claim that schizophrenics were potentially better off than the rest of society. Schizophrenic experiences are part of a spiritual journey that can lead them to a higher level of sanity (Cooper, 2007, 25). Rosenhan also casts doubt on the existence of mental illness by claiming that health professionals cannot tell what is mental illness and what is not. Rosenhan published his famous study in 1973 in a widely read article, "On Being Sane in Insane Places" (Rosenhan, 1973, Cooper, 2007, 11-13). Rosenhan first asked several volunteers to visit a hospital ER and claim they had a brief auditory hallucination. All of them were admitted without being detected by the medical staff as fake. This involved twelve different psychiatric hospitals in the US. In another experiment, he asked the staff at a psychiatric hospital to detect nonexistent "fake" patients and found that the staff falsely detected large numbers of real patients as impostors. Although Rosenhan's work was heralded as an important criticism of psychiatric diagnosis, Cooper is not sure what it means for psychiatry. According to her, all it shows is that psychiatrists can be tricked, and, as Cooper advises "it suggests that if you do not want to be locked up you should not claim to hear voices" (Cooper, 2007, 14). Most likely, admission to a psychiatric hospital would not be as easy today.

Another very vocal and influential opponent of psychiatry is Peter Breggin. His working assumption is that all psychiatric treatments have their effect by disabling parts of the brain rather than by improving brain function. So-called antipsychotic drugs work by what he calls chemically lobotomizing patients with the resulting apathy and indifference seen as treatment (Breggin, 2008a). The medical profession and society at large consider these damaging interventions beneficial and the psychoparmaceutical industry spends billions of dollars maintaining this charade.

Thus, there are variety of misgivings expressed about psychiatry: Rosenhan asserts the psychiatrists cannot distinguish patients from normal patients; Szasz claims that psychiatrists wrongly label social misfits; Laing claims that schizophrenics are made scapegoats by their families; Foucault claims that mental illness is a construct of our history (Cooper, 2007, 27). Although these voices are very outspoken and even influential, they are still a minority opinion. The large majority of the medical profession and society in general accept the traditional psychiatry as outlined in the DSM and medical textbooks. Many counter arguments to the anti-psychiatry movement have been voiced. For example, Roth and Kroll argue that the existence of similar psychiatric symptoms for millennia is evidence that mental illness is not just a social construct, but a real pathological entity (Roth and Kroll, as quoted by Porter, 2002, 4). Still, the anti-psychiatric movement had far-reaching influence. Not only did the APA set about to make a serious effort to define mental illness in reaction to their cries, but, together with the general trends in post war society of individualism and autonomy for individuals, they also influenced the direction of changes

made to Mental Health Acts in the 1970's (Gray et al., 2000, 31-66).

In summary, today's concept of mental illness has clearly been influenced by many centuries of religion, philosophy and science - classification and definition brought all these influences together. This discussion of the concept of mental illness provides a basis for our further discussion since our understanding of meaning of mental illness influences everything else related to it. For example, our understanding of meaning of mental illness influences how further research in the mechanics and treatment of mental illness develops, and how laws and regulations express our ways of dealing with problem areas related to mental illness. These topics will be discussed in ensuing chapters before we go on to discuss Gewirth's human rights philosophy with the goal of applying it to the dilemma of treatment or no treatment with which Starson has presented us.

CHAPTER 2. MIND, BODY AND BRAIN

Szasz, who made his fame by calling mental illness a myth perpetrated by the psychiatric profession (Szasz, 1960), allowed a chink in his armour of denial. He would accept brain diseases, and if mental illnesses could be shown to have a physical basis, then he felt able to accept it as a real disease (Cooper 2007, 17). Much work has been done in the last few decades on this very topic and this chapter then will examine the functioning of the brain as it relates to mental illness, from both neuroscience and neurophilosophical perspectives. The discussion will be under the following headings: neuroscientific issues related to normal and abnormal behaviour, the mind-body problem, free will, and treatment refusal.

2.1 Neuroscience and Behaviour

Many advances have been made in the neurosciences in the last few decades and are continuing. New methodology, such as neuroimaging, gives a much better understanding of how the brain works and how it affects people with conditions such schizophrenia. Schizophrenia is shown to be related to abnormalities in the brain. For example, studies using brain imaging technologies show differences in the frontal lobes, hippocampus, and temporal lobes (Glannon, 2007a, 58). Studies using magnetic resonance imaging (MRI) were able to show even minor structural brain abnormalities in schizophrenic patients when first evaluated. Even with treatment, the brains of schizophrenic patients continue to show a

certain amount of deterioration, such as a continuing reduction of gray matter in the frontal lobe (Glannon, 2007a, 67).

Of special importance in the context of schizophrenia are neurotransmitters. Glannon refers to neurotransmitters as 'chemical vehicles' bringing the message across synapses to modulate brain functions (Glannon, 2007a, 14). The main neurotransmitters concerned with neuromodulating effects are epinephrine, norepinephrine, cortisol, acetylcholine, dopamine and serotonin. Serotonin is implicated in regulating mood (Glannon, 2007a, 14). Selective serotonin reuptake inhibitors (SSRI), such as Prozac, are widely used as antidepressants and are known to work by regulating serotonin levels. Of special importance to schizophrenia is dopamine which plays a role both in cognition and in motor functioning (Glannon, 2007a, 15). While too little dopamine leads to the motor disorder of Parkinson's Disease, too much dopamine makes it difficult to filter out the irrelevant input from around us, making it difficult to pay attention to what is important (Glannon, 2007a, 15). As a result some Parkinson's Disease drugs for restoring dopamine, may cause overly vivid dreams or even hallucinations as side effect, while naturally occurring excess dopamine in schizophrenia deluges the brain with excessive stimulation.

Recent work shows that another, more widespread, neurotransmitter, glutamate, may also be involved in schizophrenia (Javitt et al., 2004). The widespread occurrence of glutamate in the brain correlates with the wide range of symptoms of schizophrenia (Javitt et al., 2004). Researchers hope that reversing the glutamate deficit may be a more effective treatment for schizophrenia than those available so far. As Glannon puts it, "When the

normal neural networks underlying cognition are severely disrupted, [e.g., as by abnormal functioning of neurotransmitters] the schizophrenic cannot tell the difference between his or her own internally generated images and images from the external world" (Glannon, 2007, 34). This, obviously, interferes with the ability to respond appropriately to the natural and social environment. These new developments and breakthroughs in the neurosciences have gone a long way toward curbing talk about the myths of mental illness. Exactly how behaviour and brain relate is still a puzzle.

2.2 Mind-Body Problem

In philosophy, the mind-body problem is an age-old puzzle of how minds or mental processes or souls are related to what goes on in the body. In the past, Christians generally accepted a dualistic view where each person in addition to a material body had nonmaterial parts such as soul and mind. Augustine developed his view of a strong body-soul dualism in which he regarded the body as the lesser and impermanent part and the soul as the essential and important part (Brown, 2005, Lecture 1). Descartes, in the context of the Age of Enlightenment, advanced an even sharper distinction between body and mind but, in contrast to Augustine, he put most of the emphasis on the physical part. He dealt with the issue of interaction between mind and brain by postulating interaction through the pineal gland (Brown, 2005, Lecture 1). Other versions of interaction have been proposed over the years; for example, Eccles and Popper's suggestion of interactions at the synapses (cited by Glannon, 2007, 25), or the need for intervention by God for the mind-body interactions.

With the ongoing emphasis on, and advances in, the neurosciences, the dualist approach of viewing body and mind/soul as distinct entities is becoming less defensible. A more generally accepted view today is monism, or physicalism, where persons are considered as single, unified, although complex beings. Physicalism contends that the mind is derived from the physical properties of the body/brain and no immaterial entities are needed to explain any of the human capacities. The two major types of physicalism are reductive and nonreductive physicalism.

According to the reductionist model all brain functions can be adequately explained by the structure and chemistry of the body - the more we learn, the more the neurosciences will explain everything (Jackson, 2000, 576). Thus, mental states are just neural states; the nature and content of mental states can be explained by the material structures and functions of the brain. As Churchland puts it: "Mental activity is brain activity" (Churchland, 2002, 30). To the question "What is Life?," Churchland answered that life consists of all of the biochemical reactions and other measurable activities of the body and that there is no other phenomenon as "livingness itself" left to be explained (Churchland, 2002, 170).

In contrast, nonreductive physicalism believes that human behaviour and life as such cannot be completely understood only by studying the details of neurophysiology or neurochemistry. There is something more and "somewhere a readjustment is made in the measurable signals coming from science" (Brown, 2005, lecture #2, 8). The term 'emergentism' expresses the concept that the total is more than the sum of its parts and a complex living organism has properties not found among its elements. These new properties

increase the scope of possibilities for the system as a whole immensely and "mental states emerge as higher level properties from lower level physical properties of the brain" (Glannon, 2007, 27). The concept of "supervenience" is used to express the concept of a dependency relation with higher level mental properties dependent on lower level physical properties (Glannon, 2007, 26). Obviously, mental states are not only impacted by neural events but also by their social, environmental and historical context (Murphy et al., 2007, 21).

The modern challenge is to find an explanation of the mind that is consistent with advances in clinical neuroscience. According to Glannon, the mind is a set of conscious and unconscious states including beliefs, desires, emotions, memories and intentions, as well as unconscious beliefs, emotions, such as fear, that are involved in our responses (Glannon, 2006; 2007, 23). The mind is not reducible to the brain because the intentionality of the mind, according to Glannon, is not solely a property of neurons, and other components of the nervous system (Glannon, 2007, 23). Searle defines intentionality as "that property of many states of mind and events by which they are directed at, or about, or of, objects and states of affairs in the world" (Searle, 1985, 1). For example, as Searle continues, if we have a fear that means that it is a fear of something, if we have a belief it must be a belief in something. It is also possible to have a fear or a belief without intentionality - just a vague fear without an object - as it is possible to have a depression, or an elation without intentionality. 'Intention-in-action' is the term coined for the intentional or mental aspects of action. Searle also emphasizes that intentionality as he uses it is not the same as consciousness (Searle,

1985, 3).

Intentionality relates to mental causation. The concept of mental causation refers to the relation between mental happenings and bodily responses, or vice versa, or, in other words, causal relations involving mental events as causes or effects. The issue of mental causation is not a problem to reductionists, as reductionism does not make any distinction between mind and body, and identifies mentality with the physical processes. The concept of mental causation, however, remains a crucial and controversial part of the mind-body problem and debate for others. The main difficulty with Descartes' dualism is that it did not explain mental causation. Mental causation is also an issue for "nonreductive physicalism." If the mental is in any way irreducibly distinct from the physical then some way is needed for the mental level to causally influence the physical processes. Brown maintains mental causation as it is often discussed is an illusion (Brown, 2005, lecture #3, 17). In his view, the mind is something that occurs in acting, and the mind is embodied. The concepts of emergence and supervenience have been postulated to make mental causation possible. The mind is a description of brain and body acting as one in solving real problems in the field of action. As Brown expresses it, the mind is causation in process (Brown, 2005, lecture #3, 17).

Another difficult concept that has been the focus of discussions by philosophers and psychologists for decades, if not centuries, is that of consciousness. While Glannon states that any attempts to explain consciousness in physical terms have failed because consciousness cannot be reduced to the organization of neural networks (Glannon, 2006, 2).

Murphy et al. describe a model based on work by Edelman and Tononi which they consider "a neurologically plausible model of consciousness anchored in neuroanatomy, neurophysiologic, and clinical neurology" (Murphy et al., 2007, 141). The two-part model consists, first of all, of a primary consciousness that allows animals to construct a "mental scene," but with limited semantic and symbolic contents; and, secondly, of a higher-order consciousness characteristic of humans, with sense of self and the ability to construct past and future scenes. This second part would require a semantic and linguistic, capacity (Murphy et al., 2007, 141). Both parts of the proposed model require a body-awareness and some degree of reference in space (Murphy et al., 2007, 141-5). Two of the fundamental characteristics of consciousness then are unity, i.e., consciousness to be experienced as an undivided whole, and privateness, i.e., the experience is accessible only to the conscious agent (Murphy et al., 2007, 141). What Murphy et al. consider the most remarkable part of the Edelman and Tononi model is their proposal of the potential neurophysiological basis of conscious awareness. Edelman and Tononi argue that a state of consciousness is a constantly changing area of activity within the cerebral cortex which has many interconnections in a widespread area which they call a "dynamic core." The dynamic core, as they define it, is made up of the specific neural groupings and the functional relations among the groupings that define the nature and content of consciousness at any point (Murphy et al., 2007, 142). Input into the dynamic core come from many other areas of the brain. Edelman and Tononi specifically name basal ganglia, (motor regulation), cerebellum (complex learned behavioural sequences), hippocampus (memory), hypothalamus

(vegetative, autonomic, and hormonal regulation) as among these areas (Murphy et al., 2007, 143-4). Higher order consciousness postulated by E&T happens when "symbolic representations and language are incorporated into dynamic cores" (Murphy et al., 2007, 142).

From the concept of consciousness, it is a short step to the question: Who, or what, is the self? Glannnon presents the self as "a function of five psychological properties [activities?], corresponding to different biological functions in the brain and body as well as their relation to the external environment" (Glannnon, 2007, 13). He considers the five components of the self to be "unity, continuity, embodiment, agency and relatedness to the external world," and stresses the importance of maintaining all five in a healthy order (Glannnon, 2007, 33). Churchland expresses the concept of self as ". . . a set of capacities that involve not only representation of the body itself but also representation of internal aspects of the brain - the brain's mental life" (Churchland, in Glannon, 2007, 179). Neuropsychiatric disorders are then conditions that adversely affect the integrity of the self (Glannnon, 2007, 32). Interferences with ability to respond appropriately to natural and social environment, as in schizophrenia, would also interfere with the person's view of the self (Glannnon, 2007, 37).

The concept of the self in legal circles is not necessarily the same as the one just discussed. For the purposes of the law, there needs to be a specific and concrete concept that can be expressed precisely, and is useful for making decisions in the legal context. According to Morse, the "legal concept of a person is that of an agent who is capable of

acting intentionally and for reasons" (Morse, 2007, 196). As part of this, the law has to determine human action to be governed by reason and the people involved to be intentional agents (Morse, 2007, 196). In addition, in the context of law but also in other concepts of the self, some measure of free will needs to be assumed.

2.3 Free Will

Two main views of free will are compatibilism and incompatibilism. Compatibilism is the belief that free will is compatible with determinism and that it is possible to accept both free will and determinism without being logically inconsistent. Incompatibilism considers free will and determinism to be logically incompatible. There are several types of incompatibilism, such as believing that determinism is reality and therefore free will is an illusion, or that free will is true, therefore determinism is not, or even that neither determinism nor free will is true (Murphy et al., 2007, 271). Murphy et al. maintain that if top-down analysis, as in supervenience, is the primary determinant of an organism's behaviour, then it matters little whether the bottom-up influences are deterministic, indeterministic, or probabilistic (Murphy et al., 2007, 276). Murphy et al. distinguish between total responsibility and primary responsibility (Murphy et al., 2007, 290) Thus, "free will is to be understood as being the primary cause of one's own actions; this is a holistic capacity of mature, self-reflective human organisms acting within suitable social contexts" (Murphy et al., 2007, 305). Accordingly, Murphy and Brown ask the question: "Did My Neurons Make Me Do It?" as a context for presenting their version of nonreductive

physicalism. At the end of a series of lectures, Brown answers the question with a resounding: "No, I did it. My neurons are merely a part of the integrated and highly complex ME" (Brown, 2005, Lecture 3).

However, even when humans accept that they are responsible for their own actions, there is still the question of the effect of brain damage on free will. There are examples of people who show moral impairment following brain damage - people who can no longer apply previously accepted rules of social and ethical behaviour after brain damage (Damasio, 2007, 177). Damasio mentions the case of Phineas Gage who sustained a brain injury in an explosion in which a metal rod pierced the frontal lobes of his brain. Gage changed from a rational and respected person to an impulsive and socially inappropriate person (Damasio, 2007, 171). Damasio concludes that one can only speak about free will, moral reasoning, and moral and legal responsibility, when there are the mental and emotional capacities that make it possible to exert control on our behaviour.

Murphy et al. provide an interesting discussion on the cognitive prerequisites for moral responsibility. They describe a person capable of morally responsible action, as one who "has the ability to evaluate, in the light of some concept of the good, the factors that serve to shape and modify one's actions" (Murphy et al., 2007, 240 & 255). In other words, a person is morally responsible for action undertaken on the basis of evaluation of one's goals in light of a concept of good. This would, obviously, assume a proper functioning brain.

Murphy et al. list six cognitive capacities needed for moral responsibility which they

base philosophically on Alasdair MacIntyre's work (Murphy et al., 2007, 244-255). The first two, a sense of symbolic self, and a sense of the narrative unity of self, can be considered the major ones, with the others following from them. By a symbolic sense of self, Murphy et al. mean having a self-concept which is influenced by stage of maturity, understanding the intentions of others, language, etc. (Murphy et al., 2007, 244). By a sense of the narrative unity of life, as per MacIntyre, is meant a sense of our past, the present and the future, and the ability to evaluate the present in terms of future consequences of present actions (Murphy et al., 2007, 249; cf., MacIntyre, 1984, 204-225). Abnormalities in brain functioning may damage this perspective, and examples are given in which brain damage affected a person's memory of the past, making understanding of the context of past, present and future difficult (Murphy et al., 2007, 250). Other suggested cognitive capacities include the ability to run behavioural scenarios and predict outcome (Murphy et al., 2007, 251); the ability to evaluate predicted outcomes in the light of goals; the ability to evaluate the goals themselves in the light of abstract concepts; the capacity to use moral concepts to describe one's own actions, etc. and the ability to act in the light of the above (Murphy et al., 2007, 255-6).

Murphy et al. provide examples of situations that might hinder the ability to act, such as being physically constrained, not being able to overcome a biological urge, malfunctioning of the brain (Murphy et al., 2007, 259). Many examples have been given of people with brain damage who show impaired judgement and, especially the example of Phineas Gage keeps cropping up. Gage was a much studied person who exhibited a

profound change of personality after an accident causing extensive brain damage. Churchland also discusses this issue, and states that she would like "to understand the neural difference between someone who, roughly speaking, is in control and someone who, also roughly speaking, is not in control" (Churchland, 2007, 181) As a reductionist, she calls for more knowledge, meaning more research, in that area in order to be able to understand this issue. Whether one is a nonreductive, or reductive physicalist, one can agree that an abnormally acting brain, e.g., because of schizophrenia, could have many types of judgement impaired, e.g., a sense of self, a sense of judging outcome of one's actions.

In the light of this complex set of cognitive capacities needed for moral judgement, we may well ask what is normal, or even what is acceptable? Glannon's definition of normal is: "Normal mental functioning consists in the cognitive and affective capacity to interact with others and to perform ordinary tasks of daily life" (Glannon, 2007, 35). Overtly mentally ill persons, such as Starson when untreated, obviously do not fit in this definition of normalcy. Still, most traits which can be used as part of the diagnosis of schizophrenia can be shown to exist in the population on a continuum, ranging from none to obvious. It is hard to decide at what point such traits become 'abnormal' and then at what point such traits are symptoms of a mental illness. The aim of pharmacological intervention is to restore brain functioning as much as possible to a normal level so that mental and physical abilities can be restored to "normal" levels - whatever normal may mean. With this uncertainty it is not surprising that the issue of treatment is not always simple.

2.4 Treatment Refusal

There have been a variety of reasons for why patients might refuse treatment, even in cases of treatment for clearly unacceptable behaviour, such as that which led to involuntarily commitment to a psychiatric hospital in the first place. First of all, treatment could be refused because of a lack of capacity to understand one's illness and of the implications of not being treated. Such lack of capacity may be because of diminished brain functioning, such as developmental delay, or Alzheimer's Disease, or because of the delusions and hallucinations of schizophrenia. Among these may be included an interesting phenomenon, called anosognosia. The term "anosognosia" is used to mean a denial of illness and is related to some kind of brain injury. For example, after a stroke, as many as a quarter of stroke victims show some form of denial of their condition (Ramachandran, lecture #5, 2003). This denial may occur even as a denial of a paralysis which is obvious to everyone else (Vuilleumier, 2004; Cocchini, 2002). More controversially, this term is also used to describe the lack of insight into their own illness by psychotic patients, as many persons with schizophrenia appear to be unaware of some or all of their disease (Pia, 2006). Such a lack of insight may include not being aware of having a mental disorder, not understanding the effects of the medication, and/or not understanding the social impact of their mental disorder (Amador, 1993). Research on the underlying neurological abnormalities, e.g., lesions to the frontal lobes that lead to these phenomena is promising, but more is needed (Pia, 2006).

Secondly, treatment refusal could arise from unacceptable side effects of the prospective treatment. The reason that Starson provided for his refusal certainly related to

the side effects - that he would no longer be able to think clearly and do the creative thinking in the sciences that he felt gave his life meaning. His mother did not agree that he was able to think better without the medicine - she felt that he was brilliant only when the schizophrenia was controlled. As that may be, this brings us to a third reason, closely related, which is the prospect of losing desirable characteristics that are part of the illness. Rightly or wrongly, Starson felt that he would lose something of great value to him. Even when the traits of value appear atypical and bizarre to others, there may still be qualities that are desirable to the possessor. There are times when an obviously abnormal trait is quite desirable, for example, persons with autism may have certain traits showing a narrow band of brilliance which could be put to good use - the savant syndrome (Treffert, 2009).

From this perspective we may ask: Should a person accept treatment when that would mean losing something which gives meaning to his or her life? Glannon refers to the story of a nun, from a book by Salzman, who suddenly began having mystical visions (Glannon, 2007, 36; Salzman, 2000). These visions gave a deep meaning to her previously nondescript life in the convent. The nun began writing poetry and a best-selling book of poetry allowed the convent to have much needed repairs done to the roof. When these visions turned out to be due to potentially life-threatening meningioma, the nun needed to decide whether she really wanted the operation, as it would mean losing what had given such renewed meaning to life, not to speak of the financial benefits to the convent. Starson also felt that he would lose something important to him, if he were to accept treatment, as he felt that treatment would take away his ability to think creatively in subjects of vital interest to

him. Treatment would not just bring him down from his euphoric and manic stage to a 'normal' level, but might even bring him down to a 'subnormal' level because of the side effects of the drugs, such as feeling sluggish, dealing with involuntary movements, etc. However, his refusal of treatment meant that he remained an untreated, committed violent offender acting abnormally and anti-socially.

This chapter reflected on the interaction of science and philosophy, particularly as new advances are being made in the neurosciences. The mind-body discussions over the centuries have shifted from the dualism accepted by the church fathers, to the physicalism accepted by most scientists and philosophers today. Both the reductionist and non-reductionist physicalists still have to find completely satisfactory ways of incorporating the mind, and concepts such as free will, into a unified mind/body model. Defining free will in terms of moral agency makes the discussion of cognitive prerequisites for moral responsibility relevant. It is now widely accepted that changes in the neurophysiological functioning of the brain underlie the aberrations in thinking and behaviour found in schizophrenia.

CHAPTER 3. LEGAL ISSUES

Mental health related issues in Canada are dealt with under provincial Mental Health Laws as applied by the courts (see Appendix: "Ontario Boards and Courts"). Thus, how mental illness is legally managed differs from province to province and territory to territory, as in the case of other provincial responsibilities. Gray et al. describe a fictitious case history of a bright law student, Victoria, who develops schizophrenia in her last year of law school and exhibits increasingly bizarre behaviour (Gray et al., 2001). Although with treatment her prognosis would be good, she consistently refuses any treatment. This fictitious case history demonstrates how refusal to acknowledge one's mental illness and refusal to accept treatment for obviously bizarre and out of character behaviour, would legally be handled in the various jurisdictions across the country. In all jurisdictions, she could be involuntarily admitted if she meets the criteria for mental illness, plus is shown to be a danger to herself or others. In some jurisdictions involuntary admission is possible if she is likely to suffer serious deterioration if untreated, and in some simply because she is in need of psychiatric treatment. Even when involuntarily committed, she would still be able to refuse treatment in some jurisdictions, if found capable of making decisions, while in other provinces best interest treatment follows as a matter of course (Gray et al., 2001).

This chapter will start with a discussion of legal definitions of mental illness, followed by a discussion of issues in forced confinement and forced treatment of inpatients, with special emphasis on Ontario. We will rely largely on the excellent book by Gray,

Shone, and Liddle *Canadian Mental Health Law and Policy*, which describes the system from a legal perspective and what they call an 'informed libertarian' perspective (Gray et al., 2000, 10-14). The authors provide a very readable 'patient-centred' discussion of the intricacies of the legal system. The discussion will continue with a summary of the psychiatric and legal history of the Starson case, leading into a discussion of the determination of mental capacity to make decisions, as well as implications of the Supreme Court decision in the Starson case.

The previous chapter discussed the development of the concept of mental illness from historical, philosophical and clinical psychiatric perspectives. This chapter will examine mental illness issues from a legal perspective, which is different from the medical perspective. The Mental Health Acts are concerned with the clinical reality of mental disorder, and are interested only in overt symptoms, outward signs, treatment, and, then, only to the extent that these symptoms affect illegal behaviour (Gray et al., 2000, 67). This will also be the concept used in the remainder of this thesis. A person with "mental illness" then will refer to someone who shows certain unusual overt symptoms of a bizarre behaviour and/or impaired judgment that may have legal implications. It is rather unfortunate to use the term mental illness as a condition with bizarre symptoms and impaired judgement, since this is often the picture that often crops up when people in daily life think of mental illness. We need to emphasize that the vast majority of people who may be called mentally ill in daily life, e.g., those suffering from anxiety and depression, generally, have judgement and behaviour similar to that of the general public.

3.1 Legal Definitions of Mental Illness

The actual legal definition of mental illness differs from one jurisdiction to another. Seven of the provincial and territorial jurisdictions have fairly specific definitions, e.g., in New Brunswick: "mental disorder means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs a person's behaviour, judgment, capacity to recognize reality or ability to meet the ordinary demands of life, but does not include the disorder known as mental retardation" (as quoted by Gray et al., 2000, 108). There are three main areas in these specific definitions which may differ among the jurisdictions: 1) Symptoms specified: all include disorder of thought, perception or mood. Some include disorders of orientation, memory or behaviour. Specifying the symptoms is an important factor in determining who may be included and who not (Gray et al., 2000, 108). 2) Consequences specified: all specify that they must 'grossly' or 'seriously' impair specified functions (Gray et al., 2000, 109). 3) Exclusions or inclusions: the main exclusions mentioned are mental handicap, substance abuse, need for treatment, psychopathic personality disorders (Gray et al., 2000, 109). In the remaining provinces, including Ontario, the definition of mental illness is much broader such as any "disease or disability of the mind." Such a broad definition with its lack of specificity may be more likely to lead to charter challenges (Gray et al., 2000, 67, 107-8).

On comparing the legal definitions of mental illness presented above to the DSM definition provided in Chapter One, important differences in emphasis are noted. The DSM codes need to diagnose mental illness even when there are no noticeable outward

manifestations, while the legal system is concerned only with determining whether undesirable or illegal behaviour is so because of mental illness. Thus, in Starson's case it is not the diagnosis of schizophrenia or schizo-affective disorder per se that is of concern, but his violent and bizarre behaviour, that time after time, brought him before the courts and eventually landed him in a forensic psychiatric hospital as a long-term involuntary patient.

3.2 Forced Confinement and Forced Treatment

In earlier years, the legal criteria for forced commitment emphasized the "need for treatment" which, of course, is the reason why any other patient is admitted to a hospital (Gray et al., 2000, 99). However, in the post-WWII decades, changes in Mental Health Acts all over North America were influenced by changes in attitudes, in general, and toward the mentally ill, in particular. Chief among these was a general acceptance of increased autonomy for any individual - the "father knows best" attitude was no longer acceptable. In health care and in many other areas of society an increased potential for self-direction by the individual emerged. Individuals wished to be in control of their own bodies, including what treatment to accept. In general, the increased emphasis on autonomy of the individual has improved the quality of life for individuals considerably, and we all reap the benefits. The 1960's and 1970's were also the time that the anti-psychiatric movement was very strong as discussed in the first chapter of this thesis. Civil rights advocates capitalized on the worries of the public about so-called psychiatric patients being incarcerated in hospitals, unnecessarily, and against their will (Cooper, 2007, 11-27). All in all, public opinion of

psychiatric illness changed drastically over the years, mostly for the better.

These changes impacted on the revisions of the mental health acts that were made at the time. Not only in Canada, but also in the United States, treatment laws were overturned by courts and amended by lawmakers (Gray et al., 2000, 31-66). By 1970, the criterion for involuntary commitment in most places changed from need for treatment to physical dangerousness, either to the patient him/herself or to others. Since detainment is sufficient to prevent such physical danger, a split developed between the need for forced commitment and forced treatment. As a result, in several jurisdictions, including Ontario, even when a patient is involuntarily committed to hospital, treatment cannot be given to a patient who refuses treatment and is considered capable of making such a decision. The issue now is when an involuntary patient can be treated in spite of refusal of treatment.

More recently, many states in the United States of America have become dissatisfied with this criterion and are broadening the criteria to again include need for treatment (Gray et al., 2000, 47-48, 99). Changes along that line are also happening in Canada. While Ontario was the first in Canada to remove 'need for treatment' as one of the criteria for involuntary commitment, more recently 'mental deterioration' was added as one of the criteria (Gray et al., 2000, 99-100). Still, in Ontario, physical dangerousness remains the main criterion.

The application of mental health act provisions for forcible confinement need to be in accordance with the charter of rights and freedoms (Gray et al., 2000, 98). Thus, while the Mental Health Act may take away a person's freedom this needs to be done with safeguards and, therefore the procedural elements of applying the laws are important (Gray et al., 2000, 98). Committal criteria include the independent assessment by two physicians, as well as a review and appeal process. In Ontario, the main purpose for allowing involuntary admission is the prevention of dangerous behaviour through detention, rather than that of compulsory treatment (Gray, 2000, 102). The definition of a psychiatric patient including the involuntary patient, in the *Ontario Mental Health Act,* is "a person who is under observation, care and treatment in a psychiatric facility" which implies that treatment needs to be provided. As Gray et al. point out, in practice the "and" before treatment is generally interpreted as "or" (Gray, 2000, 102).

Another set of relevant laws are *Medical Consent Laws* which have been developing over the years. Frequently quoted is the dictum expressed by Cardoza in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." (cited by Gray, 2000, 176). This implies that people of unsound mind were not included, and for them, someone else needed to make the decision. The challenge is - who determines that a person is of unsound mind, and based on what criteria?

Authorization for forced treatment in the various mental health acts across the country is managed by two different models (Gray et al., 2000, 175-186). Five provinces use what can be called the state model for determining the need for forced treatment, but even

within this model different mechanisms for authorizing treatment are used, e.g., the treating physician, director of psychiatric facility, quasi-judicial tribunal or court (Gray, 2000, 179-180). For the state model the standard for treatment is "best interest of patient," which is often the "best professional judgment standard" as, for example, expressed in the Saskatchewan Mental Health Act: "to provide the person with care and treatment as a result of which detention of the person in the facility is no longer required" (cited by Gray et al., 2000, 179). In this model, a previously expressed wish for no treatment will be taken into consideration, but is not binding.

Other provinces use the private model, for which a "substitute decision maker" (SDM) is chosen from a pre-specified hierarchy of relationships to the patient (Gray et al., 2000, 181-186). The treating physician has no choice but to start at the top of the list for that jurisdiction, until someone is found who is willing and able to become SDM (Gray et al., 2000, 181). The SDM themselves are also limited as to what decisions they can make, and must follow one of three types of standards depending on the jurisdiction involved. The first type of standard would be best interest as determined by the SDM. Reviews and appeals are possible if the patient disagrees. The second type of standard is that of capable wishes. In Ontario, a previously expressed wish not to be treated is to be respected regardless of putative negative consequences, and cannot be countermanded by considerations of best interest (Gray, 2000, 183). Reviews and appeals are possible, and these were used to the fullest extent in Starson's case, both by his psychiatrists who wished to be able to treat, and by Starson himself who wished to be able to refuse treatment.

Starson's mother, who would be at or near the top of the legal hierarchy of prespecified SDM, was publicly dismayed at her son not getting any treatment. The third type of standard is modified best interest, which is a combination of the first two standards. For example, in Manitoba, whenever following the patient's directive would endanger the health or safety of others, the SDM can make the decision according to best interest of the patient. The patient's wishes are still carefully considered, but are not absolute (Gray et al., 2000, 186). In Ontario, involuntary commitment could only be done if the patient presented a danger to themselves and/or to others, and treatment could be enforced only if the patient was considered incapable of making treatment decisions. This was the legal environment in which Starson's legal case played itself out.

3.3 Starson's Psychiatric and Legal History

Starson's psychiatric and legal history started in 1985 at the age of 29, when he exhibited psychotic behaviour and was first admitted to a psychiatric hospital. The next decade he was in and out of the court system, and psychiatric hospitals in Canada and the United States, because of offences such as uttering threats, causing a disturbance, and stalking celebrities. In 1998, he was again arrested for making death threats, this time against his treating psychiatrists (Sklar, 2007). The psychiatrists admitted to having filed a complaint, in the hope that Starson would be found not criminally responsible because of mental disorder, and be involuntarily confined to hospital. When in hospital they hoped he would get the treatment they felt he needed. They were successful to the extent that Starson

was ordered to be detained, but while in mental hospital Starson refused treatment. His denial of having any form of mental illness, led treating psychiatrists to consider him incapable of making treatment decisions (Sklar, 2007). The treatment proposed by his psychiatrists consisted of a combination of neuroleptic medication, mood stabilizers, anti-anxiety medication and anti-parkinsonian medication (Starson vs Swayze, #66, 2003). When Starson had received medication for his illness in the past it had been successful in reducing his delusions but the medication was accompanied by undesirable side effects. In particular, Starson felt it dulled his mind and prevented him from doing the work he enjoyed. Starson is considered by many to be an exceptionally intelligent man who has a great interest in physics and many novel ideas. He even co-authored an article with H.P. Noyes of Stanford University (Starson vs Swayze #2, #65, 2003). Starson felt that being treated with the medication proposed would not allow him to continue with such work.

Consequently, in hospital Starson refused treatment and applied to Ontario's Capacity and Consent Board (Starson vs Swayze, #4, 2003; Appendix). At his capacity hearing before the Review Board he was found incapable, since he denied that he was mentally ill (Sklar, 2007). The Board felt that if he did not acknowledge his mental illness he could not understand the benefits of the treatment proposed, nor the consequences of his decision and they ruled that Starson had a serious mental disorder and as such constituted a threat to public safety. Starson appealed to the Ontario Superior Court of Justice which reversed the decision finding him capable of refusing treatment (Starson vs Swayze, #4, 2003). Justice Molloy set aside the Board's decision as unreasonable, in that the Board had

failed to show that Starson showed an inability to appreciate the risks and benefits of treatment. Although Starson denied that he was mentally ill, he did agree that he exhibited symptoms which were similar to mental illness and made him do unacceptable things. For the courts, this was sufficient for accepting his illness. The Ontario Court of Appeal confirmed this decision. The psychiatrists now appealed to the Supreme Court of Canada - at issue was the proper interpretation of the test for capacity under *Ontario's Health Care Consent Act*, 1996, and whether the Board's decision had been reasonable.

The Supreme Court returned a split decision (six for, three against). The majority decision maintained that under Ontario law, Starson was capable of refusing medication and that the Board had misapplied the legal test for capacity by allowing best interest considerations to have influence. The Board had erred in their finding that Starson was in total denial of his illness and failed to see the benefits of the treatment and the risks of non-treatment. They accepted that Starson understood that his brain did not function normally, and that the proposed treatment would have a normalizing effect which according to the majority satisfied the decision-making capacity required by the Act (Starson vs Swayze, #120, 2003). They determined that insufficient evidence had been presented to convince them that Starson was incapable. The minority decision stated that the Board's decision was reasonable, and supported by Starson physicians who considered that he did not comprehend that lack of treatment would make it unlikely that he would be released from mental hospital.

3.4 Legal Issues in the Determination of Mental Capacity

The decisions of courts and boards all hinged on Starson's capacity to make treatment decisions. Justice McLachlin in her minority report went into some detail on what that entailed. She pointed out that in the *Health Care Consent Act*[1] (HCCA) in her paraphrase, "the person is presumed to be competent and the standard of the proof of a finding of incapacity is a balance of probabilities," (Starson vs Swayze, 2003, #13) and that "the test relates to the capability or ability to understand and appreciate, not actual understanding and appreciation" (Starson vs Swayze, #13, 2003). She goes on to outline the two components of the *Ontario Consent and Capability Act's* test of capacity. For the first component, the person needs to "be able to understand the information that is relevant to making a decision about the treatment" (Starson vs Swayze, 2003, #13), i.e., the person must be able to intellectually process information, in particular, information about the proposed treatment, such as potential benefits and drawbacks, as well as information as to how the treatment may affect the patient. For this the patient needs to be able to acknowledge his symptoms to be able to understand the treatment decision. Agreement with physicians is not needed (Starson vs Swayze, 2003, #13, #16). For the second component, the person must be

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[1]Capacity: (1) "A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision." Province of Ontario, HCCA 1996, c. 2, Sched. A, s. 4 (1)

"able to appreciate the reasonably foreseeable consequences of a decision or lack of decision" (Starson vs Swayze, 2003, #13). She explains that there are three common clinical indicators of a person's ability to understand, the consequences of refusing treatment, as summarized: a) whether the person realizes that the condition may affect him, b) that the person is able to assess how the proposed treatment, or no treatment, would affect him, c) whether the person's choice is not substantially based on delusional belief. Appreciation does not necessarily include agreement with physicians, nor does it need to be a "best interest" assessment (Starson vs Swayze, 2003, #13, #17, #18, #19).

3.5 Reaction to the Outcome of the Starson Case

There were a number of disparate reactions to the Supreme Court decision. On the one side were civil libertarians, some of whom felt vindicated. For example, CTVNews reported:

> "It is a fundamental human right not to have something happen to your body without permission. We're delighted that the Supreme Court recognized just because someone has a psychiatric diagnosis does not mean that they are incapable of making decisions" (CTVNews, 2003-07-10).

Many were on the other side. For example, Starson's mother was devastated and maintained that her son was only brilliant when he was on medication (*The Citizen*, May 18, 2005). Torrey calls this type of case, a confusion of "civil liberty with the right to remain insane" (Torrey, 2005). The psychiatric community characterizes this as "the right to rot"

(Applebaum et al., 1979, as quoted by Sklar, 2007). The honourable Beverly McLachlin, one of the judges of the minority decision, in a speech eloquently summarized the two extremes: on the one hand, "forced treatment of a capable person raises concerns re liberty, physical integrity and equality whether in hospital or not;" on the other hand, "abandoning such persons to the torments of their illness, mental and physical deterioration . . . does not respect their inherent dignity as human beings" (McLachlin, 2005). She calls it the "cruel paradox - freedom to refuse 'medication' may in fact result in institutional confinement and continued debilitation," and she asks "Is this true autonomy" (McLachlin, 2005)?

The Schizophrenia Society was particularly unhappy about the decision (Schizophrenia Society, 2003). They had intervener status in the appeal to the Supreme Court in order to be able advocate in favour of treatment. Their conclusion was that the decision was contrary "to the aims of the Society to reduce suffering caused by schizophrenia" (Schizophrenia Society, 2003). First of all, they considered the available treatment to have been misrepresented, in that the Court did not recognize advances in the available medication for treating schizophrenia. They argued this sent the wrong message to the public. Secondly, the legal process delays any treatment that can be given to persons involved in the process. In Starson's case, even if the courts had ruled in favour of treatment, he would already have been in hospital untreated for five years. As the Schizophrenia Society concludes, "This is inhumane treatment, turns hospitals into jails, and cost taxpayers an estimated $400 or more per day to maintain an individual" (Schizophrenia Society, 2003). They consider this money could have been better spent on treatment and

community services. They also point out that although no law has been changed, there are legal implications of this court case. Health professionals in future will need to present more convincing evidence to support any claim that a patient is not capable of making treatment decisions.

As the Schizophrenia Society expected, the Starson case seems to have become somewhat of a landmark case in the legal and the psychiatric world judging by the number of mentions in the psychiatric and legal literature as reviewed by Sklar (2007). There was found to be a re-emphasis that effectiveness of, and need for, treatment has no relevance to establishing capacity of patient. In the past there might have been a feeling that refusing treatment in itself was a sign of lack of capacity. Now the only relevant consideration allowed is whether the patient is able to understand the information about the proposed medication's effectiveness and to understand the foreseeable consequences of the decision. The onus is on the physicians to document this lack of capacity carefully. Sklar mentioned several later cases before the HCCB in which psychiatrists were more careful about presenting evidence about the patient's failure to acknowledge symptoms of illness, or that treatment would be beneficial, and that the patient's condition was deteriorating, and would continue to deteriorate without treatment. In these cases, the decision led to the determinations of incapacity being upheld (Sklar, 2007, 393).

Thus, treatment decisions by patients who are considered capable in Ontario are paramount. This is regardless of how much concern there is about a patient not getting the treatment needed, and the heartbreak for loved ones and health care professionals in

watching bizarre behaviour in a person who could substantially improve with adequate treatment. The "cruel paradox" as so dramatically expressed by Justice McLachlin has been the motivation behind the writing of this thesis.

Now that we have discussed the psychiatric, neuroscience, neurophilosophical and legal perspectives of the Starson case, we are ready to go with a philosophical analysis of the human rights issues in the Starson case.

Chapter 4. Human Rights in Gewirth's Community of Rights.

This chapter will provide a brief introduction to Gewirth's human rights philosophy and ethical rationalism. The chapter will culminate with two practical applications of special relevance to the Starson case: 1) how to deal with persons who cannot act as full agents, and 2) how to deal with capable agents who use their immediate freedom to make decisions that have detrimental implications for their long-term freedom to act. A conviction that "all humans, as actual or prospective agents, be enabled to live lives of dignity, self-fulfilment, and mutuality of respect" underlies all of Gewirth's thinking (Gewirth, 1996, xv). In the next chapter, this conviction will be extended to the dilemma of the Starson case.

4.1 Human Rights

Gewirth considers human rights as rights held by all just because they are human. The objectives of these rights are freedom and well-being (Gewirth, 1996, 6). Human rights relate not only to a concern for our own rights, but also need to include a concern for the rights of other persons, thus, human rights are applicable to all. A right is something belonging to a person, a just claim. The rights that Gewirth discusses are primarily claim rights, i.e., rights that have both claims and corresponding duties to refrain from certain actions (negative rights), or even the duty to actively help others (positive rights) (Gewirth, 1996, 8).

The full structure of a claim-right is: "A has a right to X against B by virtue of Y" (Gewirth, 1996, 8-9) There are five main elements to this:

The subject of right, A, is the person who has or holds the right, i.e., a purposive free agent free to make decisions that relate to himself or herself. Examples of subjects of rights in the Canadian community of rights would include children needing education, the unemployed needing food for their families, persons needing basic health care.

The nature of right, is what a right consists of, i.e., a person's interest that ought to be respected and protected.

The object of right, X, is what it is a right to, e.g., right to education, to food, the right to private property.

The respondents of the right, B, are the persons with the correlative duty to fulfil the right. These are the persons who either have the duty/obligation not to interfere with someone else's rights, in the case of negative rights, or the persons who have the duty to supply certain needs, such as support education for all children not just your own, in the case of positive rights.

The justifying basis/ground, Y, consists of the acceptance of freedom and well-being as generic rights, which through reason, Gewirth develops into a generic supreme principle on which his philosophy of human rights is based.

4.2 Human Action as a Basis of Human Rights

Justification of human right requires a foundation on which human rights can

logically be based. This foundation must be sufficient, i.e., as all-encompassing as morality itself, and necessary, i.e., unavoidable for all humans as agents (Gewirth, 1996, 13). Gewirth specified human action as the necessary basis for human rights. All moral tenets deal with actions of some sort - they either tell people how to act, or in the case of virtues, what to be, and even the 'what to be' is based on action (Gewirth, 1996, 13).

Every agent has to have the ability to act, including the freedom to do so, and the ability to achieve a level of well-being. This includes having the conditions needed for acting, or the potential of being able to achieve the desired outcome through action (Gewirth, 1996, 14). The necessary objectives of human rights are then 'freedom' as the procedural condition for action, and 'well-being' as the substantive condition for action (Gewirth 1996, 14-15). Gewirth establishes a hierarchical ordering of categories of generic rights to action and well-being with three levels of well-being (Gewirth, 1978, 53-58; 1996, 14). What he calls 'basic right to well-being,' is the lowest of the three levels of rights, and includes having the "essential preconditions of action, such as life, physical integrity and mental equilibrium" (Gewirth, 1996, 14). The next level is 'non-subtractive well-being' which consists of the abilities and conditions needed to sustain one's general level of ability to act and well-being. The highest level is 'additive well-being' which includes the conditions conducive to improvements in one's level ability to act and well-being, and increasing level of purposive-fulfilment. Productive agency is the ability to accomplish the desired objectives, with 'productive' in this sense to be understood as being able to achieve additive goods. All prospective purposive agents (PPAs) have rights to freedom and well-being at

this level (Gewirth, 1978, 48). When conflicts between rights need to be resolved, Gewirth proposes the criterion of needfulness of action (Gewirth, 1996, 45-46). According to this criterion when two rights conflict, the one most needed for action, i.e., lowest in the hierarchy, takes precedence. Thus, in a conflict between a right at the basic level and one at the non-subtractive level the right at the basic level takes precedence.

4.3 The Dialectically Necessary Method

Next Gewirth explains how moral rights can be derived from the context of action and for this he introduces the 'dialectically necessary' method, which consists of a logical deduction useful in establishing the truth of a theory or opinion (Gewirth, 1996, 16). The method that Gewirth proposes is 'dialectical' in that it begins with statements acceptable to all purposive agents and proceeds logically from there. Apparent contradictions are resolved by systematically evaluating facts and ideas with a view to resolution. The method is "dialectically necessary" in that all statements in all stages of the debate must be made by, or acceptable to, all agents because they are based on the need for purposive action (Gewirth 1996, 16).

Gewirth gives two reasons for using the dialectically necessary approach (Gewirth 1996, 16). First of all, only through the "necessary" aspect can logical debate achieve the standard-setting certainty for the grounding of rights. The mode of argumentation is "necessary" both in the sense that its initial premise is based on statements accepted by all agents, and in that the sense that the subsequent steps of the proof are logically deduced from

this premise. Arguments for rights, as dialectically necessary, are presented in such a way that every agent would logically accept for themselves. Second, only through the dialectical feature can the transition from 'is' to 'ought' be attained. The mode is "dialectical" in the sense that it based on the statements representing the point of view of the agent, rather than as statements true of the world in general. It then examines what the statements or claims, at all steps of the argument, logically imply. Each step is thus a description of what the agent thinks or implies, not what things are like independent of the viewpoint of the agent. Only through such dialectical discussion can one come to logically derived conclusion with which all purposive agents can concur (Gewirth 1996, 16).

Using the dialectically necessary approach, Gewirth establishes two theses. The first thesis is that *every agent must accept that he/she has rights to freedom and well-being* (Gewirth, 1996, 17). The initial premise "I do X for end or purpose E" is a statement that all rational agents cannot avoid accepting for themselves (Gewirth, 1996, 17). Every time agents do something, they do it because for some reason it seems good to them. Thus, all PPAs, explicitly or implicitly, make judgments about the goodness of their own purposes. Based on their judgment about their own purposes, they also make a judgement about the goodness of the freedom and well-being necessary to achieve these purposes. It is obvious then, that in order to attain the good indicated in the initial premise, PPAs need to have freedom and well-being. In this way, freedom and well-being are necessary conditions for PPAs, and all others need to refrain from interfering with their freedom and well-being. If other persons would be allowed to interfere, I would not have the necessary freedom and

well-being, which is contradicts the necessity of having freedom and well-being. Thus, every agent must accept that he or she has rights to freedom and well-being. The second thesis is that on the basis of the principle of universalizability *it follows that the agent needs to accept that all other agents also have these rights* (Gewirth, 1996, 17). If one person makes a claim because of some quality, e.g., being a rational agent, then it logically holds that all other persons with the same quality of being rational agents can make the same claim (Gewirth, 1996, 19). Thus, moral rights are universal and must be accepted within the whole context of action, and we have gone from individual, discrete rights to general, moral rights (Gewirth, 1996, 18).

Gewirth summarized these two theses as a principle of universal human rights which he calls the Principle of Generic Consistency (PGC): "Act in accordance with the generic rights of your recipients as well as yourself. Generic rights are rights to the universal features of action - freedom and well-being - which constitutes its necessary conditions" (Gewirth, 1978, 135). The dialectically necessary argument then is an argument that allows the PPAs to go from the generic features of actions to the universality of human rights, and then eventually to Gewirth's supreme principle of morality.

4.4 Direct and Indirect Applications of the PGC

There are both direct and indirect applications of PGC. In the direct applications, the requirements of the PGC govern actions of individual agents in relation to other agents. Thus, individual agents act in morally right ways, enjoy their rights and fulfill their moral

duties (Gewirth, 1996, 103). In the indirect application, the PGC requirements are imposed on social rules and institutions, and the requirements of these rules are then imposed on the actions of individuals participating in these institutions. The indirect applications of the PGC are especially true for the social rules of four kinds of institutions - voluntary associations, the minimal state, the democratic state, and the supportive state (Gewirth 1996, 103-104). Two of these are applications of the right to freedom: voluntary associations, in which people participate out of their own free will, including the family, and the democratic state in which people participate in overall decision making procedures, e.g., through elections. The other two are primarily applications of the right to well-being: the minimal state, which includes the static applications such as criminal law, and the supportive state which include the more dynamic applications. The supportive state (or welfare state) seeks to actively supply basic goods to its citizens to sustain life and essentials for those who cannot feed themselves. In addition, rights to education, health care and other additive goods need to be supplied. All persons must be equal before both minimal state and supportive state laws.

The community of rights then is the supportive state which is delegated to act on social, economic, political and other policies concerned with relieving human suffering. "The community of rights is a society whose government seeks to actively fulfill the needs of its members, especially those who are most vulnerable, for the freedom and well-being that are necessary goods for agency when persons cannot attain this fulfilment by their own efforts" (Gewirth, 1996, 5). One's community is an important component of one's well-

being for several reasons: first, being part of a supportive community is important in achieving one's purposes; second, as Aristotle put it "man is by nature a social animal" (cited by Gewirth 1996, 15), in other words, one cannot be fully human without association with other human beings. Gewirth argues that "when rights are properly understood, they entail a communitarian conception of human relations, relations of mutual assistance, social solidarity, and important kinds of equality" (Gewirth, 1996, 6).

Gewirth uses the dialectally necessary method to derive specific economic and social rights for the supportive state: i) all humans have rights to freedom and well-being as necessary conditions for their actions; ii) some good X is required to have this freedom and well-being; iii) thus, persons have a right to X (Gewirth 1996, 104). A difficulty occurs when the right to X may already be exhausted by other agents who need it, making it difficult for others to obtain the X to which they may also be entitled. Gewirth suggests that the "criterion of degrees of needfulness for action" may be able to deal with some of these conflicts, the one most needed for action takes precedence, e.g., basic rights take precedence over non-subtractive rights (Gewirth, 1996, 45-46, 104). However, in a community there are often many ways to achieve the same objective and one may need to be creative to ensure X is used as wisely and equitably as possible. But Gewirth admits that there may be many complex situations that are difficult to solve. An example of complexity is deciding how much of X is enough, e.g., how much education is enough for the development of productive agency, what kind of employment is adequate, what type of health care is essential (Gewirth 1996, 104).

4.5 Negative Rights, Positive Rights and Harm Avoidance

A claim of rights involves a correlative duty by someone else, thus, whenever one person has a right, another person has a duty. For negative rights, the correlative duty is not to interfere with another person's right; for example, if someone has the right to education, no one else ought to interfere with this right. An important feature of Gewirth's human rights theory is that he goes a step further, and also insists on positive rights as a crucial component of the community of rights (Gewirth, 1996, 31). The distinction between positive and negative rights then involves the duties of the respondents, i.e., doing something (active assistance) for positive rights, or not doing something (non-interference) for negative rights (Gewirth, 1996, 33). While for negative human rights the respondents ought not to interfere, for positive human rights the correlative duty involves an active doing something, or supplying something for others, e.g., within the community of rights a certain amount of education must be supplied for all children.

Because of the importance that Gewirth attaches to positive rights in establishing the connection between rights and community, he establishes his position for positive rights at some length (Gewirth, 1996, 38-44). Although he recognizes that there are already certain positive legal rights, e.g., the positive assistance through law enforcement, education, and social security, he does not think that they go far enough (Gewirth, 1996, 38). He wants to provide a rational argument for the existence of positive rights (Gewirth, 1996, 39). Since positive rights make great demands on others, it is important that they are justified, and thus,

it is important to ground positive rights on the PGC. Above, Gewirth's argument for negative human rights was summarized. He uses a similar argument for establishing the need for positive human rights as he did for negative human rights (Gewirth, 1996, 39-40). Every rational agent must accept: I must have freedom and well-being. But rational agents cannot ensure freedom and well being by their own efforts only and need help to ensure them. Thus, every rational agent can say: I must have positive rights to ensure my freedom and well-being. But if every agent must have positive rights, than every other agent must have positive rights as well. The existence of positive rights is for Gewirth the basis of the community of rights.

The flip side of having negative rights and positive rights, and equally important to the concept of a community of rights, is the inculcation of preventing harm to other PPAs. Harm is the deprivation of good (Gewirth, 1978, 230). Basic harms correspond to basic rights such as when potential respondents in basic right issues interfere with, rather than sustain, the basic preconditions to action and well-being of others (Gewirth, 1978, 212). Gewirth discusses situations where respondents need to take a more active role in the prevention of harm to others, i.e., positive duties to prevent harm (Gewirth, 1978, 217). An agent has the moral duty to prevent harm, when this is at all possible, and when there is little likelihood of harm to the potential deliverer (Gewirth, 1978, 217). As a matter of fact, Gewirth calls it the agent's moral duty to act to prevent any harm which it is in his or her power to prevent. The example that Gewirth works out in some detail is that of the duty to rescue another person from drowning (Gewirth, 1978, 217-226). In refusing to act, the

potential rescuer determines that the person floundering in the water and calling for help, will drown. Thus, that person's basic well-being is violated by allowing him to drown when it could have been prevented. Gewirth also discusses how far one needs to go with this idea of prevention of basic harms to others (Gewirth, 1978, 226). Of course, there are many other harmful events that could possibly be prevented, e.g., famines in Africa, traffic accidents in our city, lack of well-being for the family in the next block. Unfortunately, one agent cannot fill every need, and there are no easy answers. There is a need to discern when rescue is feasible and when it is not, and where one needs to direct one's limited energy.

Gewirth goes on to discuss harms incurred from interference with non-subtractive goods, and calls them specific harm (Gewirth, 1978, 230). Non-subtractive goods are needed to maintain the status quo, thus, over and above basic goods which consist of the basic essentials of life. There are a great variety of goods and harms that can be included under specific harms and not all of these can be acted upon by potential respondents. Harm is a value-word and the meaning of harm in this context depends on the criteria used to determine what is good (Gewirth, 1978, 231). As Gewirth points out, a very religious person may have different priorities from a very patriotic person. The problem then becomes what are the specific harms that potential respondents need to worry about most. As in the criterion for needfulness of action, basic harms need to be included highest on the list of harms to be avoided. Then Gewirth places the non-subtractive capabilities for action higher on the list than the actual non-subtractive goods themselves (Gewirth, 1978, 233).

4.6 Mutuality and Community

Gewirth disagrees with the so-called "adversarial relation" between moral rights and community and proposes a mutually caring relationship, which he calls mutuality. The adversarial relationship is based on a selfish competition of rights without regard for community, while Gewirth, in his community of rights, seeks to establish common interest, cooperation and concern for each other (Gewirth, 1996, 2). Important concepts for the community of rights are equality and mutuality, where equality is a static relationship and mutuality a dynamic interactive relationship (Gewirth, 1996, 75). Mutuality includes equality, but not necessarily vice versa. Mutuality is based on rights claim relationships in the community of rights, in that all rational agents are both subjects and respondents of human rights, and all ought to respect and protect the rights of others to freedom and well-being. Mutuality is possible because of the positive rights that Gewirth considers so important. Citizens in the community of rights have positive rights for themselves, but at the same time have the duty to provide the means for positive rights of others.

Mutuality is not the same thing as reciprocity; for example, there is a temporal difference in that in the case of reciprocity an agent only reacts to prior benefits received. On the one hand, only benefactors, who have already done something that deserves reward, can become recipients of further benefits. On the other hand, anyone who has already received benefits remains obligated to those who supplied the benefits. Mutuality is exempt from such dependency on previous favours and obligations and such mutuality is possible because of the positive rights to which Gewirth attaches such importance. Because of this

Gewirth considers positive rights, and consequently mutuality, intrinsic to the PGC as the principle of human rights (Gewirth, 1996, p.76). All members of the community have rights and all have obligations.

4.7 A Rational Agent

For a rational agent to be able to act in accordance with his or her own generic rights, he/she must have been able to act with voluntariness or freedom, and purposiveness or intentionality. Freedom to act means that action is under the agent's control through his informed and unforced choice (Gewirth, 1996, 13). The agent needs to be uncoerced, and have sufficient knowledge and understanding to be able to make decisions intelligently (Gewirth, 1978, 136). Gewirth postulates both positive and negative conditions for voluntariness and purposiveness (Gewirth, 1978, 31). Negative conditions include the absence of external compulsions, such as being forced by other people, as well as the absence of internal compulsions, such as reflexes, ignorance, or a disease that might affect the control of one's behaviour. Positive conditions for voluntariness include the access to conditions essential for intentional and unconstrained behaviour and the wherewithal for informed decisions (Gewirth, 1978, 31).

The agent not only needs to act voluntarily but also with purposiveness and intentionally, meaning that the agent has some kind of goal in mind and is working toward such a goal (Gewirth, 1978, 37). The goal could be either action itself, or something that is achieved by that action. The agent must be able to reflect on the goal and determine that the

goal is good (Gewirth, 1978, 38). Purposiveness has both a procedural component, which would be the act of purposing, and a substantive component, which is the object, or event, aimed at (Gewirth, 1978, 38). The object or action aimed at might also be negative as, for example, in the purposive avoidance of psychiatric treatment by Starson.

Being able to act as a full PPA requires certain practical abilities, although Gewirth is quick to add that persons have PPA status regardless of their level of abilities. Still, people may have varying degrees of knowledge and reasoning skills. Even within the so-called normal population, Gewirth sees variations in the qualities that make for a good PPA. Not all persons can be considered agents in the same sense of the word (Gewirth, 1978, p.120). Voluntariness, or understanding, below a certain level may interfere with the ability to act as a full PPA. For example, small children do not always have the necessary ability to control their behaviour freely, nor have sufficient knowledge to inform their decisions.

In his list of persons lacking in sufficient control and information, Gewirth includes the mentally ill and mentally-challenged and concluded that these groups are to be excluded ". . . in varying degrees and on different grounds," using criteria such as "ability for self-control, knowledge of relevant circumstances, reasoned reflection on purposes," from being full PPAs (Gewirth, 1978, p.120-1). To what extent is their voluntariness and purposiveness affected by their difficulty in understanding, reasoning and planning is not always easy to determine. Gewirth talks about degrees of approach to being a full PPA, just like there are degrees of approach to being 18 years old where 18 is the age of adulthood. Once one has reached 18, full adulthood has been achieved, as there is no partial status of PPA-ship

(Gewirth, 1978, 121). In the case of 'mental deficiency,' the degrees of approach to voluntariness and purposiveness of the person are hard to gauge and are likely different for different decisions. Still, it is an important concept that needs to be examined.

4.8 The Principle of Proportionality

For those individuals who are clearly not able to achieve the level of a full PPA, Gewirth proposes the Principle of Proportionality (PP), which states that people should have rights proportional to their ability. When persons "are less than normal agents," they still have rights to the extent to which they "approach being normal agents."(Gewirth, 1996, 65) Expressed more precisely, the PP states, "When some quality Q justifies having certain rights R, and the possession of Q varies in degree in the respect that is relevant to Q's justifying the having of R, the degree to which R is had, is proportional to or varies with the degree to which Q is had" (Gewirth, 1978, 121). Individuals with insufficient ability, i.e., insufficient Q, have rights to the extent of their existing ability to avoid "endangering both one's own and others' purpose fulfilment" (Gewirth, 1978, 121). All this with the stipulation that for those people allowed less freedom, there must be an equal, possibly an even greater, concern for their well-being than for others who are full PPAs (Gewirth, 1996, 65).

As alluded to before, the difficulty is how to determine a person's capability, i.e., the amount of Q that a person possesses. In addition, even if Q could be determined, one would still need to determine the point at which the amount of Q is enough to achieve full PPA status in practical situations. Gewirth emphasizes that the PP only works if it is interpreted

properly. One condition he gives is that the Q must be stated as precisely as possible. He gives the example of using age 18 as the age at which a person is allowed to vote (Gewirth, 1978, 121). Once one is allowed to vote, one is allowed to vote completely, as there is no partial voting. Of course, the type of situation in which a simple cut off point, like an age limit, can be applied is rare. One might even dispute whether an across-the-board cut off point, such as age, is ever a fair way of determining Q. No one would be surprised to find out that one person may be better able at age 14 to cast an informed vote, than another at age 40 who has neither the interest, nor the knowledge to make an informed decision. In this sense age is used as an indicator of, or a substitute for, Q, and this makes its apparent accuracy rather deceptive.

Still, no one will dispute that young children should not have all the independence and decision-making freedom of a full PPA. Gewirth calls children potential agents (Gewirth, 1978,141), which is not the same as prospective purposive agents who already have all their rights. Parents, and society in general, are expected to provide children with such an education that when they are older they will be able to assume full PPA status. Meanwhile, parents are allowed to, even expected to force a small child to take the medication prescribed by a doctor, even when the child adamantly refuses. The parents are expected to have the judgment to know when it is clearly in the child's interest to take that medication.

Gewirth refers to what he calls 'mentally deficient' people who hold Q in varying and impaired ways (Gewirth, 1978, 141). In such cases, it is especially difficult to obtain an

estimate of Q such that one can judge how much responsibility such a person can handle. Even indicators, such as age for children, with all their imperfections, are rarely available. When a person is already confined to a psychiatric hospital because not being guilty of dangerous or illegal activities by reason of insanity, determining Q for further decisions within hospital is even more problematic. This an especially worrisome question for those decisions that affect the future course of his or her life, such as whether to accept treatment for schizophrenia.

Difficulties with determining Q include what standard/criteria to use, and the possibility remains that these standards might be culturally or ideologically influenced. This, in fact, is a major concern for some of the critics of psychiatry (Szasz, 1970; Foucault, 1971). Certainly, history has shown us many instances where some sections of mankind, whether because of skin colour, or disagreement with the establishment, or the odd behaviour of the mentally ill, were designated subhuman, and deemed to have fewer rights than the rest of mankind. Gewirth is aware of these difficulties, and cautions that the PP is true only if interpreted properly and that the main misinterpretation bears on justifying the Q, including the respect to which it does, or does not, vary in degrees. Several others, who otherwise support Gewirth's ethical rationalism, also have expressed their concerns about implementing the PP and determining Q (Hill, 1982; Beyleveld, 2001; Dwyer, 2003, 330). Still, the idea of Q as a gradient of potential for voluntary and intentional action is an important concept, difficult as it may be to apply in practice.

Although Q as a measure of the degree of approaching full PPA status, may be

somewhat lacking in practicality, the idea of working toward increasing Q is more realizable, and also very important. Gewirth makes the important point that it is the duty of the community to help with the development of potential agents (Gewirth, 1996, 141). For example, an issue discussed in some detail by Gewirth is that of the status of children. Children will possess fewer generic rights to the extent needed for the protection of their own well-being. This lack of rights is in the anticipation, as Gewirth emphasizes, of their maturation into full-fledged agency (Gewirth, 1978, 142). Gewirth considers children potential PPAs and he is quite specific about the need for education, training and anything else to improve chances of increasing their Q to full PPA level. In the case of children, parents are generally best able to judge the Q of their children as they grow up, even as it changes as time goes on. The role of loving parents is to allow children to make decisions as they are able. Decisions which they make for their children, are to be in the "children's best interest", allowing children to mature expeditiously, in a nurturing environment.

Society has not only the right, but also the duty to increase the Q of potential PPAs other than children, at least to the extent needed to bring the person to full PPA status whenever possible. The means to be used will need to be more adaptable and more targeted than in the case of children, since they will need to be directed to the needs of the individual(s) with special and specific needs. In Starson's case, it was not because of lack of information or education that he wished to make decisions not thought to be wise by health professionals or loved ones. While our society has been fully organized to gradually bring children and young people to a position of full PPA status, taking action is much more

difficult for others with compromised PPA status, however, much potential they might have. Although difficult, everything that can be done, needs to be done to increase their Q to full PPA status.

4.9 Conflict Between Freedom and Well-Being

We would now like to explore another application of Gewirth's theory, independent of Q. This application concerns conflicts between occurrent freedom and dispositional freedom, where occurrent freedom is the freedom to act voluntarily in a particular situation at a specific time, and dispositional freedom is freedom in a wider and longer-range context (Gewirth, 1976, 253; Walters, 2001, 166). Interference with occurrent freedom removes the agent's control over a particular action but still allowing freedom in other actions or behaviour, while interference with dispositional freedom would remove long-term control over a broader portion of one's actions. As Beyleveld emphasizes, "dispositional freedom . . . is necessary in order to pursue or achieve any purpose at all" (Beyleveld, 1991, 19). As such, it is important for all PPAs to have their dispositional freedom as intact as possible, and it is of grave concern if a PPA wants to make decisions that may affect his or her dispositional freedom. Gewirth discusses to what extent society can allow member PPAs to insist on using their occurrent freedom to make decisions that will severely limit their dispositional freedom and well-being.

The question Gewirth wants to answer is: What does the PGC require of us as a community of rights, when people who meet the conditions of full PPA status and are part of

our community insist on making decisions that will harm themselves, while refusing any advise regarding, or interference with, their self-destructive behaviour (Gewirth, 1978, 264) Gewirth discusses examples such as continuing with drug addiction, wishing to commit suicide, or selling oneself into slavery, in all of which agents use their occurrent freedom to severely limit their dispositional freedom. For example, the use of immediate freedom to sell oneself into slavery, results in the long-term loss of freedom of movement, making decisions, and probably even freedom of speech. Consistent with Gewirth's ideas on mutuality, and the need for other PPAs not to stand idly by when someone's basic needs for freedom are compromised, Gewirth insists that other PPAs, or the community as a whole, have to assume responsibility when they know of "self-harmers" (Gewirth, 1978, 265). The term "community PPA" will be used for PPAs in the immediate community, who are expected to have an active caring role.

Prior to proposing a process that will deal with the plight of self-harmers in the light of the PGC, Gewirth discusses several qualifications on the proper understanding of his proposed process. First, he assumes that the self-harming person will not lose control and by violent behaviour hurt others, e.g., as may be the case in alcohol addiction (Gewirth, 1978, 265). Gewirth does not state what alternative action he would suggest but the implication is that measures need to be taken to stop the violent behaviour as soon as possible and prevent others from getting hurt. Another qualification is that the self-harmer has no dependents who would suffer lack of support (Gewirth, 1978, 265). Again Gewirth does not actually state specific concern in this situation, but, obviously, the community would then need to

worry not only about the self-harmer but also the dependents who might suffer a shortage of their basic good guaranteed them by the community of rights.

A third qualification is that Gewirth does not want to ask what the state or its laws need to do about this situation (Gewirth, 1978, 265). In other words, in proposing how to deal with self-harmers in the community, he does not here want to discuss the responsibility of institutions but that of community PPAs who need to accept responsibility when they see someone harming themselves in a major way. In this thesis, we are concerned with the responsibility of the community PPA within situations controlled by rules or laws, and the need to determine to what extent Gewirth's proposal for a process of action in case of determined self-harmers is applicable. Gewirth defines an institution as "arrangements for a purposive function socially approved because its reputed value to society" (Gewirth, 1976, 274). PPAs are subject to many social and institutional rules which in turn need to conform to the requirements of the PGC (Gewirth, 1976, 273). Since social rules define right and wrong ways of acting, they function to provide guidance for, and even constraints on, moral behaviour (Gewirth, 1976, 274). At times a social rule, e.g., a law, may put a pressure on a PPA which seems different from what the PGC requires from that individual. Gewirth uses slavery as an example of an institution that is wrong no matter what the law says about it. He would applaud the action of William Wilberforce in the United Kingdom (UK), the political activist who led parliamentary and other campaigns against the slave trade persistently and against all odds for decades before his work culminated in the passing of the Slave Trade Act 1807 and the Slavery Abolition Act in 1833. In other cases, these social

rules and laws may deprive someone of their liberty, e.g., when someone is imprisonment because of crimes committed (Gewirth, 1976, 276). In the case of criminal activity, the application of basic harms, such as loss of freedom, are not to be considered morally wrong but just. Gewirth indicates that the reason for obeying the law is not only because it is the law, but also that the law itself is justified by the PGC (Gewirth, 1976, 300). Just like disobeying the PGC is contradicting oneself, disobeying the law is also to contradict oneself. However, just like Wilberforce as a community PPA found rules about slavery to be unjust, we as community PPA need to evaluate rules in our society for agreement with the requirements of the PGC. Thus, even in situations governed by existing laws, community PPAs need to accept responsibility, even if it is for working towards changing laws rather than taking direct action.

Gewirth is adamant about the need for community PPAs to take action where there is a need, to prevent self-harmers to continue their self-destructive path. He puts it quite strongly: "Because of the central importance of basic harm for morality, the individual agent cannot rightly evade the question of what should be done when persons near him voluntarily refuse to consent to interferences with their projects of inflicting harm on themselves" (Gewirth, 1978, 265). Even when an existing law is on the books community PPA have not lost their responsibility to ensure that justice is done – not by disobeying the law but by working within the system, like Wilberforce, until human rights issues are properly resolved. While slavery was an obvious human rights issue that needed corrections, there are other situations, as for example the Starson case, where a dilemma of two contradictory options

needs to philosophically resolved before action by community PPA can be taken.

4.10 The Three-Step Process

In order for community PPAs to deal with the situation of a self-harmer within the authority of the PGC, Gewirth proposes a three-step process (Gewirth, 1978, 265). As a first step, in the spirit of mutuality, the PGC requires deep concern for PPAs in situations where basic harms may be done. Whenever there is the potential for basic harm to others, nearby agents, community PPAs, need to accept a certain amount of responsibility for those harming themselves (Gewirth, 1978, 265). Gewirth stops-short of indicating who exactly has to take the action, nor does Gewirth go into any detail on what action an individual PPAs can take without the backing of institutional entities. Certainly, trying to take responsibility for someone who is intent on harming his or herself, is a very frustrating experience. Once the intention to self-harm has progressed beyond the stage where a friendly discussion may make a difference, deciding on the next step to take may be difficult and may well lead to the involvement of community resources.

If there is obvious need for further action, Gewirth suggests as a second step in the process, a temporary interference with the intended self-harm, until it can be assessed whether the self-harmer acts in complete freedom. Gewirth goes as far as to say "interference with the would-be actor would be justified until he can be brought to a point where he is capable of voluntary participation" (Gewirth, 1978, 265). At this time, it is important to look at the self-harmer's motivation, which in cases of plans to sell oneself into

slavery might be, for example, social conditions that make selling oneself into slavery the only solution to otherwise intractable problems. If selling oneself into slavery is the only way to provide a future for one's family, then the agent is not acting voluntarily and the community of rights may need to step in and take action. Such action may consist of guaranteeing, or working out, for the family a reasonable future, at least by ensuring basic needs, and possibly even non-subtractive needs. Thus, it may be possible to remove the predicament that motivated the self-harmer.

If not, action of some sort needs to be taken to stop the self-harm at least temporarily. It is not clear what kind of active responsibility community PPAs can take to dissuade an apparently quite determined person from his or her planned course of self-destruction. Since the self-harmer adamantly refuses interference with his or her damaging behaviour, some type of forceful action would be needed. The alternative is an impotent caring without action, and, surely, Gewirth is not thinking of confining the responsibility of community PPAs to such a lack of action. Short of calling in several burly bouncers to coerce, or prevent, certain behaviours, action would almost certainly need the resources of societal institutions. While Gewirth wishes to discuss the responsibility of community PPAs, he is not necessarily disagreeing with any involvement of institutional help. Calling in societal organized resources would fall well within the responsibility and capability of community PPAs.

If the second step of Gewirth's process does not resolve the situation, then he proposes a third step. If eventually it becomes clear that the decision of self-harm was taken

voluntarily and with full understanding of its implications, then the self-harmer should be allowed to continue with, what others consider self-harming, unhindered. All further interference should be suspended (Gewirth, 1978, 266). Gewirth emphasizes that at some point, people must be allowed to live their lives even if it seems wrong to others, and for many cases of self harm, e.g., addiction, this may well be the end of action by other PPAs for the time being, unless a further crisis situation develops.

In conclusion, this chapter has provided a brief summary of Gewirth's theory of human rights with emphasis on those parts that have special application to the dilemma of the Starson case. The next chapter will go on to apply Gewirth's theory to the practical issues of the Starson case.

Chapter 5. Applying Gewirth's Human Rights Theory to the Starson case

"Forced treatment of a capable patient raises serious concerns re liberty, physical integrity and equality . . . The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy."

". . . abandoning such persons to the torments of their illness, mental and physical deterioration, substance abuse and perhaps suicide surely does not respect their inherent dignity as human beings . . . "

"We are left with two different visions, and no easy answers." (McLachlin, 2005)

McLachlin called this ". . . the cruel paradox - freedom to refuse 'medication' may, in fact, result in institutional confinement and continued debilitation," and she asks "Is this true autonomy?" (McLachlin, 2005). Justice McLachlin's statements of concern were voiced as part of her presentation on "Medicine and the Law: the Challenges of Mental Illness" in which she summarized the legal aspects and human rights concerns of the Starson case. On the one hand, the autonomy of a patient needs to be respected by allowing the patient refusal of treatment; on the other hand, allowing persons to be detained indefinitely in high security psychiatric institutions in states of delusion and deterioration when treatment is possible does not enhance one's dignity, not to speak of the cost to society. Physicians have summed up this dilemma rather graphically as "the right to rot" (Sklar et al., 2007, 390). In this chapter, we will explore how Gewirth's human rights philosophy might deal with such an

ethical predicament. In order to focus our discussion, we will examine the following hypothesis:

> That with regards to treatment refusal for the condition that led to involuntary commitment, the Saskatchewan standard of involuntary commitment to provide the patient with care and treatment with the aim that further detention of the person in the facility is no longer necessary, is an option more in line with Gewirth's philosophy of human rights, than is the Ontario standard of involuntary commitment to prevent physical dangerousness to society or the patient themselves, by detention in a psychiatric facility, with acceptance or refusal of treatment to be primarily decided by capable wishes of the patient.

In Chapter Two of this thesis, differences in the Mental Health Acts in the provinces and territories across Canada, in dealing with involuntary commitment and treatment refusal, were described. Authorization for forced treatment in the various mental health acts across the country is managed by one of two main models: the state model or the private model. (Gray, 2000, 175-186). For the state model, the standard for treatment is the 'best interest of patient,' usually meaning the 'best professional judgment standard.' For example, the Saskatchewan Mental Health Act commits the health care system "to provide the person with care and treatment as a result of which detention of the person in the facility is no longer required" (as quoted by Gray et al., 2000, 179). In this model, an expressed wish by the patient for no treatment will be taken into consideration but is not binding.

Other provinces use the private model for which a substitute decision maker (SDM)

is chosen according to their relationship to the patient (Gray et al., 2000, 181-186). The SDM themselves are limited by the Mental Health Act on how to derive their decision and must follow one of three types of standards depending on the jurisdiction involved. The first type is 'best interest' as determined by the SDM in discussion with health care professionals, etc. The second type is that of 'capable wishes.' In Ontario, a previously expressed wish not to be treated is to be respected regardless of possible negative consequences and cannot be overturned by best interest considerations (Gray, 2000, 183). Reviews and appeals relating to the capability of the patient to make decisions are possible, and these were used to the fullest extent in Starson's case, both by his psychiatrists who wished to be able to treat, and by Starson who wished not to be treated. Starson's mother who, even as the SDM, was publicly dismayed at her son not getting any treatment. The third type is modified best interest, which is a combination of the best interest and capable wishes. For this option, the patient's wishes are still carefully considered but are not absolute (Gray et al., 200, 186).

The hypothesis for this chapter, as stated above, contrasts two of the most extreme alternatives in the provincial mental health acts of dealing with human rights concern in the case of treatment refusal by involuntary patients. On the one hand, the Saskatchewan Mental Health Act's commits the health care system to protect the human rights of involuntary patients by providing treatment, wanted or not, until the person no longer needs to be involuntarily committed. Thus Saskatchewan emphases the restoring of dispositional freedom even if it is at the cost of occurrent freedom in the issue of refusing treatment. On the other hand, Ontario's Act commits itself to protect the human rights of involuntary

patients by detaining a person so that they will not be dangerous to themselves or others, but then allowing capable involuntary patients to decide whether to accept or refuse treatment. Thus, Ontario emphasizes the occurrent freedom in specific issues, i.e., consenting to treatment, for capable persons. This chapter will first examine to what extent Gewirth's principle of proportionality (PP) relates to the issue of treatment refusal for their mental illness by involuntarily patients. Next, we will examine the application of Gewirth's discussion of people using their occurrent freedom to limit their dispositional freedom.

5.1 Principle of Proportionality

Although Gewirth devotes the most space to the discussion of children as potential PPAs, he also refers to others, e.g., what he calls 'mentally deficient' people, who hold Q in insufficient amounts. Here not even indicators for Q, such as age for children, with all its imperfections, are available. In Starson's case determining his Q level is even more problematic. Surely, the fact that courts judged him unable to live in society without being a danger to others or to himself, reflects that the level of his Q is already considered less than that of a full PPA in certain contexts. What level of Q does Starson need to have to be allowed to make treatment decisions within the hospital to which he is confined? In other words, what would be considered a capable decision as permitted by the Ontario Mental Health Act? This an especially crucial question for those decisions that affect the future course of his life, such as whether to accept treatment for his schizophrenia. Determining capacity in persons with schizophrenia is extremely difficult. As we have seen in Chapter

Three, schizophrenia typically has manifestations of delusions and hallucination that make judgement difficult or, at least, rather unusual. In addition, many people with schizophrenia are thought to suffer from anosognosia, which is a term used to refer to a denial of illness related to some kind of brain injury. As many as 25% of stroke victims are thought to suffer from anosognosia (Ramachandran, lecture #5, 2003). In the case of a stroke victim, a lack of awareness of a paralysed arm, will be quite obvious to everyone else. In the case of persons with schizophrenia, anosognosia is much more difficult to detect. What are delusions, what is denial of illness, what is normal judgment?

The discussion in Chapter Three regarding the cognitive prerequisites for moral responsibility provides further detail on some of these difficulties. Murphy et al. list what they think are the most basic cognitive capacities needed for moral responsibility (Murphy et al., 2007, 244-255). The first of these is that a person needs to have a symbolic sense of self, meaning they have a self-concept which is influenced by stage of maturity, understanding the intentions of others, language, etc. The second one is that a person needs to have a sense of the narrative unity of life, as per MacIntyre. In order to make proper judgements, we need to learn from our past, and evaluate the present in terms of future consequences of present actions (Murphy et al., 2007, 249). Abnormalities in brain functioning may damage this broad understanding of our actions, and examples are given where brain damage affected persons' memory of the past, making such an understanding difficult, if not impossible (Murphy et al., 2007, 250).

Clearly, determining Q is difficult in persons with schizophrenia. Starson certainly

shows symptoms of brain malfunctioning and impairment of his cognitive capacities which is what landed him in a psychiatric facility as an involuntary patient. One may wonder what are differences between deficits in Q that lead to loss of freedom because of endangerment to others or oneself, and the size of a deficit in Q needed not to be allowed to make treatment decisions for themselves. Apparently in Ontario, there is considered to be a substantial difference to the extent that these are two separate and substantially different capability determinations - one by the courts relating to his pre-incarceration behaviour and another one related to his cognitive abilities in understanding the need for, and outcome of, treatment.

The criteria used for the latter test of capacity, are specified by the *Health Consent and Capability Act* (HCCA) and consist of two components. For the first component, the person needs to be "be able to understand the information that is relevant to making a decision about the treatment" (cited by Sklar, 2007). The patient needs to acknowledge that he has symptoms before being able to understand the treatment decision. For the second component, the person must be able to understand predictable consequences of the treatment decision. McLachlin in her minority position lists the three common clinical indicators of a person's ability to appreciate the consequences of refusing treatment: a) whether the person realizes that the condition may affect him, b) that the person is able to assess how the proposed treatment, or no treatment, would affect him, c) whether the person's choice is not substantially based on delusional belief (Starson vs Swayze, 2003, #13, #17, #18, #19). The issue on which the Supreme Court majority decision rested was not so much that Starson

was considered to have made capable decision when he refused his treatment, but that the Starson's treating physicians had not made an adequate case of his being not capable (Starson vs Swayze, 2003, majority decision). The fact that several of the Supreme Court judges felt the need to issue a minority report which judged that sufficient evidence had been presented for the lack of capability for treatment decisions, further illustrates the difficulty in determining whether a person with schizophrenia has sufficient capability to make treatment decisions.

As is now obvious, the difficulty in measuring Q makes the PP a difficult principle to apply in a practical situation. Still, the idea of Q as a gradient of potential for voluntary and intentional action is an important concept, difficult as it may be to apply in practice. This leads us to the obligation of society to do all they can to increase the Q of potential PPAs to bring them to full PPA status. In Starson's case, the medical treatments as outlined by his psychiatrists have the best chance of bringing him to a state where he no longer needs to be incarcerated. That Starson did not have the necessary level of Q to allow him full freedom, was not because of lack of information or education. In spite of careful and repeated explanations by qualified persons, and the access to all types of information, Starson made the decision not to accept the recommendation of his psychiatrists. To what extent, his decision was influenced by internal compulsions flowing from his illness, is hard to say.

5.2 Conflict Between Occurrent and Dispositional Freedoms

Another application of Gewirth's theory, i.e., regarding conflicts between occurrent

and dispositional freedoms, shows promise, particularly, since this approach has the advantage of being independent of Q, thus, eliminating the necessity of making a judgement of the adequacy of his Q. Occurrent freedom is the freedom to act voluntarily in a particular situation at a specific time. Interference with occurrent freedom removes the agent's control over a particular action, while still allowing freedom in other actions or behaviour. Dispositional freedom refers to wider and longer-range types of activity where interference would remove long-term control over a broad portion of one's actions. Thus, it would conceivably be possible for PPAs to use their occurrent or immediate freedom to make decisions that would interfere with their dispositional, or long-term, freedom or well-being. Gewirth uses the example of selling oneself into slavery which certainly would hamper one's long-term freedom and, most likely, one's well-being.

The example of selling oneself into slavery has features similar to the Starson case. By selling oneself into slavery, supposedly voluntarily, one makes the decision to forego one's long-term freedom and, most likely one's well-being, for whatever immediate benefit the person receives. Refusing treatment when the alternative is forcible detainment in hospital has similar issues. Starson is willing to forego long-term freedom by opting for long-term incarceration in a forensic psychiatric hospital, rather than accepting the treatment that he dislikes so much. A difference is that the prospective slave makes a one-shot decision which is irreversible, while Starson is already in long-term confinement, already has lost his dispositional freedom, but daily uses his occurrent freedom, the limited personal freedom that he does have, to keep it that way. Treatment in Starson's case will almost

surely result in at least a measure of increased freedom, such as a less restrictive movement about the institution, or movement to a less restrictive institution, and possibly lead to sufficient improvement to be able to live in open society - not to speak of achieving some measure of freedom from the demons within him, of which Justice McLachlin spoke so eloquently (McLachlin, 2005).

Consistent with his ideas on mutuality, Gewirth insists that community PPAs have to assume responsibility when they know of self-harmers (Gewirth, 1978, 265). Before going on to elaborate on his proposition, Gewirth stipulated that the self-harmer not harm others by his self-destructive behaviour, nor have dependents who may be hurt (Gewirth, 1978, 264-5). In Starson's case, he was placed in a forensic psychiatric hospital for that very reason - for the protection of others and himself. The issue of debate in this thesis is whether once in hospital, he should be allowed to make decisions which will most likely keep him there indefinitely - whether to accept treatment or not.

In order to deal with the situation of an intentional self-harmer, Gewirth recommends a three-step process as described in Chapter Four (Gewirth, 1978, 265). As a first step, in the spirit of mutuality, the PGC requires a willingness to accept responsibility by community PPAs for those PPAs who are making decisions that will involve basic harm for themselves. The first step of Gewirth's three step process has been met fully in Starson's case. Deep concern in his condition and his need for treatment and involvement to the greatest extent possible in encouraging him to accept treatment was evident prior to and at the time of the court cases including his loved ones, health professionals and even the Canadian Society for

Schizophrenia which acquired intervener status during the legal process. Starson in the past has expressed his concern that medication would make him dull and prevent him from being able to think creatively. All has been done by his psychiatrists to make treatment palatable to him and avoid as much as possible the side effects he fears.

As a second step, Gewirth suggests a temporary interference with the intended self-harm, until it can be assessed whether the self-harmer acts in complete freedom. Gewirth goes as far as to say "interference with the would-be actor would be justified until he can be brought to a point where he is capable of voluntary participation" (Gewirth, 1978, 265). Since it has not been found possible to placate Starson's concern about the effect of his medication, a trial period for the medication regime as proposed could be implemented to fulfill Gewirth's second step. It is assumed that this may be done with all the ethical safeguards possible, e.g., approval of the treatment plans by the hospital ethics review board, and taking Starson's concerns into consideration as much as possible. Hopefully, with treatment, certain inner compulsions would be expurgated, allowing him a freedom to make decisions which he did not have before.

If the second step of Gewirth's process does not resolve the situation, then there is a third step. If eventually, it becomes clear that the decision of self-harm was made voluntarily, and with full understanding of its implications, then the self-harmer should be allowed to continue with, what others consider his self-harm, unhindered. In Starson's case the self-harm would be the lack of freedom that he would continue to choose and experience, unless his condition would improve spontaneously. All further interference related to forced

medicinal treatment should be suspended (Gewirth, 1978, 266). Gewirth emphasizes that at some point, people must be allowed to live their lives even if it seems wrong to others, and for many cases of self harm, e.g., addiction, this may well be the end of action by other PPAs unless a crisis situation develops, e.g., in Starson's case that would mean a further deterioration of his condition that cannot be ignored.

Gewirth insists that in his three-step-process, his concern does not relate so much to the responsibility of institutions but that of community PPAs who need to accept responsibility when they see someone seriously harming themselves (Gewirth, 1978, 265). Clearly, the state and laws are already involved with Starson, as clear from his involuntary commitment to a psychiatric hospital. Gewirth is a proponent of the supportive society, the community of rights, and as such would certainly support the action of society to remove Starson out of a position of danger to himself and others, by means of the courts and other society institutions. The institutions and social services of an effective community of rights, as proposed by Gewirth, are expected to improve our freedom and well-being, e.g., our government run health care system, the laws that keep society running smoothly. So, obviously, Gewirth is not opposed to legal or criminal supportive measures, as such. However, our discussion involves the quandary when Starson refuses the treatment when in hospital. Should Starson be left confined to hospital where he will not be dangerous to himself and others because of his detainment, or should he be treated against his will with the potential for improvement in his condition, resulting in more freedom? Even within the psychiatric hospital, it is possible for him to use his occurrent freedom to limit his

dispositional, or long-term, freedom.

5.3 Application and Implication

Our hypothesis is stated as follows:

> That with regards to treatment refusal for the condition that led to involuntary commitment, the Saskatchewan standard of involuntary commitment to provide the patient with care and treatment with the aim that further detention of the person in the facility is no longer necessary, is an option more in line with Gewirth's philosophy of human rights, than is the Ontario standard of involuntary commitment to prevent physical dangerousness to society or the patient themselves, by detention in a psychiatric facility, with acceptance or refusal of treatment to be primarily decided by capable wishes of the patient.

In other words, Saskatchewan ties involuntary commitment to hospital together with the necessary treatment when in hospital so that the person can be discharged as soon as possible, while Ontario separates the commitment from treatment decisions allowing for the possibility of treatment refusal leading to indefinite hospital stays. I would like to reemphasise that this discussion refers only to the treatment for the psychiatric condition that led to the involuntary commitment in the first place.

Obviously, neither option is perfect - the Saskatchewan option has the potential for having to force treatment on unwilling patients while the Ontario option has the potential for indefinite incarceration. It is always difficult to make across the board rules or laws which

will be fair and appropriate in every possible application. There is especially no perfection when dealing with mentally ill people who are already committed to psychiatric hospital. Gewirth indicated that for those people allowed less freedom because of diminished Q, there must be an equal, possibly an even greater, concern for their well-being than for others who are full PPAs (Gewirth, 1996, 65). Saskatchewan and Ontario have enacted entirely different ways of expressing such concern. Saskatchewan fulfills its duty to protect the human rights of involuntary patients with their commitment to shorten the length of confinement as much as possible, thus regaining dispositional freedom, which is also accompanied by increased occurrent freedom as soon as possible. Ontario fulfills its duty to protect the human rights of involuntary patients by allowing involuntary patients the same right to refuse treatment as have other hospital patients. In this case, Ontario emphasizes the importance of occurrent freedom for particular decisions, i.e., treatment decisions, over the potential for greater dispositional freedom.

In Saskatchewan, the commitment to hospital of an involuntary patient could be considered the start of step two of Gewirth's process. Step one of the process would have consisted of the likely long history of encouragement by relatives, friends, health professionals to accept treatment, not to speak of his legal history to discourage his unacceptable behaviour. Because of their obvious lack of success and the crisis situation which landed him in psychiatric hospital, going on to step two is reasonable. As part of Gewirth's process, one would expect all the possible safeguards to be in place, taking the patient's concerns into consideration as much as possible, involving an ethical review board,

etc. before starting the actual treatment. A huge advantage of the Saskatchewan approach is that treatment can be started without delay, which would minimize irreversible deterioration that comes with further delays in treatment. To what extent something similar to step three of Gewirth's process, is implemented if the patient continues to refuse the treatment and does not show improvement after suitable length trial period, is not certain, possibly some sort of maintenance treatment is maintained regardless of the patient's wishes. Since the crucial part of the hypothesis as stated concerns step two, it may be concluded that the Saskatchewan approach follows Gewirth's three steps quite closely. Concerned citizens and community PPA may make a further study of what happens of cases of continued refusal of treatment and determine whether a policy of increased emphasis on treatment withdrawal in those cases is needed.

For Ontario, when the Mental Health Act was changed to make danger to self and others the main criterion for involuntary commitment, commitment to hospital by itself could fulfill that particular purpose as discussed in more detail in Chapter Two (cf., Gray et al., 2000, 176). This led to the separation of admission to hospital from the application of treatment. Consequently, it became possible for refusal of treatment by the patient to result in indefinite incarceration. In terms of Gewirth's three step process, this would be the equivalent of never going beyond step one. A person would be able to use their occurrent freedom to limit their dispositional freedom in this type of context, without anyone, health care professionals, substitute decision maker (SDM), friends, relatives, SDM, and other concerned PPAs being able to do anything to alter the process. Patient's "capable" wishes

have priority over all, even when the capable wish was made long before the present episode and at a different time and in a different context. As we have seen, determining capability, or Q, in psychiatric patients is very difficult at the best of times, but according to Gewirth, even a person considered fully capable of making decisions should be strongly discouraged from using his occurrent freedom to put sizable restrictions on his dispositional freedom, even to the extent of forcible restraint.

Saskatchewan and Ontario have two different approaches to preserving human rights for involuntarily committed psychiatric patients. Ontario's approach has been to allow capable patients the choice of treatment refusal, while Saskatchewan's approach consists of a commitment to shorten the need for involuntary commitment. What are some of the practical implications of each?

Ontario's approach opens the hornet's nest of determining capability, which is difficult enough at the best of times, but especially so for psychiatric cases. Patients committed to hospital because of a "not guilty because of insanity" plea in a court case that centres on unacceptable behaviour, obviously already have problems with capability, and determining capability to make treatment decisions for psychiatric patients may be most difficult of all. A very unfortunate development is the lapse of time before a final decision is delivered by the court system. Even when psychiatrists are given permission to treat at the first level of the court system without further appeal, there are months of delay. When the process goes through the courts as far as possible, it is a matter of years. Starson was first committed in 1998, and even if the Supreme Court decision in 2003 had agreed to

involuntary treatment, he would have been without treatment for five years. In Saskatchewan, Starson would have been treated in 1998.

This delay in treatment has implications of increased cost to both the health care and legal system, and, arguably, Starson's general right to well-being. Even if the decision had been for treatment in 2003, there would have been five years of health care cost and the five years of legal cost, both funded by the province. There is also the cost to Starson's health as five years of potential deterioration even if treatment had started then. Less tangible results are the emotional costs to the close relatives and friends. Watching their loved ones continuing with a dreadful disease for which treatment is possible is heart-wrenching. Certainly, Starson's mother expressed public dismay when the Supreme Court ruled in favour of Starson decision of no treatment.

One type of harm at issue here is the harm done through poor application of distributive justice when one patient receives millions of dollars of avoidable treatment, e.g., hospitalization because of refusal of more effective treatment. The resulting limited resources will harm others who need treatment but are not receiving adequate treatment, e.g., inadequacy of mental health treatment for children and teenagers. These choices are not made deliberately but by default. The choosing of what to cover and what not to cover are extremely difficult decisions. To (probably, over-) simplify and (perhaps, over-) dramatise the situation, we consider a choice between years of expensive treatment for one person (Starson) and the outpatient treatment of many disturbed children/ teens who if not treated at an early age may become very costly to health care/ legal/ social welfare systems.

In conclusion, Saskatchewan's approach to preserving human rights is a commitment to shorten the enforced stay as much as possible. Their process follows Gewirth's proposed three-step process very closely, especially the first two steps. The process is amazingly simple compared to that of Ontario. There is no need to agonize over capability, since capability has been considered to have been decided by the courts when the patient was committed. Advantages are the quicker treatment with less chance of unnecessary deterioration, and the achievement of improvements. Improvements can lead to less restrictive confinement or even freedom, thus, lower cost to the legal and health care systems, and, hopefully, fewer emotional costs to loved ones.

In conclusion, Gewirth expresses a conviction that "all humans, as actual or prospective agents, be enabled to live lives of dignity, self-fulfilment, and mutuality of respect" (Gewirth, 1996, preface, xv). Saskatchewan's approach of treatment with high chance of improvement and a greater measure of freedom and well-being would provide a larger measure of dignity and self-fulfilment than the Ontario approach of allowing the involuntary patient to use his occurrent freedom to severely limit his dispositional freedom, and remain confined to hospital and subject to detainment.

CONCLUSION

This thesis was based on the story of Scott Starson, his illness, and his brushes with the law until in1998, when he was committed to a forensic psychiatric hospital as an involuntary patient by an Ontario court. This time, when he refused treatment, his treating psychiatrists started legal proceedings to be able to treat forcibly. The case went through Ontario courts up to the Supreme Court of Canada. Starson fought this every step of the way, and, eventually, in 2003, the Supreme Court brought out the verdict that allowed him to continue refusing treatment.

However, had he lived in Saskatchewan, this trek through the courts would not have been possible. According to the Mental Health Laws of Saskatchewan, he would have been treated immediately upon commitment in 1998.

This thesis then compared two different approaches to the protection of human rights for the involuntary psychiatric patient, to determine which one was most in accordance with Gewirth's theory of human rights as summarized by the following hypothesis:

> That with regards to treatment refusal for the condition that led to involuntary commitment, the Saskatchewan standard of involuntary commitment is to provide the patient with care and treatment, with the aim that further detention of the person in the facility is no longer necessary, is an option more in line with Gewirth's philosophy of human rights, than is the Ontario standard of involuntary commitment to prevent physical dangerousness to society or the patient themselves, by detention

in a psychiatric facility, with acceptance or refusal of treatment to be decided by capable wishes of the patient.

On the one hand, Saskatchewan ties involuntary commitment to hospital together with the necessary treatment when in hospital, so that the patient can be discharged as soon as possible. This emphasizes a return to dispositional freedom as soon as possible, which incidentally will also be accompanied by increased occurrent freedom? On the other hand, Ontario separates the involuntary commitment to hospital from treatment decisions by the patient. This allows for the possibility of treatment refusal by the patient, thus, giving him or her more occurrent freedom, but also has the potential for indefinite detainment in hospital, thus, a serious loss of dispositional freedom as well as a loss of much, if not most, occurrent freedom.

In order to fully understand the issues involved, the thesis started with a review of relevant issues in psychiatry, Canadian legislation, the neurosciences and mind-body issues, especially as related to capability of a schizophrenia patient. With that background, the human rights philosophy of Gewirth was applied to the dilemma of Ontario vs Saskatchewan, i.e., being given best possible treatment regardless of patient wishes, versus being able to refuse treatment no matter what the consequences. Gewirth discusses the principle of proportionality by which people with less capability would have less responsibility according to their capability but as much, or more, consideration by the rest of the community. The drawback is the difficulty in determining capacity. For this reason another one of Gewirth's applications which is independent of capability was considered.

Gewirth discusses the dilemma of people using their immediate freedom to drastically limit their long-term freedom and suggest a three step process in which the second step involves a trial period of treatment. This process as suggested by Gewirth is much more like the Saskatchewan process than the Ontario process and has the advantages of both of early treatment preventing irreversible deterioration, and the potential for much earlier release with its increase in both personal and situational freedom.

The discussion of this human rights dilemma is done within the context of a specific case, the Starson case. It should be emphasized that this thesis was not so much about a better resolution of the Starson case but about looking at a conflict in human rights issue from all angles. It is not about saying that the court should have made another decision, or the psychiatrist or lawyers should have made a better case. The courts were concerned with whether the evidence supplied by psychiatrists and lawyers was adequate for establishing that Starson was incapable about deciding on his own treatment. This thesis was about taking a complete look at all the issue surrounding the Starson case over a rather extensive, what we may call, a "catchment area"[2] of issues surrounding treatment decisions in the context of involuntary patients.

The reason for using the Starson case as a particular case on which to build the discussion is that this allows us to conduct the discussion within the limits of the case,

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[2] Like the catchment area of a hospital which is all the population in a specific area surrounding the hospital from which patients will be drawn for this particular hospital.

without getting mired in trying to cover all possibilities of a more general approach. One may wonder whether the discussion related to this case is applicable to all situations where people have been committed to psychiatric hospital through their plea of not guilty because of insanity. By their plea all such patients have admitted a lack of capability which landed him in psychiatric hospital because their unacceptable behaviour attributable to their mental illness. If they then refuse treatment for that particular mental illness when effective treatment is known to be available, then they should be considered part of this discussion. The advantage of Gewirth's three-step process is that it is not necessary to determine capability of the involuntary patient, which has already legally been deemed to be compromised to the extent that they cannot live in open society. In this thesis, we have concluded that a trial of the proposed treatment, with many ethical safeguards in place, in the context of Gewirth's three-step process, is consistent with protecting the human rights of such an involuntary patient.

We may now ask should the Ontario Mental Health Act be modified accordingly. When the time comes to update the Ontario Mental Health Acts, it will be important for the legislature to take an in-depth look at this issue, and discuss whether, for a person already committed to hospital because of insanity, effective treatment for the condition that led to his detainment is not the best protection of his human, rights after all.

There are a number of points that flow from this discussion:

1. We need to again emphasize that the term mental illness as used in this thesis was that of the legal definition which deals with the kind of overt symptoms and manifestations that

bring a person in contact with the law. Very few of the people in the population who have a diagnosable mental illness display such overt symptoms.

2. Determining capability in a person already sufficiently incapable to be detained as an involuntary patient, and thus not considered capable by the courts to be out in open society, and who continues to act out of the ordinary, is difficult, if not impossible.

3. As many have pointed out and is borne out again by this discussion, the delay of the courts in this type of case is not acceptable. After five years delay, much irreversible damage would be done, even if treatment had been started the day of the Supreme Court decision. As the final verdict allowed a continued refusal of treatment, the delay became immaterial.

3. In the analysis of human rights issues we need to look beyond the immediate. Some civil rights advocates were overjoyed at Starson being allowed to refuse treatment. These advocates were not necessarily looking beyond the surface at the profound implications for Starson of decision to refuse treatment, especially in continued loss of freedom. That is why Gray et al. in their book emphasize the importance of looking at the issues in depth, calling themselves informed civil rights advocates (Gray et al., 2000). One needs to look at the implications of decisions, and then balance the implications, before deciding on the best option. This is what this thesis tried to do by presenting an in-depth look at the issues.

Starson update

The advantages of a trial period as suggested by Gewirth and the Saskatchewan approach of immediate treatment upon commitment was also borne out by the course of

Starson's illness after the Supreme Court decision of June 2003 (O'Neill, 2005, E1-E5). By the winter of 2005, Starson refused to take any of the hospital food, thinking that it was poisoned. His doctors' offer to bring in food from Swiss Chalet was not accepted. His weight dropped from 175 lbs to 118 lbs which is clearly insufficient for his 6'1" height. When his doctors feared for his life, they went back to the Ontario Consent and Capacity Board in February 2005, and received permission to treat him against his will at this level. This time, when Starson appealed, in May 2005, the Ontario Superior court dismissed Starson's appeal, and Starson's doctors were able to inject him with Haldol. He soon regained his weight and his psychiatrists, mother and friends soon noticed improvement in his behaviour. In August 2006, Starson was much improved and still taking his medication. The Ontario Review Board gave permission for Starson to be transferred to a supervised group home in Toronto. Gewirth's suggestion of a trial period as step two of Gewirth's three-step process would have been been vindicated.

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APPENDIX: ONTARIO BOARDS AND COURTS

The **Ontario Review Board** annually reviews the status of every person not criminally responsible or unfit to stand trial for criminal offences on account of a mental disorder. The Ontario Review Board is established under the Criminal Code of Canada and is made up of judges, lawyers, psychiatrists, psychologists and public members appointed by the Lieutenant Governor in Council." (http://www.orb.on.ca/english/default.htm)

The **Ontario Consent and Capacity Board** is an independent body created by the provincial government of Ontario under the Health Care Consent Act (HCCA). It conducts hearings under the Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act, the Substitute Decisions Act and the Mandatory Blood Testing Act. Board members include psychiatrists, lawyers and members of the public appointed by the Lieutenant Governor. The Board sits with one, three, or five members. (http://www.ccboard.on.ca/scripts/english/index.asp)

The **Court of Ontario** has two divisions: the Ontario Court of Justice (the lower or provincial division) and the Superior Court of Justice (the higher or general division)

The **Ontario Court of Justice** is the trial court in Canada before which most cases appear. It is composed of provincially appointed judges and justices of the peace. The justices of the