On psychiatric wills and the Ulysses clause: The advance directive in psychiatry

Alok Sarin
Department of Psychiatry, Sitaram Bhartia Institute, New Delhi, India

Poised as we are, with the new Mental Health Care Bill very much on the cards and waiting to go Parliament, it may be wise to reflect on at least some of the provisions of the Bill which may not have received the thought or consideration that they have deserved. While much has been written about how the proposed legislation is different, and what this difference entails, some aspects of this I would think are worthy of a larger discussion.

One such provision is the planned introduction of the use of advance directives in psychiatry. An advance directive is a mandate that specifies a person’s preferences for treatment, should s/he lose the capacity to make treatment decisions in the future. The use of advance directives in terminal illness has been in place for some time, but its use in psychiatry is a rather recent phenomenon. Any reflection on the use of the advance directive in psychiatry raises some rather interesting issues. This also remains an area on which there remains paucity of both literature and of discussion despite some existing reviews.[1-3]

The first issue is that while the use of the advance directive in terminal illness is rather straightforward, as the expression of intent for a time when the individual may be incapable of expressing intent, in psychiatry this is different. It is an expression of intent of expected treatment for a time when the expressed intent may actually be saying completely the opposite. It is an attempt to reconcile the facts of patient autonomy and choice, with the possibility of involuntary treatment that has been agreed upon in advance. It is thus an attempt to reconcile seemingly irreconcilable issues, namely, those of choice and involuntariness.

Proposed first by Thomas Szasz,[4] the influential and vocal critic of psychiatry, the advance directive was the proverbial “olive branch” to psychiatry. It offered a means of breaking the logjam that often appeared when somebody who was diagnosed as violent or psychotic and deemed to be in need of treatment by the medical profession refused it. It was originally hailed by both activists and professionals alike, but has subsequently been characterized by a rather dichotomous and often contentious debate. So, the position on the one hand is that since the advance directive gave the user of the system autonomy, it is unquestionably a good idea. The counter position is that both conceptually and practically there are many difficulties with the use of advance directives, which have not been adequately thought about.

In a well-argued article, Szasz recognizes the inherent differences between the positions of those who accept the reality of mental illness as a medical reality and those who view this as a form of myth and metaphor – an individual dealing with unacceptable circumstance – as a moral, not a medical issue. Identifying these as the “medical protectionistic” positions as opposed to the “voluntaristic,” he recognizes the fact that as the two groups speak different languages, a meeting ground appears impossible. He also accepts the fact that this may not be a situation that is easily amenable to “therapy by the judiciary.” To circumvent this, he offered the “psychiatric will” as the olive branch to psychiatry, where a person, in times of “competence,” may mandate a directive for treatment if he were ever to become “psychotic.” For this, the use of a novel tool, “the Ulysses clause,” was suggested. Based on the tale of Ulysses, who asks his crew to bind him to the mast of his ship as he sails past the isle of the sirens so that he can both listen to the song and not run his ship aground, the clause says that the person may mandate treatment for anticipated “incompetence.” On the other hand, the advance directive may actually say that the person, if he ever were to be diagnosed as “psychotic,” would wish that he not be treated.

Address for correspondence: Dr. Alok Sarin, Department of Psychiatry, Sitaram Bhartia Institute, New Delhi, India. E-mail: aloksarin@gmail.com

How to cite this article: Sarin A. On psychiatric wills and the Ulysses clause: The advance directive in psychiatry. Indian J Psychiatry 2012;54:206-7.
So, the situation is that what was offered by Szasz as a seemingly irrefutable argument for reconciliation actually depends on the world view that the individual espouses. If I believe in the reality of mental illness, I may write an advance directive to decide the sort of treatment that I should get during the time I think that I may need it, even if this is contrary to my expressed wish at that point of time. On the other hand, if I do not share that view, I will use it as a tool to refuse treatment regardless of whether medical, family, or societal opinion suggests the contrary. Chodoff and Peele,[5] in a response to Szasz, have compared the "olive branch" to a "thorny thicket." Dresser,[6] in an equally eloquent piece, cites all the difficulties in moving, as she says, "from literature to law." So, while Ulysses entered into a bipartite contract with his crew, for the Ulysses clause to be a tripartite contract between the individual, the medical profession, and the state raises some rather interesting complications, especially if the state – through the process of legality – is to monitor enforcement of the clause.

Apart from the difficulties involved in determining “competence,” which is what makes the directive valid, the issue has been raised as to which is the “real self” – the one that writes the directive, or the one that it is written for?.[7] The “paternalistic” issue, of one “self” deciding for the other, is also an aspect that needs to be further explored.

The next point is that appealing as the concept of the advance directive is at one intellectual level, the fact that there is actually little to support it in the form of evidence for effectiveness needs to be clearly understood. In an extensive meta-analysis of literature as part of a Cochrane review, Campbell et al.[8] conclude, “Currently it is not possible to recommend advance treatment directives for people with severe mental illness due to the lack of supporting data.” The authors note that only a few studies have been done, with variable parameters, and the fact that data does not emerge is not necessarily an argument against the advance directive, and in fact suggests other interventions like advance treatment planning, which seem to offer more evidence of effectiveness.

Another question that has been raised is whether people suffering from what is severe mental illness may have difficulties in utilizing the provision of the advance directive. While this is a valid point, there does seem to exist data suggesting that people with mental illness can both understand the concept and plan for eventualty, as has been pointed out by Thara.[9] Thara also points out the need to be able to listen to people and help them to be participative in decision making regarding treatment. In my view, this is actually an irrefutable argument, and the need for a both participatory and inclusive model of treatment planning is certainly essential. The basic question, however, is whether this should be a clinical tool or a legal one. By the process of legislating it and making it a legal instrument, the likelihood that it will have unintended consequences – both medical and sociological – is an aspect that I think we may want to think about.

Also, what happened in the West was that as a consequence of the ongoing debate between the activist, the anti-psychiatry position, and the medical position, the advance directive was envisaged as a sort of a via media. Even in the West, this has certainly not had its intended benefit, as pointed out. For the Indian reality, to be rushing in with legislation on this count seems in my opinion rather hasty and ill-conceived. I would suggest that more debate, discussion, and research are certainly called for. My personal position is also that we may want to think about this slightly differently from the “dominant narrative” that I think we are presently hearing. In any case, it would certainly be wise for all people dealing with issues of mental illness to inform themselves about the debates that characterize the subject.

DISCLAIMER

The author is a member of the Mental Health Policy Group, created by the Ministry of Health, Government of India. The views expressed here are, however, personal.

REFERENCES

1. Wilkinson A, Wenger N, Shugarman LR. Literature review on advance directives. Rand Corporation, 2007 Jun. Available from: http://www.rand.org/topics/advance-directives.html [Last accessed on 2012 Aug 28].
2. Jankovic J, Richards F, Priebse S. Advance statements in adult mental health. Adv Psychiatr Treat 2010;16:448-55.
3. Sarin A, Murthy P, Chatterjee S. Psychiatric advance directives: Potential challenges in India. Indian J Med Ethics 2012;9:104-7.
4. Szasz TS. The psychiatric will - A new mechanism for protecting persons against 'Psychosis' and psychiatry. Am Psychol 1982;37:762-70.
5. Chodoff P, Peele R. The psychiatric will of Dr. Szasz. Hastings Cent Rep 1983;13:11-3.
6. Dresser R. Bound to treatment: The Ulysses contract. Hastings Cent Rep 1984;14:13-6.
7. Widdershoven G, Berghmans R. Advance directives in psychiatric care: A narrative approach. J Med Ethics 2001;27:92-7.
8. Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. Cochrane Database Syst Rev 2009;21:CD005963.
9. Thara R, Rameshkumar TC. Psychiatric advance directives: Challenges of implementation. Indian J Med Ethics, 2012;9:108.