

Dignity, patient's autonomy and mental illness

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Abstract

Human dignity, intrinsically linked to autonomy, is vulnerable in situations of severe mental disorder, either to participate in medical research or to participate of therapeutic decisions. The author discusses the concept of dignity, the principle of autonomy and the informed consent, and, by reviewing the literature, suggests that ethical action is the constant exercise to identify *when* and *how* it is easier to disregard dignity and avoid doing it. He concludes by stressing that to deny autonomy to others, simply because one is in a position to do so is to respect his dignity. Attention should be paid to the fact that paternalism and beneficence are not always good solutions for the mentally ill.

Key words: Personal autonomy. Bioethics. Vulnerability. Informed consent. Mental health. Mental competence



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Man is he and his circumstances

Ortega y Gasset

How to deal with autonomy issue when one deals with subjects who were destitute of all and any possibility of its use if they are labeled mentally ill? In view of this limitation, apparently insurmountable, this work proposes to discuss two essential aspects: mentally ill patients' capability to exercise their autonomies in face of therapeutical possibilities, and the inclusion of these in medical research groups, under the risk of abuse for being a vulnerable group. Reflection will point still toward the issue of treatment access, considering mentally ill who are without access to appropriate therapeutics would not have their autonomy affected in double.

Dignity: principle that defines human being

The notion of dignity as intrinsic and common feature to every human being is relatively recent. History shows that human being's primacy was not extended always to all humans. Slavery demonstrates this, reigning both in Oriental civilizations and in classic European Antiquity, as well as persecutions promoted by the Holy Inquisition, in which discrimination was notorious and, usually, accepted pacifically by legislators, historians, religious people, and philosopher at the time.

The notion of human being's dignity rests in his real being and in his capability of being able to be, not been restricted just to what effectively one does out of this capability. Thus, one considers it as inherent attribute. *Human dignity is, then, the acknowledgement of a value; is a moral principle based in the usefulness of the human being, and not in his use as a means.* This notion, since it is proper of human condition, is considered also as inalienable that cannot be taken away or suppressed¹. Equity among human being in attribution of dignity bases the philosophy of human rights. It is from this value that basic human rights derive.

It is usual to see the first enunciation of the dignity principle attributed to Immanuel Kant, for who dignity is a value that covers all that which there is not price, that is, it is passable to be replaced by an equivalent. In Kantian thought,

Dignity is a quality inherent to all human beings, as moral beings, and just to these, for being completely inseparable of autonomy for the exercise of practical reason. As they exert autonomously their practical reason, human beings build different personalities, each absolutely individual and irreplaceable. Consequently, dignity would be inseparable from autonomy to exert practical reason, and for this reason is that just humans dresses up on dignity.

The great legacy of Kantian thought for human rights philosophy is the equity in attribution of dignity. Considering that freedom in the exercise of the practical reason is the sole requirement in order to a being dresses himself up on dignity, and that all humans enjoy this autonomy, one has that human condition is the physical support needed and sufficient to dignity, independently of any type of social recognition. For Kant, *human being is an absolute value, an end in itself, because is gifted with reason. His autonomy, for being rational, is the root of dignity, as it is what makes Man an end in himself*².

Principle of autonomy

Etymologically, the word autonomy derives from *autos*, self, and *nomos*, law. One of the theoretical basis for elaboration of the *principle of autonomy* derives from John Stuart Mill's thought, for whom the individual is sovereign over himself, his body and mind. But, in Kantian view, autonomy is the power of the self over oneself – the freedom -, exerted

by the mediation of a law (*nomos*) that reason imposes on itself. Moral occurs from this self-imposition. Therefore, according to this proposition, autonomy and freedom are solidaristic concepts, but not coincident. Whoever does evil acts freely, but without autonomy, one submits freely to that part of his being that effectively is not free of his instincts, passions, weakness, interests, and fears³, forgetting both law and its reflection in moral conscience.

An autonomous person is an individual capable to deliberate on his personal objectives and to act toward this deliberation, considering moral values from the context in which he is inserted. An autonomous individual acts freely in accordance to his own plan, in analogous way to an independent country that manages its territory and establishes its policies. To respect autonomy is to value consideration about opinions and choices, avoiding, in the same way, the obstructions of autonomous subject's action, except if they are clearly harmful to others.

To show lack of respect toward an autonomous agent would be to not consider his judgments, to deny the individual freedom to act based on them or to omit needed information in order to a judgment can be made when there are not convincing reasons for it. Charlesworth goes beyond and he introduces the social perspective in defining individual's autonomy, pointing that this may lead to the own notion of citizenship. And he states that *nobody has the capacity to develop personal freedom and feeling autonomous if he anguished by poverty, deprived of basic*

*education or if he lives deprived of public order. Equally, primary health care is a condition to exercise autonomy*⁴.

The *Belmont Report*⁵, which established the bases for adequacy of research ethics in the United States (USA), designed autonomy as Principle of Respect for People. In this perspective, it proposed that autonomy incorporates, at least, two ethical convictions: the first one, that individuals should be treated as autonomous agents; the second one, that people with decreased autonomy should be protected. Thus, one divides the issue in two separate moral requirements: that of recognition of autonomy, and that of protecting those with decreased autonomy.

Respect for people with decreased autonomy

Aristotle and Saint Augustine admitted the distinction between things, animals, and human being². Departing from premises coming from distinct conceptions of the world, both recognized in human beings unique qualities that distinguished them from the others. Currently, one considers that the fundamental difference between human being and the other animals is not in affectivity, but rather in the capability to think symbolically, to represent and to project contents of conscience, using them in creation of human culture⁶. Consequently, conscience, is one of the capabilities of human cognition, it is valued as essential component of that which characterizes *humanity* – as one gets from Kant's reasoning.

According to this formulation, conscience could be classified as the *a priori* for the exercise of practical reason. Associated to notions of autonomy and dignity, its existence would constitute, therefore, in prerequisite to qualify humans as moral beings. Thus, it would be only in consequence of it that these would be embodied of dignity. But, if it is conscience that fundamentals dignity, autonomy, and freedom, how can we classify those mentally incompetent or those who, in reason of their age or health condition, are taken as incapable to exert their autonomy? Would they stop being humans because they are deprived of full use of their mental faculties? Departing from such premise, both very young children and the sick destitute of full use of their conscience could not be classified as humanly dignified².

The deadlock generated by unilinear application of this rationale, which associates mistakenly humanity to reason, establishing that the first is a function of the second, deepens itself when one analyzes closely the issue. If conscience can be associated to a biological basis, related to cognition capability, and if this is what differentiates and qualifies humanity, allowing to presuppose human dignity, the insane or terminal sick person, who is unconscious or in persistent vegetative state, would not have the right to the same dignity as a healthy person, and in full use of his faculties. Moreover, the merely biological body may be taken even as an abstraction, in as much as we are a lived-body, a personal-body, which becomes human in consequence of

the inter-relational process in society. Thus, considering this, how do we attribute this same humanity to those who are deprived of this relational existence, of this materialization of themselves while persons, either because they never had it, as the case of the newly born, or because they have lost it in consequence of health conditions?

In reply to such paradox, one may argue that the prerequisite of conscience and, consequently, the attributes of dignity and moral autonomy should be understood as inherent to human species, biological characteristics of the *Homo sapiens*, independently of their manifestation in plenitude in each specific human being. That is, human dignity would be an attribute of the *potential* human for the exercise of practical reason. One may conceive that, in this perspective, even those deprived of full use of reason may be entitle to it, being, thus, carriers of the same essential dignity, as well as the same intrinsic and inalienable rights than the others right .

However, seif this perspective allows to expand humanity's classification, untying it from the effective use of reason, and relating it to the potential for the practical exercise of this use, the same does not apply to the notion of autonomy, which cannot be considered just as inherent possibility, but only as effective capacity, materialized in moral choices of the social life. The concept of autonomy, particularly in mental health realm, seems to be recovered by inaccurate meanings², which may be exemplified in the requirement of informed consent, in the

clinic, what requires rational capability to understand information and from them to make decisions – skill that the mentally disabled do not have or have it severely compromised ⁷. The presumed incapability of the mentally ill to exert their autonomy in view of therapeutical possibilities, and participation in medical research groups would turn them into a group particularly vulnerable to abuse.

The fundament of the informed consent medical doctrine consists in understanding that decision-making on health is a sort of self-determination. The right to informed consent is not just a political or legal requirement, linked to one the most fundamental ethical principles of contemporary society, namely autonomy and respect for the individual. The exercise of this right departs from the premise that patient has the capacity to make decisions, to understand the nature and implications of options presented to him, and making free choices. However, as discussed, other elements are indispensable for conscious choices beyond understanding of alternatives, mere conceptual items that need to be valuated ⁸.

Autonomy of patient with mental illness

According to Eike-Henner ⁸, mental processes behind behavior derive from cognitive capability. Cognition is the act or knowledge process, involving attention, perception, memory, reasoning, opinion, imagination, thought, and language.

– exactly the resources for information processing that are affected in mental disorders.

Psychiatric patients may (or not) find themselves clinically deterred to consent in sovereign manner, given that there is the possibility that the disorder affecting them makes it difficult or deters the use of one or more cognition attributes. It occurs, equally, with the immature or those who, for other health reasons, become incapable to make choices or to make decisions. As people, even if in such conditions, must be treated as human beings, that is, carriers of inherent dignity that confers to all and anyone, simply because they are people, one can conceive that this includes the right of not been discriminated.

However, even respecting the prerogative of every individual be equal in rights, not all of them have the capability to self-determine in the same measure. Generally, this capability matures during individual's life, and some people lose it totally or partially due to illnesses, mental disorders or circumstances that severely restrict freedom. Given this differential in the capability for the exercise of autonomy, it becomes necessary to consider, in these cases, the principles of justice and equity as well, that is, it is indispensable to bear in mind that relevant differences that may affect autonomous choices should be pondered for effective application of justice. There should be and, therefore, one must seek for a way to ensure the right to self-determination in the absence of decision-making capability.

Eike-Henner ⁸ warns for the mistake that it would be to treat incompetent person in the same way that one would treat any individual, what he understands as punish him for its incompetence. Thus, he teaches, even in his incompetence there must be a way to understand and respect his autonomy. Similarly, the respect for the immature and for the incapable may require his protection as they mature or while they are incapable.

Someone with decreased autonomy is, at least in some aspect, controlled by others or incapable to deliberate and act based in his wishes and plans. Mental incapability limits autonomy in the same way that coercitive institutionalization does with prisoners. Peel ⁹ admits that in psychiatry many patients are considered incompetent in consequence of their clinical condition. Thus, formal medical ethics falls back into beneficence to decide how they should be treated.

Abreu ¹⁰ sustained that, in these terms, autonomy may be included in the axis dependence-independence. The higher independence level, greater the probability of autonomy, but in conditions of partial dependence, the subject still may have his autonomy preserved, depending of social arrangements that he is capable to establish. The binomial dependence-autonomy should not be considered, in principle, as a contradiction, but rather as non excludent opposition.

Arrangements among people in the context of social contracts may turn feasible the increase in quality of life and, consequently, in autonomy also ⁹.

According to Santos et al ², it seems that the nodal point is in defining what can be understood as autonomy, both for us and for the psychiatric clientele. According to these authors, autonomy production may be characterized in two paths: i) abandonment of expectation of solubility and efficacy by comparing with our own performance; and ii) creation of other possibilities of life from this other subjectivity standard. Directly relating to this issue, one should discuss the possibility to rethink the cure process in psychiatry, departing from the idea of *possible autonomy*. Thus, the polemics between autonomy and tutorship enters in scene as well.

Both Abreu and Santos et al studies sustain that every care implies in some level of tutorship, as every assistance service with protector character has the tutor function. According to these authors, a possible conception for autonomy would to think it as a moment in which a subject starts to live with his problems in a way requiring less assistance devices from the service itself. Thus, caberiait would be psychiatric intitution's competence to work as intermediary space, a passage place, in the ratio that it would enable users to increase their contracting power. It is less important, in this sense, to create and impose autonomy criteria for this clientele, but to observe what would be the place occupied by this issue inside the new perspective of caring

for insanity, as institution that conceives and promotes care for their users ².

In view of the discomfort awoken by the high risk of abuse in the relations between society and its insane, Basaglia ¹¹ contested medical culture traditional posture that changed the individual and his body into mere objects of clinical intervention. In the field of relations between society and insanity, he assumed a critical stand toward classic and hospital psychiatry, because it centers in isolation principle of the insane (internship as treatment model), therefore, being excluding and repressive. This kind of contestation of confinement regime for carriers of mental disorders gave start to the movement that was known as the Psychiatric Reform ¹².

In order to align itself to the international effort toward implanting psychiatric reform, the Federal Council of Medicine (CFM) approved Resolution no. 1,407/94, adopting the principles that the United Nations Organization (UNO) issued in the general assembly undertaken in December 17, 1991: *the principles for protection of people with mental disorders, and for improvement of mental health care*. The UN document, among other rights and safeguards, integrally incorporated by CFM, has references to psychiatric treatment defining that *treatment and care to each user will be based in a plan individually prescribed, discussed with him, regularly reviewed, modified whenever necessary, and administered by qualified professional personnel*³.

Regarding informed consent, the document specifies: *consent [should be] freely gotten, without threats or undue persuasion, after appropriate clarification with suitable and intelligible information, in form and language understandable to user* ¹³. Thus, Brazil started to be formally committed with ethical imperative of humanization of mental health care, and with recognition of citizenship rights of people with mental disorders.

In the Brazilian Psychiatric Reform context and of implementation of open assistance centers, Santos et al² consider that autonomy is important from the stand point of resolution capacity of service, as one believes that improvement of users come from the highest possible level of autonomy, enabled by the new anti-asylum approach. According to this approach, it is not the subject that must adequate to clinical proposal, but rather the opposite, it is the service that must be able to absorb users' specific demands, what requires the most diverse tactics. However, authors admit that in the protected field of the clinic, it is possible already that these subjects transit and are able even, in certain way, to establish social bonds, but it in the space of the *polis* that barriers remains almost unchanged ².

Moura Fé ¹⁴ speculates been possible that the trend to consider natural the treatment of the mentally ill against their wills or opinions, has relationship with two prejudices that were established in regard to patients: their dangerousness and incurability.

He adds that the frequent use of physical or chemical contention suits to hide the quantitative or qualitative scarcity of health area personnel, that is, to mask the lack of patients' health care, what he considers as one of the dramatic and revolting features of asylums, which should be denounced always.

Author reminds, still, that there are tests attempting to evaluate the rationality of patient's choice in accepting or refusing treatment or certain forms of treatment, as well as its real capability to understand information related to proposed therapeutics. It is of special relevance to set if patient's decision is rational, wise, or if it is compromised by his illness. However, in the end, it is the physician who *defines if patient is competent or not to decide if what he does should be considered wise, rational, or not*¹⁵ – what sets under suspicion the pretention to grant him autonomy

In the opposite sense, Gessert¹⁶ argues that excessive emphasis on patient's autonomy results in feeling of abandonment by them and in frustration on physicians' part. He highlights that *in the past 50 years, the physician-patient relationship was changed from strong paternalism to one that now strongly reflects patient's autonomy*¹⁷. And he goes on by stating that the right to autonomy makes sense, and it is easier advocated for lucid and well informed adults, but routinely we face patients whose competence (*legal status*), and *capability*

*(present skill) may be in question as it deals with minors, prisoners, for been carriers of cognitive deficits, mental illness, or intoxicated. Sometimes, we suspend autonomy of such patients, but we do it rarely in favor of another ethical principle, beneficence, the non-maleficence, or justice*¹⁷.

Attempts to extend application of the autonomy principle, for the author, to children and mentally incapacitated configure distortion (overuse).

Research involving vulnerable groups

As reflect of Nazi researches that led to the Nuremberg trials, even today one recognizes that the tension between researchers' intensions to produce scientific knowledge and comply to ethical principles of protection to research participants is a space of continued risk. Ethical transgression cases, occurred in the second half of the 20th Century, during undertaking of experiment in which participants were not considered, unfairly treated, jeopardized in their interests or, even, mutilated and killed have stimulated continued monitoring of researches, as well as designing of guidelines for protection of participants in these experiments.

As Scott and Kim¹⁸ highlight, science is not merely a technical activity; it has ethical rules without which could not even be qualified as science. Normally, ethical questionings in clinical research fall back into seven categories that define validation premises of the research:

1) to be social or scientifically useful; 2) to have scientific validity; 3) to have a fair selection of participants; 4) to have a favorable risk-benefit ratio; 5) to go through independent review; 6) to get informed consent, which in Brazil corresponds to the expression free and clarified consent (TCLE); and 7) show respect for potentially involved individuals.

Authors refer, still, that in research with children the United States federal regulation defines that these cannot be exposed to minimum risk when research involves intervention or procedure that does not have a perspective of direct benefit to participants, restricting participation of this group in the experiments. However, there is not analogous policy for incapable adults. The setting of acceptable risk-benefit limit is a social policy more than scientific expertise.

In this context, Schuklenk¹⁹ states that people in disadvantage or vulnerable to harm and risks, independently of required conditions by determined clinical trial, should be target of constant ethical concern. These are participants, for different reasons, already socially marginalized and, therefore, susceptible to exploitation. Generally, they occupy an inequality place in power relation with other people or, in some specific cases, they present different cognitive skills, which makes them less capable and autonomous. It is what happens, for example, with mental deficiency carriers.

Economic and gender inequalities, in the other hand, associate themselves to vulnerability of the poorer, victimizing women – particularly, pregnant women – and prisoners. A roll of all subjects in such situation, nevertheless, could be more comprehensive.

Vulnerable populations are inviting to trials exactly in virtue of their vulnerability, a condition that gives potential for the risk of ethical transgression during data assessment phase. One cannot forget, additionally, that compulsory confinement practice is but a violation of rights. According to Kingdon et al²⁰, such cases should be within the criminal judiciary scope. At this regard, the European Council emphasizes that the mental health system should not be used for strictly custody reasons, even in situation of severe risk for third parties, without having therapeutical purposes²⁰.

Independently of understanding and decision capability, free and clarified consent is required always as requisite for inclusion of participants in clinical trials. The *Nuremberg Code* establishes that *voluntary consent of human participant is totally essential*²¹ to carry out correct trials from ethical point of view. Nevertheless, Schuklenk observed that this criterion – absolutely essential – *would turn the undertaking of trials with participation of the incapable mentally ill impossible. However, if we wish to contribute to improve the situation of those who suffer*

from illnesses that imply in their incapability to manifest free and clarified consent, it is necessary to carry out research involving such universe of people²². It is worth stressing, however, that suppressing participant's or his representative's voluntary consent, even if in behalf of possible benefit for carriers of such incapacitating illnesses, may be the first step to incur in serious risk of opening a fundamental ethical precedent, regarding human rights assurance of clinical trials participants.

It was in consequence of this same consideration that the World Medical Association (WMA) adopted, during initial formulation of the *Helsinki Declaration*²³, the free and clarified consent by means of power of attorney as acceptable alternative for those research participants not apt to directly consent, which should be represented by third parties²⁴. Even if laudable WMA attempt to ensure to those incapacitated their rights as research participants, one should consider that consent gotten by means of power of attorney is always problematic. Perhaps, the most important pondering to be made is about who should give legal consent. The general mechanism adopted by society is the delegation of the right of decision to someone who has the conditions to decide and to ensure that the best choice is made. However, which values should be taken into account on the part of the substitute? When one deals with someone who has been competent in the past, the substitute has the parameter to suppose how the stakeholder would act probably and, then, to decide as if it was really him⁸. But, as one knows, there are

not objective conditions always to guide choices.

Scott and Kim¹⁸ highlight, on informed consent in research, three essential elements: i) individuals need to be clearly informed about the purpose, methodology, risks, benefits, and alternatives to research; ii) they need to have capability to make decisions; and iii) to have the possibility to make voluntary choice.

The severe and incurable nature of many neuropsychiatric disorders sets patients in position especially vulnerable for exploitation, and authors call attention for the need of future studies, taking into account the concept of vulnerability may be reasonably operational. They indicate that there is continued need for research specifically focusing on the decision point to respond questionings that arise throughout undertaking of research with partially capable or incapable people.

The importance of this type of research becomes clear when one realizes that from these initial considerations arise a series of other questionings, for example: how does incapability changes into capability? How do we adjust the intensity of the incapability evaluation process in accordance to the risk-benefit ratio of proposed protocol? How do we carry out the selection of the non-incapable in a process that is ethical and efficient procedurally? What is the relation between capability to provide informed consent and to nominate a legitimate representative to decide for replacement?

Another major consideration that outstands from this discussion is to what end legal consent should be given, that is, in which research and in what conditions could it be accepted. In this case, difference between therapeutic and non-therapeutic research is under stake²⁴. The first ones confer direct benefits to research participants, and the second does not. By contemplating research participation possibilities to include mentally incapable individuals, the initial version of the *Helsinki Declaration*²³ allowed for carrying out therapeutic research involving these people, as long as they are *particularly beneficial* especially to this group. Studies may include psychiatric drugs trials, behavioral therapies, or surgical interventions.

Non-therapeutic researches, however, do not contribute in order to mentally incapable people to change their clinic condition, thus, they can be carried out with participation of adults capable to consent, not demanding, necessarily, the involvement of vulnerable populations. Regarding mentally incapable people, non-therapeutic researches may include from efficacy tests of new vaccines against HIV to risk evaluations of the side effects of a new drug. This type of research may encompass also studies that seek specific data that do not directly benefit the universe of incapable people participating in the research. Researchers may get interested, for example, in understanding the incidence of hereditary dysfunctions among mentally incapable people. In this case, it is

evident that the involvement of this specific universe of individuals is necessary for the study, but no direct benefit will arise for participants.

Differently from research with adults without cognitive restrictions, where free and clarified consent through power of attorney is rare occurrence, research with mentally incompetent people requires constant monitoring, continue communication between participants in order to ensure that the first one will be informed always and apt to consent²⁵.

Finally, it is fit to highlight the legal aspects that define incapability condition in the country and, consequently, decrease of autonomy. OThe Brazilian Civil Code, in its Article 4, considers relatively incapable certain acts, or the way to exert them, the exceptional, the habitual drunk, drug addicts, and those that, due mental deficiency, have reduced discerning, and incapable to personally exert the acts of civil life, *those who, due to illness or mental deficiency, do not have need discerning to practice these acts, and those who, even because of transitory cause, cannot express their will*. Therefore, medical researches involving such groups and carried out in the Brazilian territory need to consider the limits of law that, by nature, are expressed in generic way when referring, for example, to *necessary discerning*, issue of complex evaluation, subject always to sound criticism. One gets out of this, once again, the necessity of following up

case by case in studies undertaken with this kind of patient in order to the ethics of experiment, and participants' dignity be respected effectively .

Final considerations

Autonomy is the fundament of human dignity of all rational being. It is in the expression of his autonomy that human being dignifies himself, while it may not (the autonomy) imposingly restricted under the pretext of replacing free will by that which one believes to be better or most appropriate.

Vulnerable people, like the mentally disorder carrier, are among the most subjected to abuse that violate this attribute of his dignity. However, the limit between the withdrawal of power/autonomy, justifiable in view of the clinical situation and the disrespectful imposition of force aiming at assuring greater facility, precisely for those who have strength, is very thin.

Ethical acting is, therefore, the constant exercise to identify, precisely, how and when is easier to disrespect dignity and to avoid doing it. Refraining to deny autonomy to others, because simply one is in position that allows him so, is to respect his dignity.

One must be attentive to the fact that paternalism and beneficence are not always good solutions for the mentally ill and that, perhaps, State tutorship and medical control are much more at service of the mentally ill contention, stigmatized or dangerous for society, than seeking real comfort and treatment or him.

It is up to everyone who assists these patients in any way, and to those that have disposition to produce science in collaboration with these, to act with his consent, getting it in the manner that is possible, but assuring to seek for it with genuine effort and interest.

In view of a therapeutical or medical research proposal in which bioethical principles of self-determination and autonomy cannot be fully applicable, one must valuate, particularly, the principles of beneficence and non-maleficence. Psychiatric patients have the right to benefit from innovation and research that, however, should be carried out only when is clear enough that direct benefit for the health of those involved – contemplating, thus, the principle of justice and equity in access to new therapeutical possibilities.

Resumen

La dignidad, la autonomía del paciente y la enfermedad mental

La dignidad humana, intrínsecamente vinculada a la autonomía, es vulnerable en situaciones de trastorno mental grave, ya sea para participar en la investigación médica o para proporcionar información sobre los requisitos del efecto terapéutico. El autor discute el concepto de dignidad, el principio de autonomía y consentimiento informado, y mediante la revisión de la literatura, sugiere que la acción ética es el ejercicio constante para identificar *dónde* y *cómo* es más fácil hacer caso omiso de la dignidad y evitar hacerlo. Concluye aseverando que negar autonomía a otros, simplemente porque se está en posición que así permita, es no respetarle la dignidad. Debe prestarse atención al hecho de que el paternalismo y la beneficencia no siempre son buenas soluciones para los enfermos mentales.

Palabras-clave: Autonomía personal. Bioética. Vulnerabilidad. Consentimiento informado. Salud mental. Competencia mental.

Resumo

Dignidade, autonomia do paciente e doença mental

A dignidade humana, intrinsecamente vinculada à autonomia, fica comprometida em situações de distúrbio mental grave, quer para participação em pesquisas médicas quer para opinar sobre as prescrições de caráter terapêutico. O artigo discute o conceito de dignidade, o princípio da autonomia e o consentimento informado e, com base em revisão da literatura, preconiza que o agir ético é o constante exercício de identificar *quando* e *como* é mais fácil desprezar a dignidade e evitar fazê-lo. Conclui asseverando que negar autonomia a outrem, porque simplesmente se está em posição que assim permite, é desprezar-lhe a dignidade. Deve-se atentar para o fato de que paternalismo e beneficência nem sempre são boas soluções para o doente mental.

Palavras-chave: Autonomia pessoal. Bioética. Vulnerabilidade. Consentimento livre e esclarecido. Saúde mental. Competência mental.

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