Ulysses Contracts: Bound to Treatment or Free to Choose?

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Abstract

By using "Ulysses contracts", a form of advance directive, mentally ill persons who are deemed to be competent and in remission, are able to give prior permission for treatment to be implemented at a later time when they are incompetent, uncooperative, and are refusing care. The benefits of Ulysses contracts are preventing relapses and sustaining good mental health. However, Ulysses contracts also raise a number of ethical questions, including the nature of patient autonomy, competency and how to handle refusal of treatment. This paper will discuss these three facets of the Ulysses contract.

Mary is a mother of two and a successful stockbroker. She is also a diagnosed schizophrenic. For her this presents few complications, if she stays on her treatment regimen. However, according to Buchanan and Brock (1989), due to the nature of the illness, schizophrenics will sometimes stop taking medication at perceived remission times. Mary does not realize, until it is too late, that her medications were in fact responsible for the remission. As a result Mary suffers a relapse, often showing symptoms, such as hearing voices and paranoia, that make her jobs as mother and stockbroker close to impossible to fulfill. She may even disappear and end up on the streets if her condition is not identified. After Mary is once again put on treatment she may be fine for long periods of times, until she stops taking her medication. Unfortunately, this cycle may repeat endlessly unless Mary's inability to consistently follow a treatment regimen is resolved. Some psychiatrists would maintain that Mary's free will, that is her autonomy as a person, allows her the right to refuse medication at all times, even when she is symptomatic. Yet others will contend that Mary should, for her own well being, submit herself to be willingly bound to treatment at a later date, even if she is not willing or able to follow treatment at that later date. In other words, she should consent to a Ulysses Contract.

The term "Ulysses Contract" is derived from the mythical example of Odysseus and the Sirens. In Book 12 of the *Odyssey,* the goddess Circe gives

Odysseus the option to hear the beautiful but deadly Sirens. However, since their voices bewitch men into their lethal arms, Odysseus must allow his crew mates to bind him to the mast of their ship, while they themselves have their ears molded with wax. As Odysseus hears the Sirens' song he begs his crew to release him from the mast. The sailors ignore his pleas and bind him tighter to the ship. After having rowed beyond the Sirens, the crew members remove the wax from their ears and free a very grateful Odysseus. He was thankful that the crew heeded his rational wishes, rather than the irrational ones brought on by the trickery of the Sirens (Perseus Digital Library Project, 2004).

In modern terms, a Ulysses Contract allows a person, specifically a mentally ill patient, to give an advance directive as to future course of treatment. Odysseus' crew was deaf to the requests of the bound Odysseus and heard only his unbound rational requests; psychiatrists are not as lucky in dealing with mentally ill patients. According to New York State Law via precedent of Schloendorff v. Society of New York Hospital, 1914, an adult patient has the right to refuse treatment at all times (Health Care Decision-making and Declarations in New York, 2004). The nature of the Ulysses contract contradicts this in that it declares the competent wishes of the patient to be the only ones that are followed.

This paper will explore the three main aspects of a Ulysses contract and its impact on patient autonomy via the classic example of Odysseus and the Sirens. The first issue examined will be the rationality of the contract in terms of prior informed consent of the patient. The second issue discussed will be the point during treatment at which Ulysses contracts may come into effect, that is when a patient is no longer deemed "competent." Finally, the paper considers the options for enforcement of the Ulysses contract.

RATIONALITY OF ULYSSES CONTRACTS

Informed Consent

Informed consent is seen as the first step in any medical trial or treatment. The lack of such a process of informed consent may lead to many human rights abuses. In Odysseus' case, were the sailors to have bound him without his expressed consent to do so, it would have been a violation of his rights as an autonomous person. Indeed, such an action would not only harm him, but full disclosure may not have been given to Odysseus, thus invalidating the treatment (tying to the mast) as a whole. Further, Bernard (1927) indicates that this method is irrational in that no experiment should be performed on a patient that may be harmful to him, despite the benefits to humanity and medical science.

Bhutta (2004) further goes on to elucidate a plan for obtaining informed consent of the patient. The first step he outlines is discussing the possible treatment

within the research team and any internal review board to assess rationality of the treatment. The next step would be to involve the patient in the discussion of the treatment options. After a "true understanding" is obtained from the patient, then and only then can the patient either choose to accept or reject the proposed treatment. Upon acceptance, a written, verbal, witnessed or recorded agreement is secured from the patient and medical official, and treatment will then be implemented.

According to the American Psychological Association (2002), informed consent exists merely between a patient and his or her physician. In order to obtain informed consent, the physician is required to disclose and discuss the diagnosis, the nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, any possible alternatives (and their risks and benefits) and finally, and perhaps most importantly in the case of mentally ill patients, the risks of not receiving treatment.

Although informed consent is usually assumed as valid for a patient who is competent, what is to be said of a mentally ill patient? Buchanan and Brock (1989) insist, "The informed consent doctrine requires the free and informed consent of a competent patient" (p. 26.) However, several studies on capacity to consent to psychiatric treatment among patients with mental illnesses like schizophrenia have been published. In Appelbaum and Grisso's (1995) study, schizophrenic and non-symptomatic subjects' ability to consent to psychiatric and medical treatments was measured. Participants' abilities to meet the four legal standards of competency, (choice, understanding, appreciation and rational reasoning) were assessed using a MacArthur Competency Assessment Tool (MacCAT). The subjects with schizophrenia were shown to be unable to exercise decision-making capacity compared to other subjects, with the most difficulty occurring in the area of "understanding."

Carpenter (2000) used a method of "enhanced informed consent" with the same MacCAT to assess decision making capacity in patients with schizophrenia. The schizophrenic group performed more poorly on the MacCAT than the non-symptomatic group, as was expected. However, a subset of patients with schizophrenia received an additional educational presentation consisting of reviewing the protocol, having questions answered, and working on a computer program designed to teach basic research concepts such as placebo, drug withdrawal, protocol and random assignment. The MacCAT was readministered after the educational presentation. The "understanding" scores of this subset of subjects with schizophrenia improved to the level of the non-symptomatic group. Thus, it can be concluded that informed consent from mentally ill patients is possible if reinforcements such as educational interventions are given to the patient.

Analysis of Self: Past and Present

Some psychiatrists such as Dresser (1989) find the authority of Ulysses contracts to be questionable from the personal identity standpoint. The primary challenge presented by personal identity is the determination of when a person's life stages are of the same person, or when the circumstances indicate development of a different person. As Parfit (1984), argues, psychological changes through time, as is seen in bipolar disorder and schizophrenia, raise questions about psychological continuity and connectedness between different stages in a person's life, or the possibility that a different personality has emerged. Ricoeur (1986) even argues that under specific conditions a Ulysses contract is a method for the former self to enslave the later self of the person.

For one person to issue directives about what should happen to another person, Buchanan & Brock (1989) have asserted, even when that other person was housed in the same body, would be morally abhorrent and akin to slavery. They counter, however, that people who issue advance directives about their own future care before suffering these severe and irreversible dementias cannot be considered guilty of wrongfully enslaving another person because they cannot be considered to have become another person. Thus, the person who issued the advance directive no longer exists, but no further person has succeeded her. As a result, the issue of slavery of selves, as touted by Ricoeur (1986), becomes a non-issue.

One may further argue that a Ulysses contract underscores the unity of the patient's life, and focuses not on individual selves, but on unifying the person's wishes and goals as a whole. The Ulysses contract is usually put into effect when a person anticipates his or her life may be in crisis. The Ulysses contract does not imply that one phase of life (a clear period) is more important than another one (a period of crisis). It merely indicates that at these times of crisis, the patient still recognizes he or she is part of the whole person and thus this stage of life may be overcome in the future, hopefully with the treatment provided.

Patient Competency

In the myth of Odysseus and the Sirens it was clear that the unbound Odysseus was completely competent in issuing his directives, and the bound Odysseus was under the influence of the Sirens and thus incompetent to issue directions to his crew. However, this clear dichotomy is hardly the case with modern makers of Ulysses contracts. While the Patient Self Determination Act of 1991 indicates that a federally funded hospital must inform patients of their rights to create an advance directive, it says nothing of what level of decision making

capacity the undertaker must have (or have lost) to implement their prescribed Ulysses contract (Watson, 2001). It is unfortunate, but Ulysses contracts cannot be worded to take effect just when, according to this standard, "incompetence" is determined.

Additional complexities arise in judging competence. While the victims of degenerative diseases like Alzheimer's may show a shifting pattern of competence, rather than a slow and inexorable decline, they all eventually reach a degree of incompetence that is definitive. In contrast, psychiatric patients may never exhibit clear and indisputable competence on the one hand, or unmistakable incompetence, on the other. These cases pose an additional problem for whatever standard of competence is chosen. Psychiatric patients are grouped in the sphere between competence and incompetence, but they cross and recross the disputed boundaries with the varying relapses and remissions. Week by week, even, in some cases, day by day, these patients' level of competence shifts. In order to put into practice a policy of honoring advance directives just when or until competence is achieved, a degree of stasis greater than possibly achievable is required.

Application of any standard of competence in psychiatric settings, then, is likely to be particularly difficult. A related point, as noted by Carpenter (2000), is that too often the autonomy and rationality of mental patients are assessed against the higher standard of autonomy and rationality construed as ideals instead of against the measured autonomy and rationality of the same patient during different stages of treatment.

It is clear that there must be formal standards of competence. The least rigorous of these standards require only that the patient be able to focus on the decision's outcome in light of what other rationally deemed persons would see as the outcome. That is, by discontinuing treatment, the patient can realize they may never attain the level of mental health they once had (Appelbaum & Roth, 1981). Other standards emphasize the process by which the decision is reached, and the level of competence exhibited in the patient's understanding and reasoning capacities. That is, the patient understands that discontinuing treatment is not wise, regardless of the conclusion, even if that conclusion is that treatment is liable to make him or her sicker, or even that he or she may not be sick in the first place (Hackler, 1989). As a middle-of-the-road solution, Buchanan and Brock (1989) have proposed that patient competence be understood and assessed in terms of three abilities: understanding the relevant options, understanding the relevant consequences for the patient's life in each of the relevant options, and evaluating the consequences of the various options by relating them to his or her values (p. 49). Focused on the patient's decision-making process rather than upon the outcome of that process, this standard falls midway between the other standards and would seem to be the wisest choice in terms of judging competency.

ENFORCING ULYSSES CONTRACTS

Right to Refuse Treatment

In many states, such as New York, the psychiatric patient has a legal right to refuse treatment. Ulysses contracts undermine this right because the prior consent leads to the possible overruling of a later refusal of commitment or treatment (Radden, 1988). The issue then becomes, what justification can be given for overruling future refusals of treatment solely on the basis of the past authorization?

Proponents of Ulysses contracts argue that an overruling of a refusal of treatment can be justified if the patient has become incompetent (Brock, 1993). The notion of incompetence enables the doctor to raise doubts about the refusal, and not to give in automatically. For example, if a schizophrenic patient similar to Mary were to feel as if she were no longer ill yet clearly showed symptoms such as paranoia, it is evident that this would show incompetence. In this case, the patient's doctor would undoubtedly medicate despite the patient's objections that she was no longer suffering from schizophrenia.

According to Spellecy (2003), the application of a Ulysses contract during a refusal time requires the doctor to interpret the Ulysses contract in an adaptive way. That is, the doctor must be able to adequately persuade the patient to be compliant with his or her written Ulysses contract. If this were not possible, a possible reevaluation in terms of adequacy and relevancy of the Ulysses contract must occur. For example, a very successful bipolar writer finds that when she is in her manic phase she is very productive, but she also has a son whom she must care for. She deems that her son is more important to her than her career. As a result, she enters into a Ulysses contract with her psychiatrist to stay on her treatment regimen. However, a month later her son is tragically killed in an accident. At this point, the Ulysses contract becomes a liability to her career. In this case, the writer and her psychiatrist would most likely choose to invalidate her Ulysses contract (Moody, 1992). Analogously, this would be as if the Sirens no longer presented a threat to Odysseus, and he longer had a young son and beautiful wife at home in Ithaca. If the Sirens represented the only joy Odysseus could possibly have in his life, it is possible that his shipmates might have considered untying him from the mast. Thus, a justification for overruling or upholding refusals can always be found in a specific declaration in the past, but only in the process of constant reevaluation of the patient's social, emotional and mental status.

Legal Applications of Ulysses Contracts

Judges or other decision makers in the legal system sometimes order people who have severe mental illness, and are deemed to be a danger to themselves or others, to comply with treatment. Even in the absence of a judicial

order, people may agree to adhere to treatment requirements to avoid an unfavorable judicial order, such as incarceration or civil commitment to an inpatient facility. In these contexts, judicial authority to impose commitment and curtail freedom through incarceration provides the leverage for enforcing Ulysses contracts.

In fact, a new type of criminal court called a mental health court has been developed that makes explicit the link between treatment and its legal enforcement (Matthews, 1970). In a mental health court, cases are heard and handled by a specialized team of legal and mental health professionals. Further, a bill to create 100 demonstration mental health courts across the country by 2004 was signed into federal law in November 2000 (Steadman, 2001).

Faced with the possibility of undergoing mandated treatment if their condition deteriorates, many patients choose to specify their treatment preferences before a disabling crisis actually occurs (Srebnik, 1994). Some patients may even see the use of Ulysses contracts as an antidote to mandatory treatment orders (such as commitment or incarceration.) As Gallagher (1998) states, "The advent of advance directives for psychiatric care offers an unprecedented opportunity to reconcile, or at least accommodate, the opposing values represented by proponents of involuntary interventions, on the one hand, and by civil libertarians, on the other" (p. 756).

CONCLUSION

The "Ulysses contract" is clearly useful in many cases, but we must remember it has at least two responsible participants: the person who draws it up and the person(s) who must implement it. Advance directives like Ulysses contracts, whether seen as enhancing patient autonomy or promoting partnerships and collaboration, demand a mutual understanding of the directive and an appropriate response, whether this be Odysseus' crew or a patient's psychiatrist.

Odysseus' advance directive was successful in that he and the crew navigated the hazard (the Sirens). His experience can be analyzed for certain criteria by which all future Ulysses contracts should be judged. First, the idea for the plan and its instructions did not originate with him, but with Circe, a known expert on the Sirens. In modern terms, this indicates a patient must be diagnosed by a physician as mentally ill and must further understand and consent to treatment proposed. Second, Odysseus required restraints. To us, this means the written Ulysses contract binds a patient to his words. Third, Odysseus made provisions for a change of mind - he was to be ignored and restrained further. This is similar to what modern Ulysses contracts do in one sense; they place less credibility on non-treatment options. Unlike Odysseus' case, however, modern circumstances may change and the Ulysses contract

must be evaluated continually by the psychiatrist and the patient. And finally, Odysseus and the crew were in agreement about the goal - to come safely past the Sirens. A common goal among both patient and psychiatrist to restore mental health to the patient is perhaps the most important aspect of the Ulysses contract.

It is clear that Odysseus' advance directive worked because it was, in effect, a limited plan that had the agreement of those who had to implement it. It dealt with a very specific set of circumstances, with known outcomes and agreed goals. It is likely that the more an advance directive conforms to these parameters, the more acceptable it will be to both the patient and psychiatrist. Patients also need to accept the responsibility that comes with having their choices honored, even if these choices do not always have the expected outcomes. After all, Odysseus knew that passing the Sirens would only lead to the twin dangers of Scylla and Charybdis. In this respect, both patients and staff can find themselves between a rock and a hard place when balancing patient choice and uncertain outcome.

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