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There Are No Grey Areas in Applied Ethics

A Guest Article by Michael A. Gillette, Ph.D.

When I was working on my doctoral dissertation in clinical ethics over thirty years ago, the topic that caught my interest was that of paternalism – when is it ethically permissible to restrict an individual's liberty of action for that person's own good? Most would agree that one necessary condition for ethically justified paternalism is that the subject of the intervention under consideration is unable to make relevant autonomous choices, and that autonomy, unlike liberty, requires the capacity to understand the alternatives, risks, and benefits of the decision at hand. In an effort to consider this topic in its most complex presentation, I decided to work in an area where capacity and autonomy were most likely to be questioned from the outset- mental health services.

My doctoral work addressed the question as to when a patient with a diagnosed serious mental illness retained the right to refuse psychotropic medications.

After decades of work consulting in clinical ethics, I have come to appreciate the process of good ethical reasoning even more than the content of any particular ethical decision that needs to be made. I have developed a rubric for ethical analysis that involves four steps: a) identify the default assumption, b) assign the burden of proof, c) engage in casuistic exploration, and d) apply the results of that exploration to the current case. We must begin by recognizing that all arguments are not created equal. At the beginning of any real-world argument, one side or the other to a question or dispute will have a natural advantage. There will invariably be a *ceteris paribus*, all other things being equal, or standard operating procedure that generates a default assumption. The burden of proof then rests on the alternate party to make the case as to why it is appropriate to divert from the default assumption.

The concept of the burden of proof is so strong that I can confidently proclaim that “there are no gray areas in applied ethics.” For example, in the court of law where the default assumption is innocence, when the facts are unclear and the outcome uncertain, a jury cannot return a “guilty-ish” verdict. Defendants are never found “sort-of-not-guilty”. So too, when it comes to ethical arguments, there is always an unambiguous response to ambiguity. If the matter is ambiguous and the burden of proof has not been met, then the default assumption remains intact and the argument is decided decisively, not ambiguously.

The most serious ethical mistake that can be made in any clinical ethics scenario is to misidentify the default assumption, which then inverts the burden of proof. I would argue that this sort of mistake forms the heart of many of the ethical issues that arise in mental health ethics. It has been my experience that providers have often under-valued the autonomy of the individuals served, precisely because blanket assumptions regarding the capacity and autonomy of individuals with SMI were inappropriately made. When disagreement exists, should we listen to the doctor, the patient, the family, or involved care providers? Too often, the patient was the last person on the list whose voice might be heard, and yet in the first paragraph of this article I asked when patients “retain” the right to make their own decisions. By using the word “retain”, I make it clear that the default

assumption should be patient autonomy and that the burden of proof would rest on those who wish to subvert that authority.

With the development of person-centered planning and the extension of recovery principles to mental health services generally, we have made great strides in placing the patient in the center of the story and we have shed our belief that individuals lose capacity simply because of a diagnosis that they carry. This recognition, that individuals have a right to control their care all other things being equal, and that those who would force a decision over objections must satisfy a burden of proof, demonstrates that we have made great moral progress in mental health ethics over the years.

Dr. Michael Gillette is an ethicist who has presented numerous keynotes and workshops nationally and internationally for over 25 years. Dr. Gillette contracts with dozens of healthcare organizations and other agencies to provide ethics case consultations and policy work. His energetic and interactive style engages his audiences and helps them think critically about ethical decisions in their work and beyond. He presented a keynote and workshop session during mhca's Summer Conference in Raleigh and recordings of these sessions are available to members on mhca.com.

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