SPECIAL PAPER

‘Freedom is more important than health’: Thomas Szasz and the problem of paternalism

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Possible to give brief (single) job title for the authors?

When Thomas Szasz summed up his philosophical principles at the Royal College of Psychiatrists’ annual meeting in Edinburgh in 2010, he declared that ‘freedom is more important than health’. Psychiatry is the arena in which the conflict between freedom and health come most sharply into focus, according to Szasz. This paper proposes some parallels with medicine in low-income countries for pointers towards a resolution of this conflict.

When Thomas Szasz summed up his philosophical principles at the Royal College of Psychiatrists’ annual meeting in Edinburgh in 2010, he declared that ‘freedom is more important than health’. This view was nurtured by his experience of fleeing the Nazis in the 1930s, and his eventual arrival in the USA, the land of the free. For the whole of his career Szsaz maintained that fostering the ability of individuals to make their own choices was the most important principle of a modern society, ‘a society in which man has a chance, however small, to develop his own powers and to become an individual’ (Szasz, 1988, p. 128). He opposed prohibitions on the use of any class of drug, restrictions designed to prevent suicide and anything that he perceived as state interference in the private lives and actions of individuals.

The importance Szasz placed on freedom was associated with a concern for human dignity, and a belief that dignity comes from the ability to live an independent, self-determined life, free of control and potential humiliation at the hands of others. Since freedom (and responsibility) is the ‘crucial moral characteristic of the human condition’ (Szasz, 1988, p. xv), any circumstance that renders people dependent on others to make decisions for them automatically makes individuals less than fully human, and consequently reduces the dignity of human life.

Sickness and infirmity involve dependency and hence a loss of dignity, but medical treatment also renders the ‘invalid’ dependent on the doctor or healer, and in this sense treatment is also inherently undignified. In this position Szasz is close to Ivan Illich, and the thesis set out in the latter’s classic book, *Medical Nemesis,* that the dependency-inducing effects of modern medicine have depleted the natural resources of human beings to endure and combat suffering. Rather than enhancing life, medicine has, in this view, diminished humanity as a whole (Illich, 1976).

When people are very sick, they may become incapable of making informed and thoughtful decisions about what they want to be done. In this situation, relatives, friends, carers and doctors have to make judgements on the patient’s behalf. The idea that people can make judgements that are solely in another person’s best interests is what we call ‘paternalism’. Szasz, among others was, perennially suspicious of paternalism, seeing it as an evil to be avoided if possible and quoting Kant, who said ‘nobody may compel me to be happy in his own way. Paternalism is the greatest despotism imaginable’ (cited in Szasz, 1990, p. 39).

As well as infringing the autonomy of the individual, paternalism is dangerous, according to Szasz, because it disguises the fact that other motivations are always at stake. No decision about how to treat another human being is ever truly neutral or objective. In medical situations, there are always interests other than the patient’s that intrude, whether this be the interests of the family, the doctor or the community or organisation the doctor represents. The idea of paternalism only obfuscates these other influences (Szasz, 1988).

It has been argued, however, that freedom is a preoccupation of those who are already healthy, wealthy and secure. Where daily existence remains a struggle, the self-determination of each individual may seem relatively unimportant. The French philosopher Georges Canguilhem cited the surgeon René Leriche when he described health as the ‘silence of the organs’ and drew attention to the fact that the impact of disease and infirmity is often not appreciated when good health is taken for granted (Canguilhem, 2012). In some low- and middle-income countries, as in the ghettos of Western cities, where freedom means the freedom to scratch a living from the margins of affluent society, its loss may not be greatly mourned. Moreover, the health problems that continue to beset much of Africa for example – malnutrition and infectious disease – are significantly reduced by simple procedures such as improved sanitation, nutrition, immunisation and the administration of antibiotics that involve little loss of dignity. The health benefits that accrue help to increase individuals’ capacity to lead autonomous and independent lives.

Even in high-income countries, freedom is sometimes subordinated to the general health of the populace. In the USA, for example, vaccination of children is mandated because the immunity of society in general is prioritised over the choice

of individual families. Similarly, many countries, including the UK, have public health laws that contain measures to enforce treatment of tuberculosis, including the forcible confinement of an infected individual if this is thought necessary.

Although Szasz may have acknowledged that a self-aware paternalism was necessary in the care of people who are seriously physically sick, he was critical of the extension of the paternalistic principle to other areas of life, including psychiatry. In fact, Szasz argued that the reason for constructing certain forms of behaviour as illness is precisely in order to justify managing them in a paternalistic fashion. Famously, for Szasz 'mental illness' is not the same sort of entity as a bodily illness or disease, and can be rightly understood as an illness only in a metaphorical sense. The metaphor has been mistaken for reality because of the social functions it serves, one of which is to provide a convenient mechanism for the management of socially disruptive and unpredictable behaviour.

The purpose of the concept of mental illness in this account is thus 'to disguise and render more palatable the bitter pill of moral conflict in human relations' (Szasz, 1970, p. 24). Defining such situations as the illness of a particular individual enables the freedom of that individual to be curtailed and interventions to adjust unwanted behaviour to be represented as 'treatment'. In other words, an individual can be subjected to the will of others, including being removed from society, confined in an institution and forced to take mind-altering substances, but these actions can be construed as being in the individual's 'best interests'. So psychiatry is the arena in which the conflict between freedom and health come most sharply into focus, but it is also an artificial conflict, according to Szasz. The language of health and illness is only a gloss that is applied to the daily struggles that occur between people who want to behave in a certain way, and those who want them to behave otherwise.

Mental health problems do not need to be conceived of as illnesses in order to justify paternalistic intervention, however. Although ultimately rejected by the British government, the notion of basing mental health legislation on the concept of 'capacity' has been proposed by various commentators, including the government-appointed Richardson committee in 1999 (Department of Health, 1999). Under these proposals, intervention that was judged to be in an individual's 'best interests' could be justified when that individual was deemed to have lost the capacity to make rational decisions, whether the loss of capacity was occasioned by a bona fide brain disease or an episode of mental disturbance that would be diagnosed as a mental disorder of some kind.

Reservations about paternalism apply regardless of how mental disorder is conceptualised, and judgements about the nature of 'incapacity' and what really constitutes the individual's 'best interests' are always going to be subjective. Removing the link with illness might make the nature and purpose of coercive interventions in psychiatry more apparent, however.

Szasz felt that individuals should not be forced to receive an intervention they do not want, even if their life without such an intervention appears to be squalid, limited, unrewarding and uncomfortable. In contrast to physical medicine, where paternalism might sometimes be a necessary evil, in psychiatry it is unacceptable, because it denies human beings the dignity of making their own choices, however unwise or self-destructive those choices might sometimes seem to be. Reflecting on Canguilhem's insights, however, suggests that, although from the point of view of sanity it may be possible to value the dignity of human freedom above the ability to function in the actual world, someone has to have a basic level of rational capacity in order to make that judgement. When this is impaired, then a paternalistic approach that aims to restore that capacity could be seen as supporting human dignity and autonomy, rather than depleting them.

Psychiatrists who work with people who are severely mentally ill face these dilemmas daily. Do they leave patients who are deeply psychotic to themselves, allowing them to sink into a state of extreme apathy and internal preoccupation, or do they force them to take antipsychotic medication that might restore some degree of contact with the external world? Similarly, do they attempt to engage such individuals in some social interaction that initially, at least, they might resist, in order to try and establish what appears to be a more rewarding and socially engaged life? If all patients woke up from their psychosis and thanked their psychiatrists for restoring them to sanity, the quandary would not exist. But most do not. Many people who are forced to receive psychiatric treatment, such as antipsychotic drugs, against their wishes either feel they have not benefited, or that the benefits do not outweigh the negative impact of the treatment. Although symptoms may be reduced, some people feel that an important aspect of their personality has been lost too, and that their mental life has become more limited. One patient summed up the dilemma like this: 'In losing my periods of madness, I have had to pay with my soul' (Wescott, 1979, p. 989).

Using forced treatment to increase autonomy in mental health services is thus fraught with difficulties. It is impossible to predict reliably who is likely to appreciate the effects of treatment and who might feel diminished by them. Again, a parallel with medicine in low- and middle-income might provide pointers towards a solution.

Although the benefits of simple health measures such as improved sanitation appear obvious, they may still be resented and resisted if they are imposed from outside. Only when healthcare is designed and implemented by the community itself will it be able to foster the development of capable and autonomous individuals. In a similar way, society as a whole needs to take responsibility for the things we do to people who are designated

as having mental disorders. There needs to be a transparent debate about when it is justifiable to subject someone to forcible confinement and mind-altering interventions. Crucially, the verdicts of people who have experienced such measures need to be heard. As Szasz identified, however, this is unlikely to happen as long as these conditions are defined as medical illness and intervention as 'medical treatment'. A system is possible, however, which reduces the gap that sometimes exists between freedom and sanity.

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