The Ethics of Treatment Over Objection

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Financial disclosures

- none

Objectives

The learner will be able to name the ethical principles underlying informed consent.

The learner will be able to name the elements of a decisional capacity evaluation.

The learner will better understand the considerations involved in treatment over objection.

Plan of Talk

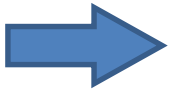
- Informed Consent
- Decision Making Capacity
- Calculus of Treatment over Objection


THE FACTS OF LIFE
norman rockwell

The Essentials of Medical Necessity

Medical Necessity

Informed Consent



Decision Making Capacity

Schloendorff v. New York Hospital (1914)

Justice Benjamin Cardozo

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."

Informed Consent

- The diagnosis and the nature of the condition being treated
- The reasonably expected benefits from the proposed treatment
- The nature and likelihood of the risks involved
- The inability to precisely predict results of the treatment
- The potential irreversibility of the treatment
- The expected risks, benefits and results of alternative or no treatment.

Beneficence versus Autonomy

Two Principles

Autonomy

- "self rule that is free from both controlling interference by others and from limitations*, such as inadequate understanding that prevent meaningful choice*" (Beauchamp and Childress, 2009)

Beneficence

- "connotes acts of mercy, kindness, friendship, charity…
- "…a moral obligation to act for the benefit of others"
- "Many acts of beneficence are not obligatory*, but some forms of beneficence are obligatory*." (p.203)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Assessment of Patients' Competence to Consent to Treatment

Paul S. Appelbaum, M.D.

…the presumption intrinsic to a modern democracy is that the vast majority of persons are capable of making their own decisions. Hence, only patients with impairment that places them at the very bottom of the performance curve should be considered to be incompetent. (ibid. p.1836)

N Engl J Med 2007;357:1834-40

Some reasons Capacity matters

One study of 302 medical inpatients with acute conditions estimated that as many as 48% were incompetent [incapacitated]to consent to medical treatment. (ibid. p. 1835)

In addition, since consent obtained from an incompetent [incapacitated] patients is invalid, physicians who do not obtain a substituted decision may be subject to claims of having treated the person without informed consent. (Ibid. p. 1834)

Capacity

- Communicating a choice (consistency)
- Understanding
- Appreciation
- Reasoning

Choice

Have you decided whether to follow your doctor's recommendation for treatment?
Can you tell me what that decision is?
What is making it
hard for you to decide? (ibid. p. 1836)

Understanding

Please tell me in your own words what your doctor told you about:

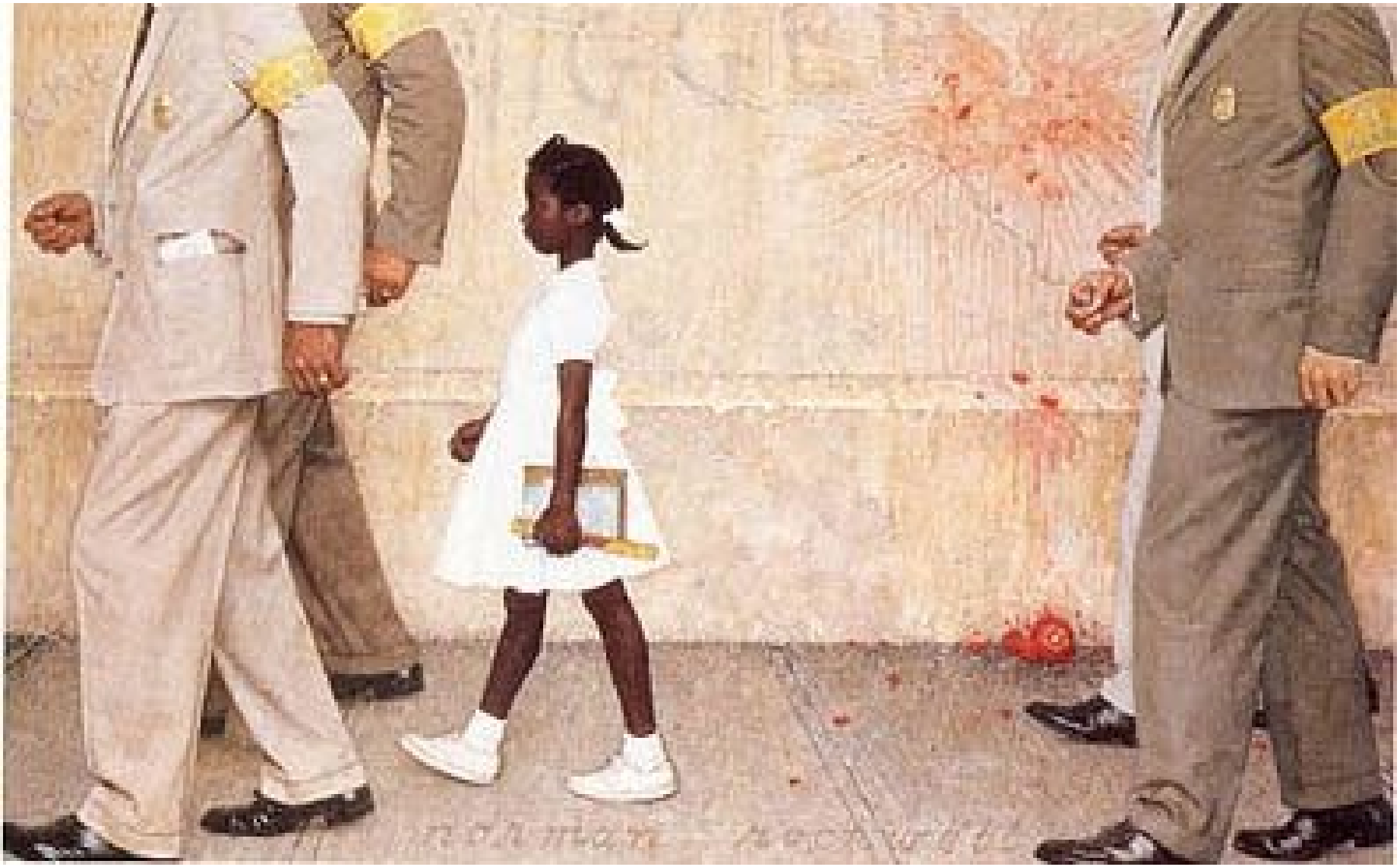
The problem with your health now
The recommended treatment
The possible benefits and risks (or discomforts) of the treatment
Any alternative treatments and their risks and benefits
The risks and benefits of no treatment (ibid. p. 1836)

Appreciation

What do you believe is wrong with your health now?
Do you believe that you need some kind of treatment?
What is treatment likely to do for you?
What makes you believe it will have that effect?
What do you believe will happen if you are not treated?
Why do you think your doctor has recommended this treatment? (ibid. p. 1836)

Reasoning

How did you decide to accept or reject the recommended treatment?
What makes one option better than another? (ibid. p. 1836)



Guidelines for Medical and Surgical Treatment Over Objection

Draft 3/2019 * Do not distribute

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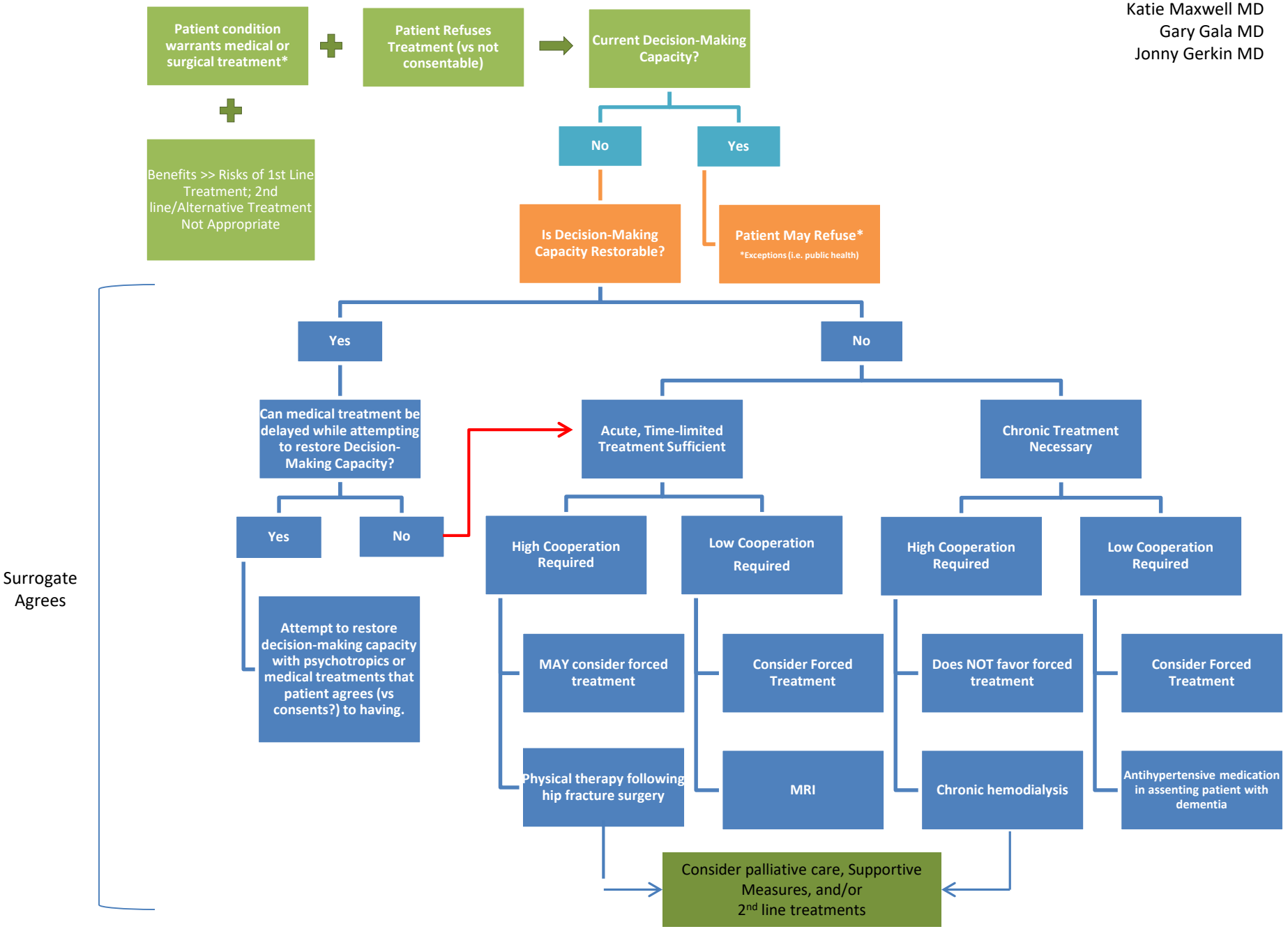

It’s Cooperation Stupid…

Case 1: 75 year old with Alzheimer's Dementia and Cholecystitis

- However now he has had 20 pound weight loss, daily fever &worsening abdominal pain
- Family requests surgical intervention, believing that he does not understand his condition
- Psychiatry is consulted for capacity to refuse surgery

Case 1: 75 year old with Alzheimer's Dementia and Cholecystitis

- **Other pertinent information:**
  - Montreal Cognitive Assessment score of 19.
  - Confabulations are present
  - Thought process is superficial. Poor memory of events prior to hospitalization.
  - GI: "The patient is a good surgical candidate. Without surgery, the patient is likely to die."

- **Capacity Assessment**

✓ **Consistency-** The patient makes a consistent choice

X **Understanding-** The patient does not understand his condition.

X **Appreciation-** He does not demonstrate an appreciation for the consequences of his choice

X **Reasoning** – He fails to demonstrate sound reasoning for how he arrived at his choice.

- 75 y/o male with Acute Cholecystitis

Recovery expected with first line treatment?	• Yes. • Likely restorable to previous level of functioning with surgery.
Imminent risk of death without treatment?	• Yes. • Risk of sepsis is imminent, and patient is at high risk of death without surgical treatment.
Risks of forced treatment appear favorable?	• Yes. • Risks include general anesthesia. • Risks of surgical procedure.
Certainty of treatment effectiveness?	• Yes, there is relative certainty of treatment effectiveness. • 2nd line treatment has failed twice.
Practicality of forcing	• Appears favorable. • He has been cooperative with other treatments. • Degree of cooperation required post op to achieve favorable outcome is minimal.

Case 2: 56 y/o with Schizoaffective Disorder & Renal Failure

- 56 y/o male with schizoaffective disorder, bipolar type, & ESRD, DM II
- Takes haldol decanoate injection with long periods of compliance and very rare non-compliance
- He does well with hemodialysis while taking medications, and he has poor physical and mental health when off medications
- After the patient refused his haldol decanoate, he began refusing dialysis shortly thereafter, developing paranoid delusions about his treatments ("I'm being injected with poisons") as well as his medical providers.
- Delirium superimposed on psychosis
- + Responding to internal stimuli. Tells providers that they "cannot imprison" him, believing the providers to be part of a conspiracy to kill him.

Case 2- 58 y/o with Schizoaffective Disorder and Renal Failure

- **Capacity Assessment**
  - ✓ **Consistency**: (recently) consistent choice to refuse antipsychotics and hemodialysis
  - ***X*** **understanding**: He does not demonstrate understanding of his condition
  - ***X*** **reasoning**: He shows psychotically disturbed reasoning of the causes of his medical problems and circumstances.
  - ***X*** **appreciation**: He does not demonstrate appreciation of his condition.

- Schizoaffective Disorder, Delirium, Hemodialysis Refusal

Recovery expected with first line treatment?	• Yes. • There is a good chance that with antipsychotics and dialysis, he can be restored to previously good level of functioning.
Imminent risk of death without treatment?	• Yes. • Certain death without dialysis.
Risks of forced treatment appear favorable?	• Yes, though risks are significant. • General risks of dialysis; risks of conscious sedation and restraint for dialysis; risk of physical harm to staff as a result of forcing treatment.
Certainty of treatment effectiveness?	• Yes. • Patient has had good functioning with regular antipsychotics. • He has also done well with dialysis.
Practicality of forcing	• Forcing is difficult given lack of cooperation, but is worth trying at least temporarily with antipsychotic treatment to restore decisional capacity. Long-term dialysis over objection would be unfeasible.

Case 2- 58 y/o with Schizoaffective Disorder and Renal Failure

- Psychiatry Recommendations & Outcome:
  - Risks of treatment over objection outweigh the risks of supportive/palliative treatment → death
  - Use surrogate decision-maker
  - Forced dialysis with conscious sedation & antipsychotics would be offered for a trial period
    - However, if his condition did not improve within reasonable time, the cumulative risks associated with cooperation & worsening clinical status would outweigh the risks of alternative treatment
  - Delirium & paranoia improved with 3 dialysis sessions
  - Capacity was restored

Case 3

- 68 y/o male residing in a psychiatric hospital with treatment refractory psychotic disorder with acute on chronic renal failure.
- Patient is chronically aggressive and paranoid. He routinely refuses medications and hygienic care. He is transferred to a local academic center for assessment and management of worsening renal failure.
- Labs: Cr of 7.9, significantly elevated CK, and other electrolyte abnormalities.
- He is constantly in restraints, aggressive, and removes IV lines

Case 3: 68 year old chronically aggressive and psychotic male with acute on chronic renal failure

Recovery expected with first line treatment?	• No. • Patient has had treatment-refractory psychosis prior to renal failure.
Imminent risk of death without treatment?	• Yes. • It can be reasonably expected that the patient will die within weeks without dialysis.
Risks of forced treatment appear favorable?	• No, risks are prohibitive. • Risks include: General risks of dialysis, risks of conscious sedation and restraint for dialysis, risk of physical harm to staff as a result of forcing treatment with no foreseeable endpoint.
Certainty of treatment effectiveness?	• No. • Forced psychotropic medication has not been successful in the past despite multiple trials of high dose agents.
Practicality of forcing	• Forcing treatment is not practical because of the cumulative risk of forced dialysis over time especially considering a lack of a foreseeable end point.

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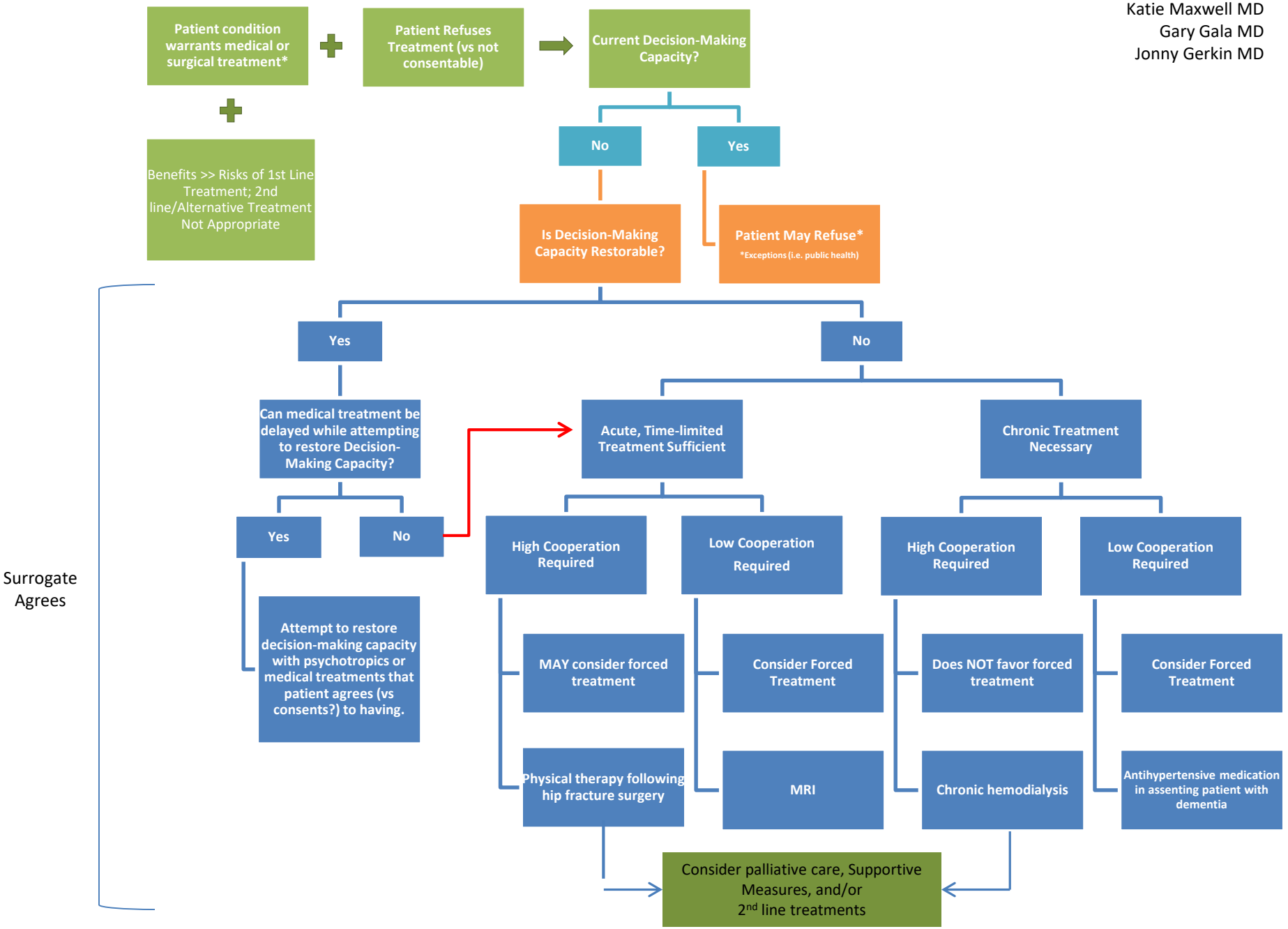
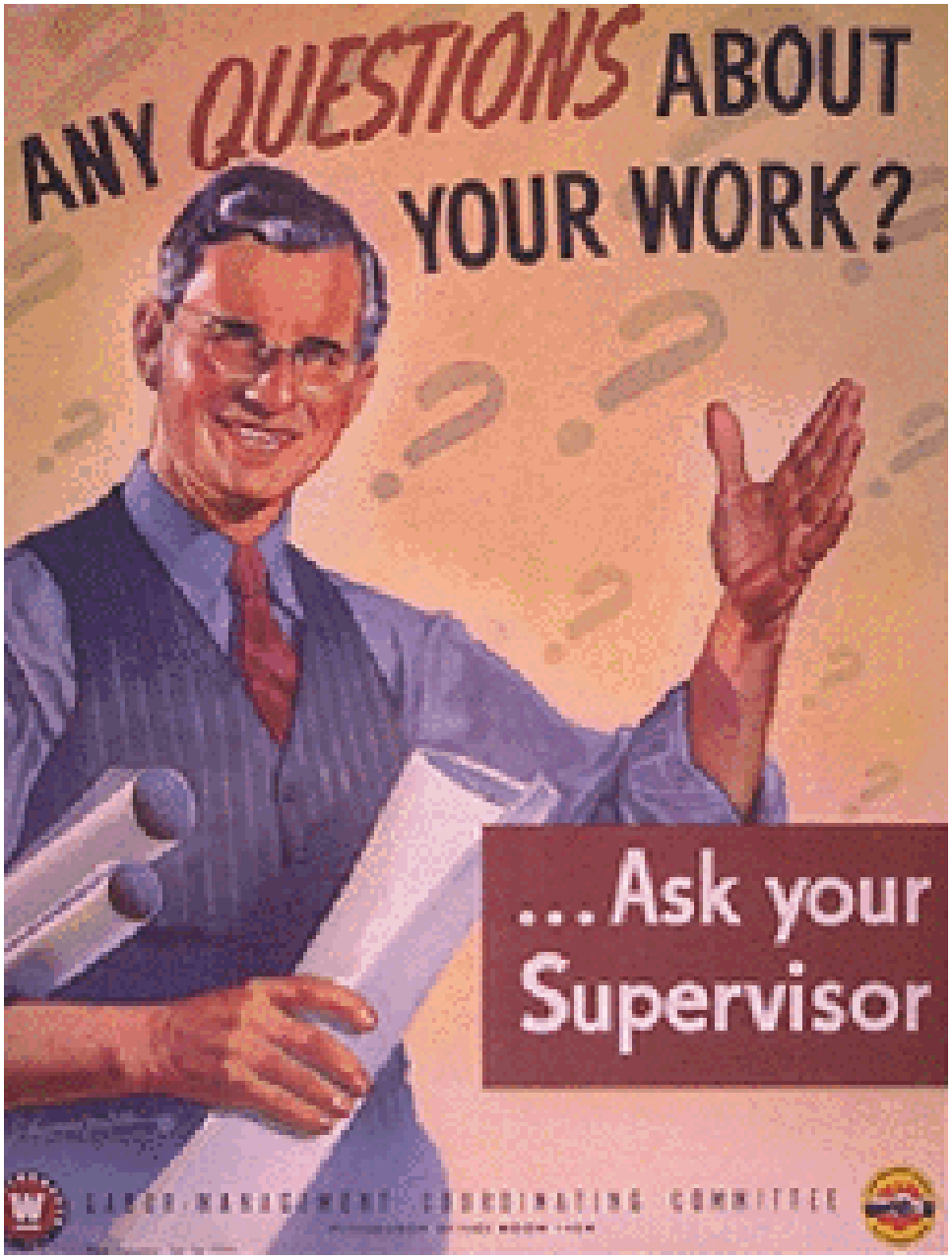
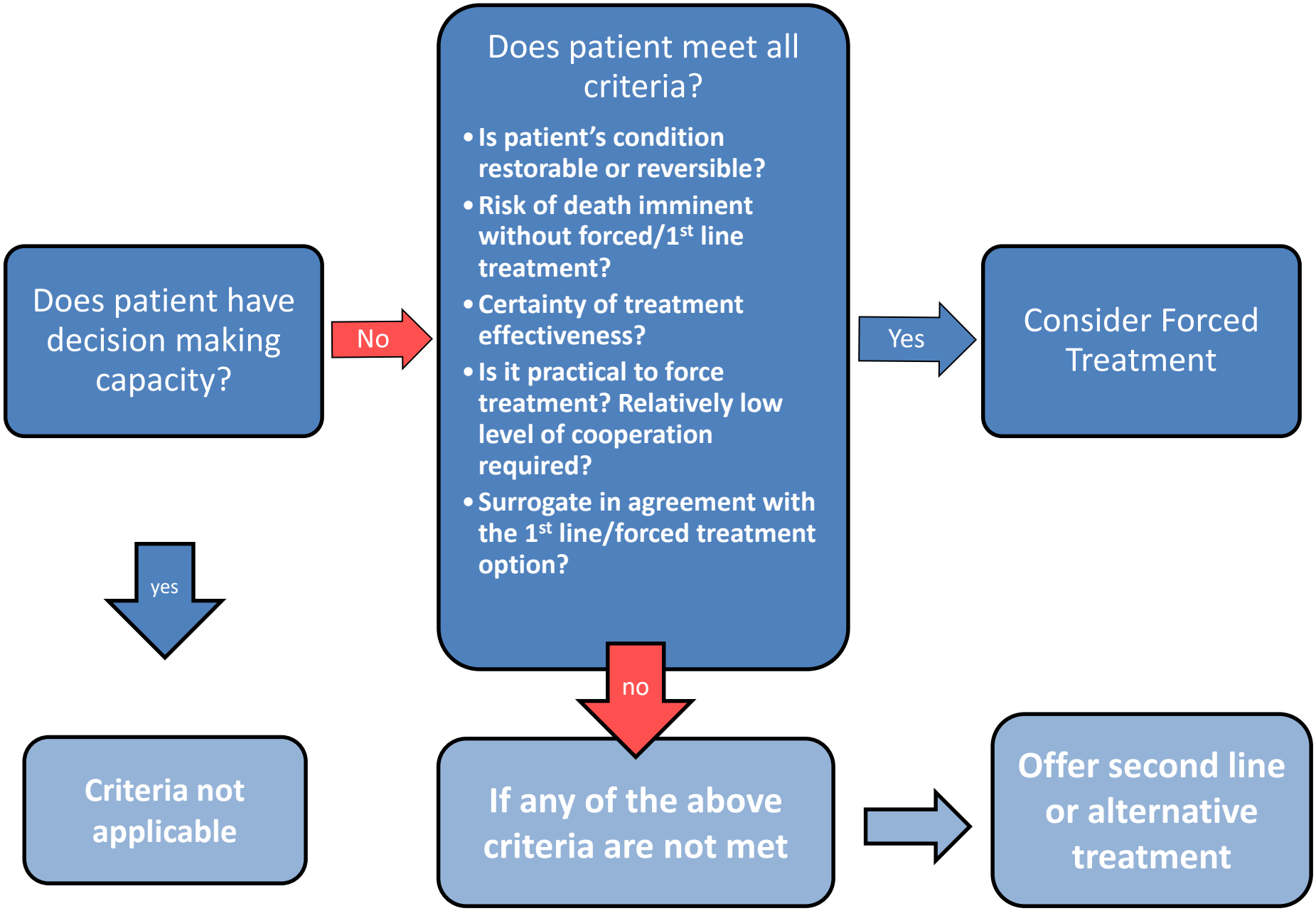



ANY QUESTIONS ABOUT YOUR WORK?
...Ask your Supervisor
LABOR-MANAGEMENT COORDINATING COMMITTEE

The Runaway, 1958


Does patient have decision making capacity?
No
Does patient meet all criteria?
• Is patient's condition restorable or reversible?
• Risk of death imminent without forced/1st line treatment?
• Certainty of treatment effectiveness?
• Is it practical to force treatment? Relatively low level of cooperation required?
• Surrogate in agreement with the 1st line/forced treatment option?
Yes
Consider Forced Treatment
yes
Criteria not applicable
no
If any of the above criteria are not met
Offer second line or alternative treatment

Capacity and Commitment

Capacity

- Understanding
- Appreciation
- Reasoning
- Choice

Commitment

- Mental Illness
- Dangerousness

Are all patients we commit to the hospital *incapable* of refusing the recommended treatment of hospitalization?

Capacity/commitment

- Is hospitalization itself a treatment?
- Or is it a mechanism of *control* that allows for treatment

Capacity involves treatment situations since it is driven by medical necessity

"Mental illness" means:
(i) when applied to an adult, an illness which so lessens *the capacity* of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance**, or control**;
and (ii) when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is in need of treatment.

a. "Dangerous to himself" means that within the relevant past:

1. The individual has acted in such a way as to show:

I. That he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety;

Maybe

- Commitment criteria are a shorthand for a lack of capacity

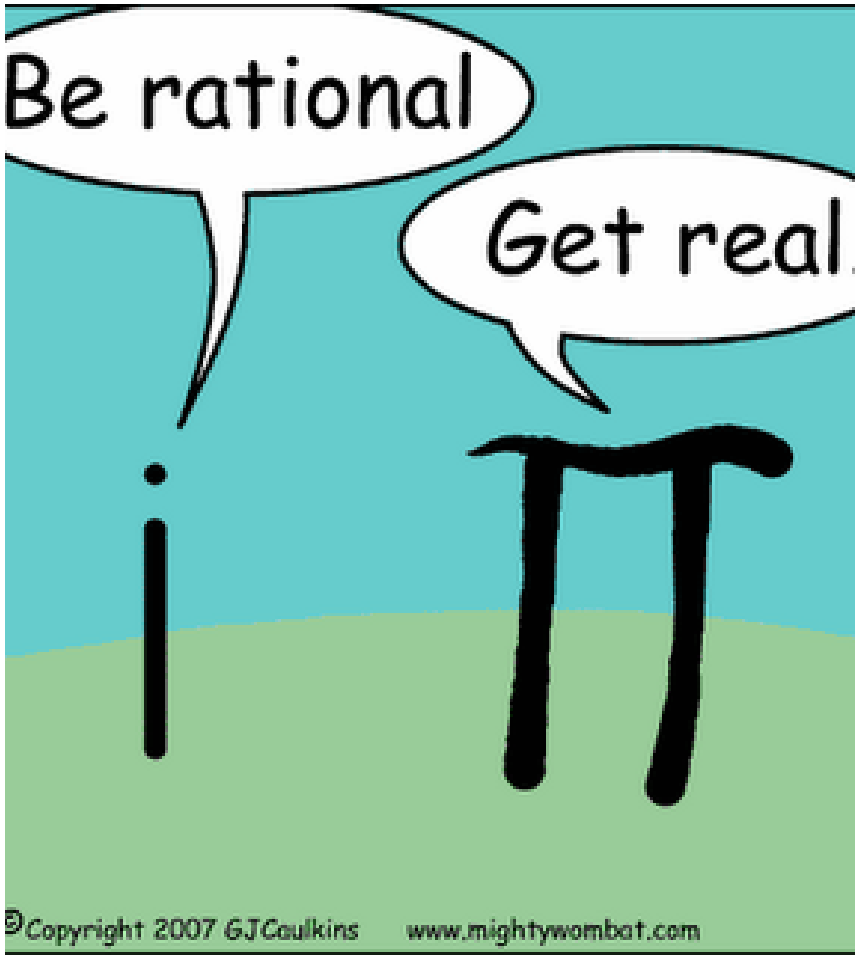
- This would bring our practice into line with the general approach to treatment over objection

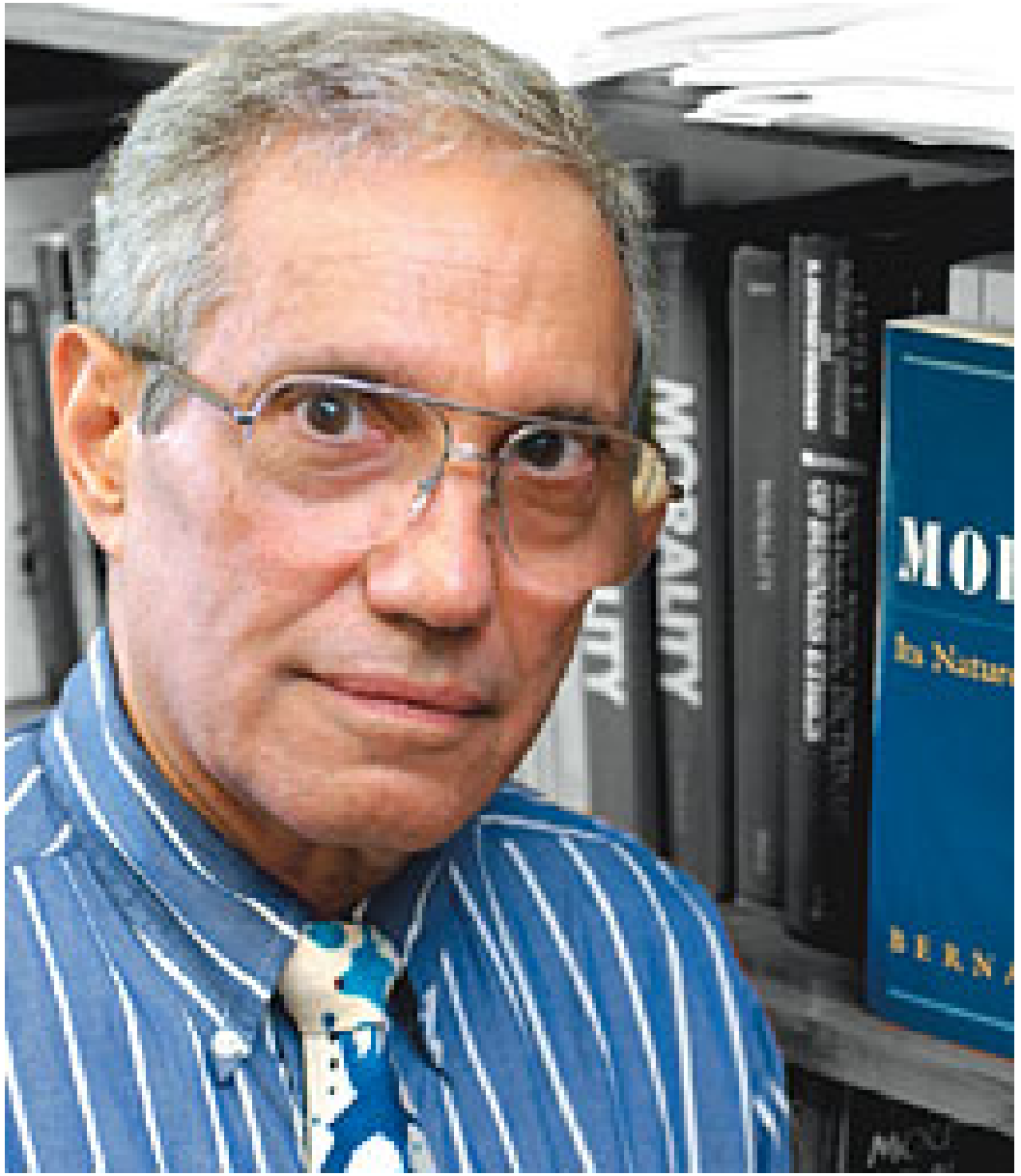
More Capacity

- Voluntariness
  - External
  - Internal

Reasons, Reasoning, Rationality

- Kant: means-ends
- Appelbaum: weighing pros and cons

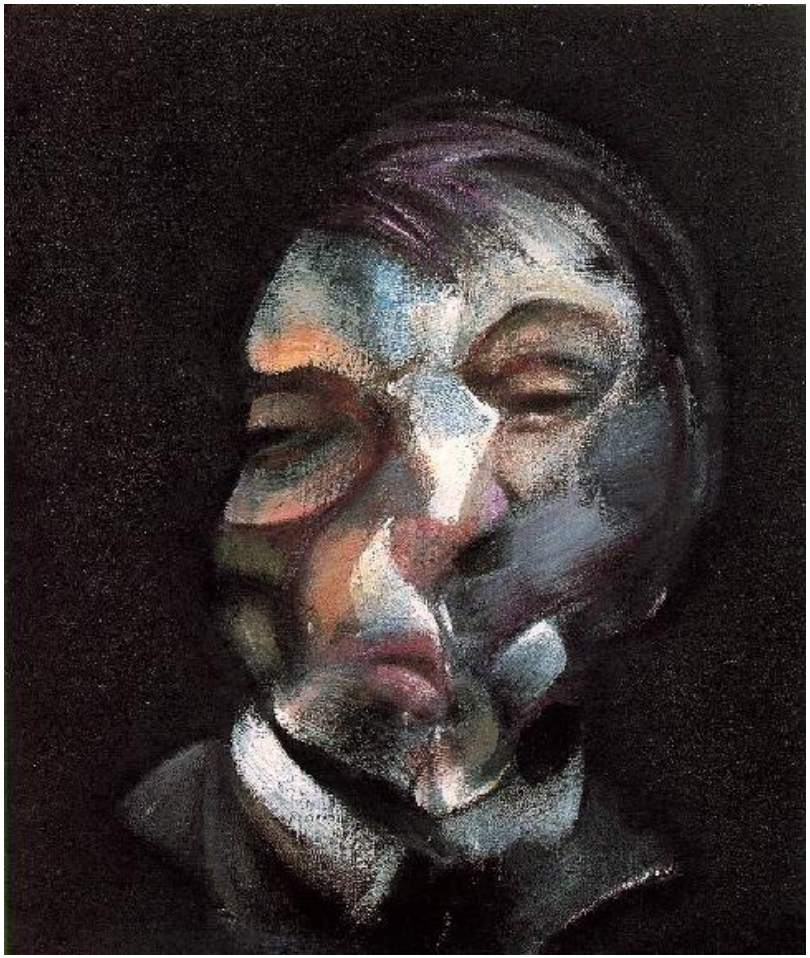




Morality. Oxford University Press, 2005

Gert

- Takes irrationality as basic to rationality
- Links process to content
- Places mental disorders at forefront of irrationality (includes the mad and insane)



irrationality

An irrational *action* is one that will cause

(1)death,
(2)pain,
(3)disability,
(4)loss of freedom
(5)or loss of pleasure

And
there is no *adequate reason* for the action

Photo # SC 320901 Troops in a LCVP approaching Omaha Beach, 6 June 1944

Adequate reasons

Reasons (as opposed to motives) are limited to considerations about harms to be avoided or good to be gained

Adequate reasons are contextualized and to some extent depend on the agreement of others. (Rational persons can disagree about whether or not a person has given an adequate reason thereby turning an irrational action into a rational one.) Paradigm cases: Pain vs. death. Breast conservation vs. mastectomy.

Thomas Hill (Rational Autonomy)

1. min capacity to see causal connections (for example, to understand what will happen if one does this or that)
- 2. to be aware of a variety of wants (future states of affairs and present ones)
- 3. to set oneself ends and adopt policies and plans to achieve them
- 4. to revise ends and policies in the light of new information
- 5. to form and alter goals and policies in response to one's own deepest wants and values

6. to be, to some extent, independent of blind adherence to tradition, authority and the opinions of others

- 7. to resist immediate temptation in the pursuit of adopted ends, values and policies

- *Hill, T: Self –regarding suicide: a modified Kantian view (!983)*

Rational Autonomy (Walker)

- Autonomy: “self rule that is free from both controlling interference by others and from limitations, such as inadequate understanding that prevent meaningful choice” (Beauchamp and Childress, 2009)
- “Choose intentionally, with understanding and without controlling influence” [internal or external] (Walker,2009, 348)
- Autonomous choices should not be irrational
- Threshold concept of rationality: once “above” irrational that is enough

Walker, RL. Kennedy Institute of Ethics Journal, Volume 19, Number 4, December 2009, pp. 339-366

Walker 2

- Draws logical conclusion from accepted propositions
- Infers proper implications from matters of fact
- Substantiates claims with supporting argument
- Holds largely coherent sets of beliefs
- Able to draw general conclusions from experience with specific events
- Reason based on probability and statistics

- Irrational: Will an end but not will the means
- Self destruction may be *prima facie* irrational

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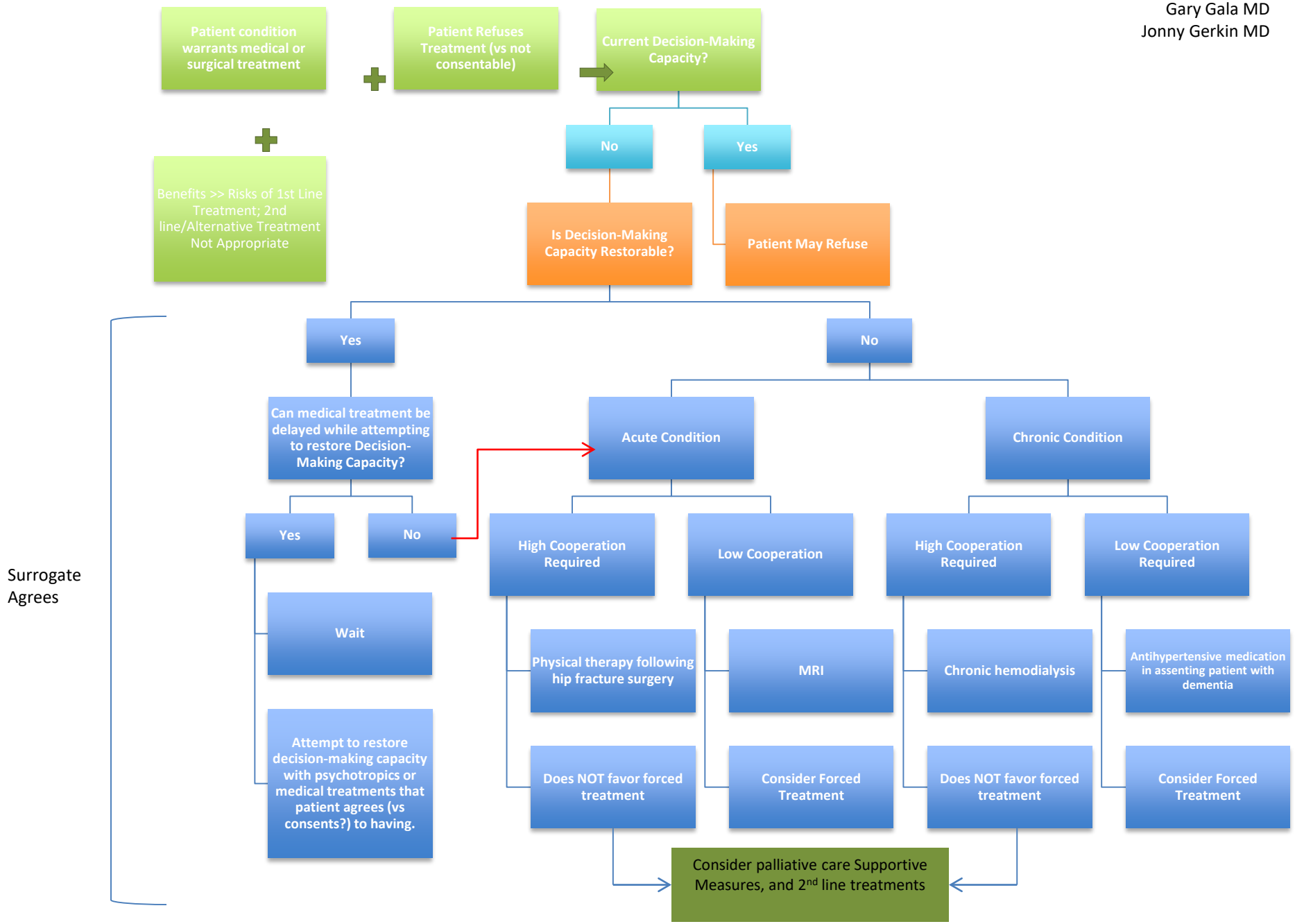

Objectives

- To better understand the elements of decisional capacity.
- To understand the role of decisional capacity in treatment over objection.
- To better appreciate the considerations involved in treating over objection when a person lacks decisional capacity.
- To explore the relationship between decisional capacity and involuntary civil commitment