

Capacity and Coercion in Medicine



ETHICS CONFERENCE

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Today's speaker has no conflict of interest to disclose.

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Mr. O.



- **58 yr old man**
 - Develops hypertensive urgency and flash pulmonary edema; is brought to VA ER, treated with improvement and transferred to the CCU.
 - On transfer to the floor he refuses PO medication.
 - Psychiatry evaluation reveals disordered thinking but psychiatry says Mr. O has capacity to refuse treatment.
 - Ethics committee is asked whether Mr. O really has capacity and whether anything else can ethically be done to treat him.

Capacity and Consent: the Default Position in Medical Ethics



- Legitimate treatment is premised upon consent
- Elements of consent
 - Information (risks/benefits/alternatives)
 - Absence of coercion
 - Capacity

Capacity and Consent: the Default Position in Medical Ethics



- **Capacity**
 - Understanding of information
 - “appreciation of situation”
 - ✦ Patient has a sense of what he/she wants
 - ✦ Patient understands how present situation is relevant to what he/she wants
 - Ability to reason about the information
 - Can communicate a choice

Capacity and Consent: the Default Position in Medical Ethics



- **When capacity is absent: treatment decisions (accompanied by coercion if necessary):**
 - By what the patient would have wanted (if known)
 - Shared decision making with surrogates
 - Physician judgment of best interests of the patient

Capacity and Consent: the Default Position in Medical Ethics



Discussion

Questions raised by the case of Mr. O.



- **What is it to lack capacity?**
 - Lack of capacity vs. being “just a bit odd”
- **When and how far do we coerce those lacking capacity?**
 - What does “a danger to self or others” mean?
 - Does the etiology of the incapacity matter?
 - ✦ **Mental illness**
 - ✦ **Medical illness (e.g. delirium)**
 - ✦ **Thought disorders neither mental/medical illness**

Capacity and Consent: Default Practice



- **Comprehensiveness of capacity (or incapacity) matters.**
 - We prefer capacity to be all there or all gone; but it often isn't that simple. And we then may seek to coerce selectively.
- **Degree of danger attributable to the incapacity matters**
 - We're less prone to seek coercion of an incapacitated patient who fails to take their lipid medication

Capacity and Consent: Default Practice



- **Etiology of incapacity matters**
 - We readily coerce the delirious or the demented
 - There is a higher bar for coercing the mentally ill (danger to self or others)
 - Mr. O; thought disorder not affecting all mentation and likely not rising to the level of a DSM diagnosis → ?
- **Reversibility of the incapacity matters**
 - In cases of danger to self, we're more prone to coerce if coercion is a way station to capacity than if ongoing coercion is necessary (other things being equal).

Problematic re Mr. O



- Mr. O's incapacity is due to neither (clearly) mental nor physical illness.
- Incapacity seems clear but is very much isolated to the issue of medications; Mr. O is mostly intact.
- Danger to Mr. O from his incapacity is high.
- There is no clear path from coercion to restored capacity in Mr. O's case.

Psychiatry and Mr O.



- **Why did they so readily conclude he had capacity and should not be compelled?**

Table 1 Discipline specific variables associated with capacity assessment

Bioethics	Psychiatry
Does the patient understand his/her medical condition?	MMSE™
Does the patient understand the risks and benefits of the proposed interventions?	Is the patient a danger to self or others?
Does the patient understand the consequences of refusing the proposed interventions?	Can the patient manage activities of daily living—for example, cooking, feeding, grooming, dressing, bathing?
Can the patient weigh the burdens and benefits of each proposed intervention (test, medication, procedure)?	Is the patient holdable under state mental health law?
Does the patient understand the concept of life saving interventions?	
Can the patient express his/her health care values?	

MMSE™, Mini-Mental State Examination

Schneider and Bramstedt. When Psychiatry and bioethics disagree about patient decision making capacity (DMC) J Med Ethics 32(2006): 90-93

“Danger to Self or Others”



- Restrictive Definition (has been the norm)
....there has been a general consensus among the states that danger is not "imminent" when, even if harm is virtually certain to occur, the harm is not about to occur in that moment. It appears that, in the absence of a clear definition of "imminent danger," a court will determine whether a mentally ill individual poses an "imminent danger" based on whether he exhibits signs of dangerousness at the hearing that day.

Pfeffer A. "Imminent Danger" and inconsistency: the need for national reform of the imminent danger standard.. *Cardozo Law Review* 30(2008): 277-315.

Danger to Self or Others: Alabama



- **Pre-1990s: overt act required for the demonstration of danger**
- **Mid-90s: standard amended to require:**
 - “a real and present threat of substantial harm” to self or others.

Danger to self or others; less restrictive definitions



- Less restrictive definitions; gaining ground in several states. E.g. Wisconsin permits coercion of a patient if:

after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, **evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication** or treatment and the alternatives, **or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives** to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment;

Danger to self or others; less restrictive definitions



and evidences a substantial probability, as demonstrated by both the individuals treatment history and his or her recent acts or omissions, **that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm** that will result in the loss of the individuals ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions.

Mr. O's Legal position



- He likely would not have met Alabama criteria for commitment/coercion (although he might have in Wisconsin).
- His family members were against coercion, making any effort to commit him more difficult.
- Above likely informed Psychiatry's opinion in Mr. O's case

Possible approach to Mr. O.



- **Our view of Mr. O:**
 - In the critical regard, he lacks capacity.
 - Coercion is warranted if:
 - ✦ Danger if untreated is imminent and severe (e.g. Mr. O develops severe hypertension again)
 - ✦ Brief period of coercion might be a bridge toward Mr. O's voluntary compliance with his medication.
 - ✦ Family cooperation would almost certainly be necessary.

Possible approach to Mr. O.



- Given that Mr. O has normal BP on day 3, he would be discharged.
- Mr. O's family might monitor his BP; in the case of severe elevation, they might persuade him/bring him to the ER. There he might be involuntarily admitted if necessary for treatment of his BP and a trial of coerced treatment (PO).
- Coercion attempted would be “soft”; we wouldn't literally tie him down if that's what it took to administer parenteral meds. But short of that, we would give him parenteral meds.
- Within a day or two he would either be willing to take PO BP meds or not.
- He would then be released without further attempts at coercion.