

# ANESTHESIOLOGY™ 2014

OCTOBER 11-15 | NEW ORLEANS, LA

Session: L018  
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## **To Coerce or Not to Coerce: What Are the Questions?**

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**Disclosures:** This presenter has no financial relationships with commercial interests

### **Stem Case and Key Questions Content**

You are on the Anesthesia hospital consultation service and are asked to see a patient on the floor who refuses all food and treatment. She is a 53 year-old woman who is combative with the nursing staff and, despite 4-point restraints, kicks, yells and spits at anybody who approaches her. The Medical team tells you they would like to pass an NG tube to feed her and also start an IV to administer antipsychotic medications. In order to accomplish that, however, the Internist claims the patient will require anesthesia to make her safely approachable. He says, "We know you have a dart or something that stops patients in their tracks!" The patient's PMH is significant for paranoid schizophrenia, renal insufficiency secondary to dehydration, and homelessness. She has no known family and was brought into the hospital by ambulance when she passed out in a grocery store.

How do you respond?

After examining the patient's medical record, you come to the conclusion that, other than a BUN/Cr ratio of 42/2, there is nothing in the patient's profile to indicate an emergency situation. Who or what can you consult for further management advice?

You decide to interview the patient yourself. Upon entering the room, you find a thin, quiet-appearing woman lying on a hospital bed with all four extremities bound. You introduce yourself and she says, "Go away." When you ask her to state her name, she answers appropriately. You then ask her if she knows where she is and she responds, "In prison, can't you tell by looking at me?"

How do you obtain this patient's permission for sedation? Should you do so? How do you assess her ability to consent for treatment?

As you return to the nursing station you find a Social Worker going over the patient's medical record. He says he believes he has found an appropriate surrogate decision-maker, a son with whom she has lived on-and-off for years. After speaking with the son you learn he is the only person in her life who has been able to maintain contact with the patient. He states his mother prefers a nomadic existence to living in his home ("...the children are too loud"), and she has always been distrustful of the medical community. He says he has supported her lifestyle choices because she has remained consistent in her desire to live on the street. He admits, however, that he has never really known her to be in a lucid state and she consistently refuses to take her psychiatric medications.

# ANESTHESIOLOGY™ 2014

OCTOBER 11-15 | NEW ORLEANS, LA

How does one assess whether or not a surrogate decision-maker for healthcare is appropriate for the patient? How do you assess whether or not the decisions made by the surrogate decision-maker are appropriate?

After the son visits his mother in the hospital for a couple of days, the patient consents to taking oral antipsychotic medications. After a week of treatment she is no longer violent and the restraints are successfully removed. She still refuses to eat and is fed via the NG tube. Because of worsening renal function, the Medical team wants to place a dialysis catheter. Once again, you are consulted to evaluate the patient for anesthesia and surgery. Once again, the patient refuses treatment.

What do you do?

Miscellaneous scenarios for discussion (time permitting)

(1) You are on call. A 23 y.o. patient with traumatic brain injury has arrived on your doorstep for closed reduction of a fractured ulna. He is intubated and nonresponsive to verbal stimulation. The surgeon approaches and says, "We've already discussed the surgery with the family. Let's get going!"

(2) You have just completed an anesthetic on a 55 y.o. man who had intraoperative hypotension and ST-segment changes. Chemistries in the PACU suggest a perioperative MI. The patient remains intubated so you seek out his son to discuss his father's progress. The son says, "Don't tell him what happened. We [family] make decisions for him and that sort of information will be harmful if he hears it."

## Model Discussion Content

### *The Anesthesiologist's ethical duties*

Ethical medical practice is based on at least four (4) basic principles: Respect for autonomy (self-determination), Nonmaleficence (first, do no harm), Beneficence (promotion of good health), and Justice (fairness.)(1) Administering medications to a reluctant patient, particularly one who is psychologically impaired, raises concerns of misapplication of all four principles. Is the forceful administration of a parenteral medication to a combative patient a disregard for her right to self-determination? What is the potential harm in doing so? Will the benefits of doing so outweigh the risks? Will the patient's right to be treated justly, as an equal member of society, be disregarded? Both the American Medical Association (AMA) and the American Society of Anesthesiologists (ASA) have promulgated opinions and guidelines which embody these basic ethical tenants and can offer direction to anesthesiologists when faced with treatment dilemmas such as this one.(2, 3)

### *Coercion*

Prior to treating a patient, physicians have a duty to not only educate patients as to the proposed treatment, along with the alternatives, inherent benefits, and risks, but to involve the patient in a shared decision-making process regarding the best available treatment options.(3) Undue influence by a physician during the informed consent process can come in several forms. Oft quoted as "paternalism", a patient may be coerced or manipulated into agreement. Whereas coercion involves a direct threat on a patient (such as withholding pain medication until the consent form is signed), manipulation consists of convincing the patient to take a specific course

of action through “information manipulation” which may involve lying, misinformation, or simply withholding of material facts.(1) Professional persuasion, on the other hand, preserves patient autonomy through a process of shared decision-making whereby the patient is assisted in making a beneficial choice.(4, 5) Pursuant to this, the ASA recognizes the unique susceptibility of anesthetized patients to coercion and undue influence. The Guidelines for the Ethical Practice of Anesthesiologists states, “Anesthesiologists respect the right of every patient to self-determination... Anesthesiologists should not use their medical skills to restrain or coerce patients who have adequate decision-making capacity.”(2)

### *Patient autonomy*

Respect for patient autonomy is a respect for a patient’s dignity as an individual and reflects an understanding of the patient’s right to self-direction in matters of healthcare. Recognition of this principle stems from the constitutional interpretation of a citizen’s right to privacy and freedom from undue influence.(6) Informed patient consent as a necessary element of patient autonomy was legally established in the case of *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914), when the New York Court of Appeals held that a competent patient may make independent decisions in matters affecting his or her body, and also that it is assault when a surgeon performs surgery without a patient’s consent. Under the AMA Code of Medical Ethics, which is nonbinding opinion but nonetheless standard medical care, “The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician’s obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice.”(3)

An anesthesiologist may find the informed consent process challenging as s/he encounters patients for the first time who are frightened, uncooperative, or outright belligerent. Furthermore, certain patients are incapable of autonomy, such as small children or those in a comatose state. Other may be autonomous, capable adults but may subvert the informed consent process or even refuse treatment because of an altered state (such as drugs, head injury, or outright panic.) And some patients may be in a state of psychotic delusion, incapable of cooperating in a reasoned, informed decision-making process. In any informed consent process, however, the anesthesiologist must ask: Does this patient have decision-making capacity to actively participate in the informed consent process? If not, does this patient or his/her behavior qualify as an exception to the requirement for informed consent?

### *Informed consent*

A patient is competent to actively participate in an informed process prior to anesthesia if s/he has decision-making capacity. Competency is the ability to understand the nature of the proposed treatment, its alternatives, benefits, and risks, and the consequences of his/her choice; it is a legal term and is used interchangeably with the term “capacity” by physicians to designate the patient’s ability to make an informed decision regarding a specific task.(4) For instance, a patient who speaks only Spanish may be competent to give informed consent for a proposed anesthetic plan, but without an interpreter s/he may lack capacity to participate in the informed consent process with the anesthesiologist. All patients who are legally competent must also be able to receive, evaluate, and synthesize the information provided by the anesthesiologist to meet the threshold for decision-making capacity. It is important to note that lucid and competent adult patients who have decision-making capacity have the right to accept

# ANESTHESIOLOGY™ 2014

OCTOBER 11-15 | NEW ORLEANS, LA

as well as refuse medical treatment on their own behalf once properly informed by the medical care team.(4)

There are recognized exceptions to the anesthesiologist's ethical duty to involve the patient in an informed consent process. Under the AMA Code of Medical Ethics, "Informed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent. In special circumstances, it may be appropriate to postpone disclosure of information."(3, 7) Thus, there may be instances where the urgency of the situation or other circumstances preclude informed discussion; immediate treatment may be required. Other exceptions to the physician's duty to seek an informed consent include statutory legislation involving the treatment of minors in matters of sexuality and pregnancy. A pregnant minor in California, for instance, is "emancipated" regarding pregnancy-related issues. Children over 12 years of age in California can obtain be treated for some mental health, birth control and STD conditions without parental knowledge and consent (but, in these exceptions, the physician has a duty to educate and inform the teen under the adult standard.)(8) In non-exigent cases, such as when a patient refuses to eat and is violent towards the nursing staff, concerns over whether or not the patient's behavior poses a serious threat to herself or others becomes legally paramount.(9) In these cases, a psychiatry consultation to evaluate a patient's mental state and decision-making capacity, along with the patient's medical care team to assess the medical urgency of the situation, is necessary before the anesthesiologist makes a decision to proceed in administering unwanted medication.

### *Surrogate decision making*

In the case of a patient who requires treatment but does not have decision-making capacity, the anesthesiologist has other channels for determining what course of action to take. Advance directives or "surrogate" (proxy) decision-makers may be sought to guide care that comports with what the patient would have wanted in a competent state. Under the Patient Self-Determination Act of 1991, hospitals receiving federal monetary support such as Medicare must make the advance directive vehicle part of the hospital admission process.(10) Advance directives may take several forms, including formal written documents ("living will"), conversations the patient may had with a close acquaintance (the most common type), or discussion with the patient's physician.(4) All physicians should avail themselves of the opportunity to educate the patient about the importance of discussing their views and wishes concerning medical care with a family member, close friend, or physician in the event of incapacity.

If an advance directive is not available in guiding medical treatment of an incapacitated patient, a surrogate may be sought to provide what is termed "substituted judgment": Reasoned information and guidance for the patient's medical team based on what the surrogate knows to be in line with the patient's know values, personal history, and lifestyle choices.(11) As the AMA Opinion on Surrogate Decision Making aptly states, "When there is evidence of the patient's preferences and values, decisions concerning the patient's care should be made by substituted judgment. This entails considering the patient's advance directive (if any), the patient's views about life and how it should be lived, how the patient has constructed his or her identity or life story, and the patient's attitudes towards sickness, suffering, and certain medical procedures. If there is no reasonable basis on which to interpret how a patient would have decided, the decision should be based on the best interests of the patient, or the outcome that would best

# ANESTHESIOLOGY™ 2014

OCTOBER 11-15 | NEW ORLEANS, LA

promote the patient's well being. Factors that should be considered when weighing the harms and benefits of various treatment options include the pain and suffering associated with treatment, the degree of and potential for benefit, and any impairments that may result from treatment. Any quality of life considerations should be measured as the worth to the individual whose course of treatment is in question, and not as a measure of social worth."<sup>(11)</sup> Some states specify the appropriate surrogate through legislation (e.g., spouse, followed by children, then parents, etc.), but in many cases a legal surrogate may simply be a person best acquainted with the patient's chosen way of life and value system.

Unfortunately, it is not always evident just what the patient would have wanted had s/he possessed decision-making capacity, or there is disagreement amongst persons known to the patient. In those instances, the "best interest" standard is applied to help determine which course of treatment (or not) is most beneficial to the patient. The standard can be complicated because what is "best" for the patient as understood by a proxy, Durable Power of Attorney, or legal guardian for healthcare may be subject to information gaps or even personal bias. The patient's physician may have a larger role at this point, particularly if it appears the surrogate is not acting in the patient's best interest, if the patient is unbefriended, or there is intra-family disagreement as to what the best course of treatment may be. The physician must devote additional time in seeking out the source of disagreements and information gaps. Outside consultation, such as with the hospital bioethics committee, legal department, or risk management, should be sought.

In addition to the physician's role in counseling patients as to the best course of action to take, physicians have a duty to protect their patients from harm, including harm that is self-inflicted or reversible.<sup>(4, 6, 9)</sup> This is a dilemma for any anesthesiologist who, attempting to act in the patient's best interest, would be rightfully concerned that someday his/her actions will be second-guessed by a third party. Recent studies in psychiatry have demonstrated that patients who are hospitalized against their will while suffering from mental illness fare as well and sometimes better than patients who voluntarily commit themselves.<sup>(12-14)</sup> Still, surrogate decision makers are likely to want to maintain control of healthcare decisions made on behalf of a dying patient. In a 2011 study involving 230 surrogate decision-makers at a large teaching hospital, more than one-half preferred to be the ultimate decision-maker in value-laden life support issues, after receiving the necessary medical information; only 5% of surrogates felt the physician should make life-sustaining decisions on behalf of the patient.<sup>(15)</sup>

When caring for a patient who is refusing treatment, the anesthesiologist should be cognizant of a distinction between treating an uncooperative patient who has decision-making capacity and one who does not; the latter patient is particularly susceptible to undue influence by third parties. Likewise, a distinction must be made between treating an uncooperative patient who is harmful to herself versus harmful to others such as nursing staff.<sup>(4)</sup> Widespread precedent exists in support of treating a person who may be harmful to other persons, as in the practice of mass vaccination and quarantine. In the case of our nomadic patient, she (while restrained) is harming only herself. The anesthesiologist's best course of action may not be so clear, and consultation with the hospital bioethics committee, risk management department, or legal services should be sought. Patient restraint with the anesthesiologist's "dart" at this point may be tantamount to coercion unless the patient is in imminent danger of death or critical illness because of her refusal to receive further care.<sup>(3)</sup>



# ANESTHESIOLOGY™ 2014

OCTOBER 11-15 | NEW ORLEANS, LA

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