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When psychiatry and bioethics disagree about patient decision making capacity (DMC)

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The terms “competency” and “decision making capacity” (DMC) are often used interchangeably in the medical setting. Although competency is a legal determination made by judges, “competency” assessments are frequently requested of psychiatrists who are called to consult on hospitalised patients who refuse medical treatment. In these situations, the bioethicist is called to consult frequently as well, sometimes as a second opinion or “tie breaker”. The psychiatric determination of competence, while a clinical phenomenon, is based primarily in legalism and can be quite different from the bioethics approach. This discrepancy highlights the difficulties that arise when a patient is found to be “competent” by psychiatry but lacking in DMC by bioethics. Using a case, this dilemma is explored and guidance for reconciling the opinions of two distinct clinical specialties is offered.

DMC is very different. We argue that these differences are often the root cause of discordant patient assessments by these two disciplines.

In the United States, physicians treat patients under health laws that vary from state to state. Similarly, mental health laws that govern how psychiatrists and others take care of patients with and without competency vary somewhat across the nation. Additionally, these laws dictate under what circumstances incompetent patients (or patients lacking DMC, pending competency adjudication) can be held in the hospital against their will and given psychiatric and/or medical treatment, pending judicial review of the case.

In the state of California, the Welfare and Institutions Code statute 5150, also known as the Lanterman-Petris-Short (LPS) Act,² governs the rules by which physicians can hold—that is, detain—and treat mentally ill patients who are felt to be a danger to self, a danger to others, or are gravely disabled. Because the LPS act is the only mechanism by which a psychiatrist may hold and treat a patient against his/her will in California, it has become, we suspect, the means through which psychiatrists in our state tend to assess DMC.

CASE

First hospitalisation

Psychiatry and bioethics consultations were requested with regard to an 81 year old male patient's refusal of all diagnostic and therapeutic interventions. The patient had been brought to the Veterans' Administration (VA) Medical Center by police after having been found alone in his non-functional motor vehicle. The officers reported he had generalised weakness, but the patient denied any complaint whatsoever. When asked why he was brought here, he was unable to give any coherent reply. On admission, he said he disliked being in the hospital but would accept treatment. Initial medical investigation revealed a profound microcytic anaemia, mild hypothyroidism, a huge (football sized) scrotal hernia with superficial cellulitis, and possible dementia. Review of records showed that he had only come to the medical centre for dental clinic appointments in the past despite the fact that he had been receiving a VA pension for a diagnosis of chronic paranoid schizophrenia for many years. He denied any psychiatric history, diagnosis, treatment, or symptoms at all. He gave a history of being a prisoner of war in the second

When a hospitalised patient refuses medical treatment, the physician's task is to assess whether the refusal is truly informed or not. Akin to the process of informed consent, the process of informed refusal is aimed at safeguarding a patient's right to self determination.¹ All patients should have the right to make the wrong medical decision—that is, all patients who have medical decision making capacity (DMC). When patients do not demonstrate the functional capacity to make medical decisions, either because of mental illness or some other cause, the refusal is by nature not informed, and thus, invalid. What is the physician to do in this dilemma in which patient autonomy is pitted against the physician's desire to do medical beneficence?

It is frequently the psychiatrist who is called to see hospitalised patients who refuse medical treatment, in order to assess “competence”, even though competence is a legal determination made by judges after reviewing medical information and testimony. “Competency” and “decision making capacity” (DMC) are terms often used interchangeably in the medical setting. The bioethicist is consulted on these patients frequently as well, sometimes as a second opinion or “tie breaker”. As we will show, not only are the terms “competency” and “decision making capacity” used interchangeably, they have different meanings for bioethicists and psychiatrists. In fact, the diagnostic approach that these two specialties take to assess competency and

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Abbreviations: DMC, decision making capacity; VA, Veterans' Administration

world war and of having been operated on against his will by the German army. He indicated he had been raised in Indiana, received a bachelor's degree in business and worked for 30 years as a real estate broker. He admitted to several years of homelessness with a hobby of raising dogs.

Once admitted to the hospital, the patient refused any treatment for his medical conditions as well as any diagnostics to determine their cause(s). The patient was evaluated by psychiatry, who conducted an examination of the patient and spoke with a friend of the patient. The friend confirmed that the patient lived independently out of his car and mostly shunned human contact, preferring the companionship of his dog. The patient's Folstein Mini-Mental Status Examination (MMSE) score was determined to be 27/30. The consulting psychiatrist was unsure as to his actual psychiatric diagnosis (possibly schizotypal, possible residual schizophrenia), but felt that in any case, he could not be detained under California mental health law (Welfare and Institutions Code section 5150–5157), and that psychoactive medications were not indicated. He felt that the patient could make his own medical decisions regarding the anaemia and other conditions. In sum, he felt that the patient was more odd than mentally ill and that his refusal of medical treatment was based in an appropriate general understanding of his medical condition(s) and of his treatment options.

One of the authors (PLS) was then asked to evaluate the patient as the consulting bioethicist. During this evaluation, the patient denied having ever been told that there was anything wrong with him medically. Specifically, he said his doctors never mentioned anaemia or any abnormal laboratory test to him. The bioethicist knew this to be false because he was the emergency department attending physician at the start of the hospitalisation and had told the patient he had abnormal laboratory reports originally, in some detail. The patient thought he was brought to the hospital because: "My car couldn't get a few inches up a curb. The Gestapo brought me here." He said he did not want anything from the medical staff, only to return to his dog.

Bioethics offered the opinion that the patient did not possess DMC, as evidenced by his continued belief that he did not have any medical problems and that no one had informed him of any problems. Moreover, the patient was unable to elaborate substantially on his reasons for refusing interventions (an enigmatic refusal).¹ Bioethics suggested that a second psychiatric opinion regarding the issue of DMC might be appropriate and suggested the name of a physician who is well recognised in this area.

The second psychiatrist evaluated the patient and reported that the patient had a history of being shot down during the second world war, being operated on by the Germans and escaping. He found the patient pleasant, although ornery at times. The patient indicated he had cared for himself for 81 years and did OK without doctors and did not need them or want them now. He would not answer orientation questions because he said they were not important, even after he was told why they were important. His stubbornness made it difficult to know whether he did not know the answers to questions or enjoyed being difficult. The patient did not remember seeing the bioethicist or the first psychiatrist, but he commented that he had seen a lot of people during his time at the hospital.

The second psychiatrist concluded that it was difficult to make a clear assessment of the patient because of his lack of cooperation. It was felt that the patient had some memory difficulties but it was not clear that they were sufficient to impair his DMC in a serious way. There was the possibility that the patient might have been covering up incapacity by non-cooperation. The second psychiatrist admitted that because of the unclear situation, the risks and benefits of

treatment/no treatment were potentially significant. The patient was very anaemic but it was probably chronic and not acute. The psychiatrist believed it therefore would require significant impairment to require going against the patient's wishes at that point. He admitted that the patient did not appear to be exercising good medical judgment, but felt the patient had a pretty good idea of what he was doing; after all, he had managed for years with no doctors and seemed able to care for himself outside the hospital setting. Considering all this information, the second psychiatrist indicated he would give the patient the "benefit of the doubt" and consider him "competent" to refuse treatment. The patient was discharged from the hospital the next day, to his car. He was given a follow up appointment for the clinic, which he missed.

Second hospitalisation

Seventeen days after his discharge, the patient was again brought to the emergency department by paramedics, again because he did not appear to be thriving well in his car. He continued to deny any medical complaints except for chronic knee and leg pain which made ambulation difficult. He was admitted to the hospital and underwent head computed tomography which was normal except for chronic sinusitis and mild microvascular ischaemic disease. The patient was then re-evaluated for DMC by the first psychiatrist (from the first hospitalisation).

This third psychiatric evaluation identified dementia and a possible chronic psychotic disorder, but the patient was not actively psychotic at the time. He was felt to be eccentric, isolative, and probably gravely disabled. With respect to the determination of grave disability, psychiatry felt that further information should be obtained from the patient's next of kin regarding whether or not he had been able to obtain food or eat while living in his car. Psychiatry found the patient to lack DMC due to his impaired understanding of his medical condition, the proposed treatments, and the risks and benefits. Given that medical treatment was not urgently needed and that the patient did not demonstrate clearly delusional or inaccurate reasons for refusal of care, the psychiatrist argued that a court would likely not order compulsory treatment. Psychiatry recommended a second bioethics consult for the patient, and offered to facilitate court proceedings if the medical team wanted to pursue forced treatment.

Bioethics (PLS) conducted a second consultation and found that the patient continued in his refusal to accept that he had any medical problems. He would not even accept that his doctors thought that he did. His examination was very similar to that of the first bioethics consult, and it was felt that he continued to lack DMC.

With various opinions at hand, the bioethicist spoke with the two consulting psychiatrists. During these discussions, it was determined that although both disciplines were asked to assess capacity, the two disciplines had, in fact, two different concepts and processes in mind. While bioethics felt that the essential task was an assessment of the patient's ability to understand, process and communicate facts about the patient's medical condition, possible therapies, and the consequences of refusing therapy, psychiatry felt that the essential task was an assessment of whether or not they could prove in a California mental health court that the patient was gravely disabled, or was a danger to self or others. For the psychiatrists, their evaluation was much more important than that of bioethics, since the only mechanism to impose continued hospitalisation on a patient who refuses such hospitalisation is through the mechanism of a mental health hold or detention (not a bioethics consult). This hold, in California, must be upheld through the mechanism of

proving to the court that the patient is gravely disabled or a danger to self or others.

Both bioethics and psychiatry agreed that using a bioethics approach to evaluate DMC would have resulted in all opinions concurring that the patient lacked DMC. In the end, bioethics concurred with psychiatry's recommendations and also offered that one should be exceedingly careful about doing any medical interventions against the patient's will due to concerns about the safety of the hospital staff and the patient.

The patient was put on a psychiatric hold/detention for grave disability and transferred to a medical/psychiatric unit for continued care. During this hold, it was discovered that the patient had experienced a 30 pound weight loss in recent months and chart review confirmed that he had not received care in any other VA facilities for his chronic psychosis. During the hold, he underwent extensive neuropsychiatric testing. It was felt that he had numerous areas of cognitive defects consistent with chronic psychosis and that he would benefit from conservatorship. He was seen in consultation by general surgery in regards to his massive hernia, who felt that the hernia was reducible, but did not require surgical treatment because it was not causing any symptoms. He was also seen by haematology in regards to anaemia; haematology recommended a transfusion, which the patient refused.

Mental health conservatorship was granted by the courts and specific permission for transfusion against the patient's will was granted. He continued to refuse all medications. Ultimately he was transferred to a VA nursing home where he remained unhappy at losing his independence and his dog. He eloped several times from the nursing home and was found wandering the VA grounds by police. He was transferred to an inpatient psychiatry ward where permission was granted by his conservator for him to receive anti-psychotic medication by injection, monthly. He had improvement in his overall level of paranoia and agitation but continued to refuse all other forms of medical treatment. More than two years after his initial presentation, he is still living in the VA nursing home, and has now asked for his hernia to be fixed.

DISCUSSION

This case highlights the innately different philosophy and methodology of bioethics and psychiatry with regard to capacity assessment. The fact that both disciplines operate with two distinct notions of capacity, namely DMC and competency, sets the stage for different assessment outcomes. The fact that both disciplines operate with distinct assessment approaches further enhances the potential for differing opinions. As can be seen from Table 1, psychiatry relies heavily on the MMSE, while bioethics is less reliant on it. The bioethics approach is more focused on a patient's comprehension of his/her medical condition and treatment options, thus the assessment is usually in terms of the patient's functional capacity to make medical decisions. Bioethicists also weigh patient refusals in light of the benefits and burdens of the proposed treatments, as well as in light of whether the interventions are life saving.

When bioethics and psychiatry offer differing opinions about a patient's DMC, this sets the stage for requests for second opinions within these two disciplines—a time consuming effort that can have professional ramifications when consultants feel their judgment is being second guessed. In this case, there were five lengthy capacity assessments, three by psychiatry and two by bioethics; however, in the end, it was determined that there was no disagreement among the parties. The approach and goals of the staff were different, as has been reported elsewhere.³ In

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

addition to different training and skill sets, there is the argument that psychiatry has traditionally ignored or rejected the contributions of philosophy—the sphere in which bioethics arises and ruminates. On the flipside, philosophers (including bioethicists) customarily respect the relevance of behaviour and mental illness to clinical medicine. The field of bioethics supports Dr Lederberg's conclusion that “establishing capacity is often a subtle and difficult one”,⁵ with bioethics adding that a patient's values and preferences about health care (philosophical notions) are key elements in the understanding of why patients make the decisions that they do.

As was demonstrated in this case, one possible way to address a disagreement between bioethics and psychiatry with regard to DMC is to try to reach consensus about what exactly is agreed upon and what exactly is not agreed upon. In this case, there would have been agreement at the end of the first hospitalisation that the patient was not able to demonstrate DMC. The disagreement would have been over what to do next. The crux of this disagreement revolves around the question of whether it is right or wrong to allow such a patient who lacks DMC, but is felt to be legally unholdable, to leave the hospital without treatment. Using a bioethics paradigm, one could argue that it would be ethically appropriate to try to convince the patient to stay voluntarily while simultaneously treating the mental illness and trying to identify a surrogate decision maker who could authorise treatment for him. The psychiatric paradigm would hold that in this case, one should “do the wrong thing in order to do the legal thing”. It may well be that some of the field of psychiatry's approach to this problem has been shaped by the desire to avoid both malpractice claims as well as potential criminal allegations of false imprisonment. After all, much of current mental health law is seen by many as a protection for patients against the abuses of psychiatry's past. It is conceivable that with some of the liability for potential medical malpractice shifted away from psychiatry to bioethics, psychiatry would become more comfortable with the bioethics paradigm, and consensus for doing the morally right thing could be reached.

CONCLUSION

Clearly, both bioethics and psychiatry support respecting the medical decisions made by patients with DMC,⁶ and to this end, there are roles for both disciplines in understanding and assessing capacity. Bioethicists can tease out the philosophical notions of healthcare values and preferences, while psychiatrists can tease out the clinical and pharmacologic

variables. Whether a person needs to be detained—holdability—may indeed be best ascertained by psychiatrists, but the necessity to detain, to hold someone, should not necessarily be equated with the functional capacity for medical decision making. In settings where bioethicists are part of the hospital staff, we recommend that disagreements between the two disciplines be discussed and narrowed as much as possible. In settings where bioethicists are not part of the hospital staff, we recommend bioethics education for psychiatrists in order to increase their knowledge and skill set with regard to bioethical theory, and the concept of healthcare values.⁷

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