Case Conference

Amy was admitted to the acute psychiatric ward of the hospital on a Sunday morning. Amy is 23 and lives in a flat with two others. She had been placed under a Compulsory Treatment and Assessment Order after being brought to the attention of the psychiatric services by a flatmate concerned about her behaviour.

Her flatmate was worried about Amy because she had in the past couple of days had several sexual partners and she thought this was out of character for Amy. When she saw Amy running naked down the street she decided to get help and rang the hospital.

Amy suffers from a bipolar disorder, for which she had been treated in the past. The psychiatric team assessed her as being manic.

Staff on Amy's ward thought it would a good idea for her to take the morning after pill as she was not on contraception and had had unprotected sexual intercourse with several partners the night before her admission.

Amy was asked whether she would be willing to take the morning after pill. It was felt at the time that, due to her manic mental state, that Amy was not competent to consent to treatment. However due to the immediacy of the need for her to take the pill and the fact that the team did not consider it was a major medical decision anyway they decided that they would ask her for consent.

Two days later Amy was still in a manic phase and was very distressed that she had been given the morning after pill. She claimed that the doctors asked her what she wanted to do when she was "not herself". As a result she claimed that the psychiatric team had "murdered her baby".

Did the psychiatric team act correctly?

Commentary One

Hugh Clarkson
Psychiatrist

The issues which arise for me in reading this story are the difficulties faced by the treatment team about which decisions to allow Amy to make and how to deal with her accusations of infanticide (an allegation so obviously false that we might expect it to need little comment) and pressuring her into consenting to this murder whilst she was ill.

Competence

The question of competence is central to the series of decisions and actions taken by those concerned in this case. Amy's flatmate decided that Amy was not competent to make decisions about her life (she was behaving 'out of character') and asked for help. 'Society' has set up legal and medical systems to respond to this situation by temporarily overriding Amy's normal rights to make her own decisions until she is back to a state where she can make those decisions for herself again. It follows that the decisions made by the psychiatric team will not be those that Amy would herself have made (otherwise there is no point to the intervention) and her objection to the decision is inevitable and her distress is not necessarily evidence for any incorrect action. It is always comforting for us if our patients come to agree with our decisions later when they have recovered but this cannot be expected to happen as a matter of course - indeed, we must take care to not deal with the discomfort we experience in coercing our patients by coercing them into approving of our actions later.

In this case it seems that no-one, including Amy herself, is questioning that she was affected by her mental illness and not able to make the kind of decisions which she usually makes when well.

The treatment alliance

Whilst Amy's distress is not in itself evidence of wrong doing it is also important to recognise that it does threaten the relationship between Amy and her carers. The longer term goal of the treatment is for Amy to accept and learn to manage her illness herself, and that requires that Amy learn how to let others help her when she is unwell. The task for the team is to keep in mind that Amy remains a 'person' with all the responsibilities and problems that entails, that we can alienate those we seek to help by exaggerating the difference between 'insanity' and 'health' and by controlling others to meet our own needs. To guard against this involves depriving Amy of her autonomy as little as possible, involving her in her own care and trying to listen to what she is trying to say. Mental illness does not necessarily render the person incompetent in all respects. On the basis of this awareness the team may have made the decision to seek Amy's consent for the contraceptive.

However we are told that the team's decision was not for these reasons but rather because 'of the immediacy of the need' and 'the fact that the team did not consider it was a major medical decision'. I suspect the team sought Amy's consent partly because they wanted her to take the tablets without being forced since physical force is both practically difficult and highly unpleasant for staff. Secondly the belief that this was not a major decision sounds like a rationalisation for significant discomfort about the issue which was not identified and emerged later in Amy's distress and accusations. This discomfort is mostly Amy's, perhaps to do with conflicts about sex and children, but in minimising the issue the team appears to be avoiding something difficult for them as well. Could this be something to do with her overt display of sexuality and their job to 'control' it? Would, for instance, decisions around the prescription of antibiotics have been handled differently?

The team do not appear to have acted incorrectly but they have not completed their job until they have tried to address these feelings with her and talked through the feelings brought up for themselves.

Commentary Two

Robin Stent
Health and Disability Commissioner

There are two issues under right 7 of the Code of Health and Disability Services Consumers' Rights. The two issues are as follows :

Was there an appropriate determination of whether Amy was, or was not, competent to make this particular decision?

Right 7 (2) states that every consumer must be *'presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent'.*

Right 7 (3) states that where *'a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence'.*

Applying these rights to the case history, we must consider whether the institution staff correctly determined Amy's competency to make a decision concerning treatment with the morning after pill. It seems that the staff did not think that Amy was competent to consent to this treatment. If this was indeed the case, they cannot simply rely on her consent to disclaim responsibility for the decision.

Rights 7 (2) and 7 (3) require the provider to show that a reasonable assessment led to a conclusion that a consumer was not competent to make a particular decision. Indeed, the actual assessment of a person's competency is a health procedure which should be performed with 'reasonable care and skill' under right 4 (1) of the Code. In Amy's case, this may have required the psychiatric team to further assess Amy to determine whether she was able to understand the ramifications of her decision. If there were reasonable grounds for the staff to conclude that Amy was not competent, to avoid breaching the Code they must take the steps specified in right 7 (4).

Were the staff making the appropriate decision for Amy?

Right 7 (4) of the Code states that :

'Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -

a) It is in the best interests of the consumer; and
b) Reasonable steps have been taken to ascertain the views of the consumer; and
c) Either, -
   (i) If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
   (ii) If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.'

For the purpose of this commentary, it is assumed that the institution took reasonable steps to find a person who was legally entitled to consent on Amy's behalf, but that the institution was unsuccessful.

Once it has been determined that Amy does not possess sufficient competence to make this particular decision, the 'best interests' test would require an assessment of the immediate clinical need for the treatment. Obviously, the fact that the pill must be given within a certain time to be effective will be of particular significance. However, a determination of Amy's clinical need for this treatment may also involve other considerations including the probability of Amy regaining competence, and the risks to her if she were to continue a pregnancy while in her current health status. Assuming the provider has taken the appropriate steps to conclude that it would be clinically desirable for Amy to have the morning after pill, he or she must still comply with the remaining obligations in right 7 (4).

If the consumer is not competent to make a particular decision, then the provider must take reasonable steps to ascertain what the consumer's opinion would have been, if he or she had been competent. What is reasonable will depend on the circumstances. For example, an assessment of whether reasonable steps have been taken will take into account emergency situations and lack of information. It may be that Amy previously made it clear that she is a 'pro-life' supporter who is against any kind of contraception or abortion. Alternatively, Amy may have been taking contraception before suffering from this recent disorder. The provider is now obliged to make these sorts of inquiries.

If there is sufficient evidence to indicate that Amy, if competent, would have refused the treatment, the provider must abstain from that treatment or seek other legal authority (for example, a court order) to over-ride her rights. This conclusion is reached because, it's in Amy's 'best interests' *and* there are reasonable grounds to believe that Amy would have consented, had she been competent.

If there is insufficient evidence to indicate what Amy's choice would have been, the decision is once again in the hands of the responsible clinician. However, the provider must still seek out, and take into account, the views of those available family, partners or friends who have a sufficient relationship with Amy to make them suitable advisers on what would be appropriate for Amy's care. The Code requires the provider to treat these views as one of the considerations in determining the appropriate course of action. At this stage, the 'best interests' test moves from the narrow clinical focus to a wider inquiry as to what would be appropriate in the consumer's circumstances. This wider focus would include considerations as to the consumer's quality of life after the treatment.

If, after taking all the above steps, the staff still consider that :

i) it is in Amy's best interests; *and either*
ii) it would have been Amy's choice if she was competent; *or*
iii) if Amy's views cannot be ascertained, the views of Amy's friends and family have been taken into account,

then the treatment can be given without fear of breaching the Code.

These procedures in Right 7 will promote the wider investigation of factors that would indicate the consumer's choice if competent, and the views of others who know the consumer better than the provider. It may also encourage consumers to discuss these types of decisions with family members, or make advance directives indicating their choice. If consumers know that providers will make these inquiries, then they may be encouraged to make preparations in advance of any foreseeable incompetency such as dementia.

Commentary Three

Respect For Autonomy is Paramount

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I will begin by defining an appropriate response for managing the concerns about the patient having been at risk for an unwanted pregnancy, based on the concept of chronically and variably impaired autonomy. I will not address management of her risk for sexually transmitted diseases including AIDS although this should not be forgotten.

To participate in the informal consent process, including in decisions about contraception, patients must first be able to attend to, absorb, retain and recall the information disclosed. The psychiatrist must provide the information to the patient in language the patient can understand and at a pace the patient can manage. The patient should understand that the decision has consequences for the future (cognitive understanding) and should be helped to evaluate those consequences on the basis of her beliefs (evaluative understanding). The psychiatrist should help the patient achieve cognitive and evaluative understanding and to communicate a decision based on these types of understanding.

In an earlier paper, we showed how patients with chronic mental illness including bipolar affective disorder may be chronically impaired in their ability to participate in one or more of these steps. In addition, in chronically mentally ill patients, this impairment may vary over time, resulting in a clinical ethical phenomenon we have termed chronically and variably impaired autonomy (1).

The variability of chronically and variably impaired autonomy calls into question that the capacity to make decisions is always absent for chronic mental patients. In other words, even should a patient be impaired in any of the steps of decision-making, she likely retains substantial autonomy. Therefore, the perception that Amy was incompetent suggests that staff viewed her competency as dichotomous. Instead, the autonomy of chronic mental patients typically falls along a continuum.

Therefore, one implication of chronically and variably impaired autonomy is that attempts at informed consent cannot be justifiably omitted. This is no less the case when a patient is under a compulsory treatment order. The standard procedure of informed consent for treatment includes presentation of the alternatives of management strategies and their possible consequences, including doing nothing, eliciting the patient's values about the alternatives, eliciting her value-based preference, and formulating an appropriate plan based on her values-based preference.

When possible, efforts to ameliorate the patient's variable impairment of autonomy should be undertaken. One possibly effective way to enhance her autonomy is to invite her to consider what is important in her life regarding the decision to be made. In this case, the psychiatrist could ask what are her feelings about possibly becoming pregnant and rearing a child. Treatment of conditions underlying the variable impairment of autonomy (eg, by initiating treatment of psychosis and agitation) may also enhance her capacity to participate in the informed consent process.

This process should be handled as non-directively as possible. The patient's impaired autonomy, in light of concerns about the possible adverse consequences of an unwanted pregnancy, might lead the treatment team to act paternalistically or to strongly influence, manipulate or coerce the patient's decision-making. This might take the form of recommending the morning after pill without informing her of the possible risks and benefits of doing so including of doing nothing. This might alternatively take the form of refusing a request to provide the morning after pill. These responses are not ethically justifiable when some substantial, even if variably impaired autonomy is violated in the process. Furthermore, the risk of an unwanted pregnancy is potentially serious, but cannot be predicted with certainty. Should she have become pregnant, risks concerning her mental health during pregnancy, pregnancy outcomes and future possible children are also unpredictable in many cases, or preventable or reversible over time (1). Thus, even should the patient be so severely impaired that she cannot meaningfully participate in decision-making, these possible risks are not sufficient to justify a paternalistic response by forcing, manipulating or coercing her into taking the pill. Psychiatrists should be especially assiduous in avoiding any possibility of coercion in her decision since she is confined to hospital and under a compulsory treatment order.

This case provides insufficient information about whether these management strategies were followed. Her response, two days after admission, suggests but does not conclusively show, that the management was problematic. Problematic management includes, as I have shown, treating her decision as authoritative without assessing whether her decision-making capacity is impaired and without seeking to enhance that capacity. Problematic management also includes paternalistic responses.

Instead, the treatment team including the treating psychiatrist has an ethical responsibility to evaluate the patient's level of autonomy and to employ strategies that ameliorate variable impairment of autonomy.

References

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