

## Ethical Issues in Obtaining Informed Consent and the Right to Refuse Treatment in the Emergency Context

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### Introduction

The practice of obtaining informed consent for treatment is part of ethical health care. The right to refuse treatment is similarly acknowledged, and both are enshrined in New Zealand law.<sup>1</sup> However there are many situations in health-care practice where obtaining an informed consent to treat or honouring the right to refuse is problematic, such as in the field of emergency health care.

My interest in informed consent and the right to refuse treatment in the emergency context is both academic and practical. Over the last 2½ years I have been studying bioethics here at the Centre, and during 1995 I was involved in a rural ambulance service as a volunteer, initially as an observer, and then as an officer. It was the tension between academic theory and the practicalities of emergency work that provoked this essay. It is within this tension that I seek to explore the ethical issues surrounding the practice of informed consent and the right to refuse treatment in the emergency context.

### A Case for Discussion

It was one case in particular that I was involved in that started my thinking. We were called urgently to someone who had been stabbed at a party, but were prohibited from treating the patient until police arrived because of the nature of the incident. They took some time to arrive which distressed his friends and possibly the patient. With police assistance we got him into the ambulance, however he resisted physically, and verbally refused treatment, also saying that he wanted get his assailant or go home (in so many words). The physical resistance and verbal refusal of treatment was repeated many times and he had to be restrained by a police officer while we took him to the medical centre to see a doctor. We (the doctor and ambulance officers) treated him as we were able and then transported him to the closest hospital (20 min. away), where he stayed

temporarily until he was transported to a base hospital (2½ hrs. away).<sup>2</sup>

The patient was a male in his twenties. He had been drinking at a party and then had an argument with an assailant. In the ensuing fight he was stabbed in the abdomen and arms. The seriousness of the wound to his abdomen (potentially life-threatening) was difficult if not impossible to properly ascertain outside a base hospital because of lack of facilities in our location. However his vital signs (level of consciousness, pulse, blood pressure, respirations) were good and stable throughout our involvement, probably due to his age and physical health.

This case raised two questions for me. First, did his refusal of our aid constitute a valid claim on the right to refuse treatment? Second, how in the situation could we have gained an informed consent to treat?

### Issues of Autonomy

The two questions are related. Both arise as issues of patient autonomy. Autonomy literally means 'self-rule' or 'self-law'. Its meaning comes from the Greek words *autos* meaning self, and *nomos* meaning law. Essentially the rights to refuse treatment and to give an informed consent recognise a patient has the right to self-

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determination - to choose for themselves what ought to be done with their own body.

An autonomous person (or patient) is someone who has the various capacities to act or decide autonomously. To decide or act autonomously is to act or decide, intentionally, with understanding, free from coercion, what to do in accordance with a self-chosen value structure.<sup>3</sup> However, a normally autonomous person may not always decide or act autonomously. Their decisions or actions may not reflect



the usage of their capacities for autonomy and therefore one can distinguish between autonomous persons and their actions.<sup>4</sup> For example, a person who is drunk may not be able to act autonomously because the capacity to understand may be temporarily diminished, although normally this person would be autonomous.

The practice of gaining informed consent before medical treatment, and the right to refuse it, are designed to protect and promote the autonomy of the patient by ensuring the choices of the patient are made autonomously. Autonomy of choice is highly valued in our society, hence it is protected and promoted by giving someone the right to refuse treatment and by gaining an informed consent to treat. Informed consent

protects and promotes positive autonomous choice, while the right to refuse medical treatment protects and promotes negative autonomous choice. Essentially a valid informed consent or a valid claim upon the right to refuse treatment are opposite choices of an autonomous patient.

For a choice to be autonomous it must fulfil a number of criteria. The person first of all must be competent and free from coercion. Second, the person must have all the information pertaining to the decision disclosed, and must also be able to understand this. Finally, a

course of action needs to be recommended and that needs to be rejected or affirmed.<sup>5</sup> The criteria for positive or negative autonomous choice depend upon the same capacities of the patient, the same obligations upon medical practitioners, and essentially identical procedures for their proper implementation or expression.

### A Discussion

Before I begin to discuss the issues the case raised, two preliminary remarks need to be made. First, patient autonomy is recognised in modern medical care since it is realised that the patient is the best person to determine what treatment accords with her values, beliefs and goals. (Even if this means the patient's life may be incidentally shortened). This is in marked contrast to the older paternalistic model of medicine, where it was thought the best person(s) to determine what is the appropriate treatment regime were the medical care-givers acting in the patient's 'best interests'. These interests were usually construed as being the protection and preservation of life, and minimisation of suffering.

Second, a respect for patient autonomy is emphasised. It is recognised that sometimes a patient will not be autonomous but still deserving of respect for what capacities she may have. In addition, it is also acknowledged that merely recognising a patient's autonomy is not sufficient, it must also be positively encouraged and facilitated. Hence the recognition in New Zealand of the right to refuse treatment and the right to give an informed consent.

The question remains that did the patient in my case make a proper claim on the right to refuse treatment? I found and still find answering this question difficult. My answer was and is ambiguous. A proper claim on the right to refuse treatment is determined by whether the patient made an autonomous choice. At the time the patient seemed to have a degree of autonomy even though he had been drinking, yet was this sufficient to justify his refusal of treatment? He knew where he was and what had happened and was determined to either go home and 'lie down', or go after his assailant. These are *prima facie*

signs of competent person, a prerequisite for making an autonomous decision. Yet I am not convinced he really understood the potential seriousness of the wound because he did not seem to listen to us or to his friends when we said it could be life-threatening. This is possibly because he did not feel in mortal danger, even though he was bleeding and in pain.

On a theoretical level it is also ambiguous. On a minimal

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interpretation of the criteria for autonomous choice, the criteria were fulfilled. He was not coerced to refuse treatment (in fact the opposite), he seemed competent, and we disclosed that his wound could be serious and the potential consequences. He apparently understood the information but ignored it and still refused treatment. However, his understanding was in doubt. If a person is acting in their own self-interest they do not usually act to shorten their life. There was no evidence that the patient wanted to end his life, in fact the opposite. He wanted to apprehend his assailant. The ambiguity arises because on a more stringent interpretation of the criteria, it is difficult, if not impossible to determine if the patient's choice is autonomous because of the possible influence of the trauma on his competence and the lack of time to properly resolve the doubts regarding his understanding.

As an aside, a minimal interpretation probably does not substantially protect and promote the autonomy of the patient, which is the *raison d'être* for informed consent and the right to refuse treatment. If the evidence and the patient's comments were taken at face value, he would not have received any medical treatment, assuming everyone (including his friends) honoured his cry to be left alone. Then he would probably have died, and considering the circumstances this would not have been the wishes of the patient. He obviously did not want treatment, but also wanted to live.

The answer to the question is that I do not know if it was a valid claim on the right to refuse treatment. However, the question that remains is did we act properly? Despite the ambiguity of the evidence I believe we did. The matter for me seems to rest on what should be the presumption to act in cases of ambiguity and doubt. It seems obvious that the presumption should be on the course of action that is more likely to protect and promote the future autonomy of the patient. In a

potentially life-threatening situation this seems to best served by presuming to treat. If one is dead, one cannot be autonomous.

The presumption to treat has two caveats. First, if the patient had autonomously decided not to have life

sustaining treatment and it can be corroborated within the time-frame of the emergency, it ought to be honoured. Alternatively if the patient had decided before an emergency not to have life-sustaining treatment it ought to be honoured. Do not resuscitate orders (made in conjunction with the patient) or living wills are examples of such a decision. However, in the Ambulance service this situation would not occur often - if at all, but would be an issue in a hospital setting. Second, if the life sustaining treatment were likely to be futile (by the clinical signs), there seems room for discretion. What is the point in initiating treatment when you know in the overwhelming majority of cases it is not going to work? For example someone who has a cardiac arrest and is in asystole when the ambulance arrives is not likely to be revived. However, treatment is sometimes initiated for the benefit of the ambulance crew (that they tried everything) or relatives (that everything was done) despite its likely futility. Opinions of what ought to be done in this type of situation varies.

Any questions regarding providing informed consent in an emergency suffers from the same problems as determining a valid claim on the right to refuse treatment mentioned in the case above. And any decision would be problematic on any substantial notion of informed consent for the reasons outlined above. The problems and issues are similar because informed consent and the right to refuse treatment are opposite poles of autonomous authorisation.

## Legal Issues in Gaining Informed Consent and the Right to Refuse Treatment

Space precludes a proper discussion of the legal issues involved regarding informed consent and the right to refuse treatment, never-the-less, a few remarks need to be made. The right to refuse treatment is enshrined under section 11 of the Bill of Rights Act 1990; and the right to give an informed consent is enshrined under right 7 of Health and Disability Commissioners (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (under the Health and Disabilities Commissioners Act 1994). However, an obligation to gain informed consent to treat and the right to refuse treatment have been acknowledged for some time under Common Law, doctors' codes of ethics and through litigation.

With respect to the right to refuse treatment the Bill of Rights states in section 11 that: 'Everyone has the right to refuse to undergo medical treatment', but this right limited by other legislation. Section 4 states that other enactments are not effected. For example one cannot refuse to have medical treatment if one comes under the Mental Health Act 1992. The legislation does not consider how this right ought to work in an emergency. The issue is left open.

With respect to the right for patients to give an informed consent the Code does not explicitly define the necessary elements required to give an informed consent, although the various rights in the Code seem to follow implicitly the model for autonomous authorisation I have outlined. The rights to be treated with respect, to freedom from discrimination, coercion, harassment and exploitation fulfil the pre-condition element of voluntariness, and the rights to effective communication and to be fully informed fulfil the informational elements, and the right to make an informed choice and give and informed consent seem to fulfil the decision elements. Significantly, what is not defined is competence. It only provides what ought to be done when a patient is not competent, but does not give any indication how competence is to be determined. It states that '[e]very 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.'<sup>6</sup> What

these reasonable grounds are is not stated. Presumably in cases of contention the notion of reasonable grounds would be tested in the courts.

Both the right to refuse treatment and the obligation to gain an informed consent to treat is grounded in the common law. Failure with respect to these are actionable either under the torts of battery or negligence. Simply speaking the tort of battery results from unconsented touching, and the tort of negligence results from the failure to fulfil or perform a duty which is reasonably expected of a medical practitioner (in this case) and from which a harm is caused and can be measured by monetary damages. With respect to an emergency, the obligations entailed to gain consent to touch, and to fulfil the duty of gaining an informed consent can be overridden with respect to the doctrine of necessity. Mason and McCall Smith in *Law and Medical Ethics* state

The basis of this doctrine is that acting unlawfully is justified if the resulting good effect materially outweighs the consequences of adhering strictly to the law...[T]he doctor is justified and should not have civil or criminal liability imposed upon him if the value he seeks to protect is of greater weight than the wrongful act he performs - that is treating without consent.<sup>7</sup>

When the doctrine of necessity applies is unclear, however, it seems obvious that in life-threatening situations, such as emergencies, it does. However, there seems to be no *a priori* method of determining necessity, so practitioners are left to act first and then suffer the consequences later if they judge wrongly.

## Conclusions

The obligations to gain an informed consent or to honour the right to refuse treatment are difficult to discharge in the emergency context. The ambiguity of what a patient means and the lack of time to resolve difficulties being important factors. Since it is almost always the case that there is doubt and a lack of time to determine what the patient would autonomously choose, there ought to be a presumption to treat. This is unless there is good evidence that the treatment is likely to be futile, or there is independent evidence confirming the patient doesn't want treatment that is available within the time-frame of the emergency.

<sup>1</sup> Bill of Rights Act 1990 (section 11); Code of Health and Disability Services Consumers' Rights 1996 (right 7).

<sup>2</sup> The hospital does not have an accident and emergency department, operating theatre, or intensive care facilities.

<sup>3</sup> T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics*, 4th ed. (Oxford & New York: Oxford University Press, 1994), p 120-187

<sup>4</sup> R. R. Faden & T. L. Beauchamp, *A History and Theory of Informed Consent* (New York & Oxford: Oxford University Press, 1986), pp 8-9, 235-94.

<sup>5</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, p 145-146.

<sup>6</sup> Right 7(2)

<sup>7</sup> J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics* (London, Dublin, Edinburgh: Butterworths, 1994), 220.

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