

Responsibly Managing Psychiatric Inpatient Refusal of Medical or Surgical Diagnostic Work-Up

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This column uses the tools of normative ethics—analysis and argument—to provide a reasoned account of and to identify ethically justified responses by the psychiatrist to psychiatric inpatients' refusal of medical or surgical diagnostic work-up. There are three relevant ethical considerations when psychiatric inpatients refuse medical or surgical diagnostic tests: balancing autonomy with beneficence, surrogate decision making and confidentiality, and managing strong feelings. Assisted decision making and assent are key management strategies for promoting patients' autonomy and for protecting against adverse consequences of decision making. (*Psychiatric Services* 61:868–870, 2010)

Psychiatric inpatients with major mental disorders are vulnerable to medical problems that require diagnostic evaluation and management, which these patients sometimes refuse. When the decision-making capacity of these patients is significantly impaired and the clinical risk of honoring their

refusal progressively increases, should such refusals indeed be honored?

Given the clinical ethical urgency of such refusals, we searched PubMed, Medline, PsycINFO, and Embase databases in order to identify the relevant literature. We used combinations of the following key words: “psychiatric,” “psychiatry,” “refusal,” “diagnostic,” “surrogate,” “confidentiality,” “ethics,” “capacity” OR “competence,” AND “diagnosis,” OR “medical testing.” Our goals for this review were to identify the clinical ethical components of refusal of nonpsychiatric diagnostic evaluation and to organize these components into a comprehensive clinical tool for responsibly managing the ethical challenges that such refusals create for psychiatrists and other physicians. We did this by using the methodology of ethical analysis and argument, which involves clarification of concepts, followed by use of those concepts to formulate reasons that together support a conclusion. The argument-based methodology of normative ethics is a systematic, disciplined process that is analogous to evidence-based clinical reasoning (1–3). The decision-making model that we propose integrates and organizes several well-recognized concepts in the psychiatry and ethics literature.

Balancing autonomy with nonmaleficence and beneficence

Mental illnesses such as major depression and psychosis and associated factors can impair a patient's autonomy, decision making, and capacity for voluntariness over the course of illness

and to varying degrees over time (4–8). One influential study found that 5%–24% of patients hospitalized for major depression had substantially impaired decision making (9). Severe depression, including depression with psychosis, can be associated with profoundly withdrawn behavior, such as unresponsiveness to requests to participate in assessment or treatment decisions, including cooperating with laboratory assessment of possible dehydration when the patient is not eating or drinking. Psychosis can also result in refusal to participate in medical assessment or treatment decisions, such as neuroimaging to rule out underlying medical conditions.

The possible effect of mental illness on decision making should be assessed and then addressed by education and treatment. For example, if dealing with a patient with depression, the physician may assess the impact of the disorder on the patient's decision-making capacity by administering the MacArthur Test for Competence to Consent to Treatment tool (10), educate the patient about how depression has impaired decision making, and consider medication options to remedy the impairments. The physician may also use educational interventions, such as corrected feedback or multiple learning trials. Organization, simplification, and repetition of key elements in consent forms might also assist in remedying deficits in decisional capacity (11,12).

When diagnostic testing is required urgently, the ethical concepts of assisted decision making and assent become important. (A box on the next page

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shows key ethical considerations in managing patients' refusal of treatment.) The process of attempting to remove impediments to autonomous, capacitated, voluntary decision making and achieve patient assent is referred to as assisted decision making. The concept of assent is distinguished from the concept of informed consent and has been developed in the pediatrics literature to acknowledge that sometimes children are not developed enough to give informed consent (for example, to understand and weigh the risks and benefits in light of values) but do have the ability to be involved in their decision making—to be told what the physician is planning and at least agree to go along with the proposed procedure (13). Assent attempts to respect and bolster a patient's autonomy by involving the patient in treatment decisions as much as is appropriate given the patient's mental or developmental capacities.

Beneficence and nonmaleficence, which along with autonomy are important ethical considerations and professional obligations, call for an assessment of the clinical seriousness of the issues at stake, along with the clinical consequences and outcomes of the proposed diagnostic test and follow-up intervention (see box) (14). They also require consideration of the degree of intrusiveness of the proposed diagnostic test. The consequences for the staff, family members, and other patients of witnessing or performing a diagnostic test with an unwilling patient are also ethically significant (15,16). As the issues at stake become more life threatening, serious, or potentially irreversible, obligations of beneficence may outweigh the patient's expressed decision (17). For example, a depressed inpatient who is only periodically eating and drinking is probably not yet in grave enough danger to justify an unwanted and forced blood draw for an electrolyte panel. On the other hand, an inpatient who is noted to have an asymmetric unilateral weakness may warrant urgent head imaging to rule out a stroke or a tumor. The example of head imaging is an important one, because it is not uncommon for psychotic patients to find this procedure particularly disturbing and to refuse it. Although head imaging itself is minimally invasive, if sedation

were needed for the procedure, the level of invasiveness would be greater.

Surrogate decision making and confidentiality

If the patient's ability to meaningfully participate in the decision to undergo testing remains impaired despite attempts to bolster it through education and medication and if the treatment team has a reliable evidence base for the clinical judgment that the issues at stake are very serious and urgent, then the team is faced with an imperative to make a decision. When a decision has to be made but the patient lacks decision-making capacity despite attempts to restore it, the ethical mandate is to exercise "substituted judgment" in deciding what the patient would want if he or she were capacitated (18). This mandate is usually fulfilled by a surrogate decision maker, because it is as-

sumed that the surrogate will know the patient's wishes better than the physician will. The surrogate decision maker is either someone named by the patient as legal health care proxy, someone appointed by the court as the patient's guardian, or in the case where no such legal designation has been made, the patient's next of kin (the usual order being spouse, majority of adult children, parent, and then sibling). Although surrogate decision making is not without its problems (19), the aim is that the surrogate will exercise judgment on behalf of the patient, deciding what the patient would want were he or she capacitated and hence exercising the patient's autonomy by proxy (18).

Inpatient psychiatric treatment, however, raises concerns about confidentiality in obtaining a surrogate. There is an ethical mandate (and often a legal mandate) to seek consent from

Ethical considerations in managing psychiatric inpatient refusal of medical or surgical diagnostic work-up

Autonomy

An ethical principle that obligates the physician to provide the patient with information needed to make decisions, to support the patient in the decision-making process, and unless there are compelling reasons to the contrary, such as impairments in decision-making capacity, to implement the patient's decisions

Decision-making capacity

Ability to understand, appreciate, and reason about the information given (including diagnosis, prognosis, and risks and benefits of proposed treatments) and to communicate a treatment decision

Capacity for voluntariness

Ability to reflect on and decide in accordance with one's authentic sense of what is right, good, or best in the context of one's history, values, and situation. To be determined by considering developmental factors; illness-related factors; psychological, cultural, and religious factors; and external pressures

Beneficence

An ethical principle that obligates the physician to provide clinical management that is reliably expected to result in a greater amount of clinical goods over clinical harms for the patient. Components to weigh include the seriousness of the medical issues at stake and the invasiveness of the diagnostic testing.

Assisted decision making and assent

A key strategy constituting attempts to remove any existing decisional impairments by both education and psychiatric treatment, followed by attempts to persuade the patient to assent to, or go along with, proposed diagnostic procedures

Standards for surrogate decision making

Standard 1: substitute judgment, based on a reliable account of the patient's beliefs, values, and preferences. Standard 2: the patient's best interests, such that when substituted judgment is not achievable, the surrogate makes a beneficence-based judgment

Right to confidentiality

Especially important in psychiatry; may limit the use of the substituted judgment standard for surrogate decision making while the patient is in the psychiatric inpatient unit

Management of strong feelings

Management of emotions in order to preserve professional, evidence-based judgment and behavior on the psychiatrist's part

the psychiatric patient before contacting and talking with the patient's family members. The American Psychiatric Association states in its ethics manual: "Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care" and "A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion" (20). Should the patient refuse to allow contact with the family in order to obtain substituted consent for the proposed diagnostic test, a "best interests" standard may apply (19). Of course, in cases of conflict between confidentiality and a true medical emergency, the latter prevails.

Professionalism and managing strong feelings

It is natural that when psychiatric inpatients refuse proposed diagnostic and surgical work-ups, a sense of worry and foreboding about the safety of the patient and a sense of frustration about the patient's lack of cooperation will arise. Such strong feelings have the potential to unhinge thoughtful clinical judgment and to lead clinicians to dishonor the weight of a patient's decision to refuse physical and laboratory examinations for the present situation and to force compliance with diagnostic testing. Alternatively, such feelings could also lead clinicians to neglect the care of their patients by accepting their stated preferences to refuse testing without further evaluation of possible impairments to decision making and without helping the patient overcome these impairments. The physician's response to such strong feelings should at first include recognition of their potential for the clinical team to attempt to unduly control the patient's decision making.

Risk to the patient and the appropriate balance of respect for autonomy and obligations of beneficence to the patient should be thoughtfully judged in collaboration with colleagues from other relevant specialties. Perhaps one of the most difficult cases is when a psychiatric inpatient is pregnant and refuses examination and diagnostic work-up (because of psychotic denial of pregnancy) and when the psychiatrist must balance beneficence-based obligations to the fetal patient and au-

tonomy- and beneficence-based concerns for the pregnant patient (21). Concern about the influence of emotions on professionalism is meant not to validate emotional detachment but to remind clinicians that a model such as ours can be useful in helping them reason through strong feelings and countertransference that can unhinge thoughtful judgment.

Conclusions

The issue of decision making about diagnostic testing for nonpsychiatric conditions by psychiatric inpatients with impaired decision-making capacity is of great clinical relevance. Assisted decision making, consisting of attempts to remove any existing decisional impairments by both education and psychiatric treatment, and the use of assent are key components for managing patients' refusal of diagnostic testing. Respecting the patient's autonomy should be balanced by beneficence-based considerations that depend on the potential seriousness of the medical condition, intrusiveness of the diagnostic test, and the consequences of testing for the patient, other patients, staff, and family members. When patients are unable to consent or assent for testing, the surrogate decision-making standard should apply, in balance with managing confidentiality. Psychiatrists should also manage the strong feelings that can arise when patients refuse diagnostic testing so that thoughtful evidence-based decision making is not undermined.

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