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### **Ethical Issues: Treating Patients Without Permission**

Medical ethics is grounded by the notion that we must always respect the patient's right of self determination, which means that we should inform patients about what needs to be done and seek permission before doing it to them.(1) But, what about those situations when consent is unobtainable, or when the patient wants something done that may be unnecessary or unreasonably harmful to them or to others? The tenets of medicine inform us that if action is needed but consent cannot be obtained, such as in an emergency, there is a presumption that the patient or victim would want us to treat them as long as the intervention is rational and not unduly risky. Rarely, in emergency situations, do health care providers pause to ask; "Should I do this?" When experience and knowledge support an action that seems reasonable, and because we are trained to act, we tend to act and ask questions later. That's what we're supposed to do...

In health care there is a "rule of rescue" that defines right action when persons are acutely ill or injured, which drives us to treat first and ask questions later, especially when a life is at stake. (2) Whether this is considered benevolent paternalism, or prudential professionalism, most insist that when any patient voluntarily walks through the door there is an implied request and need for help, explicit or not. The greater challenge, however, is when patients are brought to us involuntarily, such as following a suicide attempt, in a state of impaired mental capacity, or through coercion by family members or other caregivers. These are times when patients, who don't themselves seek help, find themselves in our midst, sometimes quite ill, and often feeling abused by what is being done to them. Patients with the ability to fully express their autonomy in these circumstances have the right to refuse treatment, and we have the obligation to respect that decision. But, it's not always quite that simple.

What of lucid patients that seem to understand their circumstances but in our judgment still make irrational and harmful choices? These folks are often deemed to have "questionable" decision making capacity because of the irrational nature of their decisions, so we look determine the cause(s) of their incapacity and often treat them anyway, regardless of their degree of lucidity, because it would be irrational not to do so. This scenario plays out daily in the acute care setting.

For the most part, clinical situations that ethically and legally justify involuntary treatment apply to psychiatric illness or other states of impaired mental capacity. (3) Involuntary treatment policies, such as the "96 hour hold" and those for chemical and physician restraint, have been designed to protect individuals that, due to mental illness, are not autonomous and therefore need to be protected from

their own irrational behavior. Restraint policies explicitly state that physical or chemical restraints are only to be used to prevent harm to the patient or to others. (4) The implication is that such maneuvers be used only if the patient is confused or otherwise of diminished capacity. Such maneuvers cannot, therefore, be used when patients “of sound mind” are simply refusing what we feel is reasonable treatment.

The “96 hour hold” policy, which essentially imprisons the patient in the hospital for 4 days, only applies in the face of psychiatric illness with potential harm to self or others, and therefore must have a psychiatrist directing their care for it to pertain legally. The ethical dilemma is that when a patient is refusing life saving treatment and is of diminished mental capacity, but is as yet not under the direct care of a psychiatrist (ie: patients refusing treatment following a drug overdose or with anorexia nervosa) clinicians must still find a way to treat these patients, recognizing the risk of litigation and ethical precepts that both require it.

Treating fully informed patients who have full decision-making capacity against their wishes is rarely, if ever, justified. Involuntary emergent treatment of patients who have questionable capacity is an ethical and legal quagmire that is yet to be resolved. Yet, in the midst of this physicians and other health care providers must follow their conscience and are obligated to do all they can to ethically and legally act in the best interest of their patient. While often mired in a quagmire of ill definition, we can be helped by utilizing the support mechanisms available to assist in these decisions, but act we must, often with full recognition of the risks at hand...for the sake of the patient.

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4. Hope T. Rationing and life-saving treatments: should identifiable patients have higher priority? *J Med Ethics* 2001; 27:179-185
2. Hoge SK, et al. A prospective, multicenter study of patients' refusal of antipsychotic medication. *Arch Gen Psych*. 1990; 47(10): 949-956
3. UMHC Policy Number I-B-10. Patient Restraint and Restrictive Practices.