Systems and Ethical Issues in CL Psychiatry: Hospital as a Social System, Sick Role and Doctor Role, Ethical and Legal Issues

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Contents

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10.1 Vignettes

1. A 67-year-old woman with a hip fracture was referred to the psychiatrist, as she wished to leave the hospital against medical advice prior to surgery. The patient was described as being hostile, agitated, and irrational by the nursing staff. On interview, the patient insisted that she had to go home, but upon further questioning, it was found that the patient lived alone with three cats, and she was concerned about not being able to care for the cats. When the consultant called the social worker, she was unaware of the patient's concern about the cats, as she had only asked whether the patient had a home and family (human family!). The consultant explained to the nursing staff why the patient was so agitated: she was worried about her cats. They empathized with her concern. The social worker was able to contact a sister who lived in another city, who was willing to care for the cats while the patient was in the hospital. The patient was now willing to stay and have the necessary surgery.
2. An urgent psychiatric consultation was requested for a 47-year-old man with suspected coccidioidomycotic meningitis to evaluate his capacity to refuse a lumbar puncture. On examination, the patient was found to be mildly delirious, but he understood that the doctors wanted to put a needle into his spine to get fluid to help treat him. However, he was

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sure that he would be OK without the test as he had trust in God. The consultant contacted his wife, who turned out to be quite supportive, and was willing to try to persuade him to undergo the procedure as well as to sign the consent form as next of kin.

3. A 54-year-old woman was referred to the psychiatrist for "declaration of incompetence and institutionalization." She was admitted to the hospital with chest pains, and a myocardial infarction was ruled out. The referring physician stated that she had received a call from a psychiatrist working for the patient's managed care company, who stated that the patient should be certified by the hospital to be placed in a nursing home facility. On examination, the patient had no evidence of delirium, dementia, or any other psychiatric condition. The patient stated, however, that she had been previously "harassed" by a psychiatrist hired by the managed care company. The consultant called the managed care psychiatrist, who insisted that the patient was "subtly delusional and paranoid," which becomes manifest only when she is repeatedly confronted. On further discussion, the managed care psychiatrist confided that the patient was a drain in resources for the company as she had frequent presentations to the emergency department with chest pains, and that she would be better cared for in a nursing home under psychiatric certification for inability to function independently. Having no basis for such certification at present, and unwilling to "confront the patient repeatedly," the consultant refused any further intervention.
4. A 34-year-old man was admitted for pneumocystis pneumonia associated with AIDS. A psychiatric consultation was requested because the patient appeared depressed and expressed suicidal ideation. The nursing staff also stated that the patient's partner, who was always at the bedside, made disparaging remarks about the care the patient was receiving. Through an interview with the patient and his partner, the consultant found out that they had recently moved from another city because the partner's job was transferred, and that the patient and his partner had had a long-standing relationship with the health care system of their former city. As the patient fell ill, they did not have an opportunity to build a social support system in the new city. The consultant provided the patient's partner with contact information for gay and HIV support groups in the community, and restarted the fluoxetine that the patient was receiving previously but that had run out. The patient recovered uneventfully, was discharged, and has outpatient appointments with a psychiatrist who is associated with an HIV clinic.

10.2 Overview

The consultation process occurs in a social system. As we discussed in Chap. 3, the request for consultation usually arises as a result of a strain in the system around the patient, consisting of the doctors, nurses, allied health professionals, health care organizations, as well as the patient's family, friends, and, at times, social agencies.

To relieve the strain that led to the consultation, then, it is necessary to recognize the state of the social system around the patient. While treatment of the psychiatric condition that the patient manifests, such as depression or suicidal ideation, may often be sufficient to reduce the strain (i.e., anxiety of the nursing staff about a patient committing suicide on the floor), the most efficacious way to intervene to reduce such symptoms may be directed to the social systems as well as the individual patient (as in vignette 4).

10.3 The Hospital as a Social System

A general hospital is a complex organization with complex lines of authority and loyalties. The people who are found in a general hospital can be generally classified as follows:

1. Administrators
   (a) Health-care related (e.g., chief of staff, director of nursing)
   (b) Non-health-care related (e.g., CEO, CFO, director of food service, laundry)

2. Doctors
   (a) Employed by the hospital, medical school, or medical group (house staff, full-time attendings, hospitalists, etc.)
   (b) Not employed by hospital or medical school or medical group (visiting staff, consultants, etc.)
   (c) Medical students
3. Nurses
   (a) Registered nurses
   (b) Other nursing staff
   (c) Nursing students
4. Allied health care professionals (pharmacists, social workers, psychologists, etc., and, in some institutions, their trainees)
5. Non-health-care professional workers (housekeeping, food services, engineers, security, etc.)
6. Patients
7. Patient's visitors
8. Police/prison guards accompanying patients
9. Emissaries of regulatory agencies, auditors, etc.
10. Members of organizations that may encompass or interact with the hospital, e.g., county or city (for a municipal hospital), a for-profit or voluntary nonprofit health (managed) care company (e.g., Humana, Kaiser), a religious organization (e.g., Sisters of Charity, Roman Catholic Church), and/or a health sciences professional school (e.g., medical, nursing, psychology, dental, pharmacy school)

It is obvious that the mission and loyalties of the hospital community would be affected by the organizational structure and reporting relationship of the hospital administration. As an organization, a municipal hospital may be conflicted between its mission to serve as many of the underserved patients as possible and the mandate from the city government to cut costs or close down and the pressure from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) to improve its patient care and facilities.

The physicians generally have a separate line of authority from the hospital administration with concomitant autonomy in medical decision making; that is, physicians report to physicians. There are certain exceptions in managed care organizations and government agencies such as the Veterans Administration (VA) hospitals. The nursing hierarchy, on the other hand, is generally directly responsible to the hospital administration. In the hospital hierarchy, the physicians are usually near the top, followed by RNs and allied health professionals, and at the bottom is the patient. One can often distinguish a person's status in the hierarchy by the attire: the administrators are the ones in suits and ties, the attendings are in long white coats, house staff in their respective uniforms, nurses in theirs, and dietary staff and janitors in theirs. The uniform for patients is the exposed and vulnerable hospital gown, befitting their lowly, vulnerable position. The professional hierarchy in the hospital is unbridgeable through merit promotions. A patient cannot be promoted to janitor, a janitor cannot be promoted to practical nurse, a practical nurse cannot be promoted to registered nurse, and a registered nurse cannot be promoted to physician. To get promoted to another level, one must obtain the necessary educational qualifications. The hierarchy, therefore, is rigid. A side effect of this rigid hierarchy is a tendency for segregation along professional lines. Doctors generally talk to doctors, nurses to nurses, dietitians to dietitians, except when they are dealing with patients. Therefore, the lack of cross-discipline communication can become a problem for a patient (as in vignette 1).

The lack of power patients experience in the hospital often translates into timidity in asking questions, and in an increase in anxiety and sensitivity that accentuates the patient's defense mechanisms, personality characteristics, and sometimes suspiciousness and paranoia. The psychiatric consultant can help by forming a bridge between the patient and the health care personnel (the *liaison function* of consultation-liaison psychiatry), by encouraging patients to ask questions, and by encouraging staff members to respect the patient's autonomy as much as possible.

10.4 The Sick Role and the Doctor Role

A person who is ill undergoes a change in society's role expectations. Talcott Parsons (1951) described the *sick role* as consisting of two rights and two

responsibilities: the right not to be held responsible for being sick; the right to be exempt from normal social role expectations, such as going to work or school; the responsibility to consider the state of being sick to be an undesirable state; and the responsibility to seek competent help to get well. As one is not considered to be responsible for being sick, there is the general expectation that the society has a responsibility to aid the sick. The society (or a smaller unit, such as a company or an organization) defines what the limit of role exemption (e.g., sick leave) is and what competent help means (e.g., licensing of physicians).

The sick role expectations described by Parsons obviously do not apply to a number of medical conditions, such as chronic disability and behavior-induced conditions such as lung cancer (smoking) or certain cases of HIV/AIDS (unprotected sex). The expectation that being sick is undesirable is challenged when a patient has entitlements because of the fact of being sick, as in VA and other compensation cases in which the patient's livelihood depends on being sick. Entitlements such as these often result in conflicts with physicians, who expect patients to adhere to the sick role expectation of wanting to get well. A latent dimension in such cases is a values conflict: physicians universally are imbued in the work ethic through their medical training, and cannot understand or condone patients whose livelihood depends on an unearned or arbitrarily defined entitlement. Such value conflict often results in a request for psychiatric consultation for suspicion of "psychogenic" symptom or frank malingering.

Parsons also described *societal expectations of physicians,* which include technical competence, functional specificity (confining their work to the practice of areas of medicine in which they have been trained), universalism (treating all patients who seek treatment), affective neutrality (not being overinvolved emotionally), and collectivity orientation (all in the best interests of the patient—a fiduciary relationship). Current managed care environment directly conflicts with several expectations of the classical doctor role, such as treating all patients (only treat patients belonging to the particular health plan), and in the best interest of the patient (which may conflict with the economic interest of the doctor and the organization if it involves extensive workup or expensive treatment). Such strain may be directly responsible for some psychiatric consultations (as in vignette 3).

10.5 Psychiatric Consultation and Social Systems

10.5.1 Theoretical Considerations

A number of observations have been made concerning social systems approaches in psychiatric liaison settings in which the consultant is also a participant observer of the social system of a particular unit, such as hemodialysis.

A general systems approach is usually applied by psychiatric consultants, often implicitly, when they consider the patient's biologic state, psychological state, and the social and physical milieu that might contribute to the patient's distress or comfort.

Considering the group processes of the staff of a medical unit, one might consider Bion's (1961) approach to operational groups based on his experiences at the Tavistock Clinic in London. Bion conceptualized two different aspects of a group process: the *work group* and the *basic assumption group*. The work group represents the mature, responsible, rational task-oriented aspect of the group. The basic assumption group is the unconscious aspect of the group in which it behaves as if it held certain assumptions about itself, its work, and its leader. The basic assumption group may either enhance or reduce the effectiveness of the work group. There are three commonly observed basic assumption groups: dependency, fight–flight, and pairing. The basic assumption dependency group feels helpless, needing to be led by an idealized omnipotent leader. This assumption could augment the effective functioning of a hospital unit by reifying the physician's role and decreasing physician–nurse conflict. The fight–flight group is in constant readiness to act, avoiding passivity, introspection, and reflection. It awaits only its leader's choice of action and then fulfills that choice.

The pairing group accepts the current situation that must be endured until the ideal, perfect leader arrives, who might be procreated by the pairing of two of the group members. Then, all troubles will disappear. Such unconscious belief could maintain the effectiveness of a nursing unit dealing with insufferable house staff members or attending physicians (who, the nurses hope, would rotate out) (Mohl 1980).

Another application of social systems in consultation-liaison psychiatry is A.K. Rice's model, emphasizing the open system, organizational boundaries, primary task, division of labor, and delegation of authority. An open system is one that must interact with the external environment. The consultant can diagnose the problems in the open system, and intervene at different points of the system, including the boundary management (vignette 1), the input (vignette 4), throughput, and output systems (Glazer and Astrachan 1979).

Group culture, based on Kurt Lewin's field theory, is an important consideration in understanding the social systems that produce a psychiatric consultation. Group culture consists of shared norms, beliefs, and role definitions. The consultant should be cognizant of the "mythology" of a unit, and should it be incompatible with the patient's current status (e.g., "A patient in this unit *never* dies without heroic efforts on the part of the staff"), then a transfer may be in the best interest of the patient (Karasu and Hertzman 1974). Consultation-liaison psychiatry can also be conceptualized as a commodity in a marketplace (Guggenheim 1978). Guggenheim conceptualizes the liaison psychiatrist as an "ambassador" and "salesman," with the consultation being the product. The consultee is the consumer of this product. As with any other product, effective merchandising and marketing are essential for success. Guggenheim likens the initial negotiation with the primary physician to the research and development phase of production. Patient evaluation and formulation of a therapeutic plan are comparable to the manufacturing phase, and the implementation of the plan and evaluation of outcome are comparable to the marketing phase. The goals are to gain acceptance of the product (implementation of the treatment plan) and to stimulate repurchase (further request for consultation on other patients). When one considers psychiatric consultation as merchandise in a marketplace, such issues as advertising and packaging, usually not in the forefront of the consultation psychiatrist, require careful attention (Mohl 1981).

10.5.2 Practical Considerations

An understanding of the social context in which a psychiatric consultation occurs is critical in the successful implementation of the consultation process. The consultant functions in various roles, as a physician, an educator, and a link with other physicians, professionals, and systems (e.g., health care systems, family, work, law enforcement, courts, social agencies). The consultant also serves an administrative function in clearing for discharge or transfer a patient who attempted suicide or declaring a patient to be competent/incompetent to consent to a procedure. The consultant may also be a link, if only in recommending them, to such community resources as psychiatric treatment facilities, halfway houses, board and care homes, and homeless shelters.

The consultant begins the process of systems intervention through the *operational group* described by Meyer and Mendelson (1961), consisting of the doctor, nursing staff, social worker, and patient's family. Based on the assessment of the situation by the consultation, the consultant then plans intervention strategies in the biologic, psychological, and social dimensions of the patient. For the social dimension, the consultant should select the most useful strategy of intervention, considering the various theoretical models described.

10.6 Ethical and Legal Issues in Consultation Psychiatry

The consultant often encounters questions concerning medical ethics and legal issues in the course of psychiatric consultation. Such issues include the patient's capacity to consent to or refuse procedures, the patient's capacity to sign out against medical advice, advance directive

issues, requests for assisted suicide, as well as requests for involuntary psychiatric hospitalization from the medical staff or family.

10.6.1 Medical Ethics and Bioethics

The foundations of medical ethics may be traced to the Hippocratic Oath of antiquity. The first code of medical ethics, *Formula Comitis Archiatrorum*, was published in the fifth century, during the reign of the Ostrogothic king Theodoric the Great. Thomas Percival, an English physician and author, published the first modern code of medical ethics, which was expanded in 1803, in which he coined the terms, medical ethics and medical jurisprudence (MacDouball and Langley 2013).

In 1847, the American Medical Association adopted its first code of ethics, based in large part upon Percival's code of ethics.

In the twentieth century, following the revelation of Nazi atrocities with "medical research" performed by physicians during the Nuremberg war crimes trials, the presiding judges created the Nuremberg Code to define international standards for ethical use of human subjects. Concerned physicians founded the World Medical Association, whose "Declaration of Geneva" included clauses that stated: "I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient" (World Medical Association 1949)

Since 1960s and 1970s, technological developments in medicine and biological sciences resulted in an explosion of ethical issues and dilemmas such as in organ transplantation, hemodialysis, cloning, recombinant DNA, gene therapy, electronic medical records, etc. The term, bioethics, is generally used to address the greatly expanded field of human inquiry concerning ethics and biological sciences (Crowley 2008).

10.6.2 Values in Medical Ethics

Beauchamp and Childress proposed four principles in medical ethics in their textbook, *Principles of Medical Ethics* (2001). They are

1. Respect for autonomy—the right to refuse or choose their treatment. (*Voluntas aegroti suprema lex*.)
2. Beneficence—a clinician should act in the best interest of the patient. (*Salus aegroti suprema lex*.)
3. Non-maleficence—"first, do no harm" (*primum non nocere*).
4. Justice—in the distribution of scarce health resources, and in the decision of who gets what treatment (fairness and equality).

In addition, the following values are generally accepted in medical ethics:

5. Respect for persons—the patient (and the person treating the patient) have the right to be treated with dignity.
6. Truthfulness and honesty—the concept of informed consent in view of the historical events of such as the Nuremberg trials on medical experimentation and Tuskegee syphilis experiment (The Dark History of Medical Experimentation from the Nazis to Tuskegee to Puerto Rico http://www.democracynow.org/2010/10/5/the_dark_history_of_medical_experimentation)

10.6.3 Issues on Autonomy, Informed Consent, Advance Directive, Competency, and Capacity

The principle of *autonomy* is rooted in the belief that individuals have the ability to make informed decisions about personal matters. Autonomy in the medical setting has become more important as social values have shifted from "paternalistic medicine" where the medical professionals' views were paramount to defining medical quality in terms of outcomes that are important to the patient. Respect for autonomy is the basis for *informed consent* and *advance directives*. In general, autonomy is an indicator of good health as the ability to exercise autonomy is often compromised in serious illness. Consultant psychiatrists are often asked to evaluate a seriously ill patient's competency and/or capacity to make life and death decisions. *Competency* is a legal term, and any adult is

considered legally competent unless a Court pronounces the person incompetent. Thus, the consultant psychiatrist *does not* determine competency. The Consultant can, however, render an opinion concerning a patient's *capacity* to make specific decisions. When a patient is seriously mentally ill to the extent that they are unable to live independently or make decisions concerning their treatment, or when a patient has advanced dementia and thus lacks basic decision making capacity, the psychiatrist may petition the court to declare the patient *incompetent*, and assign a conservator for the patient. Such a conservator may be for limited decision making, such as financial affairs, or may be for the person. Psychiatrists may also be required to make decisions in depriving patient's autonomy through emergency holds, involuntary hospitalizations, and involuntary treatments.

Beneficence, considering patient's interests first, is a core value in medicine. It may, however, be subject to modification when a particular patient's interest (such as a scarce and expensive treatment) conflicts with justice that posits an equitable distribution of resources to patients in need (which may be codified by law, institutional policy, or insurance, such as non-reimbursement of a life-saving transplantation surgery).

Non-maleficence is also a core value in medicine, but many medical treatments and drugs have both beneficial effects as well as harmful side effects. An example of this is *double effect*, in which a drug (or treatment) such as a powerful narcotic analgesic may alleviate terminal cancer pain in adequate doses (beneficence), but it may simultaneously cause respiratory arrest and death (contrary to non-maleficence).

Autonomy, beneficence, non-maleficence, and justice may in certain situations conflict with one or more of the other values in difficult ethical decisions. Involuntary hold, hospitalization, and the double effect have already been mentioned. In addition, end-of-life care, euthanasia, assisted suicide, in vitro fertilization, abortion, paid organ transplantation, genetic testing are only some of the known areas of ethical controversy.

10.6.4 Issues Relating to Consenting to or to Refuse Treatment, or Placement, or to Sign Out Against Medical Advice

When these issues arise, the consultant should consider the following points:

1. Often, ethical and legal issues arise because of a lack of communication/understanding between the patient and the medical staff (as in vignettes 1 and 4). The consultant can be a catalyst in opening avenues of communication and understanding. The patient's significant other, family, or a friend may be able to persuade the patient to follow medical recommendations.
2. When a patient has diminished mental capacity, always try to obtain the consent of the next of kin. As a hospital lawyer remarked, "Think of who might sue you if something goes wrong, and have that person sign the consent form."
3. When a capacity evaluation is requested, the first question should be "Capacity to do what?" The capacity to consent to a medically indicated procedure should have a lower threshold than that for refusing a potentially life-saving procedure. In general, the following questions should be asked for capacity/competence evaluation concerning informed consent:
   (a) What information was given to the patient, and how much information has the patient retained?
   (b) What is the patient's understanding of the nature of the illness?
   (c) What is the patient's understanding of the risks and benefits of the proposed treatment or treatment alternatives?
   (d) What are the possible consequences of treatment refusal?
4. The consultant does not determine *competence*. A patient is presumed to be competent unless declared otherwise by a judge. A consultant can, however, render a professional opinion concerning whether the patient has the capacity to make the decision.

5. The ethics committee of the institution is usually available for difficult cases, and the consultant should recommend referral to it when indicated. The ethics committee can often untangle ethical dilemmas by bringing the patient, family, and hospital administration together. It can also "bless" a medically indicated course of action.
6. The consultant should have an open line of communication with the institution's legal counsel and risk management and consult them as indicated.

10.6.4.1 Capacity to Live Independently

Adults are presumed to be capable of living independently unless declared incompetent by a court. Generally, patients who show moderate to severe dementia may be incapable of living independently unless help is provided. Such help may be found in families, relatives, and friends as well as assisted living facilities without the patient being declared incompetent. Some patients may become temporarily and repeatedly delirious due to poorly controlled chronic conditions such as diabetes mellitus, and may require hospitalization for the acute metabolic crisis. Once the delirium clears, however, the patients may exhibit no or minimal dementia. It may be in such patients' interest to be placed in a supervised facility, but repeated episodes of delirium per se is not sufficient reason to declare a person permanently incompetent. For such patients, the consulting psychiatrist may render the opinion that the patient lacks the capacity to leave the hospital or refuse treatment while delirious, and recommend obtaining consent from next of kin temporarily. Even relatively brief periods of independent living may provide a superior quality of life to nursing home placement.

10.6.4.2 Testamentary Capacity

The criteria for the testamentary capacity, that is, the capacity to draw up a will, require that individuals are rational and cognizant at the time they draw up the will, and consist of the individuals' understanding or being aware of the following:

1. The nature of the act, i.e., a will is being written
2. The nature and extent of their estate or property
3. Who would inherit the property if no will has been drawn, i.e., who might reasonably have a claim to the property
4. To whom and in what manner they are distributing the estate

10.6.4.3 Involuntary Hold, Hospitalization, and Treatment

Most states allow an involuntary hold of a person for psychiatric reasons, usually up to 72 h, usually for being a danger to self or a danger to others, or for grave disability. Depending on the jurisdiction, such emergency certificate may be executed by one or more psychiatrists, physicians, psychiatric clinicians, emergency medical personnel, etc.

Some states allow patients in general hospitals to be held involuntarily on an emergency certificate for psychiatric treatment. Danger to self or others generally means clear and imminent danger, and grave disability is confined to being unable to provide basic food and shelter. Psychotic symptoms per se, such as hallucinations or delusions, are not sufficient grounds for emergency certification.

In many states, psychiatric patients may be given medications involuntarily in emergencies and under certain non-emergency circumstances. Often a judicial process such as a court hearing is required for such involuntary use of psychotropic drugs.

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