

---

# Ethical Framework to Guide Decisions of Treatment Over Objection



David Fischkoff, BBA, Kenneth Prager, MD, Joyeeta Dastidar, MD, Lydia Dugdale, MD, Gerald Neuberg, MD, Samantha Nemeth, MA, MPH, Katherine Fischkoff, MD, FACS

---

- BACKGROUND:** Whether to proceed with a medical intervention over the objection of a patient who lacks capacity is a common problem facing practitioners. Despite this, there is a notable gap in the literature describing how to proceed in such situations in an ethically rigorous and consistent fashion. We elaborate on the practical application of the 2018 Rubin and Prager 7-question algorithm for ethics consultations about treatment over objection and we describe the impact of each of the 7 questions.
- STUDY DESIGN:** We retrospectively review a series of consultations at Columbia University Irving Medical Center between April 2017 and May 2020 for treatment over objection in adult patients determined to lack capacity. Outcomes about the final ethics recommendation and the assessment of each of the 7 questions are reported. The statistical analysis was designed to determine which of the 7 questions in the algorithm were most predictive of the final ethics recommendation.
- RESULTS:** In our series, there was an ethics recommendation to proceed over the objection of a patient in 63% of consultations. Although all 7 questions were considered to be important to the ethical analysis of a patient's situation, the presence of logistical barriers to treatment and the imminence of harm to a patient without treatment emerged as the most significant drivers of the recommendation of whether to proceed over objection or not.
- CONCLUSIONS:** Cases of treatment over objection in a patient lacking capacity are frequently encountered problems that require a careful balance of patient autonomy and a physician's duty of beneficence. The application of the Rubin and Prager 7-question algorithm reliably guides a care team through such a complex ethical dilemma. (*J Am Coll Surg* 2021;233:508–516. © 2021 by the American College of Surgeons. Published by Elsevier Inc. All rights reserved.)
- 

When deciding whether to proceed with a medical intervention over the objection of a patient determined to lack capacity, ethical considerations are of paramount importance. Although there are several tools used by clinicians to assess a patient's decisional capacity,<sup>1</sup> there is scant literature describing a thorough decision-making algorithm about whether or not to treat incapacitated patients over their objection.

The need for a framework to manage decision making in the setting of a patient without capacity is highlighted

by the fact that such patients are frequent in the inpatient setting.<sup>2</sup> Reviews of inpatient psychiatry consultations show that up to 25% of consultations in hospitals involve patients' capacity to make treatment-related decisions.<sup>3</sup> Lack of capacity is common among patients with underlying psychiatric disorders, substance abuse, dementia, and acute illness.

Importantly, patients who lack capacity do not automatically forfeit their autonomy. When a patient is unable to participate in the process of informed consent, a rigorous and consistent approach must be taken to protect his or her best interests and act ethically. In a 2018 article based on extensive clinical experience, Rubin and Prager<sup>2</sup> suggest such an approach to the questions of when and to what extent medical treatment can be administered against the wishes of such a patient. They recommend asking a structured series of 7 core questions when presented with such a case (*Fig. 1*) to produce ethically sound and reproducible decisions. Although most ethics

**Disclosure Information:** Nothing to disclose.

Received April 20, 2021; Revised June 15, 2021; Accepted July 2, 2021.  
From the Division of Medical Ethics (Fischkoff, Prager, Dugdale), Department of Medicine (Prager, Dastidar, Dugdale, Neuberg), Center for Innovation and Outcomes Research (Nemeth), and Department of Surgery (Fischkoff), Columbia University Medical Center, New York, NY.

Correspondence address: Katherine Fischkoff, MD, FACS, Department of Surgery, Columbia University Medical Center, 177 Fort Washington Ave, 7GS-313, New York, NY 10032. email: [kf2403@cumc.columbia.edu](mailto:kf2403@cumc.columbia.edu)

consultants likely already consider many of the questions that make up the 7-question algorithm, the Rubin and Prager article was the first of its kind to attempt to standardize and disseminate a structured approach to such difficult decisions.

We review ethics consultations at our institution about patients without capacity to determine the utility and applicability of the Rubin and Prager<sup>2</sup> approach to a consecutive series of patients. We also seek to describe whether any particular question carries more weight than others when making a decision.

## METHODS

### Clinical ethics consultation at our institution

Columbia University Irving Medical Center is a 745-bed, quaternary care academic hospital. The ethics consultation service is composed of 5 experienced clinical ethics consultants on a rotating 24/7 call system. This study was approved by our hospital's IRB.

All of the Columbia University Irving Medical Center's ethics consultants use the Rubin and Prager<sup>2</sup> framework and their clinical judgment when approaching a consult for treatment over objection in a patient lacking capacity. Columbia University Irving Medical Center ethics consultants typically rely on the Appelbaum criteria for determining whether or not a patient has capacity.<sup>3</sup>

Decisions to treat over objection always take into account the severity of illness. A *life-threatening illness* was defined as any illness that was expected to be fatal or result in limb loss during the patient's hospitalization. At times, this distinction is quite obvious, as in a case of perforated viscous, peritonitis, and shock, which can be immediately life-threatening. At other times, a patient might have a diagnosis that will ultimately prove to be fatal in the long term without treatment, but can be temporized with alternative interventions. As such, these cases were not considered life-threatening. Examples of this are sepsis from osteomyelitis requiring amputation that could be treated with antibiotics for short-term success or a patient with rectal cancer who would ultimately succumb to disease over time. Ethics consultants relied on the primary medical or surgical team to help evaluate the potential efficacy and risks of an intervention.

Proceeding with unwanted treatment over objection carries the risk of inflicting substantial emotional distress on a patient. The ethics team routinely discussed the "likely emotional effect of coercion" with the psychiatry team, as well as any possible strategies for mitigating adverse psychiatric effects, although oftentimes this was readily apparent even without psychiatry input. For example, it might be determined that physically

- |   |
|---|
| <ol style="list-style-type: none"> <li>1. What is the likely severity of harm without intervention?</li> <li>2. How imminent is harm without intervention?</li> <li>3. What is the efficacy of the proposed intervention?</li> <li>4. What are the risks of the intervention?</li> <li>5. What is the likely emotional effect of a coerced intervention on the patient?</li> <li>6. What is the patient's reason for refusal and can it be addressed?</li> <li>7. What are the logistics of treating over objection?</li> </ol> |
|---|

**Figure 1.** Core questions to guide treatment over objection in patients without decisional capacity.

restraining a patient and administering sedation before the procedure could present a considerable trauma to a patient and damage a fragile therapeutic relationship. The loss of a limb could trigger a worsening of the underlying psychiatric illness, or the presence of a new pacemaker battery pack in the subcutaneous tissue of the chest wall could trigger paranoid delusions in a patient with psychosis.

Question 6 assesses the patient's reason for refusal. Patient capacity exists on a spectrum. Some patients might have complete lack of capacity, such as in advanced dementia or intoxication, and some patients might be able to communicate but lack capacity due to their inability to manipulate complicated information. For this reason, it is important to note when a patient is able to voice reasonable concerns or fears despite the lack of formal capacity, as these can give the ethics consultant valuable information about how to proceed. When applied to our cases, question 6 had multiple nonquantifiable answers and, therefore, was not incorporated into the analysis. Finally, the issue of the logistics of a procedure involved the practical aspects of carrying out the proposed intervention. For example, it might be logistically straightforward to proceed to a lower extremity amputation over objection by sedating the patient preoperatively; however, a resistant patient who would require repeated sedation before recurring interventions over time (eg repeat dialysis sessions) presents an insurmountable logistical barrier.

### Statistical analysis

We analyzed 35 consecutive ethics consults involving treatment over objection in patients without capacity from April 2017 to May 2020. A few of the patients had more than 1 treatment recommended during the course of his or her hospital stay and, therefore, represented a total of 41 individual decisions on treatment over objection. The consults were drawn from a prospectively maintained database. Consults were reviewed and answers to each of the 6 questions were extracted from the ethics note. Two separate investigators (DF, KF) extracted the responses and compared the classification; all differences were reconciled after discussion.

**Table 1.** Summary of Proposed Interventions and Ethics Recommendation

Proposed intervention	Final recommendation per intervention type			
	Proceed		Do not proceed	
	n	%	n	%
Invasive workup (colonoscopy, lumbar puncture, biopsy, myelogram) (n = 10)	8	80	2	20
General consent to treatment (inpatient admission, laboratory tests, antibiotics) (n = 6)	4	67	2	33
Disposition (n = 6)	3	50	3	50
Dialysis access/dialysis (n = 6)	3	50	3	50
Feeding tube (n = 3)	2	67	1	33
Amputation (n = 3)	2	67	1	33
Surgical procedure (TURP, repair of hip fracture, hysterectomy) (n = 3)	2	67	1	33
Incision and drainage of abscess/wound care (n = 3)	2	67	1	33
Cancer treatment (n = 1)	—	—	1	100
Total (n = 41)	26	63	15	37

TURP, transurethral resection of the prostate.

Demographic data were collected on each consult, as well as data about the decision-making process. The 'car,' 'rpart,' and 'tableone' packages of R statistical software (version 3.6.1, R Foundation) were used for statistical analyses and all figures. Data are expressed as frequencies and percentages for categorical variables and compared by either chi-square test or Fisher exact test based on size (more than 5). Continuous variables are expressed as either mean (SD) or median (interquartile range) depending on normality, which was tested via quantile-quantile plots, and were compared using the *t*-test or Mann-Whitney test, respectively. Univariable logistic regression was used to determine associations between questions (independent variables) and whether there was a recommendation to proceed (dependent variable). A *p* value of 0.05 was deemed significant. Next, a classification tree was built using the 'rpart' package. The tree was built by iteratively selecting the core questions (independent variables) based on the largest reduction in heterogeneity to best classify whether patients proceeded to their procedure (dependent variable). Default parameters of rpart, including a complexity parameter of 0.01 and Gini Index, were used such that nodes were built out until there were 7 or fewer patients left in a group.

## RESULTS

Our study of 35 patients represents 41 individual consult adjudications. Median age of the patients consulted was 55 years. Forty-three percent were men and 57% were women. All patients were admitted in an acute care

hospital setting but none were in the ICU at the time of the consult.

Of the 35 patients, 80% were determined to lack capacity based on pre-existing psychiatric conditions, such as a psychotic disorder, personality disorder, or bipolar disorder. Twenty percent of patients were thought to lack capacity based on medical illnesses, such as dementia, severe cognitive impairment, or encephalitis. These medical illnesses were not thought to be reversible. Finally, of the 35 patients, 4 (12%) had never been diagnosed with a psychiatric illness before their admission.

In 63% of consults, the ethics recommendation was to proceed with the intervention over the patients' objection and in 37%, the recommendation was not to proceed. Table 1 describes the nature of the proposed interventions. Table 2 summarizes the assessment of the consultant with regard to 6 of the 7 proposed questions.

Table 3 shows the relationship between the questions and the likelihood of a recommendation to proceed over objection. In univariable logistic regression, questions 2 (imminence of harm) and 7 (logistics of proposed intervention) were the 2 questions most associated with the recommendation. If there is imminent threat of harm without the intervention, then the odds of undergoing the procedure are more likely (odds ratio [OR] 5.57; 95% CI, 1.04 to 29.29; *p* = 0.045), suggesting a strong preference to treat over objection if an immediate threat to the patient is present. Conversely, question 7 shows that if logistical barriers are high, we are markedly less

**Table 2.** Description of Treatment over Objection Consultation

Characteristic	n	%
Life-threatening		
Yes	24	59
Potentially	3	7
No	14	34
Imminence of harm		
Imminent	14	34
Not imminent	27	66
Efficacy of proposed intervention		
High	17	41
Medium	20	49
Low	4	10
Risk of proposed intervention		
High	3	7
Medium	7	17
Low	31	76
Likely emotional effect of coercion		
High	18	44
Medium	19	46
Low	4	10
Logistical barrier to proceeding over objection		
High	10	24
Medium	19	46
Low	12	29

likely to proceed with the proposed intervention (OR 0.01; 95% CI, 0.001 to 0.019;  $p = 0.002$ ).

Next, a classification tree was generated based on the 41 consults (Fig. 2). This is a graphical representation of which questions were most associated with our final recommendation. Logistical concerns emerged as the main driver of the decision of whether to proceed over objection. The life-threatening nature of the condition provided the second most relevant decision point and the imminence of harm the third most relevant decision point. In all consults about patients with a life-threatening or potentially life-threatening illness who did not have a high logistical barrier to proceeding, the recommendation was to proceed over objection. Neither the risks and benefits of a proposed intervention nor the potential impact on the patient of proceeding over objection appeared to have a major influence on the decision of whether to proceed or not.

Finally, 14 of 35 patients did not have a readily available surrogate at the time of the ethics consultation (eTable 1). The presence of a surrogate had no statistically significant impact on whether the ethics consultant recommended to proceed over objection ( $p = 0.185$ ).

## DISCUSSION

In this study, we retrospectively assessed the relative utility of Rubin and Prager's<sup>2</sup> 7 key questions, as used by our ethics consultants in deciding whether to recommend treatment over objection in hospitalized patients found to lack decisional capacity. For the 41 decisions studied, we found that logistic considerations had the strongest influence over the ethics consultant's decision, followed by imminence of harm, but that other questions did not have significant predictive value in this series.

Lack of decisional capacity is a common occurrence in hospital settings, but is very often not identified.<sup>4</sup> In our anecdotal experience, when a patient with questionable capacity agrees with the physician's recommendation, capacity determination is carried out infrequently. It is far more frequent for capacity to be assessed when a patient refuses recommended treatment. Although there is no single accepted method to assess a patient's capacity to consent to treatment, the generally accepted framework for capacity evaluation considers the patient's ability to understand information about their conditions and proposed treatments, appreciate the gravity of their situations, rationalize potential risks and benefits of their choices, and express a clear preference for themselves.<sup>3</sup>

Unlike competence, which is a legally defined determination in court of a patient's soundness to make a specific decision,<sup>5</sup> a patient's capacity can change and be situation-specific.<sup>6</sup> Patients can experience impaired capacity resulting from a fully reversible medical condition and can regain capacity when the condition resolves (eg an intoxicated patient regains capacity on sobering).<sup>7</sup> Patients might be deemed to lack capacity about complex medical decisions, but have capacity for simple decisions. For example, a patient might be judged to have capacity to appoint a healthcare agent or designate code status, but lack capacity to decide on the advantages and disadvantages of chemotherapy or a complex operation. Critics object to this "sliding scale" approach.<sup>8</sup> However, others note that it is sound policy and has been endorsed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.<sup>2</sup>

The assessment of a patient's decision-making capacity has important legal, social, and ethical implications. The key ethical issue in these cases involves balancing a patient's right to self-determination (autonomy) vs a physician's obligation to do what he or she thinks is in the patient's best interests by advancing the patient's health (beneficence) and protecting the patient from harm (non-maleficence). The default position in every case is that a patient has capacity unless proven otherwise. However,

**Table 3.** Association Between Questions and Whether the Procedure Proceeded

Question*	Odds ratio	95% CI	p Value
1: Severity of harm without intervention			
Yes	Ref	Ref	Ref
Maybe	1.43	0.11–18.00	0.783
No	1.79	0.43–7.35	0.422
2: Imminence of harm without intervention			
Not imminent	Ref	Ref	Ref
Imminent	5.57	1.04–29.79	0.045
3: Efficacy of proposed intervention			
High	Ref	Ref	Ref
Medium	2.67	0.66–10.70	0.167
Low	0.89	0.10–7.86	0.916
4: Risk of intervention			
High	Ref	Ref	Ref
Medium	0.38	0.02–6.35	0.497
Low	1.05	0.08–13.00	0.970
5: Likely emotional effect of coercion			
High	Ref	Ref	Ref
Medium	3.50	0.88–13.93	0.075
Low	5.31e07	0.00–inf	0.993
7: Logistical issues			
Low	Ref	Ref	Ref
Medium	0.25	0.03–2.51	0.241
High	0.01	0.0006–0.19	0.002

\*Question 6 captures the reason for a patient's refusal. Because this question had multiple nonquantifiable answers, it was not incorporated into the analysis.

physicians are understandably loathe to permit a patient to harm him- or herself when it is clear that the patient is making a dangerous decision. Studies of patients who refuse medical care and leave the hospital against medical advice report substantially elevated risks of morbidity, mortality, repeat emergency department visits, and readmissions, and represent a considerable cost to the health-care system.<sup>9-12</sup> It is worth noting that in our series, although many of our patients returned to the hospital multiple times with ongoing and incompletely addressed problems, resource use was never a consideration as to whether or not to treat over objection.

At times we must consider other stakeholders alongside the patient. For example, 1 patient in our series was a woman with pregnancy-induced psychosis who refused to accept any blood products or a possible hysterectomy during a scheduled high-risk cesarean section. In this case, we had to consider the risk of potential harm to the baby during delivery and the possibility of leaving the baby motherless.

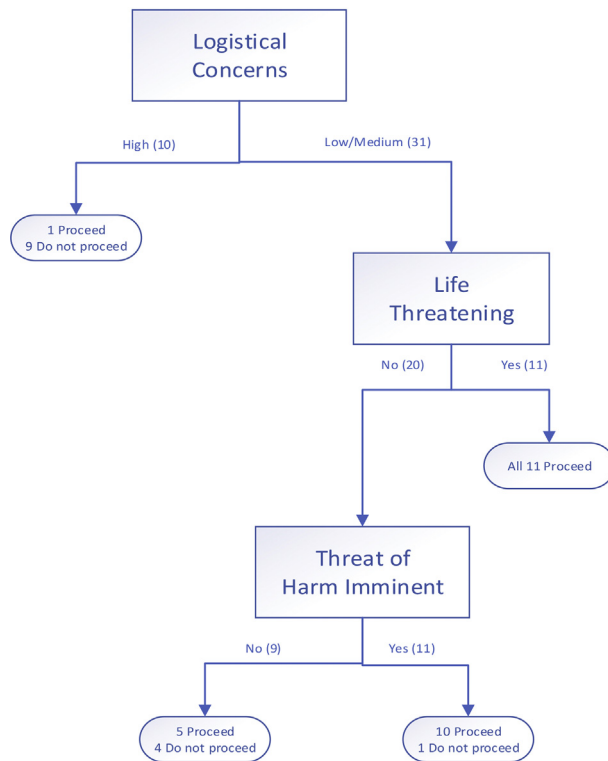
It is very important to note that lacking capacity in itself does not negate a patient's right to autonomy. Western society in particular assigns high importance to an individual's autonomy.<sup>13</sup> When patients without capacity

refuse beneficial treatments, their decisions might not reflect their true goals or values.<sup>14</sup> Even so, it does not always follow that their rights of autonomy can be overruled by the principles of beneficence and nonmaleficence. It is therefore surprising that there is little guidance in the literature for practitioners on how to proceed, given the fundamental ethical issues involved in these scenarios and the frequency with which they occur in clinical settings. As we have indicated, Rubin and Prager's 2018<sup>2</sup> proposed 7 questions on whether to treat a patient over objection helps lend structure and consistency to the decision-making process.

When physicians are faced with the ethical dilemma of whether to treat a patient lacking capacity over objection, we recommend involvement of a multidisciplinary team that includes the primary team, nursing, social work, a clinical ethicist, and psychiatry and/or neurology when relevant, depending on the etiology of the lack of capacity. When necessary, a representative from patient services or legal affairs might be involved. The ethics consultant should systematically consider all 7 questions with input from the rest of the team.

Input from surrogates, when possible, is vital to the ethics consultant. A surrogate can often share a patient's





**Figure 2.** Classification tree.

baseline values and preferences, as well as help support the patient and liaise with the care team throughout the hospital stay. A surrogate who believes an intervention to be in the best interest of a patient will certainly add weight to a consultant's determination. However, the presence of a surrogate does not solve the ethical dilemma of whether or not to proceed with treatment over objection. Because a patient who lacks capacity does not automatically lose his or her right to autonomy, the patient similarly does not forfeit all decision making to the surrogate. In the current study, the presence of a surrogate did not predict the ultimate recommendation of the ethics consultant. In fact, in our experience, surrogates of patients without capacity often look to the medical team for recommendations. In addition, there might be times when the requests of surrogates are not ethically appropriate based on our proposed algorithm or, less commonly, when surrogates themselves lack capacity.<sup>15</sup>

The logistics of how to proceed over objection was the question statistically most associated with the ethics consultant's recommendation, and appears first in the classification tree. Clinically, we tend to focus first on the urgency of an intervention but, statistically, logistical factors had the strongest influence on decision making in this series. Assessment of such logistical barriers included

whether a patient was likely to cooperate with treatment (ie if a patient was aggressive and would require sedation), how often the proposed intervention would take place (ie 1-time pacemaker placement vs dialysis 3 times per week) and the complexity of post-procedural care (such as post-operative wound care for a wound debridement). This assessment was often made with psychiatry's assistance. In nonurgent cases, when it was thought the patient could regain capacity (with treatment of a patient's underlying psychiatric or medical condition), we favored delaying the decision when possible until the patient could make it for themselves. There were occasions when the team thought that with treatment of a psychiatric illness, a patient might not regain capacity, but would be more likely to cooperate. This would influence the assessment of logistical barriers and favor waiting until the patient was treated before proceeding in cases that did not involve an imminent threat to life. Ultimately, if the logistic barriers to a proposed intervention were too high, the team would consider an alternative, less invasive, treatment when possible.

Although Rubin and Prager's<sup>2</sup> questions 3 through 6 were not significantly associated with the final recommendation, they remain an important part of the ethics evaluation. It is likely that procedure risks and benefits were not significantly associated with the decision of whether to proceed over objection because an intervention with a poor risk to benefit ratio would never be proposed, as evidenced in Table 1 by the few consults we received about procedures that involved high risk or low benefit. However, the ethics consultant should nevertheless confirm that the risk to benefit ratio is favorable, taking the overall medical scenario into consideration.

Historically, the "best interests" approach has been one way to guide decisions about treatment over objection.<sup>16</sup> In this approach, the ethics consultant considers what a reasonable patient would want in a given situation. However, statistical analysis of the Rubin and Prager<sup>2</sup> algorithm suggests that what is truly in the best interest of a patient might not be attainable. Indeed, the logistics of a proposed intervention (question 7) often superseded what would be considered in the best interest of the patient (questions 1 to 3). For example, in the case of a patient with a large brain tumor in whom herniation was thought to be imminent, radiation therapy, although in the patient's best medical interests, was not logistically possible. Because the patient had a history of psychosis and violence, it would have been difficult and dangerous to repeatedly sedate the patient to carry out the requisite number of radiation treatments.

Interestingly, the 2 most patient-centered questions (questions 5 and 6), which addressed the likely emotional

effect of a coerced intervention and the patient's reason for refusal, had very little statistical impact on the ultimate decision of whether to proceed over objection. This does not imply that the ethics consultant should disregard the reason for the patient's refusal or the emotional impact on the patient of proceeding over objection. Rather, it is in these questions that the input of the ethics consultant is invaluable. Proceeding with an intervention over objection is the ultimate breach of a patient's autonomy, even when it is determined to be in his or her best interest. With this in mind, when deciding to proceed we must do our best to minimize risks and discomforts to patients as much as possible. The assessment and discussion of questions 5 and 6 by the patient's entire care team, although not statistically related to the final recommendation, is critical to maintaining the dignity and humanity of the patient.

We believe that although not all questions reached statistical significance, assessment of all of the questions is paramount in reaching an ethically sound decision. In addition, the careful consideration of all 7 questions in the Rubin and Prager<sup>2</sup> algorithm is extremely important to ensure a consistent approach to all patients and reinforce the belief in the minds of the physicians that they are proceeding in an ethically appropriate manner.

The limitations of this study include those of any retrospective review of medical records. Although this is the largest study to date of these consultations, the overall number is still low, so subtle influences on ethical decision making might have gone undetected. Most notably, in this study, there was no way to formally validate the proposed algorithm by Rubin and Prager<sup>2</sup> because there is no "gold standard" with which we could compare outcomes. Inherently, the outcomes of ethics consultation achieve their legitimacy through the application of ethical norms, adherence and respect for precedence, multidisciplinary input and consensus, when possible, among caregivers, family, and ethics. In many of the cases reviewed, respect for autonomy was thought to be the only acceptable choice, even if it resulted in the unfortunate death of a patient. However, treatment over objection was recommended in 63% of this series. This might seem like a high percentage, given the high value we place on patient autonomy, but it surely reflects referral bias, that is, the selection of more compelling cases with higher benefit to risk ratios for ethics consultation.

## CONCLUSIONS

In patients lacking capacity, treatment over objection is a common and challenging ethical conundrum.<sup>17</sup> In such

cases, physicians must balance patient autonomy with their obligation to act beneficently and protect patients from harm,<sup>6</sup> and ethics consultation is often requested for guidance on whether to proceed. The Rubin and Prager<sup>2</sup> 7-question ethical framework offers a systematic approach that provides consistency and rigor that can be helpful to clinicians and ethicists who face these ethical dilemmas. A review of this framework found that the logistical feasibility of treatment and the imminence of harm from nontreatment were the strongest predictors of the ethicist's recommendation.

## Author Contributions

Study conception and design: D Fischkoff, Prager, Dastidar, Dugdale, Neuberger, Nemeth, K Fischkoff  
 Acquisition of data: D Fischkoff, Prager, K Fischkoff  
 Analysis and interpretation of data: D Fischkoff, Prager, Nemeth, K Fischkoff  
 Drafting of manuscript: D Fischkoff, Prager, Nemeth, K Fischkoff  
 Critical revision: D Fischkoff, Prager, Dastidar, Dugdale, Neuberger, Nemeth, K Fischkoff

**Acknowledgment:** The authors are extremely grateful to Karin Sobek for her diligent transcription of years of ethics consultations, which have made this article possible.

## REFERENCES

- Okai D, Owen G, McGuire H, et al. Mental capacity in psychiatric patients: systematic review. *Br J Psychiatry* 2007;191:291–297.
- Rubin J, Prager KM. Guide to considering nonpsychiatric medical intervention over objection for the patient without decisional capacity. *Mayo Clinic Proc* 2018;93:826–829.
- Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med* 2007;357:1834–1840.
- Sessums LL, Zembruska H, Jackson JL. Does this patient have medical decision-making capacity? *JAMA* 2011;306:420–427.
- Buchanan A. Mental capacity, legal competence and consent to treatment. *J R Soc Med* 2004;97[9].
- Moser DJ, Schultz SK, Arndt S, et al. Capacity to provide informed consent for participation in schizophrenia and HIV research. *Am J Psychiatry* 2002;159:1201–1207.
- Ganzini L, Volicer L, Nelson W, Derse A. Pitfalls in assessment of decision-making capacity. *Psychosomatics* 2003;44:237–243.
- Culver CM, Gert B. The inadequacy of incompetence. *Milbank Q* 1990;68:619–643.
- Alfandre DJ. I'm going home": discharges against medical advice. *Mayo Clinic Proc* 2009;84:255–260.

10. Ramakrishnan N, Ranganathan L, Abraham BK, et al. What happens to patients discharged against medical advice? *Indian J Crit Care Med* 2018;22:580–584.
11. Siegel MD. Alone at life's end: trying to protect the autonomy of patients without surrogates or decision-making capacity. *Crit Care Med* 2006;34:2238–2239.
12. Bandy R, Sachs GA, Montz K, et al. Wishard Volunteer Advocates Program: an intervention for at-risk, incapacitated, unbefriended adults. *J Am Geriatr Soc* 2014;62:2171–2179.
13. Saks ER, Jeste DV. Capacity to consent to or refuse treatment and/or research: theoretical considerations. *Behav Sci Law* 2006;24:411–429.
14. Choi M, Kim H, Qian H, Palepu A. Readmission rates of patients discharged against medical advice: a matched cohort study. *PLoS One* 2011;6[9]:e24459.
15. Allen N, Mishkin A. the incapacitated surrogate: what is the consultation-liaison psychiatrist's role? *Psychosomatics* 2020; 61:672–677.
16. Kopelman LM. The best-interests standard as threshold, ideal, and standard of reasonableness. *J Med Philos* 1997;22:271–289.
17. Baruth JM, Lapid MI. Influence of psychiatric symptoms on decisional capacity in treatment refusal. *AMA J Ethics* 2017; 19:416–425.

## Invited Commentary

### Classic Ethical Dilemma: When Is it Acceptable to Treat Patients over Their Objection?



Peter Angelos, MD, PhD, FACS, MAMSE  
Chicago, IL

Informed consent is the foundation of the ethical practice of surgery. All surgeons are familiar with the ethical responsibility to obtain informed consent from patients or their appropriate surrogates before performing surgical procedures. Given this broad acceptance for respecting the autonomous choices of patients, which is manifested by the requirement for informed consent, how can it be that many patients undergo operations or have other interventions despite their objections to having the procedures?

This seemingly paradoxical question is addressed by Fischkoff and colleagues<sup>1</sup> in the current issue of the *Journal of the American College of Surgeons*. These authors studied patients for whom ethics consultations were sought at Columbia University Irving Medical Center between April 2017 and May 2020 for treatment over objection. Their results, although a small sample from a single institution, provide helpful information to all physicians who are in the position of recommending treatment interventions to hospitalized patients.

The central feature of the patients reported in this series is that all of them lacked the capacity to make an autonomous decision about the interventions recommended to them. The concept of capacity is an important ethical one. For a patient to have the capacity to give informed consent, the patient must be able to communicate a choice, understand the relevant information, appreciate the situation and its consequences, and reason about treatment options.<sup>2</sup> The assessment of capacity is one that is made clinically, in contrast to *competence*, which is a legal term. When patients lack the capacity to give informed consent, an intervention can be performed on a patient over their objection. However, doing so should trigger a careful assessment of the ethical basis for such a choice.

As the authors of this study have pointed out, the question of whether to treat a patient over their objection creates a stark ethical dilemma—should the patient's right to self-determination be overridden by the physician's assessment of what will benefit the patient? The balancing of respect for patient autonomy with the importance of beneficence (ie acting to benefit the patient) is a central challenge in the ethical care of patients. The data from the current study showed that when such important ethical issues are at odds, physicians should proceed carefully with full consideration of the following questions:

What is the likely severity of harm without intervention?

How imminent is harm without intervention?

What is the efficacy of the proposed intervention?

What are the risks of the intervention?

What is the likely emotional effect of a coerced intervention on the patient?

What is the patient's reason for refusal, and can it be addressed?

What are the logistics of treating over objection?<sup>3</sup>

Although all of these questions are important, among the patients included in the current study, the question that had the greatest impact on whether the ethics consultants recommended treatment over objection was the logistical factors associated with the recommended treatment. The questions about whether the recommended treatment was a single episode or a recurring one, and the likelihood of the patient to cooperate with the proposed treatment had a large influence on whether it was ultimately performed over the patient's objection.

What are the most important messages to take home from this important study? First, all physicians should stop to carefully consider whether a patient has the capacity to make a decision before going along with the patient's wishes. Although the chances of questioning capacity when patients refuse our recommendations



are much more likely than when they go along with our recommendations, capacity really should be based on a clinical assessment of the patient rather than on the decision made. Second, when patient choices must be overridden for the patient's benefit, physicians should stop to consider whether an outside opinion of capacity and patient benefit would be helpful. In such circumstances, consultation with psychiatry and/or an ethics consultant or committee will often be helpful. Third, the ethical integrity of the practice of medicine depends on patients trusting their physicians, and decisions to treat over the objection of even patients who lack capacity should only be undertaken in limited circumstances when the risk to the patient is great and the benefit of

treatment significantly outweighs the burden of the treatment itself.

#### REFERENCES

1. Fischkoff D, Prager K, Dastidar J, et al. An ethical framework to guide decisions of treatment over objection. *J Am Coll Surg* 2021;233:508–515.
2. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med* 2007; 357:1834–1840.
3. Rubin J, Prager KM. Guide to considering nonpsychiatric medical intervention over objection for the patient without decisional capacity. *Mayo Clin Proc* 2018;93:826–829.

**Disclosure Information: Nothing to disclose.**

**eTable 1.** Presence of Available Surrogate and Final Recommendation

<b>Surrogate available</b>	<b>Recommendation to proceed</b>		<b>Recommendation to defer</b>	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Yes	19	46	6	15
No	9	22	7	17