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Emancipation, Capacity, and the Difference Between Law and Ethics

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THE CASE

TE was 16 years old and 29 weeks pregnant when she was admitted to an urban Maryland hospital for fever and back pain. She was admitted to labor and delivery (L&D), where she was diagnosed with pyelonephritis, inflammation of the kidney due to bacterial infection. Within one day of admission, TE's condition worsened, and she developed systemic inflammatory response syndrome (SIRS). She was transferred to the intensive care unit (ICU).

Shortly after transfer, the patient began insisting that she had to leave the hospital because her room was too small and she wanted to take a bath in her mother's hot tub. TE's course in the ICU was characterized by recurrent high fevers (up to 103°F), and at times she was agitated, angry, and incoherent. She received antipyretics and a cooling blanket, along with other treatments. After 72 hours she continued to run a high fever. Because it was suspected that she also had a renal abscess, a sonogram was scheduled.

TE's attending physician and consultants, along with the nursing staff, informed her of the potential risks to herself and to her fetus if she were to leave the hospital in her current state. When she was asked if she cared about her pregnancy, she said she wanted to have a healthy baby, but moments later she would again act as though she would leave, complaining that her room was too small.

TE had registered late for her obstetrics care and had had only two prenatal visits prior to her hospitalization. The obstetrician (OB) attending her met her for the first time on this admission. TE was not speaking to the father of the baby, who was not involved with her during the pregnancy. She lived with her mother and four siblings. Her mother was with TE during much of the hospitalization and tried unsuccessfully to convince her daughter to stay. The nurses caring for TE related that she was verbally abusive to her mother, and that her mother seemed unable to influence her daughter's behavior. TE's cousin was close to her, and, when present, was able to convince TE to stay. Invariably, however, TE would repeat her intention to leave, and,

when agitated, would act in furtherance of her stated intention—for example, she would try to pull out her lines and climb out of her bed.

Late in the evening of TE's third day in the ICU, the risk manager for the hospital was consulted. Because TE was pregnant, the risk manager said that TE was an emancipated minor under Maryland law, and, as such, she had the legal right to make her own decisions, which included leaving the hospital against medical advice (AMA). The risk manager and the hospital attorney advised the treatment team to document that they had explained the risks of leaving the hospital AMA to TE, and then to let her walk out. The treatment team felt moral distress on receiving this advice. They sensed it was unsound, but believed they must follow legal counsel.

ON ROUNDS

The next morning during ICU rounds, which the hospital bioethicist joined weekly, the attending physician and treatment team reported on the advice they received from risk management. The attending made it clear that the consensus on the team was that the advice went against their better judgment and was antithetical to their understanding of their clinical obligations. They admitted, however, to being unsure about how to reconcile their ethical assessment of the case with legal advice.

The bioethicist, the attending, and the treatment team began a lengthy discussion. They first reviewed the basic matter of standards for assessing capacity to make medical decisions, which are the same whether a patient is an emancipated minor or an adult. The bioethicist underscored that upholding the principle of respect for persons included protecting those whose ability to be self-determining is limited. The group discussed the ancient deontological principles of nonmaleficence and beneficence, which obligate caregivers to avoid and prevent harm, and to act in the patient's best interest, respectively. They also covered an abbreviated listing of possible consequences, good and bad, short and long-term, of following this legal advice. They reviewed the various possible mechanisms that were available to hold a patient who is acting in ways that pose imminent harm to herself and/or others, and briefly reviewed the ethical issues related to maternal/fetal conflict. They considered the differences between law and ethics, and agreed that when legal advice is counter to sound ethical analysis, it is appropriate to challenge the legal advice.

THE CONSULT

To that end, they consulted with the hospital ethics committee (called a patient care advisory committee in the State of Maryland). The consultation involved the ICU attending and members of the ICU treatment team, a social worker and a nurse on the ethics committee's consultation subcommittee, the ethics committee chairman, the bioethicist, and the hospital obstetrician/gynecologist who transferred TE to the ICU. It also included representatives from Child Protective Services (CPS), who did not consider TE to be an emancipated minor.

During the ethics consultation meeting, the patient's nurse reported that she had documented that there was a correlation between the patient's behavior and her temperature. That is, when the patient did not have a fever, she verbalized her intention to leave, but did not make any attempt to act on her intent. It was when TE's temperature exceeded 101°F that she began to pull out her lines and attempted to climb out of bed. This information confirmed the ICU attending's clinical judgment that the patient's decision-making capacity was severely impaired, and all agreed.

TE did not seem to appreciate the potential consequences of her actions in leaving the hospital AMA, nor was she able to reason in a consistent manner about what was in her—or her fetus's—best interest. That there was a pattern that connected the changes in TE's clinical symptoms to fluctuations in her impaired mental function added confidence to the appropriateness of assessing her capacity. The criteria for determining a patient's capacity, which are well-established clinically and ethically, are explicitly incorporated into Maryland law on healthcare decision making.

The group then agreed that simply documenting that they explained the risks of leaving the hospital AMA to TE was not sufficient to meet their ethical obligations for her care. Instead, and only as a last resort, it was agreed that if TE could not be managed so that she stayed willingly through a diagnostic workup and a course of treatment, which would be the standard-of-practice care for any patient in her condition, pregnant or otherwise, then the attending and the consultants would resort to initiating involuntary commitment procedures, and sign certification papers for a 72-hour temporary stay, pending a court hearing.

It was central to the plan of care, however, that this step would be avoided if at all possible. Therefore, the group developed a plan to transfer TE back to L&D, where the rooms are larger and TE would be able to take a bath. The only way to do this safely, however, would be to attach an ICU nurse to TE on a one-to-one basis, with continued care by the consulting intensivist. This unusual utilization of an ICU nurse was considered by all to be a fair use of hospital resources, because there were times (albeit rare) when the OB department provided the ICU with a nurse to assist in monitoring a pregnant patient who was transferred to the ICU. The plan also included marshalling other resources, including asking the cousin with whom TE was most comfortable to spend additional time with her in the hospital. Also, the patient's OB changed her order for PRN [as-needed] acetaminophen to acetaminophen around the clock, to attempt to better manage TE's fever and to maximize her mental status.

TE was transferred to L&D. Her sonogram was negative for an abscess and, over the next two days, she responded to the treatment for infection. Approximately 72 hours after TE's transfer back to L&D, her treatment was successfully concluded and TE was discharged to out-patient follow-up with her obstetrician.

POST-CONSULT FOLLOW-UP

The discrepant interpretations that TE was an emancipated minor by hospital counsel and risk management, and that she was not by Child Protective Services, confused the treatment team and those who participated in the ethics committee consultation. During the consultation, this issue was put aside because it quickly became apparent that TE did not meet reasonable criteria to be deemed a capacitated decision maker, which rendered her legal status as an emancipated minor moot. To sort it out, however, several days after the case concluded, advice was sought from the Maryland State Attorney General's Office. This advice is summarized as follows.

> A minor's legal authority to decide about healthcare issues may be based on either the status of the minor or the nature of the healthcare decision. As to status, a minor is deemed to have the same capacity as an adult to make healthcare decisions if he or she is married or the parent of a child. It is important to note that a minor who gains legal authority on this basis is subject to the same exception as an adult; that is, if the attending and a consulting physician determine that the minor is incapable of making an informed decision, decision-making authority passes to a proxy (usually the next of kin).

The Maryland Attorney General's advice also included a consideration of whether TE might have other legal authority to reject treatment for her acute condition. A minor is authorized to consent to treatment (and so, by implication, to decline consent) for a variety of specific health matters, including "treatment for or advice about pregnancy."

This provision, like its counterparts that allow minors to consent to treatment for substance abuse and sexually transmitted diseases, deals with medical conditions that a minor might not wish to be revealed to a parent. A pregnant young woman is thus enabled to seek treatment that is related to the pregnancy without the need for parental consent.

The provision, however, does not emancipate a minor for all healthcare decisions simply because she is pregnant. To be sure, many aspects of the health of a pregnant woman might have an indirect effect on the pregnancy, but the grant of legal authority here is limited to treatment for the pregnancy itself.

Because TE was neither married nor a parent, she was not emancipated for general healthcare decision making, in the view of the Maryland State Attorney General's Office. Moreover, because the treatment

initiated in the ICU was for an acute infection that was unrelated to the pregnancy itself, TE did not have legal authority to refuse the treatment under the "treatment for pregnancy" provision of the law.

ANALYSIS

CAPACITY

This case raises important issues about how paying attention to patients' legal rights and law-driven risk assessment can affect morally coherent actions in the clinical care setting. On the surface, this can be read simply as an interesting clinical ethics case in which capacity assessment is the central issue. From this vantage point, whether or not TE was an emancipated minor and the fact that she was pregnant are irrelevant to a determination of what was ethically and clinically optimal care. What comes through most clearly at this first level of analysis is how complicated capacity assessment can be. Although TE showed fluctuations in her mental functioning that were connected to rises and drops in her fever, it took skill and attention on the part of her nurse to connect the two. TE was never overtly delirious. And although TE's fever curves were charted in a way that allowed physicians and nurses to track them hour by hour, the subtleties in her levels of agitation, which swung back and forth from merely verbal to more active, would not necessarily have been charted in a way that would make the connection between her fevers and agitation obvious, across changes of clinical staff over only a few days in an ICU.

Performance of a thorough and refined capacity assessment requires skills that many house staff have not learned. Especially in the ICU, where so many patients are unable to communicate verbally or at all, a physician who is inexperienced in performing refined capacity assessments is likely to make the common error of equating lucidity with capacity. In this case, wanting to leave because the room is too small and because one wants a bath is certainly odd, and, at the very least, a demonstration of immaturity and poor judgment, but it is not the kind of nonsensical talk a physician is able to immediately define as disordered thinking.

Because TE was not floridly psychotic, the house staff did not think that they needed to call psychiatry to have her declared so. Even if psychiatry had been called, a psychiatric evaluation may or may not have assisted, and perhaps could have made matters worse. Although a highly skilled psychiatrist would most probably have determined that, although she was lucid, TE was impaired because she was suffering from a disassociative disorder, it is just as likely that this degree of diagnostic skill would have been absent. Instead, a psychiatrist, most likely a psychiatric resident, would have determined that TE was not suicidal, psychotic, or depressed, and, therefore, was capable of making her own decisions about leaving AMA. Once that psychiatric consult report form was on the chart, the ability to challenge the consultant's assessment would be greatly diminished.

Medical consults carry substantial weight—as they should. ICU care is markedly enhanced through consultation by infectious disease specialists, cardiologists, and the many other subspecialty experts who are regularly called to assist in the care of ICU patients. The value of a psychiatric consultation for the purpose of assessing a patient's capacity to refuse treatment is more debatable. In this case, it is possible that TE would have met the criteria for a disassociative disorder. If a psychiatrist had evaluated TE when her fever was down and she was functioning at her highest cognitive level, however, she might not have. Also, the standards one applies for determining the ethical validity of a patient's decision making are different from the criteria that a patient must meet to be diagnosed with a psychiatric disorder. *Instituting mechanisms to protect patients from the bad consequences of impaired mental function does not always require that patients be psychiatrically diagnosable.* That point moves this analysis to a key ethical issue.

The assertion just made—that ethical care may require taking actions that protect patients from self-harming decisions, in the absence of frank psychiatric disease—is open to debate. Because the contemporary ordering of the principles of respect for persons and beneficence places such emphasis on the autonomy of patients, clinicians have internalized this notion to mean that whatever patients or surrogates want is what they should get. Throughout medicine today there is a disinclination to probe or to challenge patients' or

surrogates' expressions of preference. Although a discussion of the implications of this phenomenon is well beyond the scope of our current analysis, relevant to TE's care, it reduced the level of suspicion among the house staff that what they were interpreting as valid expressions of preference on the part of a decisionally capable patient were, instead, evidence of mental impairment sufficient to require instituting additional patient protections. In fact, during discussion on rounds about what might be done, the residents indicated that the only alternative to letting TE walk out AMA was to keep talking to her to try and persuade her to stay. Equating an expression of a patient's preference with ethically meaningful autonomy is so ingrained in young physicians that temporary involuntary commitment never crossed the residents' minds. This bias towards making ethically valid self-determination synonymous with acceding to whatever patients say is seen, also, in the results of capacity assessments that physicians other than psychiatrists make.

Evaluation of data that one obtains from a thorough capacity assessment is, no matter how well conducted, subjective. The now generally accepted criteria for capacity are the ability to:

1. Express a choice,
2. Understand the information being provided,
3. Appreciate the implications of one's situation and the potential consequences of one's decisions, and
4. Reason in a way that is consistent with one's beliefs about what is in one's own best interest.

These criteria do not give one a neat list of behavioral manifestations to check off, or laboratory values to measure. Words such as "understand," "appreciate," and "reason" are not easily concretized. Thus, the biases of the clinician performing the assessment will influence how the data obtained from the assessment are marshalled and evaluated. Given the context that expressed patients' preferences usually go unchallenged, one can see how TE's talk of leaving based on room size and the need for a bath were frustrating, but not seen as manifesting decisional impairment.

PREGNANCY

From problems of interpreting TE's mental status, our analysis next moves to the issue of deciding if, and if so what, moral role TE's pregnancy held in this case. Physicians and nurses in an ICU view an infected patient as a patient who needs treatment. But TE was not merely an infected patient. She was an infected pregnant patient. Clinicians treating a pregnant woman really have two patients, the pregnant woman and the fetus. Putting to one side, as beyond the scope of this article, the debate over the ethically appropriate extent of clinicians' obligations to treat an adult female patient who is also pregnant, it is important to note that the emphasis on patients' preferences influences this aspect of the case analysis. Concerning the fetus, we shall simply make the claim that, at a minimum, some moral consideration is owed. In TE's case, the fetus was estimated at 29 weeks and assumed to be viable, increasing by some margin the moral consideration owed to the fetus.

When called about the case, risk management and hospital counsel focused on the patient's pregnancy as giving her legal control over her own decisions. Although one wonders why they, like house staff, missed the issue of capacity, it is possible that the house staff described the patient in such a way as to reduce the possibility of the risk manager's asking a question about TE's mental status. Taking that as a reasonable working hypothesis, it is not surprising that the legal bias was towards autonomy and liberty rights, contemporary principles in medical ethics that have been imported into modern medicine from the law. These autonomy and liberty rights, as society and the courts have tended to view them, privilege the rights of decision making of the woman over any rights that might be owed to a fetus. Again, this issue brings our analysis to a point of heated social debate that far exceeds the boundaries of this case discussion. Nonetheless, given that the position of the treating team is that they had two patients, and the view of the rest of those involved in the consult that the fetus is owed at least some moral consideration, in the face of TE's decisions that seemed beyond what a reasonable person might make, the legal recommendations produced dismay and moral distress. Although some might view the legal recommendations as reasonable legal practice, they were inconsistent with sound medical practice.

LIABILITY

Herein we arrive at the final point of the case analysis, the paralyzing influence the legal recommendation had on the moral imagination of the treating team. Physicians, risk managers, and hospital attorneys are exquisitely aware of the risks of being sued. Whether an action that is brought goes to trial or not, simply being named in a legal action is a terrifying prospect to a physician, and an event that clinicians, risk managers, and hospital attorneys want to avoid at all costs. These costs, however, may be the most serious and important lessons this case has to teach.

Not wanting to get sued is understandable, and there is a sense within medicine today that if one disagrees with a patient or surrogate, the patient or surrogate will become angry and sue. What risk managers, hospital attorneys, and clinicians need to remember is that simply doing what someone asks is not necessarily the path to avoiding lawsuits. *Instead, the best hope for avoiding lawsuits is to practice good medicine.*

Clinicians can be sued for doing something or for not doing something. In the case of TE, forestalling her from acting on a preference that was not ethically or legally valid was the correct path to pursue. In medicine and law alike, an ethically and legally valid autonomous decision must be informed, comprehending, and voluntary. Common sense, as represented by the notion of the reasonable person, regardless of whether one is an emancipated minor or not, dictates that a mentally intact person with a life-threatening infection will want to have it properly treated. When that patient is also a pregnant woman, the reasonable person would be expected to be especially eager to get the infection properly and quickly treated. These common sense responses, which seem to easily meet the law's reasonable person standard, are consistent with clinical intuition and ancient ethical norms of medical conduct.

That the treating team reacted with despondence, rather than indignation, incredulousness, and a willingness to challenge the legal and risk management advice, was deeply disturbing. It indicates a learned helplessness within the medical community and a conceptual confusion on the part of risk managers and hospital attorneys over the fundamental goals of medicine and how to achieve them. This is particularly sad in light of the legal advice given by the Maryland State Attorney General's Office, which allied good legal practice with good medical practice. The advice demonstrates how well-crafted laws, interpreted wisely, support excellence in medicine. Somehow, clinicians, risk managers, and hospital attorneys need to find ways to educate each other about what the goals of medicine are, and to challenge each other when one or another comes to conclusions or makes recommendations that are obviously inconsistent with ethically and clinically optimal patient care.