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Features

Repetitive Foreign Body Ingestion: Ethical Considerations

Sarah Lytle, Susan J. Stagno, and Barb Daly

ABSTRACT

The treatment of persons who frequently present to the healthcare system following repetitive foreign body ingestion has been addressed in the psychiatric literature. However, there has been little exploration of the ethical considerations regarding the treatment of these patients. The complexity of their medical and psychiatric presentation raises fundamental ethical questions regarding the duty to treat, patient autonomy, justice, and futility. Careful ethical analysis is particularly important in this context, since the frustration that medical professionals may feel in response may lead to false assumptions that can negatively impact patient care. A careful exploration of these questions can increase awareness and understanding, which in turn can lead to improved treatment of patients who repetitively ingest foreign bodies. Care for patients who inflict self-harm, particularly by repetitive foreign body ingestion, is not futile. The patients have a right to treatment and are entitled to resources. Efforts should be made to provide a more comprehensive treatment approach to these patients.

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BACKGROUND

A 19-year-old female with a history of repetitive foreign body ingestion (RFBI) and removal presented to the emergency room after swallowing the blade of a knife. Following admission, a physician approached the patient and questioned the patient's motives for swallowing objects and implied that she was inappropriately using up valuable resources. The patient became agitated and threatened the physician with bodily harm. The consulting surgeon indicated she did not want to do surgery because she was concerned about her safety and the safety of her staff. Transferring the patient to another hospital was suggested. The perceived futility of providing treatment, since the patient had presented repeatedly after ingesting foreign objects that required multiple expensive interventions, and would likely present again, was also expressed.

The treatment of patients who present with RFBI may involve a variety of healthcare workers including emergency room and security personnel, gastroenterologists, surgeons, anesthesiologists, nursing staff, and psychiatrists. A

recent retrospective case series in an urban hospital reported that 92 percent of ingestions were intentional, 85 percent were in psychiatric patients, and 84 percent of the patients had a history of foreign body ingestion.[1] Of the 33 patients who presented with RFBI, 79 percent had psychiatric diagnoses coded in their medical record.[2] RFBI may be a presentation of various psychiatric disorders including impulse control disorder (ICD), malingering, borderline personality disorder (BPD), pica, or psychosis.[3] Impulse control disorders are characterized by the failure to resist an impulse to perform an act that is harmful to the individual, in this case swallowing a foreign object.[4] An increase in tension may be experienced before committing and relief may be felt following the act. In malingering a patient feigns symptoms intentionally for an external reward.[5] For example, a malingerer might swallow an object with the explicit intention of being hospitalized in order to avoid incarceration. BPD is characterized by impulsivity, and patients may display repetitive self-injurious behavior such as swallowing.[6] Pica involves intentional ingestion of non-nutritive substances. In psychotic disorders, self-harming behavior may occur as a result of disordered thinking or paranoia. Self-injurious behavior most commonly occurs in patients with BPD.[7]

Regardless of the etiology of RFBI, the management of such cases is often complicated. It is not uncommon for patients' characteristics—including anger, impulsivity, entitlement, aggression, repetition, dependency, ingratitude, and manipulation—to elicit strong countertransference reactions in treatment providers.[8] Patients with RFBI combine self-punishment and the punishment of others and essentially force physicians to provide care, placing the patient in a powerful position.[9] Intervening in the actual act of foreign body ingestion is nearly impossible, and, following ingestion, patients have considerable leverage.[10] Countertransference may be manifested as feelings of frustration, anger, futility, foreboding of recurrence, helplessness, vengeance, and apathy by caregivers, with resultant feelings of wanting to blame, punish, and withdraw from care of the patient.[11] This combination of patients' traits and providers' reactions can result in suboptimal treatment and raises questions about the justification for limiting the scope of a duty to provide care for patients who present with RFBI.

This article examines concepts related to the duty to treat, patient autonomy and intentionality, allocation of resources, and futility in regards to patients with RFBI. A careful exploration of these questions can lead to awareness and understanding, which in turn can lead to improved treatment of patients who repetitively ingest foreign objects. Finally, suggestions are made for providing a more comprehensive plan of care for this population.

DUTY TO TREAT

When considering patients who present with repeated acts of self-harm, it is not surprising that the question arises as to whether or not we, as physicians or other healthcare workers, have a duty to continue to treat. However, medical situations in which patients engage in indirect self-harming behavior are not uncommon. Common scenarios might include non-adherent insulin-dependent diabetic patients who repeatedly present in diabetic ketoacidosis or smokers who continue to smoke despite a diagnosis of emphysema. In these cases, patients are engaging in repetitive self-harming behavior, yet they do not elicit strong countertransference reactions like those seen with RFBI. Perhaps patients who present after ingesting a foreign body are more frightening and elicit stronger emotional reactions because their behavior seems so bizarre and they present in the actual act of self-harm (for example, with the blade of a knife in their gastrointestinal tract).[12] Additionally, patients who present with RFBI are often quickly labeled as "psychiatric patients" and may be stigmatized.

A discussion of duty to treat also raises the question of legal requirements to treat. Although we are aware of no court cases involving the duty to treat patients with RFBI, this concept has been addressed in other areas of medicine. The question of duty to treat has been most extensively discussed in the dialysis literature, since non-adherence in patients with end-stage

renal disease can be life threatening and expensive. A number of court cases have centered on the debate over whether or not there is a duty to treat patients who do not engage in their own treatment, are consistently non-adherent, and cause upheaval on dialysis units.[13] The law has upheld that the duty to treat is not absolute and can be foregone in certain cases when a patient becomes threatening, abusive, or disruptive to the care of other patients.[14] Nevertheless, ethically, even under these circumstances, an attempt to resolve conflict is imperative so that a patient can be adequately treated. In addition, if one accepts that psychiatric dysfunction contributes to self-damaging behavior, denying treatment based on a psychiatric disorder is prohibited under the Americans with Disabilities Act, which prohibits, among other things, discrimination on the basis of a disability by healthcare providers.[15] Notwithstanding a legal duty to treat, psychiatric disorders including disorders such as BPD are treatable, and there is an ethical obligation to provide treatment if it will benefit the patient.

The possibility of transferring care to a different physician or facility may arise when interactions become strained between a patient with RFBI and a healthcare provider. Of course, transferring a patient may not be possible if there is an acute risk of serious imminent consequences or death (for example, the ingested knife has perforated the bowel) or if there are no other providers available. Refusing to provide treatment for a patient may be justified if a physician lacks the requisite competence, if there are limited clinical or institutional resources, or if a physician has a strong moral or religious objection to the kind of treatment requested or required.[16] While withdrawal from a patient's care may be acceptable in situations such as these, the prohibition against the abandonment of a patient is relatively absolute. In addition, while an individual clinician may justifiably withdraw from participating in care, institutions have a fiduciary duty to patients. Both individual providers and institutions are obligated to ensure that an alternate source of care is available before withdrawing or discharging a patient.

AUTONOMY AND INTENTIONALITY

In analyzing the duty to treat and the corollary right of a patient to receive treatment, the concepts of autonomy, intentionality, and responsibility are linked, and all play a role. When we assess an individual as lacking autonomy, we are claiming that the person lacks the ability to make reasoned choices consistent with authentic values. While the non-autonomous individual may be physically capable of making a decision and acting on the choice, we would not assign responsibility to that person for the action and its consequences. Further, when caring for a non-autonomous person, duties of beneficence—to promote the "good" or well-being of the person—take precedence. This might include restraining or involuntarily hospitalizing that individual. Thus, consideration of the extent to which we view RBFI as an intentional act of an autonomous person will have implications both for our analysis of the duty to treat and, potentially, for justification of an involuntary hospitalization.

A full exploration of the application of the concept of intentionality would require examination of all of the components of mental states in a causal chain leading to action, including judgment, commitment, volition, as well as intentionality.[17] There are also legal constraints and requirements that would be relevant and possibly determinative. For our purposes, though, we are more concerned with the clinical reasoning that should be brought to bear in directing care decisions.

One potential approach is to consider the behavior of repeated ingestion as a kind of addiction. The literature suggests that patients who are addicted to drugs and alcohol cannot control their use due to their dependency and have lost their autonomy, as it relates to use of the addictive substance.[18] The goal of rehabilitation in this case is to restore the patient's autonomy.[19] Similarly, in self-injurious behavior the patient may not be responsible for his or her actions if these behaviors are a manifestation of the psychiatric or personality disorder. Difficulty controlling and expressing emotion (secondary to traumatic childhood experiences,

for example) may underlie the behavior of RFBI.[20] If a patient has little control over behaviors (the volitional component of action), then it is less appropriate to deny treatment.[21]

As previously mentioned, RFBI may be a manifestation of BPD. One of the prominent features of BPD includes impulsivity that implies acting without adequate rational thought about relevant facts (the judgment component of the action). The expected consequences of an action likely play some role in the patient's decision making and may fulfill a goal (that is, avoiding abandonment or communicating anger). In addition, in BPD it is not clear if an action is irresistible or merely unresisted, with the impulse simply being stronger than any other motivation at that time. People who self-harm may experience dissociated states when under stress, possibly secondary to a history of childhood abuse, trauma, or neglect. Dissociation can cause disturbances in memory and manifest as derealization (a feeling that the external world is unreal), depersonalization (feeling of being detached from oneself) and hallucinations. Impulsivity and mild disassociation do not vitiate the patient's responsibility, since the action (swallowing) in response to powerful emotions and desires is secondary to rational decisions, and the patient is responsible for making the decision to tolerate difficult emotion or act impulsively.[22]

The concepts of responsibility and competency have been explored with regard to patients with BPD, and treatment is generally based on the premise that they are autonomous.[23] "When a patient is able to function competently in the world and then finds herself cutting her wrists and overdosing over some trivial disappointment, she struggles to maintain her dignity, denying the seriousness of her recent behavior and accusing helpers of humiliating her. The only justification for depriving that patient of her liberty is the belief that she has regressed so severely that her adult, functional self could not re-emerge to prevent her from killing herself, or, very rarely, someone else."[24] An inability to control specific self-harming behavior, in and of itself, does not render an individual incompetent. The patient may be autonomous while it is only the act that is non-autonomous. If it is just the decision (or act) that is non-autonomous, then we may have the obligation to try to prevent or interfere with only the act itself, and withholding treatment for a non-autonomous act would be a violation of our ethical duties, as would abandoning the patient. In addition, if we question a patient's autonomy, the goal of treatment should be to restore autonomy, again providing treatment, which in turn would be designed to restore the patient's capacity for responsibility.[25]

ALLOCATION OF RESOURCES AND FUTILITY OF CARE

It is sometimes necessary and morally required to limit care to assure a just distribution of finite resources and non-maleficence to other patients and staff.[26] RFBI tends to be recurrent and resistant to treatment.[27] Of patients who inflict self-harm, 86 percent will repeat a self-harming behavior within one year, and 84 percent of people who present with RFBI have presented previously with similar behavior.[28] Some argue that patients can not claim greater than their "fair share" of resources, and that physicians should disallow futile treatment to conserve and redirect finite resources to those who would most likely benefit.[29]

The repetition of self-harming behavior can instill a sense of futility in healthcare workers involved in their treatment. Clearly, removing a foreign object from a patient's gastrointestinal tract is not physiologically futile, but is the RFBI patient's long-term outcome so poor that it makes sense to not provide treatment? The American Thoracic Society has put forth recommendations that treatment is futile and can be withheld if it will lack medical (physiologic) efficacy and if it will not lead to meaningful survival (as judged by a patient's personal values).[30] No such guidelines exist in the psychiatric world. While there are no studies that specifically follow the long-term outcome of RFBI patients, one study has reported that, over a 16-year period, 78 to 99 percent of patients with BPD had remission of their symptoms (with 10 to 36 percent eventually having a recurrence of

symptoms).[31] Thus, while it can be frustrating and expensive to care for patients with RFBI, there is at least some evidence that treatment is associated with a meaningful chance of recovery. In most cases, then, claims of futility will not provide justification for limiting the duty to treat.

At this time, there is no social consensus about healthcare allocation and we have no way to assess "fair" limits on treatment. This means that we may not pick and choose the patients on whom we will impose limits. If there were a standard way to judge effectiveness or to set limits on how much we spend on any one person, it might be theoretically justifiable to do so in these cases, but until we are willing and able to apply rules of allocation consistently, we have inadequate justification for applying them in these situations.

In addition, in a comprehensive approach to a patient, it is important to differentiate between treatment and care. In psychiatry and other fields, caring for a patient is never futile. The treatment of a patient may involve addressing specific medical or psychiatric issues with behavioral or pharmacologic management that is based on evidence-based approaches. Caring for a patient goes beyond this and encompasses a broader spectrum of investing in the outcome.

CONCLUSION

Thus far we have argued that patients who inflict self-harm, particularly by RFBI, have a right to treatment; they should be regarded as autonomous, at least legally, if not ethically (although the specific act of ingestion may be nonautonomous); they are entitled to resources; and providing care to them is not futile. We are left then with the question of what to do with patients who continue to seek care following repetitive self-harming behaviors such as the ingestion of foreign objects. Unfortunately, there are widespread and significant limitations within the current mental health system.

We suggest that more comprehensive care must be provided for these patients, based on a greater awareness of the complexity of these behaviors and establishment of effective communication. While this patient's primary presentation involves ingestion of a foreign body, her social and medical history is certainly more complicated and thus requires insight on the part of the physician to design a comprehensive approach to treating her. A thorough assessment and attempt to address medical, psychosocial, personal, family, and drug use issues must be made.[32] The use of counseling, pharmacologic treatment, education, utilization of outpatient mental health resources, and social support should all be maximized.

Patients who lack decision-making capacity or are at risk of imminent self-harm may be involuntarily hospitalized to prevent them from harming themselves. Even when it is available, inpatient psychiatric hospitalization actually may have a negative effect due to positive reinforcement of the patients' behavior.[33] Attempts to decrease the swallowing of foreign objects in the future has been mostly unsuccessful, and psychiatric treatment alone is often not effective in preventing future RFBI.[34] Patients who ingest foreign objects may not intend to kill themselves, but unintentional death may occur. A careful assessment of capacity, a determination as to whether the patient was attempting or not attempting suicide, and an evaluation of imminent risk of self-harm (for example, suicide) must be performed. Studies indicate that patients with BPD are at a high risk for completed suicide, with a rate of up to 10 percent.[35] Nearly 50 percent of completed suicides have a history of attempted suicide within the past 12 months, and 25 percent have an episode of deliberate self-harm in the year before death.[36]

If hospitalization is necessary, possible interventions to increase the effectiveness of the hospitalization include:

- outlining and spelling out protocols/approaches that are accessible to the emergency room for the next time the patient presents
- having plans to re-admit the patient to the same division/location each time for consistency of care and assurance that the team won't have to start over
- identifying a consistent and well-informed medical/psychiatric team with whom the

patient will be involved during future admissions
- planning pre-emptive staff meetings with each admission to avoid splitting among the staff (in which different members of the staff develop opposite opinions of the patient) and to deal with the inevitable frustration of the staff.

In addition, improving outpatient care with community-based models that emphasize inclusion of the patient in the treatment plan; regular patient contact through phone calls, home visits, and crisis contacts; limiting inpatient treatment; and increasing education for all personnel involved in treating patients with deliberate self-harm have been reported to be effective in reducing the number of admissions and the patient's length of stay.[37] A greater understanding of ethical issues and their application to patients with RFBI can enhance caregivers' ability to provide optimal care and improve patients' outcomes.

MASKING OF THE CASE

All of the details in the background narrative that might identify any person involved have either been removed or altered so that the substance of the issues related may be presented without infringing privacy or violating confidentiality.

NOTES

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