Voluntarism in Consultation Psychiatry: The Forgotten Capacity

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Case Presentation

Consultation Request

"Mr. B, a 36-year-old man with a history of Graves' disease and mood disorder is admitted to the inpatient psychiatric service on an emergency hold. The endocrinology service has recommended radioactive iodine (RAI) ablation of his thyroid gland to control severe Graves' disease, but the patient is refusing this procedure. Please assess for informed consent."

Informants

Information was obtained from Mr. B, the inpatient psychiatric service, the endocrinology service, and a review of most of Mr. B's outpatient psychiatric and medical records.

History of Present Illness

Police brought Mr. B to the emergency department after he was caught trespassing in a restricted area. He told the police officers that he had to go to this restricted area to punish those responsible for implanting satellite chips in his head, neck, and abdomen when he was 1 year old. On interview, Mr. B provided the same account. He denied any auditory or visual hallucinations or suicidal ideation. His mood was irritable, and he would not cooperate with an assessment of neurovegetative symptoms. Mr. B reported that he had not been taking his psychotropic medications or his methimazole for his Graves' disease. Because of evidence of psychiatric disorder, imminent harm to others, and perceived benefit of inpatient psychiatric treatment, Mr. B was placed on a 7-day hold.

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Hospital Course

Mr. B was quickly titrated to his former outpatient dose of ziprasidone (80 mg b.i.d.). Despite this treatment, he continued to have an irritable mood, impulsive and aggressive behavior, decreased need for sleep, and somatic and paranoid delusions. On multiple occasions, his disruptive and "dangerous" behavior resulted in the use of chemical and physical restraints. His cooperation with the treatment team was minimal. Mr. B's inpatient psychiatric hospitalization was further complicated by his medical problems. The psychiatric service consulted the internal medicine service to investigate malignant hypertension and the endocrinology service regarding Graves' disease. The endocrinology service was impressed with the severe stigmata of Mr. B's Graves' disease, which included visible goiter, bilateral tremor, and Graves' dermopathy. Mr. B's thyroid laboratory test results on admission were equally impressive, with his thyrotropin level undetectable and his T_4 level at 23.4 μg/dl. Given the failure of outpatient management with methimazole, the low likelihood of cure with methimazole with such a large gland, and the severity of the psychiatric and medical manifestations of Mr. B's hyperthyroidism, the endocrinologists recommended a definitive cure with RAI ablation. The endocrinologists explained their reasoning to Mr. B, but he refused the procedure. According to the endocrinology notes, his rationale for refusal was that he was "being held against [his] will." Efforts to contact Mr. B's family to obtain a surrogate decision maker were unsuccessful. The psychiatric intern subsequently told the patient and the endocrinology service that Mr. B "did not have decisional capacity" and would have to be forced to have the procedure against his will. The psychiatric attending physician and the endocrinology service requested a consultation to explore the ethics of this situation.

Psychiatric History

Mr. B's psychiatric history began when he was 30 years old, early in his career as a medical professional. Mr. B suffered from mood and psychotic symptoms that resulted in multiple psychiatric hospitalizations and a sharp decline in functioning. Over the course of his illness, his diagnosis changed from depression to bipolar disorder to schizophrenia. He was initially treated with antidepressants with some efficacy, and then with risperidone, which resulted in a large weight gain. He was later treated with ziprasidone, but treatment was complicated by long periods of nonadherence. Mr. B had no history of suicide attempts or chemical dependency. His family psychiatric history was significant for a father with alcoholism and depression, but there was no history of schizophrenia or bipolar illness. Mr. B's social history was significant for a high premorbid level of functioning, including training as a health professional. Mr. B was eventually forced to resign from his professional position and started collecting disability. He lived semi-independently with some assistance from his mother.

Mr. B's significant medical history began shortly before the onset of his psychiatric symptoms. He initially noted swelling in his legs, and his Graves' disease was diagnosed 18 months later. He was treated with methimazole and propranolol, and this treatment was also complicated by periods of nonadherence.

Clinical Interview

Mr. B stated that his psychiatric admission was for "psychosis" secondary to others' not believing him about the "implants and satellite chips." He reported his mood as irritable; he also said he felt distracted and reported that his thoughts were moving faster than normal and that he had a decreased need for sleep. He no longer expressed a wish to punish those responsible for the satellite chips, and he denied any homicidal or suicidal ideation or auditory or visual hallucinations. Mr. B did not describe any side effects from his current medication regimen. He frequently complained about the inpatient psychiatric service and expressed considerable frustration at being held against his will.

When questioned, Mr. B acknowledged his diagnosis of hyperthyroidism and summarized his treatment history. He was diagnosed about 5 years ago. His symptoms at that time included swelling in his legs, headache, increased heart rate, and hypertension. His previous endocrinologist had discussed RAI ablation early in the course of treatment, but Mr. B decided to take methimazole at that time. After several years of treatment, he thought he was "stable," so he discontinued his medication. He noted the return of his hyperthyroid symptoms several months ago, and he was able to recall recent laboratory test values confirming the diagnosis. With prompting, he was able to recognize and appreciate the impact of his thyroid disorder on his psychiatric symptoms and hospitalization. Despite acknowledging the diagnosis, the severity of his symptoms, and the risks of not receiving treatment, he stood by his refusal of RAI ablation because of his frustration and anger at being held on a locked psychiatric ward as well as his perception that the inpatient staff patronized him. "If I were a 5-year-old child," he said, "I would have had the same reaction."

Mental Status Examination

Mr. B was alert, appeared his age, and was moderately disheveled. He had notable lower extremity swelling, a mild bilateral resting tremor in his upper extremities, and psychomotor activity throughout the interview. He was occasionally distracted but did not appear to be responding to internal stimuli. His cooperation was initially tenuous, but he responded well to efforts to foster a collaborative relationship, as evidenced by improved eye contact and a more reciprocal conversation. His mood was observed and reported as irritable, and his affect was congruent with his stated mood, although the intensity decreased and the range increased over the course of the interview. His speech was initially rapid and difficult to interrupt, but it decreased in rate and volume over the course of the interview. His thought process was at times irrational but relevant and goal-directed. His thought content included somatic and paranoid delusions, but he denied any auditory or visual hallucinations as well as suicidal or homicidal ideation. Cognitively, Mr. B. was attentive to the interview. He was able to count backward and recite the months of the year backward, and he had no deficits in confrontational naming, repeating complex sentences, or following a three-step command. He was able to register and recall three objects, and he was oriented in all spheres. His ability to organize, sequence, and plan the drawing of a complex figure was intact. Mr. B's insight into his psychiatric symptoms was still impaired, as evidenced by his poor reality testing, but he readily recognized the impairment his thyroid disorder added to his psychiatric symptoms. His recent judgment was diminished, as evidenced by his refusal to cooperate with the psychiatric and endocrinology services.

Impression

Diagnostically, Mr. B's admission history and presentation were consistent with a manic episode, severe with psychotic features, as evidenced by irritability, decreased sleep, increased speech, increased energy, and paranoid and somatic delusions. However, secondary mania from Graves' disease had to be excluded or at least controlled to ameliorate his psychiatric symptoms. The consultation-liaison service deferred to the inpatient psychiatric service and outpatient providers for diagnostic clarification. With respect to informed consent for the RAI ablation procedure, Mr. B was able to communicate a choice, understood relevant information (his medical training helped in this regard), and appreciated the situation and its consequences. Although Mr. B. had somatic and paranoid delusions and impaired insight, his delusions were well circumscribed and did not appear to affect his ability to rationally manipulate information related to his thyroid disease or treatment. Thus, Mr. B appeared to have the information and the decisional capacity necessary for informed consent, yet both the inpatient psychiatric and endocrinology services suspected that his refusal of the RAI ablation procedure was inconsistent with his values and prior decisions. The external pressure imposed by the inpatient psychiatric hospitalization, his status as an involuntary patient on a locked unit, and his perception that the staff did not respect his self-determination were the most striking features that potentially diminished Mr. B's ability to provide authentic informed consent by impairing his capacity for voluntarism. Mr. B insightfully stated this when he correlated his refusal of RAI ablation with that of a 5-year-old child protesting a similar contravening of his free will.

Recommendations

Mr. B possessed adequate information and decisional capacity to provide informed consent for the RAI ablation procedure. It was his capacity for voluntarism that was impaired because of contextual features of his involuntary psychiatric hospitalization and his feeling that he was not being treated with respect and dignity. Recognizing the impact of the involuntary hospitalization on Mr. B, the consultation-liaison service asked the inpatient service to reevaluate the need for this status while attempting to foster a more collaborative relationship with Mr. B. The consultation-liaison service continued to work with both the inpatient psychiatric service and the endocrinology service to restore Mr. B's capacity for voluntarism so that he could participate in the informed consent process for the RAI ablation. In the event that these factors were unsuccessful in restoring capacity for informed consent, the inpatient psychiatric service was encouraged to devote more effort and resources to contacting Mr. B's mother to arrange for a surrogate decision maker.

TABLE 1. Examples of Roberts's Four Domains of Voluntarism

Domain	Example
Developmental factors	Progressive emotional and intellectual maturity of young people to make complex medical decisions (13)
Illness-related considerations	Ambivalence and pessimism of depression; compulsive use and impulsive behavior in substance use disorders (14)
Psychological issues and cultural and religious values	Family autonomy in some Hispanic, Native American, and Asian cultures (15); Catholic beliefs regarding moral action at beginning and end of life (16)
External features and pressures	Relationship with caregiver; economic burdens of extended care (17)

TABLE 2. Voluntarism Assessment

Domain	Questions for Assessment
Developmental factors	Is the patient . . .
	A child or adolescent?
	Pregnant?
	Geriatric?
Illness-related considerations	Diagnoses: Does the patient have . . .
	Depression or other mood disorders?
	A psychotic disorder?
	A substance use disorder?
	Dementia or another neuropsychiatric disorder?
	Severe, chronic, or uncontrolled pain?
	A physical disability leading to dependence?
Psychological issues and cultural and religious values	Does the patient have . . .
	Religious, spiritual, or philosophical beliefs related to illness?
	Social or cultural beliefs related to illness?
	Personality traits or defense mechanisms that affect ability to accept or cope with illness?
	A current or past history of trauma?
	Does the patient belong to a minority or disadvantaged group?
External features and pressures	Is the patient experiencing . . .
	Financial problems?
	Homelessness?
	Criminal charges or legal proceedings?
	Difficult or dysfunctional family relationships?
	Lack of social support?
	Overlapping relationships?
	Other conflicts of interest?
	Current or past institutionalization?

Follow-Up

In conjunction with the consultation-liaison service, the inpatient psychiatric service was able to foster a collaborative and respectful relationship with Mr. B. Because the patient no longer exhibited any evidence of dangerousness, the psychiatric service agreed to discontinue his involuntary status. As expected, once his voluntarism was honored, Mr. B. agreed to stay on the inpatient psychiatric ward on a voluntary basis, consented to the RAI ablation procedure, and fully cooperated with the endocrinology service. Immediately after the RAI ablation procedure, Mr. B was transferred to a monitored bed on the cardiology service for observation of ablation-induced arrhythmias. He was cooperative with the treatment team and ancillary staff for the duration of his medical admission. Several days after the procedure, Mr. B. was discharged from the hospital and returned home without incident or complication. He continued psychiatric outpatient treatment, and his symptoms and level of functioning continued to improve.

Discussion

Assessments of decisional capacity to provide informed consent for, or refusal of, medical treatments, to leave the hospital against medical advice, or to manage a variety of living situations are among the core clinical tasks of consultation-liaison psychiatrists (1, 2), accounting for an estimated 3%–8% of all requests for psychiatric consultation (3). Evaluation of cognitive functioning has been the cornerstone of capacity assessments, particularly in patients with current or past psychiatric disorders, for several reasons. First, formal thought disorders are a cardinal symptom of psychiatric disorders such as schizophrenia (4, 5). Second, impairments in cognitive functioning, such as loss of remote or recent memory, and problems with executive functioning are the clinical hallmarks of dementia, a condition frequently encountered on medical-surgical wards and in nursing homes (6). Third, most of the high-quality research on decisional capacity assessment has been done in a research context, and given ethical and legal requirements for informed consent, it has been cognitively based. Translations of research measures and methods to the clinical setting, in turn, have naturally maintained the cognitive approach (7–9).

These cognitively based assessments have substantially improved the rigor, clarity, and standardization of decisional capacity evaluations for research and treatment. They remain the essential first step in exploring the capacity of any patient to consent to treatment. However, noncognitive dimensions of decisional capacity may also be significant and require attention, especially in cases where

no serious or overt cognitive dysfunction is detected through bedside or formal neuropsychological testing. Several authors have suggested that emotional capacities, such as appreciation, and volitional components, such as voluntarism, have been historically neglected in the research and practice of capacity determination and merit further research and clinical development (10–12).

Roberts has explored the capacity for voluntarism as it pertains to informed consent (12). She defines voluntarism as "the individual's ability to act in accordance with one's authentic sense of what is good, right, and best in light of one's situation, values, and prior history." Voluntarism, she says, encompasses the classical exercise of free will or self-determination understood as the absence of excessive internal or external coercion. Roberts identifies "deliberateness, purposefulness of intent, clarity, genuineness, and coherence with one's prior life decisions" as qualities of an authentically voluntary decision (12). She cites four domains of influence that can potentially enhance or diminish voluntarism: developmental factors; illness-related considerations; psychological issues and cultural and religious values; and external features and pressures. Table 1 provides examples of each domain.

The case presented illustrates the benefit of an assessment of voluntarism that is integrated with classical evaluations of cognitive capacity and demonstrates a clinical application of Roberts's construct in the practice of consultation-liaison psychiatry. Neuropsychologically based assessments of Mr. B's ability to provide informed consent disclosed no significant deficits in the gold-standard measures—capacity to understand, reason, appreciate, or communicate regarding the clinical facts and treatment choices (18). Yet the clinicians and the consultants alike sensed a lack of consistency, authenticity, and intentionality, which are the hallmarks of deliberate, free, cohesive expressions of self-determination (19). Exploring the voluntarism aspects of this case illuminated previously undetected features of the clinical contexts that contributed to impairments in volitional capacity, which in turn compromised the patient's ability to provide informed consent. These insights enabled the treatment team to develop plans that could address and substantially improve Mr. B's deficits in voluntarism and hence in the adequacy of his capacity for informed consent. Here, the assessment of voluntarism was pivotal to the resolution of the case and permitted the patient to assert the self-determination he had always in essence possessed (20). In more difficult and less plastic cases, recognition of deficits in voluntarism may not automatically restore this capacity (21). Nevertheless, clinicians may feel that aggressively trying to address such deficits is an important component of their professional obligations, including advocating for the patient.

We analyzed this and several other cases to formulate a bedside voluntarism assessment (Table 2). This assessment is purely qualitative, but we hope to use it as the basis for development of a more quantitative assessment. In its current form, the assessment may serve as a consciousness-raising tool and a voluntarism checklist to alert health care practitioners to developmental, illness-related, psychosocial, and external features of clinical treatment that may not be identified or given their proper weight in more traditional informed consent assessments. Applying this bedside voluntarism assessment to the case presented, we find that Mr. B's capacity for voluntarism was impaired because of the external pressures from his current hospitalization.

The foundation of any informed consent assessment should be a rigorous and methodical medical, neuropsychiatric, and diagnostic evaluation. Cognitively based assessments of decisional capacity are critical, and they will remain the primary means of determining capacity for informed consent. Assessment of voluntarism may be most useful in cases where a comprehensive psychiatric interview and mental status examination do not clearly indicate the presence of psychopathology but clinical intuition, contradictory choices, or existential dissonance hint at some impairment of self-determination that merits further exploration. Just as recruitment of social support or educational interventions can ameliorate or even restore decisional capacity, similar interventions can enhance or restore the capacity for voluntarism. Indeed, the true value of the voluntarism assessment may lie in its ability to unearth these buried features of a clinical picture, thereby allowing apparently insoluble ethical dilemmas to be approached from a different and more fruitful perspective.

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