



French lay people's and health professionals' views regarding the acceptability of involuntary treatment of nursing home residents



Astrid Lhermite^a, Maria Teresa Munoz Sastre^a, Paul Clay Sorum^{b,*}, Etienne Mullet^c

^a Mirail University, Toulouse, France

^b Albany Medical College, Albany, NY, USA

^c Institute of Advanced Studies (EPHE), Paris, France

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ABSTRACT

Objectives: We examined the views of lay people and health professionals in France about involuntary treatment of residents in nursing homes.

Method: Participants (101 lay people, 20 nurses, 20 psychologists, and 10 physicians) were presented with a series of stories created by varying the levels of five factors: type of behavioral problem encountered (e.g., night-wandering), associated signs of dementia, physician's effort to explain the reason for treatment, resident's attitude (e.g., lasting reluctance), and physician's decision to prescribe psychotropic drugs or not. Participants were asked to judge the acceptability of the decision in each concrete case.

Results: Three qualitatively different positions were found. The largest group (40% of the participants) viewed treatment of residents' behavioral problems as the most important objective. They felt it also important to respect residents' wishes and, therefore, to spend much time in talking with them about treatment. An almost equally large group (39%)—which included 60% of physicians—viewed respect for residents' autonomy as the most important consideration. A smaller group (21%)—including 40% of the psychologists—focused on the importance of taking time to talk with the residents. They also thought that treating patients against their will was unacceptable. Thus they took autonomy one step further than the preceding group.

Conclusion: It is important to reduce as much as possible the conflict between the principles of patient autonomy and perceived beneficence when caring for nursing home patients with behavior problems. This can be done by promoting their decision making abilities.

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1. Introduction

Behavioral problems (BPs) are frequent among nursing home residents (Cohen-Mansfield, Marx, Dakheel-Ali, Regier, Thein, and Freedman, 2010a). They take the form of (a) agitated behavior, either physical (e.g., general restlessness, wandering, inappropriate dressing) or verbal (e.g., repetitive questions, negativism), (b) aggression (e.g., insulting, kicking, scratching, throwing objects), and (c) hiding and hoarding (Rabinowitz, Davidson, De Deyn, Katz, Brodaty, & Cohen-Mansfield, 2005). Residents may also suffer from depression and anxiety. These behavioral problems may place all residents at risk of harm, and they can also be distressing for caregivers and visitors. Psychotropic drugs have commonly been used to treat BPs, and their use has been increasing in France (Savoia, Godet, & Dubuis, 2009). But their use is highly controversial: their efficacy on BPs is known to be low, and adverse effects are not uncommon (Cohen-Mansfield et al., 2010a,b). In addition,

residents may refuse to take psychotropic medications because they do not necessarily understand the nature of their effects, they may have trouble swallowing them, they may have directly or indirectly experienced undesirable side effects, or they may have negative attitudes toward caregivers and the institution (Vuckovich, 2010).

When residents are very agitated or aggressive, when they are unwilling to take psychotropic drugs, and when there are no alternative non-pharmacological techniques available in the nursing home—a not infrequent configuration in France or elsewhere—caregivers can be led to administer these drugs against the will of the residents. Involuntary treatment—specifically, coercing nursing home residents to take medications—clearly involves a weighting of ethical concerns. The principle of autonomy of the residents is outweighed, in the minds of the caretakers, by the principles of beneficence toward them and responsibility to those who might be affected by the residents' actions (assuming the caregivers are not acting merely to make their jobs easier). The grounds for not respecting autonomy are, first, that residents lack the capacity to give informed consent about their choices, and/or, second, that residents are likely to harm themselves or others if not treated.

The Section of Old Age Psychiatry of the World Psychiatric Association issued in 2009 a consensus statement on ethics and capacity in older

* Corresponding author at: Albany Medical College, 724 Watervliet-Shaker Road, Latham, NY 12110, USA. Tel.: +1 518 262 7500; fax: +1 518 262 7505.

E-mail addresses: lhermite@univ-tlse2.fr (A. Lhermite), sorump@mail.amc.edu (P.C. Sorum), etienne.mullet@wanadoo.fr (E. Mullet).

people with mental disorders (Katona, et al., 2009). It insists on respecting people's autonomy and declares, in particular, that "Older people who are competent to make decisions have the right to refuse treatment which they believe would compromise their quality of life" (p. 1322). However, the consensus statement, which includes dementia as a mental disorder, recognizes that people can make decisions about their health and social care only if they have the mental capacity to do so. Similarly, Article 5 of the European Convention on Human Rights states that "persons of unsound mind" might, "in accordance with a procedure prescribed by law," be deprived of their liberty by "lawful detention" (European Court of Human Rights, 2010). French medical ethics (Ordre des Médecins, 2012) and law are largely in accord with these principles.

The French state has long felt a responsibility to protect its most vulnerable citizens, though without articulating the legal principle of *parens patriae* that emerged in early modern England and spread to North America. The specific legal basis in France currently for involuntary treatment of nursing home patients without decision-making capacity appears to be the law of July 2011 on the rights and protection of people under psychiatric care, which sets forth the conditions for involuntary hospitalization and involuntary treatment of people with mental troubles (Gourevitch, Brichant-Petitjean, Crocq, & Petitjean, 2013; République Française, 2013). The aim of involuntary hospitalization is to prevent harm to the patient or others and to enable effective treatment of the patient. The Court of Appeals has dealt with cases of involuntary hospitalization but not with cases of involuntary treatment of nursing home patients (Cour de Cassation, 2013).

1.1. Lay people's and professionals' attitudes concerning involuntary treatment and involuntary hospitalization

Most previous studies have focused on involuntary hospitalization. Pescosolido, Monahan, Link, Stueve, and Kikuzawa (1999) found that a majority of their sample of American lay people considered that patients suffering from mental illness (schizophrenia) are not very able or not able at all to make treatment decisions (74.3%) and should be admitted against their will to the hospital if dangerous to others (90.5%) or to self (94.8%). Elger and Harding (2004) found that 44% of law students agreed with involuntary hospitalization of suicidal patients. Luchins, Cooper, Hanrahan, and Rasinski (2006) examined the opinions of psychiatrists regarding involuntary hospitalization and found that decisions to hospitalize were positively associated with the level of possible harm and differed as a function of the psychiatric diagnosis (see also Luchins, Hanrahan, & Heyrman, 2006).

Steinert, Lepping, Baranyai, Hoffmann, and Leherr (2005) conducted a cross-cultural study involving psychiatrists, other professionals, and lay people from four European countries: England, Germany, Hungary, and Switzerland. Participants were presented with scenarios describing patients with schizophrenia and indicated in each case whether they would support involuntary hospitalization. In the case describing a first episode of schizophrenia associated with social withdrawal, 74% of the participants agreed with compulsory hospitalization. In the case of recurrent episodes and moderate danger to others, 87% of the participants agreed with compulsory hospitalization. Psychologists and social workers were, however, significantly less in agreement with that decision than psychiatrists, nurses, and lay people. There were only small differences in percentages of agreement from one country to the other (see also Lepping, Steinert, Gebhardt, & Röttgers, 2004; Wynn, Myklebust, & Bratliid, 2006, 2007).

Guedj, Sorum, and Mullet (2012) found that both lay people and health professionals may take one of four qualitatively distinct positions regarding the involuntary hospitalization and treatment of reluctant psychiatric patients: never acceptable irrespective of circumstances (5%), acceptable only if threat to others (22%), acceptable if either threat to others or threat to self, associated with lack of adherence to treatment (57%), and always acceptable (16%).

1.2. The present study

The present study examined the views of lay people and health professionals in France about involuntary pharmacological treatment of residents in nursing homes. Specifically, it examined the mental process by which a person arrives at the conclusion that compulsory treatment in the nursing home is acceptable or not as a function of the concrete circumstances of the case. Like the study of Guedj et al. (2012), the present study aimed at delineating the possibly diverse positions that individuals—both lay people and health professionals—may have regarding the involuntary administration of medications. The present study, like many previous ones (Steinert et al., 2005), used scenarios; that is, participants were instructed to consider concrete cases and indicate each time whether, in their view, involuntary treatment was an acceptable solution.

The factors incorporated in the scenarios were those more commonly encountered in the literature on BPs in nursing homes. The first factor was the type of behavioral problem (see Rabinowitz et al., 2005). Four frequently encountered problems were selected: aggressive behavior, anxiety, depression, and night-wandering. Some of these problems involved major risks for the resident (accident due to wandering), or risks for others (aggression of other residents or caregivers). Other problems did not directly involve major risks (anxiety and depression). The second factor was associated signs of dementia (e.g., Cohen-Mansfield, Jensen, Resnick, & Norris, 2011). Two levels were selected: absence vs. presence of signs of dementia. The third factor was the physician's effort to explain the reason for treatment (Jackson, Mangoni, & Batty, 2003). In some scenarios, the physician has taken time to explain to the resident the benefits he/she could derive from treatment. In others, the physician has not taken much time to do it. The fourth factor was the resident's attitude (e.g., see Vuckovich, 2010). In some scenarios, the resident agrees to take a medication and in others cases the resident refuses. Finally, the fifth factor was the physician's decision to prescribe psychotropic drugs or not (see Cohen-Mansfield & Lipson, 2006). The fourth and fifth factors were, however, combined into a three-level factor: resident refuses treatment and physician prescribes, resident accepts and physician prescribes, or resident refuses and physician does not prescribe. The fourth combination would have been meaningless.

We expected to find at least two contrasting positions: (a) that the only acceptable option is to respect the resident's autonomy, and (b) that it is not acceptable to refrain from treating an agitated resident. This expectation was in accordance with many years of debates over the extent of coercion during psychiatric admissions (Taborda, Baptista, Gomes, Nogueira, & Chaves, 2004). On the one hand, patients and their lawyers, supported by civil rights advocates, have argued for due process protections and the least restrictive alternative; on the other hand, mental health professionals and family groups have argued for the maintenance of civil commitment. In other words, very different positions about coercion may co-exist in society.

2. Methods

2.1. Participants

The 151 participants (104 females, 47 males) were unpaid volunteers from the region of Toulouse, France, who were informed about the goals of the study and gave their consent. Their mean age was 33 years ($SD = 10$, range = 18–65). One hundred one participants were lay people, 20 were nurses working in nursing homes, 20 were psychologists working with elderly people, and 10 were physicians working in nursing homes.

The lay people were approached by two trained research assistants while they were walking along the main sidewalks of Toulouse, a city in southern France. Overall, 250 persons were contacted, and after having received a full explanation of the procedure, 60.4% of them agreed to participate. The professionals were contacted at the nursing

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