

IN THE CLINIC

PAIN, COMPETENCY AND CONSENT

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Mr. John Smith, a 34-year-old male, is brought to the Emergency Department by ambulance, approximately 20 minutes after a fall of 4 feet from a ladder. Prior to arrival in the Emergency Department, Mr. Smith had his right leg placed in a traction splint and an intravenous (IV) started by the paramedics. Assessment by the Emergency Physician (EP) reveals that Mr. Smith's vital signs are stable and his injuries are limited to a very painful and almost certainly fractured right femur. There is no evidence of damage to the blood vessels or nerves of his leg. Mr. Smith has previously been healthy and he has no drug allergies.

Following completion of her assessment, the EP explains to Mr. Smith that he has almost certainly fractured his right femur, and that most patients with similar injuries are treated by surgical placement of a metal rod into the thigh bone by the bone specialist, but that there are less invasive operative alternatives. Mr. Smith states that he is relieved that his injuries are not more severe and that he would like "something for pain!"

The EP explains, that if she gives him pain medication, he may not be able fully to understand everything that the Orthopaedic Surgeon (OS) will want to explain about his injury and the treatment options. Mr. Smith replies that "the pain is really terrible and I can't stand it" and that he does not want to wait for the surgeon to arrive before getting pain relief. The EP then administers sufficient IV morphine to largely relieve Mr. Smith's pain.

Subsequent X-rays do reveal a mid-shaft femur fracture and the OS, upon arrival, approximately 30 minutes after Mr. Smith received the IV morphine, finds the patient to be awake, alert, and agreeable to having the operation. However, the OS is concerned about the validity of a consent obtained after administration of IV morphine.

GENERAL COMMENTARY

A number of factors affect a patient's competency to make a valid choice (consent to accept or refuse). In the case before us, both the effects of pain and of pain medication are in question. The crucial issues to be addressed are: (i) the purpose(s) for which the EP is obtaining consent to pain medication, and thereby the sort of information that must be conveyed to the patient for his understanding and choice; and (ii) the effect of both pain and pain medication on the patient's competency and ability to make a valid choice. The specific choice is complicated: whether to choose pain medication now, foreseeing that a future choice must be made, and knowing that the pain medication may interfere with that future choice.

OS's Position

The OS's standard practice is to leave the patient in pain until he has examined the patient and the patient has made a choice regarding treatment. Such practice seems to reflect the view that provision of pain medication necessarily invalidates consent; that a patient who has been given pain relief, has a "status" inconsistent with competency to consent to treatment.

If the patient is found to be awake, alert and agreeable, why is the OS worried about validity of consent? If the only worry is that the patient's status (of having been given analgesics) in itself makes the consent invalid, such thinking may be outdated or mistaken. First, clinical practice as well as law have moved away from a global conception of competency and incompetency to a

conception of partial or decision-specific competency and incompetency. Decisions of different complexity require different abilities, capacities, or competencies. In this medical situation, decision-specific competency is at issue: Is Smith, having received pain relief, competent to make a valid choice between surgical options?

Second, if after applying standard competency tests, the patient is found to be awake, alert and agreeable the OS may proceed legally in good faith. In law, the standard of care would be phrased in terms of what a reasonable OS would believe about the patient's competence in the circumstances at hand. A reasonable OS would undoubtedly consider the use of analgesics in assessing the decision-specific competency of the patient. The OS's speculation that in law the patient may be found to be incompetent, whatever his professional judgment of the patient's competency happens to be, may lead the OS to his view of analgesia and competency. We do not discount the moral perplexity caused by such legal uncertainty, but question whether the OS would be on safer grounds (morally or legally) in acting on the direction of someone in severe pain.

Assessment of Competence

Should the determination of patient competency to consent to treatment (either to pain relief or to a surgical option) be subjective (i.e., left solely to the patient to decide)? For example, if the patient says that the EP's information is clear and that he understands, is that sufficient? Not according to law or sound moral principles. Emergency exceptions aside, the EP must be assured that the patient understands the nature of the proposed medical options (treatment), their consequences, the consequences of not having treatment, and the possible effects of both pain and pain medication on his future understanding and choice.

Unfortunately, there is no magic set of questions that guarantees a correct assessment — there is no gold standard for the determination of competency in any area of medical interest.

Hence, it is important to remember the underlying moral values of the doctrine of informed choice and the role of competency in that doctrine: we are attempting to protect not only the patient's bodily integrity (physical well-being) but also his competency so that he may make an informed choice.

Decision-Specific Competencies

At issue is the effect of pain and of pain medication on the patient's competency to make a valid choice. Two questions grounded our thinking: (i) Does the provision of pain medication **always** prevent valid choice? (ii) Does pain **never** interfere with valid choice? In our view, only if the answer to both questions was affirmative would the OS's position be correct.

Provision of pain medication may interfere with competent choice, but so too may severe pain. The EP and OS must make a decision-specific competency assessment in the particular circumstances of the case: Is Smith competent to make a treatment choice that will be put to him in his present state of pain or would pain relief assist him with decision-making?

A "sliding scale" is often used in competency assessments: the greater the risk of harm to the patient from his choice, the stricter the competency standard to be employed by the assessor (1, p. 77). Such a scale may be applied in the assessment of decision-specific competencies. If a patient is incompetent to choose pain relief because of severity of pain, then surely a patient in that state of pain must be incompetent to choose between surgical options — because, on a sliding scale of competency assessment, the standard of competency for choosing pain relief is less strict or lower than that for choosing surgical intervention because the risks involved in choosing pain relief are less than those of having surgery. At the same time, if the patient is competent to choose pain relief in his present state of pain, it does not follow that he is thereby competent to choose what sort of operation to have, since the standard of competency to consent to surgery is higher than that for consenting to pain relief. Since the risk of harm is higher for

a patient undergoing surgery than having pain relieved, according to sliding scale of competency assessment, the standard should be more strict (i.e., higher than that for pain relief).

Does provision of pain relief make it possible for the patient to meet the higher standard of competency to consent to surgery? In this case, our view is "yes."

The Relation between the EP and the OS

The trend in repairing fractures of the femur such as we have in this case is to the more invasive operation. Consent for the operation is supposed to be obtained by the OS. The OS may refuse to operate if he believes that the consent to treatment is invalid. If the OS thinks it would be unsound medical practice to proceed with surgery following provision of analgesics to the patient, he may wait until he thinks the patient is competent to make a valid choice, and then inform him of the medical options, or he may transfer the care of the patient to the care of another surgeon.

Should the EP withhold pain relief from the patient because of the OS's views concerning competence and valid choice? In our view the EP's primary duty is to secure the patient's well-being (i.e., goals and interests as he interprets them). From our perspective, tolerance of pain is determined on subjective criteria (i.e., the patient determines whether the pain is personally tolerable), and a competent patient has a right to choose pain relief even when this might interfere with: (i) an accurate diagnosis (e.g., by masking serious complications, such as internal abdominal injuries; or (ii) the validity of a subsequent choice.

To provide no pain relief when it is requested on the *sole ground* that the OS believes that a valid choice is possible *only if* no medication is given would be improper morally and incorrect medically and legally. If one keeps in mind the purpose for which one is providing pain medication, the proper course seems clear: one gives analgesics for the patient's benefit, not the surgeon's beliefs. If Smith's pain were clearly intolerable so that

communication and the likelihood of obtaining a valid choice was impaired, then the EP must be concerned to restore Smith's competency so that an informed choice might be made concerning treatment of the fracture.

Where effective communication seems reasonably possible, as it does here, the EP should ask Smith if the pain is tolerable without medication. The EP should inform Smith that she is concerned about pain control and impairing possible future choices Smith must make concerning treatment.

It is important that Smith understand that pain medication may ("likely", "most likely", "almost certainly", "certainly" — the EP's indication of probability is crucial) interfere with his ability to understand what the OS will tell him about medically indicated treatment. The response to analgesics varies with the individual: some people remain clear headed, some people not so. Generally, the effect is agent specific and depends upon: (i) the particular medication used; and (ii) dosage and time over which titrated. The EP should provide brief examples of the range of effects on clarity of reasoning and understanding, the consequences for effective communication, and indicate her own uncertainty about his specific case.

As well, Smith must be informed of the sorts of treatment decisions (to a more or a less invasive operation), that seem reasonably likely given what the EP knows of his condition. Thereby, while still in pain, Smith will have been given some idea of the choice he must later make and have been told that subsequent choices may ("likely", etc.) be affected by the analgesics the EP is going to give him. In sum, the EP will strive to clarify the different choices Smith must make at different times, and the relation between his choice of pain medication now and the choice of treatment for the broken femur later.

If the patient accepts analgesics, then the EP must seek to control the pain and at the same time to keep the patient's mind clear so that he may make a valid choice concerning medical options in the treatment of his femur. The morphine should be titrated slowly and the EP should continue to assess Smith's

competence so that she can advise the OS. The EP is thus fulfilling her duty of care to Smith and her professional duty to her colleague, OS.

CONCLUSION

Where pain is personally intolerable, it would seem to follow that the patient cannot make a valid choice until medication is provided. While there is very little literature on the effect of severe pain on a patient's ability to make a valid choice, many practitioners believe that it does interfere with communication and clear reasoning, and thus with valid choice.

In situations where patients are in severe pain and communication is impaired, the EP may properly accept an assent to pain relief and proceed accordingly. Patients who refuse pain relief in such circumstances present difficulty, but we think it acceptable not to treat. Some patients may be able to tolerate more pain than others, so that merely being "in pain" does not entail that one cannot make a valid choice.

Where analgesics are provided, it does not follow that valid choice cannot be made. Analgesia does not in itself render a patient incompetent to make medical choices. Pain medication is provided for two reasons: to relieve a harm (pain or suffering) *and* to control the pain so that a valid choice may be made later. To obtain a valid consent to the use of analgesics in the circumstances of this case, one must inform the patient: (i) that a future choice is to be made, (ii) of the possible contents of that future choice (medical options), and (iii) of the possibility that pain medication may interfere with that future choice.

REFERENCE

1. Weisstub, DN. *Enquiry on mental competency: Final report*. Toronto, Canada: Queen's Printer; 1990.