Ethical and legal issues in consultation liaison psychiatry and psychosomatic medicine

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Theme
Consultation-liaison psychiatrists frequently encounter clinical situations that have legal implications. The most common legal issue that arises in consultation psychiatry is the question of competence. Practitioners often turn to the psychiatric consultant for an opinion on whether a patient is competent when a patient is unable to consent to treatment or refuses a medically indicated procedure. This consultation request reflects a common misconception regarding the issue of competence. Competence is a legal state, not a medical one. Competence refers to the degree of mental soundness necessary to make decisions about a specific issue or to carry out a specific act. In contrast, psychiatric consultants can and should opine about a patient's capacity to make an informed decision or judgment. Capacity is defined as an individual's ability to make an informed decision.

Takeaways
The responsibilities of a consultation psychiatrist include a general understanding of the legalities of medical decision making. Competence is a fundamental requirement in medical decision making. Physicians evaluate a patient's decision-making capacity by clinical assessment; courts determine competence by a formal judicial proceeding. The most common reason for a competency evaluation is a patient's refusal to accept medical treatment. The psychiatric consultant's role in capacity evaluations is to determine if the patient currently possesses the capacity to accept or reject the proposed treatment. Consent for medical treatment is valid if the consent is voluntary, the patient is competent and the patient demonstrates knowledge of the proposed treatment. The psychiatric consultant may also serve as a vehicle of communication between the patient and the treatment team. E.g. why a patient chooses to leave the hospital against the advice of their physician and to evaluate whether the patient meets involuntary commitment criteria.

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Competency evaluation in the medically ill

Aim
The assessment of capacity to consent to a healthcare decision is an important part of day-to-day work in general hospitals. The role of liaison psychiatric services in assessment of capacity has not been well studied in Spanish practice. We looked at all such referrals (35) to a liaison psychiatric service in a teaching hospital in the course of one year. The commonest referrals were regarding capacity to consent to a therapeutic procedure, followed by post-discharge placement and ability to self-discharge. Organic mental disorders were the most frequent cause of incapacity. 20 (57%) of the referrals were for patients who had refused the intervention in question, and in 12 of these the contentious issue was resolved.

Methods
Retrospective observational studies

Results
One hundred retrospective consultation reports were reviewed and 100 prospective consultations were followed for issues relating to medical patients’ competency to make treatment decisions. Fifteen percent of consultation requests were found to involve competency issues. Short case descriptions illustrate the three most frequent types of patients in competency referrals: those who have inflicted harm on themselves, elderly patients with cognitive deficits, and persons who present management problems.

Conclusion
The development of a set of instruments to structure these evaluations of competency in the medically ill patients, and more resident training in this forensic area are highly desirable.

Reference

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**Legal issues in Psychosomatic Medicine**

**Aim**
Medical practice occurs in the setting of laws and regulations, no matter what the jurisdiction. CL psychiatrists are confronted with legal issues perhaps more than any other group of physicians as they encounter patients with disorders of affect, behavior, and cognition in the course of medical care, raising central questions about autonomy, decision-making, and consent. Issues of individual protection, confidentiality, psychiatric inpatient care, and risk assessment also frequently arise.

**Methods**
This section will focus on the above central legal topics that arise in US CL psychiatry practice and the challenges posed when legal requirements and clinically indicated care appear to diverge. The talk will engage broadly applicable general strategies for reconciling clinical care with legal regulation in the interest of the patient. Additional topics to be covered include the relationship between law, medicine, and ethics as well as the role of rights language and difference conception of “rights.” Ultimately, the talk will emphasize the importance of knowing the relevant law while primarily functioning as clinician. A multi-centric, randomized study, with a simple of 45 cases, will be presented.

**Results**
The statistical analysis will show the main outcomes differences amongst those CL services which count with a legal and forensic psychiatrist and those which does not have legal consultation available.

**Conclusion**
It is essential to consider a legal psychiatrist job in every CL team.

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Euthanasia in psychiatric patients in the Netherlands - state of the art

Aim
Euthanasia in psychiatric patients is increasing over the past 5 years, it still raises many questions and is a topic of current debate in the Netherlands.

Methods
Registered data of the RTE's will be used to describe the current practice in the Netherlands. Review of the Code of Practice and the revised Guideline of Euthanasia in psychiatric patients.

Results
Data of euthanasia in psychiatric patients from 2011-2017; an overview of the requests of patients and the role of the physicians (psychiatrist, GP and/or medical specialists)

Conclusion
Although euthanasia in psychiatric patients is a very complex field, the numbers are increasing. Nevertheless psychiatrists are more hesitant compared to other physicians and currently even more than in the past.

Reference
RTE manuals

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Euthanasia in cases with a psychiatric or psychosomatic profile

Dutch euthanasia law does not require that patients need to suffer from a lethal disease in order to meet the requirements. A psychiatric disorder can also be a legally valid source for the unbearable and irremediable suffering that the law requires. A psychiatric disorder does also not necessarily disqualify a patient to meet the legal requirements concerning an autonomous and well-considered request.

The jurisprudence of the Euthanasia Review Committees has also sanctioned some cases where the patient apparently suffered from somatic complaints, but where no specific and generally accepted medical disease or disorder could be shown to be to cause. A large majority of Dutch doctors, including psychiatrists, will not consent to performing euthanasia in such cases. A practical consequence of this has been that in a large majority of such cases where euthanasia has been performed, it was not performed by the physician responsible for the regular treatment, but by physicians working for the specialized euthanasia expertise center.

This is in itself a deplorable development, since there is consensus that especially in cases with long-term suffering without a clear somatic etiology, the assessment of the physician with a long-term relationship with the patient is key. These cases might include: Mental health problems as the prime ground for the suffering that inspires the euthanasia request; a combination of ‘somatic’ and mental health problems as ground for the suffering that inspires the euthanasia request; a specific ‘psychosomatic’ health problem as such ground, including the ones usually gathered under the umbrella of MUPS.

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