AN INVESTIGATION OF COERCION AND AUTONOMY IN MEDICAL CARE.

HOW MUCH CHOICE DO PATIENTS REALLY HAVE?

Adam James Harper Sims

A thesis submitted for the degree of

Master of Medical Science

At the University of Otago, Dunedin

New Zealand

December 2013
ABSTRACT

The experience of coercion in health care is controversial. Coercion is likely to promote negative attitudes towards clinical care. People’s attitudes to health care potentially impacts on health outcomes and future interactions with the health system. In contrast, attending to patient autonomy is likely to enhance patients’ positive attitudes to healthcare. The relationship between coercion and autonomy is not entirely clear but intuitively coercive care seems to oppose the principle of autonomy. Similarly, possessing autonomy limits coercion.

Patient autonomy is heralded as an important concept in current medical practice. A detailed literature search failed to identify any previous study that considered the association of perceived coercion with autonomy preference. The majority of clinical studies on coercion have focussed on the experience of psychiatric patients whereas very few have considered the perception of coercion during medical admission, and none were found that related to coercion in a New Zealand medical setting.

Past psychiatric research has shown the perception of coercion is not exclusively associated with compulsory status and is actually more closely associated with procedural justice. It is likely, but previously unproven in a New Zealand context, that some medical patients will feel invalidated during admission and hence report their experience as coercive. This study attempts to understand the relationship between autonomy preference and perceived coercion. It also aims to measure the amount of
perceived coercion reported by patients during a medical admission to a general hospital.

Perceived coercion and patient autonomy were measured in a cross-sectional survey of 86 general medical patients in the Medical Assessment and Planning Unit (MAPU) of a tertiary hospital in New Zealand. The socio-demographic characteristics of the sample, and perceived coercion and autonomy preferences, were evaluated using the “Admission Experience Survey” to measure the perception of coercion at admission, and the “Autonomy Preference Index” to measure the patients’ desire for information about their health status when making healthcare decisions.

Almost all survey participants showed a strong desire for information about their healthcare and treatment, although wide variations in their desire to make decisions about their health were apparent. Over one third of participants reported feeling coerced during their admission. No significant association between perceived coercion and autonomy preference was found.

This research shows that perceived coercion is not restricted only to psychiatric care and is relatively commonly reported by patients during medical admission. Confirmation that coercion exists in routine medical care may reflect on the persistence of paternalism in current general medical practice. The long term outcomes of patients who believe they were coerced during a medical admission are unknown but could influence the willingness of these patients to seek health care in the future.
ACKNOWLEDGEMENTS

This study would not have been possible without the support and assistance of a number of key people. Firstly, thank you to my wife Sarah who was gently persuaded (almost coerced) that undertaking this research would not interfere with family time or other home responsibilities! My three girls, Georgia (7), Sophia (4) and Phoebe (2) have also done their bit by complying with house rules of going to sleep at a reasonable hour to provide windows of opportunity for work. Thank you also to my parents who have assisted in editing, and made helpful suggestions along the way.

I am very grateful to my main supervisor, Professor Collings, who has been a guiding influence and has helped keep me focussed through the research journey. Special thanks to my second supervisor, Professor Ellis for his wise recommendations and continued interest in the study. Thanks also to Dr James Stanley for providing the statistical advice on a number of occasions. I also want to acknowledge Professor Romans who was kind enough to review an early version of the work and has been a valuable mentor.

Many thanks go to my work colleagues in the Consultation Liaison Psychiatry service and the Old Age Psychiatry service who have tolerated my occasional mental and geographical absences to complete this work. I am also very grateful to the participants who gave their time often in particular challenging circumstances. Thanks to the staff of the Medical Assessment and Planning Unit who were very helpful during the data gathering process.

This study received financial support through the ‘Young Investigator Grant’ of the Royal Australia and New Zealand College of Psychiatry.
# TABLE OF CONTENTS

**ABSTRACT** .......................................................................................................................... II

**ACKNOWLEDGEMENTS** ......................................................................................................... IV

**TABLE OF CONTENTS** .......................................................................................................... V

**LIST OF TABLES** .................................................................................................................. VII

**LIST OF FIGURES** ................................................................................................................ VIII

**CHAPTER 1: HISTORICAL OVERVIEW AND DEFINITIONS** .................................................. 1

The scope of this study ............................................................................................................. 1
  Historical overview and definitions ......................................................................................... 3
  Coercion: definition .................................................................................................................. 12

**CHAPTER 2: LITERATURE REVIEW** ..................................................................................... 19

Autonomy: selective literature review ................................................................................... 19
  Autonomy in medical practice ............................................................................................... 19
  Autonomy and the sick role ................................................................................................... 23
  Autonomy and medical decision making ............................................................................. 24

Coercion: literature review ..................................................................................................... 27
  Coercion and psychiatry ........................................................................................................ 28
  Coercion and substance abuse ............................................................................................ 49
  Coercion and eating disorders ............................................................................................. 53
  Coercion and medicine ......................................................................................................... 56

Summary of the literature ......................................................................................................... 59
  Justification for this study ..................................................................................................... 59

Aims and research questions .................................................................................................... 61
  Research aim A. ..................................................................................................................... 61
  Research aim B. .................................................................................................................... 61
  Research aim C. .................................................................................................................... 62
Chapter 3: Methods

Method........................................................................................................... 63
Part One: Design, setting and sample................................................................. 63
Part Two: Measures............................................................................................ 65
Part Three: Analysis ........................................................................................... 69
Part Four: Procedure.......................................................................................... 70

Chapter 4: Results

Recruitment ...................................................................................................... 71
Socio-demographic characteristics of participants.......................................... 72
Perceived coercion .............................................................................................. 75
Associations with perceived coercion............................................................... 77
Autonomy preference: information seeking..................................................... 80
Autonomy preference: clinical scenarios.......................................................... 81
Associations between perceived coercion and autonomy preference............ 81

Chapter 5: Discussion and Conclusions

Part One: Review and evaluation of key findings.......................................... 82
Part Two: Strengths and limitations of this study.......................................... 106
Part Three: Implications of the findings......................................................... 109
Part Four: Conclusion....................................................................................... 115

References..................................................................................................... 117

Appendices..................................................................................................... 131
Appendix 1: Information Sheet....................................................................... 131
Appendix 2: Consent Form............................................................................. 133
Appendix 3: Questionnaire............................................................................. 134
LIST OF TABLES

Table 1. Types of pressure................................................................. 41
Table 2. Demographic characteristics ............................................. 72
Table 3. New Zealand index of socioeconomic deprivation scores........ 73
LIST OF FIGURES

Figure 2. Distribution of responses for the perceived coercion sub-scale. ................. 75
Figure 3. Distribution of responses for the negative pressure subscale. ...................... 76
Figure 4. Distribution of responses for the procedural justice sub-scale. ................. 77
Figure 5. Distribution of autonomy preference index scores ...................................... 79
Figure 6. Distribution of autonomy preference index scores ..................................... 80
Figure 7. Decision making preferences across three clinical scenarios ..................... 81
CHAPTER 1: HISTORICAL OVERVIEW AND DEFINITIONS

The scope of this study

Unexpected admission to hospital is a challenging experience and often associated with deprivation of usual freedoms. Alongside having to cope with physical illness comes adaptation to the culture of the hospital. Patients must interact with multiple staff members as they are guided through the admission process to eventually become an inpatient. In many cases their autonomy is potentially threatened as decisions are made on their behalf, investigations are requested, and diagnoses are entertained in the pursuit of appropriate treatment. Freedoms are removed, as clothing often becomes a hospital gown, meals are delivered at set times, and patients are expected to comply with the regulations of the hospital culture.

Research conducted in psychiatric settings has demonstrated that the restrictions imposed during hospital admission are a negative experience for patients.¹ This research showed that while some rationale for regulations is understood by patients, many restrictions are considered punitive and unnecessary. Alongside more extreme coercive measures such as restraint and seclusion, less restrictive, informal practices were also perceived as being coercive. These included the requirement to wear pyjamas, limits on visiting hours, and restrictions on movement.¹ These rules could equally apply to a medical ward setting in a general hospital.

At admission patients are faced with ill health, often overlaid with diagnostic uncertainty. The decision regarding admission is a medical one but theoretically and pragmatically requires the collaboration of the patient. However, in my experience of the health system hospital services are often stretched, and healthcare professionals are balancing demanding
workloads. I therefore wonder to what extent collaboration in decision making is restricted. Healthcare professionals, whose job it is to treat illness, may see admission as in the best interests of the patient. This may not fit with the patient’s preference and potentially contributes to the patient feeling coerced during this process.

The advancement of medicine has brought with it greater specialisation, more clinicians and increasingly complex care systems possibly at the expense of individual patient care. Porter emphasises this situation in the following quotation.

_The hospital was no longer primarily denounced, however, as a gateway to death but as a soulless, anonymous, wasteful and inefficient medical factory, performing medicine as medicine demanded it, not as the patient needed it._

Impersonal experiences during admission may also contribute to a greater sense of coercion for patients.

The aim of this study is to investigate the perception of coercion following a medical admission to hospital. It specifically explores the relationship between autonomy preference and the patient’s perception of coercion. The hypothesis of this thesis is that coercion is an ever present part of an institutional process for some patients and admission to hospital often involves an element of coercion. While seldom acknowledged, in my experience, informal coercive care continues to play an important part in medical treatment and this research sets out to explore this observation.

Chapter One sets the background to understand the constructs of perceived coercion and autonomy preference from a philosophical and historical perspective. The various definitions of coercion are outlined and a definition of coercion for this study is provided. Next a focussed
literature review of autonomy preference was undertaken along with a more extensive literature review of the perceived coercion in the fields of general psychiatry, eating disorders and substance abuse (Chapter 2). A review is also provided of the limited research of the perception of coercion in a general medical setting. The method used is described (Chapter 3) and results presented (Chapter 4). Finally the findings, strengths and weaknesses are discussed together with the implications of the results (Chapter 5).

**HISTORICAL OVERVIEW AND DEFINITIONS**

This section provides an overview of the historical and philosophical understanding of both autonomy and coercion. An outline of how autonomy has unfolded through time is discussed setting the back ground for its current prominence in medical culture. Similarly the understanding of coercion as a construct has continually evolved over time. This has contributed to making it a challenging concept to define. This section focuses on the important philosophical literature that has shaped the current understanding of coercion. It then considers the various ways coercion is defined within the literature. The overall aim of this chapter is to set the back drop for understanding the principles of autonomy and coercion and therefore provide the context to understand the research questions posed in this study.

**Autonomy: history and philosophical underpinnings**

Autonomy is widely accepted as one of the most important principles shaping the current practice of medicine and is a central pillar of modern bioethics. The derivation of the word “autonomy” comes from the Greek “auto” referring to “self”, “nomos” meaning law, together giving “auto-nomos” to self-govern. Within clinical medicine, autonomy focuses upon the idea
of being able to make decisions about health for oneself. This is well described in the following quotation.

_The word autonomy literally means “a law unto oneself” — to be self-ruling, to participate in self-governance............. To respect autonomy is to assume that each rational, adult individual is uniquely qualified to decide what is in his or her best interest._

Immanuel Kant was one of the earliest philosophers to comment on autonomy. In the eighteenth century, he stated that autonomy is one of the most important values in human society. Autonomy did not, however, always hold such importance. For the first few thousand years, medical practice evolved under the umbrella of the “beneficence model” where the physician was seen to know best. The physician was portrayed as an individual with superior knowledge guided by the Hippocratic Oath requiring him/her to act in the best interests of the patient. The patient was expected to obey the commands of the physician, who relied exclusively on his own judgment to treat the patient. In this model, the principle of beneficence was dominant. Its foundation relied on the obedience and trust placed by the patient in the hands of the treating physician. In some circumstances, this model extended to such concepts as “benevolent deception” whereby information about the prognosis or treatment could be withheld if non-disclosure was considered in the best interests of the patient.

The transition from the beneficence model to the autonomy model has occurred gradually over the last century, particularly in the last fifty years. A number of possible societal factors have contributed to this evolution. Firstly, current society is more consumer driven where healthcare is regarded as another product. Secondly, greater media coverage has highlighted the frailties and problems within the medical system that in turn has led to an
erosion of public confidence in the healthcare system.⁹ I contend that with less trust the desire to maintain more individual control about healthcare decisions is more prominent than ever before. Finally, patients now are better informed due to greater access to medical information through such media as the internet.¹⁰ In my opinion, these factors have led to greater expectation of individual self-determination and a wish to be more involved in decisions about their treatment promoting the concept of autonomy.

**Coercion: history and philosophical underpinnings**

Early writings on coercion linked it closely with the law and as a tool to promote and protect the public good.¹¹ In the thirteenth century Aquinas supported the rule of law to use acts of force or violence in the interests of maintaining social order. He argued that the investment of coercive power should only be allowed to certain public officials and not be granted to private individuals.¹² During the seventeenth century, Hobbes and Locke described the need for coercion to maintain justice. However Locke was wary of the abuse of power and the potential for corruption that coercion might create.¹³,¹⁴ In the nineteenth century Mill argued that coercion should not be used for the individual’s own good but only where other people may be threatened or harmed.¹⁵ He also recognised that coercion was present within more institutions than just the State. He provided examples of child labour and marriage as potentially coercive conventions.¹⁵ For example, he argued that in marriage the cost of an equal share to property is the understanding that the woman will submit to her husband’s wishes. Mill’s writings helped broaden the context and understanding of the concept of coercion as a feature in many institutions within society.
Coercion in the 20th century

Up until midway through the twentieth century, there was little departure from the understanding of coercion held by Aquinas, Hobbes, Locke and Mill. Then Nozick in 1969 described a list of criteria that he argued defined a coercive action.16

1. P aims to keep Q from choosing to perform action A
2. P communicates a claim to Q
3. P’s claim indicates that if Q performs A, then P will bring about some consequence that would make Q’s A-ing less desirable to Q than Q’s not A-ing.
4. P’s claim is credible to Q
5. Q does not do A
6. Part of Q’s reason for not doing A is to lessen the likelihood that P will bring about the consequence announced in (3)16

In the interests of making this more understandable to the reader I have adapted Nozick’s criteria to a theoretical situation. In this example, John approaches Frank in a dark alley and states “your money or your life.” Then:

1. John aims to stop Frank holding onto his money
2. John tells Frank to hand over the money
3. John states that if Frank continues to hold onto his money then John will take his life
4. John is holding a gun
5. Frank hands over the money
6. Later Frank states he handed over the money because he didn’t want to lose his life.
This analysis set the benchmark for future philosophical interpretations and explorations of coercion but it is not without its limitations. Firstly, the concept of coercion in this analysis only requires a credible threat and does not consider the use of physical force as being coercive. In order to address this, Bayles and Nozick have since described the concept of “occurrent coercion” where the direct action of force is applied (eg. being sent to jail) from “dispositional coercion” that involves the idea of threats used to alter behaviour. While defining these terms might be theoretically useful, in many practical situations occurrent and dispositional coercion co-exist. For example, prisoners are held in prison both by the threat of further punishment should they escape (dispositional coercion) and by the presence of physical barriers restricting their free movement (occurrent coercion). Similarly in considering the setting for this research (a general hospital) there is also the theoretical possibility that both occurrent and dispositional coercion could exist. Although hospital is not a prison, patients can be detained in locked or supervised settings within the hospital walls and treatments enforced through the use of threats or with limited consent.

A further potential limitation of Nozick’s framework for coercion focuses attention away from the coercer and into the internal world of the individual being coerced (coercee). It relies on the coercee’s response to the situation to define whether coercion has occurred. If the proposal made by the coercer is not accepted by the coercee (ie. the money is not handed over and Frank is shot) then coercion by this definition has not occurred. This becomes an important concept in measuring coercion in a research setting as most tools now rely on the

1The Macarthur Perceived Coercion Scale uses the perception of the coercee to establish the presence of coercion. Likewise the Coercion Ladder relies on the subjective report of the coercee.
subjective perspective of the coercee and ignore the motives and view of the coercer. This will be discussed in more detail later in the chapter.

**The justification for coercion**

Coercion was initially justified as a tool to maintain social order. It has been argued that its existence in institutions and social relationships is considered necessary to sustain the basic functioning of society.\(^1\) Perhaps this relates to the need for specific rules, predictability and order to manage complex social systems that without an element of coercion would collapse into chaos and disorder. Given this broad interpretation which highlights its necessity for maintaining order, it seems likely that some level of coercion occurs within the hospital setting. This is based on the principle that medical care is delivered through an institution (the hospital) and relies on the relationship between the patient and health professionals (social relationship). While coercion might be deemed necessary at a theoretical level, in my experience acceptance and acknowledgment of its practical use or presence is commonly evaded or denied by clinicians in clinical practice.

The need for order and structure within the hospital setting is a prerequisite to enable high quality healthcare to be delivered. Patients are expected to comply with the system in order to receive appropriate care and thus benefit from better health. The rigidity and structure of the system exerts certain pressures on patients to comply. Efficiency and patient flow may be further reasons that the hospital requires order and structure to cope with the demand for its service. Societal expectations further promote the adoption of the “sick role” and endorses the role of the healthcare provider in making the patient better.\(^2\) It is therefore not surprising for those patients, who do not always agree, or accept the treatment being offered, that they might feel a certain amount of coercion during this process.
Philosophers have attempted to understand coercion from different viewpoints. The justification of coercive treatment can be argued both from a utilitarian perspective and a deontological or rights based perspective. The utilitarian perspective argues that coercion can be justified if it produces better outcomes (utility) than doing nothing or using non-coercive treatment. The deontological focuses more on the preservation of rights and autonomy and that even in the case of better consequences this should not be done at the expense of individual autonomy. Highlighting the difference between these perspectives is the classic example of killing one to save five. This would be accepted from a utilitarian perspective and denied from a deontological perspective.

**Offers, threats and the moral baseline**

The decision to admit a patient to hospital can be perceived by the patient either as an offer or in some cases as a threat. This section discusses the philosophical theory that helps distinguish an offer from a threat. One would expect that patients are likely to feel more coerced by the perceived threat than the perceived offer to be admitted. The philosophical literature considering the difference between an offer and a threat sets a framework for understanding these principles.

Firstly, the coercee’s position can be explored by considering the difference between an offer or a threat. In general terms, threats are considered coercive and offers are not. A deeper understanding observes that it is the “moral baseline” which defines whether an action is interpreted as an offer or a threat. To illustrate this, Wertheimer, an American philosopher writing in the late 20th century, considers the example of a man who is about to drown and can be saved by someone who states he will save him only if the drowning man gives him all his possessions. In this instance, the action of the potential rescuer can be seen
either as an offer or a threat depending on what is “normal” in society. If the drowning man would usually be rescued for free, then the proposal seems more of a threat. If not then it is an offer. Distinguishing a threat from an offer therefore depends upon the moral overview of the situation. Understanding the “moral baseline” is important to define how coercive an action appears. Wertheimer, argues that the “moral baseline” should be used as a guide to interpret actions as coercive or non-coercive.22

In considering the setting for this research, I argue that the hospital has its own unique moral baseline, which is possibly different from other institutions. Given that it is considered to be a place of compassion, and that it has high relative importance in society, arguably there is more latitude to deliver coercive interventions that may not be tolerated in other settings. For example, preventing a patient from leaving hospital with illness to protect them from harm would be more acceptable than in acting to detain an individual in other institutions such as a library or school. It would seem that the moral baseline in a health setting provides more allowance for coercive interventions to occur, hence the interest in this study in measuring the amount of perceived coercion in hospital.

To gather the facts surrounding the moral baseline Gert and colleagues have proposed a series of questions that help to establish the analysis.23 These help provide a framework from which to judge each clinical situation. The questions are listed below.

- What are the moral rules that are violated when the clinician acts against the patient’s wishes (e.g., deceit, limiting freedom of choice, causing psychological pain)?
- What are the harms thus to be perpetrated on the patient and for how long will they last?
- What is the seriousness of the harms to be avoided through the paternalistic intervention (e.g., death, disability, worsening of the psychiatric disorder), and what is their likelihood?
• What are the relevant beliefs and desires of the person toward whom a rule is being violated (e.g., religious beliefs such as those of Jehovah’s Witnesses or Christian Scientists)?
• Are there any alternative actions that would be preferable?23

The application of these questions to a clinical situation assists in determining the context and thinking about the moral baseline in more detail.

Permissible or impermissible coercion

There may be some situations where the use of coercion is justifiable. However, the use of coercion in clinical care is usually judged negatively and its use and presence in a clinical encounter remains controversial. Essentially coercion is considered to be bad and its use discouraged.24 This position does not consider the potential therapeutic benefit of coercion in some clinical situations. A more helpful approach might question whether the application of coercion is always wrong, or is it considered to be wrong, simply because it is coercive?25 Moving away from an evaluative judgement into a descriptive understanding allows coercion to be categorised into permissible, impermissible, and morally neutral actions.26 Understanding the context alters the perception of the event such that not every coercive act would be considered negative. For example, there are many situations where coercion is socially acceptable. Parents may use coercion to ensure a resistant child attends school, or to prevent a young child from running across a road. The hospital may prevent a patient from self-discharging if the risks of harm are considered to be too high. Imprisonment is another example of the use of coercive power. These are examples where coercion might be considered a permissible action. Some compulsory admissions to psychiatric hospital might also be considered permissible and as such are protected by Mental Health law. Enforced or
Coerced general hospital admission may also in some cases be considered permissible based on the seriousness for harm if not used and potential benefit to the patient. This is often mandated by the reduced capacity of the patient to make a decision and in New Zealand is guided by the Health and Disability Code 7(4).²⁷

COERCION: DEFINITION

The use of the word “coercion” in popular speech encompasses such concepts as peer pressure, the power of advertising or even more broadly any perceived injustice of an individual’s rights.¹¹ Research in this area requires a more defined understanding of the concept. However, defining the exact parameters which constitute coercion proves elusive with no clear criteria or definition that has been standardised. This section deals with the varying concepts and interpretations that have been entertained in attempting to define the concept of coercion and settles on how the concept is considered in relation to this research.

Part of the challenge of research in this area is defining and understanding how an act is coercive. Wertheimer identifies that there may not be one truth or correct analysis of coercion.²⁰ In other words coercion is in the eye of the beholder. This is illustrated well in the following quotation from Harry Frankfurt.²⁸

*The Courts may refuse to admit in evidence, on the grounds that it was coerced, a confession which the police have obtained from a prisoner by threatening to beat him. But the prisoner’s accomplices, who are compromised by his confession, are less likely to agree that he was genuinely coerced into confessing.*²⁸

Wertheimer argues that, in this case, the courts and the prisoner’s accomplices may both in their own way be right and that the interpretation of coercion relies on the moral force
underlying the situation.\textsuperscript{20} This reflects back to the idea of the moral baseline and suggests coercion may be perceived differently between individuals.

Previous American studies have broadly identified coercion being present when autonomy is absent.\textsuperscript{20, 29} This leads into considering the subjective versus objective account of the individual being coerced (coercee). For coercion to be reported it relies on the belief of the coercee about the motivations of the coercer independent of the action taken.\textsuperscript{16} This implies it is the internal subjective state of the coercee that indicates coercion rather than being dependent on the motive or intent of the coercer. In the research setting the instruments used that measure coercion use the patients’ interpretation of events in order to establish if they have felt coerced. They do not consider the actions or intentions of the coercer whether this be an individual or an institution.

Coercion is closely aligned with the concept of control and the degree of influence or pressure that has been exerted to achieve a certain outcome. Coercion occurs when intentional and credible influence is used by one person to alter another person’s behaviour.\textsuperscript{30} A distinction can be made between a situation that is coercive in its own right such as having an illness where only one treatment is available versus alteration of ones choices to be unfavourable. In the former situation the will of one person is not controlling or influencing another person but the sick individual may well feel inhibited by the amount of choice available to him/her.\textsuperscript{30}

Another way of thinking about coercion during admission to hospital is at an institutional level. Weisner has considered institutional coercion and used a very broad definition describing coercion as “a form of institutionalised pressure (with negative consequences as an alternative).”\textsuperscript{31} This definition was written in relation to treating alcohol problems, but it
would seem there is a wider application to all admissions to an institution for treatment. This fits with admission for medical care where the alternative consequences are likely to be deteriorating health. Using this definition it could be argued that admission for any patient to any hospital exerts a degree of institutional pressure and is therefore coercive. Even in private hospitals where patients are usually present for elective procedures they must still conform to the processes and regulations of the environment that potentially has limits on their freedoms. The problem with this broad interpretation is that it does not define the parameters by which one situation maybe coercive and another not.

Another theoretical exploration of coercion considers voluntary and involuntary psychiatric admissions dividing coercion into narrow or wide interpretations. The wide interpretation states that if the patient is faced with no alternative other than to come into hospital then that situation is deemed coercive. This definition is independent of any competence that a patient may have or his/her refusal to comply with the process. It depends solely on the lack of an alternative. The narrow definition of coercion also incorporates the concept that the patient has no option, but also relies on he/she refusing to come into hospital or being incompetent. This narrow definition states it is only when both criteria are met that coercion is deemed to be present. Effectively the patient either comes into hospital voluntarily or refuses admission and is admitted compulsorily. This implies the patient has capacity to make the decision to enter hospital on a voluntary basis but not the capacity to choose not to refuse admission. If the patient has no option other than to come into hospital but doesn’t refuse and is deemed competent then coercion by the narrow definition is not present. This narrow definition has been criticised as being “asymmetrical” with capacity assumed for acceptance of the admission but not for refusal of the admission. It is also
challenged for patients who are confused or cognitively impaired and that if they do not put up resistance to the admission then the assumption is that they enter hospital voluntarily even though they may not have capacity to make the decision. In my experience during medical admission patients are generally assumed to have capacity and be voluntary, unless they decline admission at which point a decision is then made about their capacity. In the event they don’t have capacity in New Zealand they can be coercively treated under the Health and Disability Code right 7(4). This is the more formal aspect of coercive care used in a medical setting but only where capacity is impaired.

**Coercion on a spectrum of treatment pressure**

Another interpretation of coercion locates it on a spectrum known as “treatment pressure.” This spectrum consists of concepts such as persuasion, interpersonal leverage, inducements, threats and compulsory treatment in ascending order of pressure. This spectrum initially may seem quite useful in understanding the realm of paternalism. However, the problem with this approach lies in distinguishing and defining the criteria for these separate concepts, and without clear definitions they remain purely theoretical and not clinically useful. It can also be argued that pressure is pressure of any kind and it is questionable as to whether the distinctions make any form of difference?

Despite the argument that the type of pressure is irrelevant Wertheimer analyses it from a range of different perspectives. Firstly he proposes that coercion and inducement involve the additional feature of a penalty or reward, which is not the case when authority is exercised or persuasion used. A second perspective involves understanding the psychological effect of the action. Again this comes back to the subjective interpretation of the event by the individual. For example, if an individual feels it is legitimate for a doctor to exert pressure on a
patient to undergo a particular treatment and that it is not legitimate for a family member to
do this, then the individual may feel less constrained by the doctor’s actions. The subjective
legitimacy of the doctor’s actions may make it more tolerable to the patient even though the
exertion of power and pressure was greater by the doctor than the family member. \(^{20}\) This
emphasises the importance of the subjective interpretation of coercion over and above the
actual action.

The feeling of constraint may not always be associated with a sense of loss of autonomy
or coercion. \(^{20}\) Even in the situation of constrained choice, subjective control may still be
present if the decision made is not made by anyone else. For example, making the decision to
have lifesaving surgery on one’s own may feel less constrained, even though the alternatives
are bleak than if the decision is made by others. The empowerment behind the ability to
decide may reduce the sense of possible coercion engendered by the situation. How the
individual balances the circumstantial pressure from the personal pressure will influence how
coerced or not they feel. The context of the situation is therefore extremely important to how
the perception of coercion is interpreted. Lidz et al summarise this well in the following quote
“coercion is a contextually dependent, moralized phenomenon.” \(^{34}\)

A further proposed distinction between persuasion and coercion is that coercion
constrains freedom while persuasion and inducement does not. \(^{20}\) In the example of
persuading an individual to give blood, this does not in any way change the actual freedom
that an individual has to give blood or not. The freedom to give blood is not altered by the
action of persuasion and the individual is still in a sense free to give or not give as he/she
desires. \(^{20}\) If the individual was coerced to give blood then their sense of freedom would be
restricted.
In addition to restricted options caused by illness, admission to hospital in itself limits an individual’s choices. Such limits to free movement, mealtimes, and even sleep are all factors that are associated with hospital admission.\textsuperscript{1} If the individual is choosing to stay of his/her own accord, then there is an implied acceptance of the conditions of admission.

While restrictions are common place in such institutions, this research is focussed directly on the decision to be admitted to hospital and the factors surrounding that decision. Health professionals play an active part in deciding the best course of treatment for patients as they enter hospital and it is during the interaction between clinicians and the patient that coercion may be experienced. However, the extent to which health professionals actually coerce (either consciously or unconsciously) an individual to accept hospital admission is uncertain in a medical setting.

**Coercion in this study**

Coercion in a healthcare setting can be interpreted as objective, subjective or a combination of both.\textsuperscript{35} The most accepted interpretation of coercion in the psychiatric literature involves the concept of subjective perceived coercion as measured from an individual’s perspective. Perceived coercion can be conceptualised as a subjective state that arises from a compulsory action.\textsuperscript{35} This seems a reasonable definition to work with for the purpose of this thesis.

The perception of coercion and autonomy were considered to be mutually exclusive concepts when the MacArthur perceived coercion scale was developed.\textsuperscript{29} Autonomy was not present where the perception of coercion was found.\textsuperscript{29} However, this relationship may not be as simple as first appreciated and this study sets out to investigate how these two constructs relate in a real world setting.
The perception of coercion in my study refers to the restriction in choice associated with the lack of control or reduced choice about being admitted to hospital. It ultimately reflects that the decision to be admitted was not that of the patient.\textsuperscript{29} Being forced is part of being coerced. However in this study, I define force more narrowly as relating to physical compulsion. The measurement of perceived coercion considers how patients subjectively feel about the admission process.
CHAPTER 2: LITERATURE REVIEW

This chapter reviews the literature on coercion and autonomy. The section on autonomy specifically focusses on how autonomy impacts on medical practice, its relation to the idea of the “sick role” and how it relates to medical decision making. The section on coercion is dominated by the psychiatric literature and it describes how our understanding of this construct has evolved over time and the varying themes in investigating this concept. A brief overview of the literature pertaining to eating disorders and substance use are considered which have some relevance to general medical care. Finally the very limited research into coercion in the medical field is described.

In compiling this review a computer based literature search using Medline and PsychINFO databases was undertaken. Owing to the extensive literature in both of these areas the focus has been on a more comprehensive review of the literature on coercion and a more selective approach to the autonomy literature.

**Autonomy: selective literature review**

**AUTONOMY IN MEDICAL PRACTICE.**

Autonomy has arguably become the pre-eminent ethical principle in medical practice. However, this has not come without a cost. A recent commentary on the consequences of relying too much on this principle at the expense of justice, beneficence and non-maleficence contends that in some cases patient care is compromised. The authors argue that favouring autonomy without considering the wider moral principles of compassion, honesty and respect for patient care can lead to the non-delivery of appropriate and timely medical intervention. They argue that the established bioethical model of autonomy, beneficence, non-maleficence
and justice proposed by Beauchamp and Childress would work better if the principles of non-maleficence and beneficence were combined into a category known as “good clinical care.” They contend that a more paternalistic style of practise is sometimes necessary and would be moderated by understanding the limitations of medicine and using honesty and humility in managing patient care.

In hospital, the principle of autonomy centres on the assumption that patients will be able to make decisions about their welfare when provided with adequate information. The theoretical and ethical understanding of autonomy, however, has shown to be much broader than the clinical understanding of autonomy in a hospital setting. To illustrate this breadth Feinberg described autonomy as having four different meanings:

> the capacity to govern oneself, the actual condition of self-government, a personal ideal, and a set of rights expressive of one's sovereignty over oneself.

By comparison the notion of autonomy in a clinical setting is usually restricted to thinking about how much influence one has in being able to make decisions about one’s health. One study that investigated medical decision making in 22 clinical cases through observation and interviews illustrates this restriction. Firstly, it showed that autonomy in hospital practice tends to focus solely upon the right to self-determination with regard to medical decisions. Secondly, it showed that the actual process of decision making is dynamic and often involves multiple clinicians thereby reducing the autonomy for the patient. For example, the decision just to be admitted to hospital may involve a range of medical staff including the General Practitioner, then junior medical staff, and finally the oversight and direction of senior
clinicians. As a result, this research showed that patients themselves often have limited involvement in the decision making process.

In addition, health professionals try to cope with the complexity involved in medical decisions (e.g. incorporating the views of the patient and family, weighing up treatment efficacy and expectations alongside the balance of minimising the harm of decision making) by reducing the actual process to a search for a solution to a medical problem. As a result of simplifying the decision to make it more manageable, the cost to the patient is potentially one of greater confusion and frustration with the perceived loss of autonomy.

The concept of autonomy when being admitted to hospital can be divided into two separate areas. Independence is the first of these areas and relates to the ability to act and do something for oneself. The second is control and relates to how much perceived power an individual has in a certain situation. A number of factors reduce autonomy in a hospital setting including the disease or illness, the decisions made by health professionals on behalf of the patient and driven by the immediacy and urgency of the risk encountered, the consent to treatment, and succumbing to the inflexibility and alien environment of the hospital that does not always cater to individual preferences. An individual experience of being admitted to hospital is captured by the following quotation of a patient’s reflection of hospital admission.

*I can’t even explain what I mean...It just seemed like they [staff] took away everything. It was like you were at everybody’s mercy and you didn’t count... When I was good and sick, it didn’t matter, I guess. Their word was law.*

The threat to autonomy by being admitted to hospital was very real to the patients in this study and articulated very well by the following quotation.
Anything that is a threat to my independence is very scary. Being in the hospital is somewhat of a relief, but it has also raised many questions about how I look after myself.\textsuperscript{40}

In this qualitative research, the patients commented about the need to conform to the hospital schedule and the sense of disempowerment this created. Lack of information was another theme that was encountered with frustration felt about what was coming next and not feeling fully informed about the process. This research also considered the views of the staff caring for the patients and is well explained in the following quotation by a staff member.

\textit{One of the major problems that they have is that all of their routines that they are used to doing is taken away from them. We're telling them when they can go to the bathroom...A lot of them are used to taking medications on their own schedule at home and we're telling them “No, you have to take your medications on an every 12-hour basis.” I think it's frightening, I think it's frustrating. I think every patient does [feel this] on some level. I think it's more overwhelming for some, but I think on some level they all do.}\textsuperscript{40}

Interestingly this qualitative research identified that the diminished independence and autonomy was thought to be greatest during the early stages of the admission and reduced as discharge approached.

There is one New Zealand based qualitative study that has examined the patient journey from the Emergency department through to being admitted onto a ward and then discharged.\textsuperscript{41} This research has relevance to this thesis because it was also undertaken within the New Zealand public health system and patients were first approached and interviewed within 48 hours of admission. One specific point of difference was that patients were aged 80 and above in this study as opposed to 18 and above in my study. Themes surrounding passive acceptance of the admission, deference to the hospital system, and relinquishment of control
were repeated amongst the subjects interviewed. Interestingly there was very little expression of dissatisfaction with the system or process by these individuals. This led the researchers to wonder if this sample of elderly individuals were less likely to complain about their care as a result of their age and life stage.41

AUTONOMY AND THE SICK ROLE.

Sociological research has shown how the delivery and acceptance of healthcare has changed over time. The modern era has brought an increasing specialisation of medical practice.42 This has meant that more people across a range of differing medical disciplines are involved in a single patient’s care.43 Clinical contact time with patients has decreased.43 In the United Kingdom, and more than likely in New Zealand, hospitals have grown in size, processes have become more complex and the demands on hospital services continue to rise.43 In my view, all this contributes to a climate where patient autonomy is continually threatened.

Overlaying this dynamic is the sociological concept of the “sick role” first described by Talcott Parsons in the mid twentieth century.19 The sick role describes the sociological rules that apply to those who are unwell. Inherent within the sick role is the surrendering of the responsibility for their own care to the physician or specialist. The sick role has been accepted as a validated social norm for the functioning of society whereby those identified as sick are given dispensations such as not going to work.44 Adoption of the sick role at admission to hospital allows for the smooth running of the health care system whereby a significant amount of autonomy is handed to the treating clinicians.

As society has moved from a period of modernity to a post-modern period, chronic illnesses are more apparent and self-awareness greater.44 In this new era, patients are less prepared to defer to clinical expertise placing more value upon knowledge of themselves,
their identity and experience.\textsuperscript{45} The effect of being admitted to hospital is therefore more likely to compromise one’s sense of autonomy. The move from the modern era with the adoption of the sick role to the post-modern period is characterised by patients who know more about medicine than ever before. As a result, they are more vocal in ensuring their wishes are known and where possible observed.\textsuperscript{44} Autonomy in this situation is more threatened and the potential for perception of coercion greater.

**AUTONOMY AND MEDICAL DECISION MAKING**

The way medical decisions are made in hospital is central to the delivery of healthcare and directly impacts on a patient’s outcome and experience of hospitalisation. The literature identifies three models of decision making.\textsuperscript{46} The first is the paternalistic model where the clinician is expected to take control of the decision making. The second is the shared model where decisions are shared equally between the clinician and patient. The third is the informed model where the clinician is expected to provide adequate information to the patient who then makes his/her own decision. In my view the type of model utilised is dependent on the specific situation and influenced also by the patient and clinician factors.

Once admitted to hospital patients are then confronted with a wide range of possible decisions about their health and wellbeing. One study of 459 participants showed patients have less desire to make decisions requiring medical expertise than they do decisions that do not require medical expertise.\textsuperscript{47} In such situations, a careful negotiation between clinician and patient must occur to provide the right amount of autonomy to the patient for each medical decision. The importance of optimising patient autonomy has been shown to improve patient outcomes as patients are more likely to follow medical guidance.\textsuperscript{48} Despite this, other research has shown that in some cases family members were consulted more by clinicians
about the medical decisions than patients themselves. The reasons for not involving the patient are uncertain. Lack of involvement is likely to promote feelings of coercion driven by reduced validation and voice about the medical decision.

The concept of autonomy in relation to medical decisions can be divided into the wish to acquire information about a condition and the desire to participate in decisions regarding treatment. An early study that helped develop a research instrument to measure autonomy (the Autonomy Preference Index) showed wide differences in respect of individuals’ desire for autonomy. In this study, 312 patients in a primary care clinic of a teaching hospital were asked about their desire for information about their health and preference in making medical decisions. Their desire to receive information about their illness was high, while the wish to make decisions about treatment was less, but nevertheless they still wanted a degree of control about decisions concerning their healthcare. In this sample a spectrum of different healthcare preferences was demonstrated from a desire for complete autonomy to wanting the clinician to make decisions on their behalf. It was also shown that as the severity of illness increased, the desire to make medical decisions decreased.

A follow-up study showed that the extent of medical knowledge that patients had did not greatly change their desire for information nor their wish to participate more in medical decisions. In this study 151 physicians were asked about their experiences of being a patient. Although they were slightly more interested in being involved in decision making, the pattern resembled that of the non-physician patients. This suggests that patients’ knowledge of illness may only play a minor role in the desire for decision making and that the severity of illness or other factors may play a more major role. Both these studies were conducted in the United States of America and conducted over twenty years ago.
A more recent study investigated decision making and information seeking in psychiatric patients using the API (Autonomy Preference Index) showed psychiatric patients also wish to have a high degree of information about their care and they also want some degree of control about decision making. Overall these studies show that the desire to have information and to make decisions about medical care is important to patients. While context such as the type of illness or prior medical knowledge are factors that might influence autonomy, generally speaking individual desire for autonomy remains high.

Autonomy or the desire for self-determination is an important guiding ethical principle that underlies the practice of medicine. Enabling choice and attending to the wishes of the individual patient are understood to be central to the idea of good clinical care. At a theoretical level, the concept of retaining autonomy in a healthcare situation seems to oppose the presence of coercion. There is no research that has investigated the relationship between autonomy preference and the perception of coercion. There is also very little known about how medical patients might perceive coercion.
Coercion: literature review

Research investigating perceived coercion in healthcare has been steadily increasing. A literature search on perceived coercion restricted to a healthcare setting showed it has increased exponentially over the past twenty years. This is shown in figure 1. The x-axis has been divided into groupings across three years. The literature search was done in April 2013 and this may account for the lesser number of studies in the year category 2011-2013 rather than a tailing off of the research in this area.

![Figure 1. Number of studies of perceived coercion in healthcare over time](image)

This review begins with an overview of the research into perceived coercion within psychiatry. It mainly covers perceived coercion in general adult psychiatry but also touches
upon the literature in the area of substance abuse and eating disorders which are considered specialist areas within psychiatry. The chapter concludes with an overview of the very limited research on perceived coercion within general medicine.

**Coercion and Psychiatry**

The majority of studies investigating the concept of coercion are found in the psychiatric literature. This is not surprising given the association that psychiatry has with enforced treatment. This review describes how perceived coercion has developed as a research construct followed by the application of this construct across the domains of general psychiatry, substance abuse and eating disorders. In particular I focus on the prevalence of perceived coercion, how it relates to other concepts such as procedural justice and the association with the therapeutic relationship, as well as looking at the effect perceived coercion has on outcome measures.

**Perceived coercion and involuntary treatment**

Psychiatry stands apart from other areas of medicine with its legal powers of compulsory treatment. By definition compulsory treatment or treatment delivered without patient consent is coercive and patient autonomy is absent. One of the earliest studies that considered the consequences of formal coercion in healthcare was from a study conducted in the 1970s investigating the opinions of psychiatric patients about being coerced.\(^\text{52}\) Compared to a non-coerced sample the coerced patients felt staff were less helpful, that they did not receive appropriate treatment and that the hospital was not “the right place for them.” Their view of the hospital was more akin to a prison. Another study also in the 1970s investigated the attitudes of patients following compulsory treatment and showed involuntary psychiatric
patients were more likely to feel angry about the admission, and were less likely to believe the staff were acting in their best interests.\textsuperscript{52}

Research then used formal coercion (eg. treatment under the Mental Health Act) as a proxy for coercive care.\textsuperscript{53} However, the experiences of patients who were voluntarily admitted to psychiatric hospitals did not always reflect their perceived voluntary status. This was demonstrated in an observational study in the 1970s that identified the majority of informal or voluntary patients had been admitted under the threat of an involuntary admission if they did not comply.\textsuperscript{54} Further evidence of informal coercion being applied during voluntary admissions was shown by Beck and colleagues in 1988. They found more than half of the patients admitted voluntarily for psychiatric care recalled a major element of coercion during the admission process.\textsuperscript{55} Of the 18 voluntary patients, 10 reported a high level of perceived coercion. Of the 49 patients detained under legal compulsion, 11 reported that the admission to hospital did not feel coerced. Additionally, Rogers and his colleagues showed that voluntary patients who felt coerced had more negative attitudes towards treatment and were more likely to reject future help.\textsuperscript{56} In contrast, the voluntary patients who did not feel coerced were more able to accept the diagnosis and treatment provided.\textsuperscript{56}

Further evidence reflecting this finding is shown in a study where approximately 10\% of patients admitted voluntarily felt coerced and 35\% of involuntary patients (admitted under legal duress) did not feel coerced.\textsuperscript{57} It has now been reasonably well established by a number of different studies that legal status is limited in the approximation of the experience of coercion.\textsuperscript{56,58,59} If some patients detained involuntarily in hospital report not feeling coerced and other patients admitted voluntarily report feeling coerced, this invites the question as to what factors determine the experience of coercion?
In the mid-1990s the MacArthur Network on Mental Health and the Law began to examine the determinants of coercion in more detail.60 One of the first studies conducted by this group looked at 157 randomly selected psychiatric patients admitted to a Psychiatric hospital. It used focus groups with patients, family members and clinicians to collect their opinions in regard to patients’ recent admission to a psychiatric hospital.61 This research identified the importance of the patient’s desire to be included in the decision process, the importance of the perceived intentions of the admitting staff, and the absence of deceit and respect as factors that could influence the perception of coercion.

**Perceived coercion and the Macarthur Perceived Coercion Scale**

The development of an instrument to measure coercion as a dependent variable was an important step in the research on coercion.29 The Macarthur Perceived Coercion Scale (MPCS) is an empirically-validated tool to measure the amount of coercion someone has experienced. It has become a widely used instrument in assessing perceived coercion, internationally across a range of different healthcare settings.62,63 An example of its international application is demonstrated in a study done in the Nordic countries looking at perceived coercion in involuntary and voluntary patients. They found voluntary patients across different countries (Sweden, Norway, Iceland, Denmark) reported similar levels of perceived coercion. The relative stability of MPCS scores (range 1.5-2.2 where 0 indicates no coercion and 5 indicates high coercion) in voluntary patients has also been shown in other jurisdictions such as New Zealand64 (MPCS=1.9) and the United Kingdom65 (MPCS=1.9). The exception is a study from the United States that found much lower amounts of perceived coercion (MPCS=0.6).58 These results are important to this study because voluntary patients in a psychiatric setting are in theory more closely representative of medical patients than involuntary psychiatric patients.
The main theoretical difference between voluntary psychiatric and medical patients is the possible threat of involuntary admission for the psychiatric group. How this impacts on the perceived sensitivity to coercion is unknown. Despite this potential difference it still seems feasible that if some voluntary psychiatric patients report feeling coerced then some medical patients might also report feeling coerced on admission to hospital.

The MPCS has been extensively used since its development and has helped identify factors that might contribute to the perception of coercion in a range of settings. In a large (N=9123) European multicentre study of psychiatric inpatients using the MPCS $^{66}$ 3818 participants reported experiencing significant amounts of coercion (defined as >2 on the MPCS (0-5)). As might be expected, involuntary admission was associated with more perceived coercion. Other associations with perceived coercion included female gender, and poorer global functioning. They also showed that as time passed, the sense of perceived coercion diminished in reported intensity. This was hypothesised to be due to a recall bias effect where the memory of the admission faded with time.

Uncertainty of the face validity of the MPCS and relying on the coercee’s account has been investigated in a study that considered the “most plausible factual account” (MPFA) of coercion. To create the MPFA this study recorded the accounts of the admission from a variety of sources including the patients, clinicians and other informants. $^{34}$ The Admission Experience Interview that incorporates the MPCS was one of the collection measures used. While no one individual account matched the MPFA the patients report was shown to be the best match. This study lends weight to the use and reliance of the MPCS and its continued application in research investigating coercion.
**Perceived coercion and procedural justice**

Procedural justice is a concept that considers the perceived fairness of process. Initial studies into procedural justice were done in a court room setting and identified three key areas.\(^{67}\) These are the perceived fairness of the process, the extent of participation or voice in the process and finally the perceived motives of the professionals involved in terms of respect, neutrality and motivation.\(^{67}\) Procedural justice is now recognised to have salience across many clinical domains including at hospital admission.\(^{68,69}\)

A reasonable number of studies have now been conducted investigating the association between perceived coercion and procedural justice. One relatively early qualitative study analysed interview transcripts and showed that perceived coercion was linked to the amount of voice patients had in the decision making process, the concern shown by the admitting clinicians (validation), the absence of deceit, and how respected the patient felt (fairness).\(^{61}\) These three areas, voice, validation and fairness are collectively known as “procedural justice” and have been shown in later studies to be more closely associated (inversely) with perceived coercion than the use of threats and physical force or legal status.\(^{57,58}\) The relationship between the concepts of voice, validation and fairness are mutually dependent within the procedural justice framework. For example having “voice” without “validation” or the sense of not being heard may lead to further frustration and heighten the perception of coercion.\(^{67}\)

It has now been fairly well established across a range of studies that the perception of coercion is strongly associated with feeling respected and validated during the admission process.\(^{58,69–71}\) There have been a couple of studies investigating procedural justice and perceived coercion in a New Zealand psychiatric setting. In the first of these studies, legal status in the form of involuntary commitment was shown to strongly correlate with perceived
coercion.\textsuperscript{64} As might be expected, less perceived coercion was reported by the voluntary patients compared to the involuntary group but a relatively high amount of perceived coercion was still found amongst the group of voluntary patients. Procedural justice was found to have a strong association with the perception of coercion, mirroring other international findings.\textsuperscript{58,72} A second follow on study aimed to investigate the variables that are important within the procedural justice framework in a New Zealand context.\textsuperscript{67} The key finding from this research showed a substantial minority of patients (both voluntary and involuntary) admitted to a psychiatric ward reported not being provided with sufficient information during the admission. While over 70\% of the voluntary patients felt well treated in respect of procedural justice measures, a significant minority (approximately 20\%) reported feeling they did not have enough voice or validation and felt deceived by the admission process.\textsuperscript{67} This finding has relevance to my study as voluntary psychiatric patients admitted to hospital more closely reflect voluntary medical patients than do the involuntary psychiatric patients. The discovery that a significant number perceived themselves to have limited information during the admission, and that some felt unheard or even deceived, could be similar in a population of medical patients.

My research is reliant on the patient’s recall of the admission process. In order to understand the reliability of patient accounts, a study was conducted incorporating the views of clinicians, patients and family members.\textsuperscript{73} This triangulated account of the admission showed that the patient’s lack of voice was important in the perception of coercion. The retrospective accounts of the admission provided by the patients, family and staff members were equally plausible and complete, adding weight to the validity of measuring perceived coercion. The different groups did have different views about the admission. The patient
group felt there may be other unexplored options to admission to hospital but were unable to provide examples when requested. Family members usually saw the admission as the last option after many previous interventions. Interestingly family members did feel they had pressured the patient to go into hospital but this was not reflected in the patient’s description of events.

Providing an opportunity for dialogue and the patient to have voice has been shown to affect the way patients interpret the outcome, even if the outcome is not what was wanted by the patient.\textsuperscript{69} It is likely this principle is generic to all areas of medicine and not restricted to the psychiatric setting. It is also probable that, as found in the psychiatric literature, perceiving clinicians to be acting in good faith and in an impartial way will reduce the perception of coercion in a general hospital.\textsuperscript{53,73}

Physical restraint occurs in both psychiatry (calming and restraint, seclusion) and medical hospital (cot sides on a bed). These are used to ensure the safety of the patient or others around them. One study of involuntary psychiatric patients found that perceptions of procedural justice was not altered by the experience of physical coercion.\textsuperscript{74} Interestingly, they also found that greater perceived procedural justice did not predict future engagement with mental health services, despite participants stating that it would affect their future willingness to engage with services.

The research into procedural justice within psychiatry has shown that the perception of coercion is modifiable through attending to and optimising the principles of respect, validation and fairness during the admission process. Of particular relevance to this thesis is the finding that procedural justice has been shown to be closely associated with the perception of coercion in the one study done on a non-psychiatric population.\textsuperscript{75} Given the importance of
procedural justice in relation to the perception of coercion shown in the psychiatric literature and in the one study conducted in a medical population, it remains an important concept to measure when investigating the perception of coercion.

**Perceived coercion and prevalence**

Prevalence rates of perceived coercion in the psychiatric literature are quite variable. A recent systematic review investigated all the past research of psychiatric patients who reported perceived coercion during the admission. The eligible studies spanned a number of European countries, the United States of America, Australia and New Zealand. In total, 3489 subjects were included across 18 separate studies. The prevalence of perceived coercion ranged from 16-90%. Not unexpectedly, those under legal detainment experienced quite high levels of coercion (74% with a confidence interval of 63-82%). Of particular interest to this thesis was the finding that 25% of voluntary psychiatric patients reported the perception of coercion. The use of the MPCS tended to show higher levels of coercion than those assessed using a different scale known as the Coercion Ladder. Another interesting finding showed that time of collection of information did not affect the reporting of perceived coercion.

In another using the MPCS one third of voluntary patients admitted to psychiatric care reported feeling coerced at the time of admission. This study also found that those patients who a month later seemed more satisfied with the admission were less likely to report feeling coerced.

In summary the research demonstrates varying degrees of perceived coercion in the studies conducted with psychiatric patients. In general terms, it appears greater perceived coercion is experienced in patients admitted involuntarily to hospital. However a proportion of voluntary patients admitted to psychiatric care report feeling coerced despite their
voluntary status. The extent to which this finding might translate to medical patients being admitted to a medical hospital is not well established.

**Perceived coercion and related variables**

A recent systematic review of the psychiatric literature investigated the last three decades of research which focussed on perceived coercion. The aim was to find themes or correlates related to the perception of coercion across a broad data set. Five of the 23 studies were qualitative studies. The five qualitative studies showed perceived coercion was negatively experienced with major themes identified as a feeling of disrespect, dehumanisation and lack of voice or validation during the admission process. The other 19 quantitative studies showed that no single demographic or other variable significantly and consistently correlated with the perception of coercion. Non significant and weak correlations with perceived coercion were found with the use of physical force, social leverage and lack of voice or validation during the admission. While no conclusive associations were identified this study concluded that perceived coercion may be found in any clinical setting and that it is intrinsic to interpersonal human relationships.

The lack of a clear association between any one demographic factor and the perception of coercion across multiple studies illustrates the diffuse nature of this area. Minimising the perception of coercion is not as straightforward as altering one variable and it seems more likely that a multitude of factors impacts on the experience of coercion. Other factors that may impact on the perception of coercion have not always been investigated. For example, as the measure of coercion relies directly on the patient’s report, personality factors might be important. Additionally past experience of coercion in school or family life may influence the future perception of coercion.
Perceived coercion and the therapeutic relationship

The therapeutic relationship between clinician and patient is broadly considered to be a very important aspect of any professional clinical encounter. A narrative investigation of coercion in psychiatric care considering the views of the patient, nursing staff and medical staff reported that improving the quality of the relationship between staff and patients reduced the likelihood of coercion. In this study staff felt that if they knew the patient well they would be more able to persuade patients rather than resorting to greater coercion.

A number of other studies have investigated the therapeutic alliance and the perception of coercion. The most recent study in this area showed a significant inverse correlation between these concepts. High levels of coercion correlated with a poor therapeutic relationship and vice versa. It appears that improving the therapeutic relationship is likely to reduce the perception of coercion. From my observation being admitted to hospital is often a stressful process and usually involves interactions with multiple health professionals for short periods of time. In my view, this type of system reduces the chances of developing a strong therapeutic rapport thereby increasing the likelihood of coercion being experienced by the patient.

The experience of being admitted to hospital has been investigated in a qualitative study that considered the elements that were important to patients. Quality of the relationships established during this process was the most important theme from a patient perspective. Encompassed within the concept of relationships were other themes of cultural understanding, communication, coercion and trust. For example a lack of trust, increased perception of coercion, and poor communication or limited cultural sensitivity all lead to poorer relationships. This study highlights the importance of the therapeutic relationship and
emphasises the close association between the perception of coercion and a poor therapeutic alliance.\textsuperscript{81}

In contrast to the previous studies the literature in this area is not conclusive in regard to the perception of coercion and the therapeutic alliance. Traditional thinking about the therapeutic relationship emphasises the reliance on trust and autonomy, and that coercion is therefore antithetical to the therapeutic alliance.\textsuperscript{82} In contrast to other research in this area, one study found that greater perceived coercion along with involuntary admission in a sample of patients admitted to an acute psychiatric hospital correlated with a better therapeutic alliance.\textsuperscript{83} The focus on this paper was on interpersonal style and its relation to aggression and no further comment was made about the somewhat counter intuitive finding that more coercion leads to a better patient alliance. A possible explanation for this finding comes from the way the instrument measured the therapeutic alliance. For example, participants struggled to answer such questions as “I believe the staff like me” as the question relates to multiple staff members rather than particular individual relationships. This could mean that participants had some good individual relationships but still rated the overall relationships with all staff as poor.

The measurement of the therapeutic alliance in terms of coercion can be challenging and another approach is to compare how clinicians and patients each report clinical interactions individually. This research investigated the interactions between case managers and patients with long term homelessness and serious mental health and substance abuse problems. It showed that the perception of coercion reported by patients did not correspond with the actual reported coercive strategies employed by case managers.\textsuperscript{84} Interestingly, awareness by case managers of their own action was not enough to predict the subjective report of
coercion. To do this they would also need to be able to understand the subjective appreciation of the mental health contact from the patient’s perspective. Another finding in this paper showed that the greater lengths of time spent with patients tended to reduce reported coercion. Short contacts that seem more likely to occur in a medical context (15 minutes) were perhaps more to the point and therefore seen as somehow more coercive. Patients who had been involved with services for longer were more likely to report coercion indicating perhaps that somehow initial contacts seemed less coercive.

A robust therapeutic relationship enhances the quality of interactions between clinicians and patients. The majority of the research in this area suggests that the better the therapeutic encounter the less perception of coercion is reported. It is probable that this finding can be generalised to most clinical encounters and is not specific to psychiatric care.

**Perceived coercion and trust**

Intuitively trust is an important component of the therapeutic relationship. Particularly at the time of admission to hospital the patient must hand over some control to the healthcare system with the belief that they will be diagnosed and treated appropriately. It seems likely that those patients who have less trust in the system may be more likely to feel coerced if the treatment they receive is not what they expected, wanted, or feel that it is not helping them to get better.

Understanding trust in a healthcare situation can be divided into institutional trust and interpersonal trust. Institutional trust involves social systems (e.g., political, legal, economic) or institutions (hospitals, GP clinics, medical colleges, etc.). In contrast, interpersonal trust involves the understanding and trust between two individuals (e.g., patient and physician). The two main theories that dominate the literature on trust in a medical setting incorporate both
interpersonal and institutional trust. The first was proposed by Niklas Luhmann and argues that trust in the medical system (institutional trust) always precedes trust in the healthcare professional (interpersonal trust). In other words if mistrust is held with the medical system or hospital then trust can’t be developed with individuals who work within its umbrella. Additionally he argues that institutional trust in a hospital system is usually representative of the trust placed in other social systems (eg. economic or political systems). In contrast Anthony Giddens, argues that interpersonal trust precedes institutional trust, or the interaction with the health professional sets the scene for how the system is perceived by the patient. How this theoretical overview of trust relates to the clinical setting and the admission to hospital is not known.

Trust is an important component in the delivery of healthcare. Limited studies have considered trust in a New Zealand health context. One study, showed New Zealand doctors had greater cultural sensitivity than their American counterparts and it was postulated this engendered a greater sense of trust with their patients. Trust was also found to be an important theme in a qualitative study that tracked a patient’s journey through a New Zealand hospital system. The relationship between trust and perceived coercion has not been well explored. However, trust has been shown to be closely linked to the concept of procedural justice. Since there is a strong association between procedural justice and perceived coercion it seems probable that trust is also closely linked with the concept of perceived coercion.

**Perceived coercion on a spectrum**

The perception of coercion can be considered one type of pressure on a spectrum of different interventions that can occur in a clinical setting. These types of pressure are
applicable both to psychiatric and general medical settings. A variety of different pressures have been described in the literature on coercion. An early study on coercive processes divided the coercive spectrum into “positive” and “negative” pressures.\textsuperscript{58} Positive pressure was defined as using rewards (inducements) and reason (persuasion) to get patients to accept the hospital admission. Negative pressures were defined by the patient as having a worse outcome or consequence should they decline hospital admission. Force of any kind and threats fall into this category. As might be expected this research showed that the perception of coercion was greater for negative than positive pressures.\textsuperscript{58}

The type of coercive process being used is likely to have some bearing on the patient’s perception of coercion. Identifying the type of coercive practice has been set out in one study with the accompanying definitions shown in Table 1.\textsuperscript{89}

**Table 1. Types of pressure**

<table>
<thead>
<tr>
<th>Pressure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persuasion</td>
<td>Verbal effort to produce compliance through reason – desire to please</td>
</tr>
<tr>
<td>Inducement</td>
<td>Conditional statement offering something positive in exchange for compliance</td>
</tr>
<tr>
<td>Threat</td>
<td>Conditional statement in which threatener will do something negative if subject refuses to comply</td>
</tr>
<tr>
<td>Show of force</td>
<td>Demonstration of the availability of force if required to induce compliance eg. Security guards</td>
</tr>
<tr>
<td>Physical force</td>
<td>Minimally the laying on of hands to effect something counter to the patient’s wishes</td>
</tr>
<tr>
<td>Legal force</td>
<td>Using the authority of the law to effect the admission</td>
</tr>
<tr>
<td>Asked preference</td>
<td>Asking the patient what he or she wanted to do to effect the admission</td>
</tr>
<tr>
<td>Given order</td>
<td>A statement, without conditional result, that the patient must do something</td>
</tr>
<tr>
<td>Deception</td>
<td>Lies or deliberate deceit of any kind</td>
</tr>
</tbody>
</table>
The definitions provided in the table help separate out the various interventions that might be used during an admission process. This is important when considering the use of persuasion or inducement to facilitate an admission that seems to induce less perceived coercion than interventions such as threats or a show of force.58 Despite this finding it still seems possible that any of these interventions may lead to a patient feeling coerced.

Verbal persuasion is described as the most common method of coercion when patients are being admitted to hospital.90 The context of this persuasion is important as it may convey an implicit threat of involuntary hospital admission. In a qualitative review of interactions between clinical staff and psychiatric patients, verbal persuasion was described as the most common form of coercion used to admit patients to hospital.89 As psychiatric and non-psychiatric patients usually enter hospital through the Emergency department it is likely that similar types of pressures are used to admit the non-consenting or ambivalent psychiatric or medical patient. The extent and types of pressures utilised during a medical admission is unknown.

**Perceived coercion and outcome**

If improved outcomes can be demonstrated by the use of coercive interventions this would increase the justification for its clinical use. This section shows that the literature measuring outcome as the key variable has not provided a clear answer as to whether coercive interventions improve patient outcomes. It seems there are many variables that might affect both the perception of coercion and longer term outcome of care with only limited number of studies considering this question.

Various outcomes after the experience of coercive care in a psychiatric setting have been investigated. One multicentre prospective study identified all those patients who scored three
or more on the Macarthur Perceived Coercion Scale (rated 0-5 with 5 indicating high level of coercion). This group were divided into coerced voluntary and coerced non voluntary categories. In total, 8071 patients were identified as eligible voluntary patients and 5004 (62%) were screened for perceived coercion using the MPCS. 1070 (21%) felt coerced during the admission. The voluntary coerced group who then participated in the baseline screening numbered 764 and were the most comparable group to the voluntary medical patients in my study. Both groups (coerced voluntary and coerced involuntary) showed improvement in symptom profile up to three months after hospital discharge. However the coerced voluntary group did not do as well as the coerced involuntary group. One way of interpreting this research is that coercion when used in an informal manner is less transparent than more formalised involuntary coercion, worsening outcomes. The severity of illness and lack of insight are potential confounding factors that should be considered when interpreting these results. Overall this finding has potential significance to inpatients in a medical setting who, if coerced, are most likely to be in the coerced voluntary group as formal commitment is seldom used in a medical setting.

Consideration of the patient experience after being coerced is another method of thinking about the outcome of a coercive intervention. A qualitative study that investigated the patient narrative after being an involuntary patient, and feeling coerced, revealed three possible categories in how coercion is regarded. These three perspectives were a “necessary emergency brake”, an “unnecessary overreaction” and a “practice in need of improvement”.

The first of these categories, a “necessary emergency brake”, relied on themes of trust in the clinicians and valued the system and process. The second theme of “unnecessary overreaction” reported that the coercive actions were not helpful and in some cases made the
situation worse. The final theme of “practice in need of improvement” questioned the extent and need for coercion. The consequences of coercion left patients feeling inadequate, with reduced self-esteem, and a sense of reduced control about their lives. Engaging with patients with more respect and understanding was suggested as a method of reducing the extent of coercion experienced by patients. This study reveals how involuntary care in a psychiatric setting is considered by patients. How this translates to individuals who are voluntary patients or who are in hospital for medical rather than psychiatric reasons has not been researched.

The use of involuntary care in psychiatry is contentious and is easier to justify if it can be shown to be beneficial. Priebe and colleagues investigated clinical and social outcomes in a sample of involuntary patients and showed no real benefits for patients up to a year after the admission. Interestingly they did find that patients reporting greater perceived coercion at admission did have better social outcomes in one of the measures used. They hypothesised that the patients’ response to coercive care was realistic and that they might be keen to avoid the experience again, thereby achieving better social outcomes. In contrast, another study that considered short term outcomes for both voluntary and involuntary patients on a psychiatric ward, found that the perception of coercion did not affect the assessment of improvement either subjectively or objectively.

Another approach investigating the effect of perceived coercion in a psychiatric ward looked at interventions to reduce the perception of coercion. The use of shared formulations, frequent patient and staff meetings and the ability to alter treatment plans did not significantly alter the perception of coercion.

From these limited number of studies it is difficult to reach a firm conclusion about how perceived coercion might affect future patient outcomes. There is support both for and
against coercion improving outcomes. This is a potential area for future research to explore in more detail, and has application both in medical and psychiatric care in regard to potential future engagement with treatment.

**Perceived coercion and satisfaction**

Retrospective satisfaction with coercive treatment could be argued to defend the use of coercive care. Patient satisfaction with medical treatment is generally considered an admirable goal. In my observation, there are now many opportunities to comment on the hospital experience with patient surveys relatively commonplace. How this impacts on coercive care is not known. A few recent studies have considered how satisfaction relates to perceived coercion.

The first study investigated how satisfaction might be associated with perceived coercion.\(^{96}\) Involuntarily admitted patients made up 66\% of the sample. This study showed that more accumulated coercive events (a combination of objective coercive measures and perceived coercive measures) reduced satisfaction for participants in regard to the hospital admission. However, when the MacArthur Perceived Coercion Scale (MPCS) was considered on its own it did not show any significant association with satisfaction. In another study of involuntary patients there was a statistically significant negative relationship found between the perception of coercion and satisfaction.\(^{71}\) Greater amounts of coercion correlated with reduced satisfaction. In this study, as other variables were accounted for, again the MPCS lost statistical significance with the satisfaction scales. In both of these studies the MPCS appears not to have the same statistical significance with satisfaction as other measures of coercion. The reason for this is curious and one hypothesis suggests the MPCS may not be easily understood by patients with severe mental illness.\(^{71}\) Another hypothesis highlights how
discrepancies between the temporal settings of the satisfaction scale and MPCS affects the outcome. For example, the MPCS questions relate to the time of admission but the satisfaction questions relate to the whole admission.

Overall patient satisfaction has a negative inverse relationship with the experience of coercion. The MPCS which is used in this study does not show this effect. There have been no previous studies that have considered perceived coercion and satisfaction levels in a general medical population and this may be another area of potential future research.

**Retrospective gratitude following perceived coercion**

Justification for the use of coercive interventions is keenly debated. One argument in favour of the use of coercive care is retrospective appreciation for the treatment delivered even if at first the treatment is resisted or refused. A few psychiatric studies have considered the retrospective appreciation of involuntary treatment. Early work in this area proposed that involuntary treatment should be directed by the need for treatment rather than the level of risk.\(^97\) This argument contends that involuntary treatment can be justified if retrospectively the patient is grateful to the physician once they have been treated. This has become known as Stone’s “thank you” theory of enforced treatment.\(^55\) One criticism of this approach is that it is not clear whether the retrospective “thank you” by the patient relates to the understanding that treatment was needed or whether it is a sentiment towards the treating clinicians for the care received.

Wertheimer uses the term “retroactive approval” in considering gratitude expressed from previous paternalistic actions.\(^20\) He argues that we should not rely on retroactive approval as a replacement for consent. To illustrate this point, he uses the example of money taken without consent to purchase shares which double in price. Gratitude may be expressed
for the extra money but it still breaches the principle of informed consent. Likewise coercing people for their own best interests should not be dependent upon the later expression of gratitude. To illustrate this point he uses the example of the law requiring seat belts to be worn in motor vehicles. While some individuals may be thankful for being forced to wear a seat belt the justification should not be restricted to only those who thank the State for enforcing this behaviour. Thus, if a significant number of coerced patients later express gratitude for their treatment, then the justification for coercion may be strengthened, not because the consent has changed, but because excessive regard may have been placed on their initial refusal for treatment.²⁰

While anecdotal evidence may exist amongst clinicians supporting the “thank you” theory, the literature investigating retrospective gratitude is mixed. One study which considered the views at discharge from those at admission of a sample of 60 psychiatric patients (two thirds of whom were involuntary patients) showed that 15 of them had altered their view of the hospital admission to being favourable at discharge from admission.⁵⁵ Overall only a minority of patients in this study who felt they were coerced aligned with Stone’s theory of appreciating and acknowledging the need for admission and treatment.⁵⁵ Further illustrating the variable findings of gratitude in respect of a coercive admission in both a systematic review and more recent studies, between 30% and 80% of patients retrospectively appreciated the need for their admission.⁹⁸–¹⁰⁰

Another American study found just over half (33 out of 64) of patients who disagreed with the admission to hospital near the time of admission later revised their belief about the necessity for the admission after discharge.⁹⁸ Despite changing their views on the need for admission, their perceptions of coercion did not change and they were not retrospectively
grateful for the experience. A small number (9) of the 198 patients who were favourable towards the admission at the time of admission, later said the admission was not warranted after discharge. This research shows that some patients change their view on the need for admission but generally do not change their recall of perceived coercion. Furthermore, investigation into the emotional attitudes to the admission process also remained stable beyond discharge. A range of emotion was identified including anger, sadness, fear and sometimes relief.

A philosophical analysis of the sentiment of gratitude has postulated that gratitude in respect of a coercive admission was aligned with the perceived motives of the admitting clinician. Where the clinician is perceived to be acting with genuine concern for the patient, as opposed to merely doing a job, the sentiment of gratitude may be more keenly felt. This finding is probably influenced by the strength of the therapeutic relationship and the need to be validated and understood during the admission (procedural justice).

The literature on retrospective gratitude shows this is seldom reported by patients in a psychiatric context. There have been no studies investigating this concept during a medical admission. While appealing in theory, retrospective gratitude does not appear to be strongly felt, and in my opinion should not be used to defend the use of coercion on the basis of the current literature.

**Perceived coercion and locus of control**

Previous research has shown that a proportion of psychiatric patients who have been involuntarily admitted to hospital report not feeling coerced during this process. One proposed explanation for this discrepancy relates to the patients’ past experience of coercion in their everyday lives. This theory postulates that situations that may have appeared highly
coercive to an external observer may not have been experienced as coercive by the patient if the patient was regularly exposed to situations where coercion or pressure was prominent. The concept of locus of control becomes important and salient to the perception of coercion in everyday life when considering how much people feel control of their own lives.  

How much control one has over such routine activities as the time to get up, what to eat, and how to spend one’s time may have an impact on how the perception of coercion is interpreted in a clinical setting. Locus of control is divided into an internal locus of control where an individual feels they maintain control from within, and an external locus of control where outside influences are deemed to determine one’s destiny or fate.  

The concept of empowerment relates to how much control one has in particular situations. Some research from a consumer and recovery perspective has postulated that the perception of coercion acts as a barrier to achieving empowerment and control. In contrast, two studies which looked specifically at the relationship between empowerment and perceived coercion using the MPCS showed that perceived coercion did not correlate with feeling disempowered. These papers suggest that feeling coerced may not relate to the lack of control one has in a situation and are likely driven by context specific factors.

A complete review of the locus of control literature is outside the scope of this study. To date, the specific literature considering perceived coercion and control has not shown a clear association between these two concepts.

**Coercion and Substance Abuse**

The use of coercive care in the substance abuse and addiction literature is extensive and a full literature review of the area is beyond the brief of this thesis. This section provides a selective review of the recent literature addressing the informal coercive mechanisms used to
treat substance abuse disorders. The majority of studies identified support the use of paternalistic care in certain clinical situations when treating a substance abuse population, although the literature remains inconclusive on the overall outcome from coerced treatment.

Firstly the substance abuse literature separates compulsory treatment and coercive treatment in a substance abuse setting. Compulsory treatment occurs when the patient has no choice and is ordered to undergo treatment by the legal system. Coercive treatment is where the patient may elect to undergo treatment in order to lighten the judicial sentence; however the choice still remains with the patient. ¹⁰⁸

There are certain parallels between the substance abuse literature on coercion and the psychiatric literature. As with the psychiatric literature, legal coercion was assumed to be coercion until the concept of informal coercion was recognised and investigated. ¹⁰⁹ This distinction is highlighted by the finding in a study where 35% of patients legally mandated to treatment did not report they had been coerced and contrastingly 35% of patients who had self-referred reported they had felt pressured into seeking treatment. ¹⁰⁹

The significance that informal coercive pressures have on motivation to seek treatment is further shown by a study that concluded legal coercion is less substantial in influencing the decision to enter treatment than informal treatment. ¹¹⁰ In this study informal pressures included family, social, medical, psychological, financial and religious domains.

Within the substance abuse literature the most well-known coercive intervention in initiating treatment is the Johnson technique. ¹¹¹ This involves confronting the individual about his/her behaviour and clearly setting forth the consequences of continuing substance misuse contrasted to the expectations and outcomes of treatment for their addiction. It is a structured technique and designed to pressure or coerce an individual into treatment. The
Johnson intervention was shown to be the most effective coercive treatment when measuring entry and then completion of addiction treatment in a sample of substance misusers. While admission to hospital for medical reasons is not usually a planned or structured activity often family members accompany patients through the hospital admission. The degree of informal pressure or coercion delivered by family members has not been studied. While this type of coercion does not have the structure of the Johnson intervention, the general principles still apply in terms of the informal coercive element in directing a type of treatment or intervention.

Contingency contracting is another form of coercive intervention designed to enforce treatment. A person is contracted to adhere to certain conditions such as abstinence from misuse and is monitored for example by means of random urine drug tests. Consequences are specified in the event that they relapse into drug use such as informing their employer, termination of their employment, or other measures designed to motivate them to remain clean. As an example of the effectiveness of coerced treatment one study compared coerced (under threat of job loss) versus self-referred substance abuse treatment. This study showed the coerced group were more likely to stay in treatment than the self-referred or non-coerced group.

Other coercive mechanisms include court mandated treatment, involuntary commitment for treatment using legislation, and child custody and child protection issues requiring compliance with treatment and abstinence to continue to have custody of a child.

Comparing the extent of coercion across different patient groups such as a substance abuse population, medical population or psychiatric population helps to identify how the perception of coercion is experienced in different disciplines. The MPCS is a tool that has been
used across all three populations and is therefore useful in making comparisons between groups. However, Klag and colleagues have criticised the MPCS as having little relevance to the substance abuse population. This is because it was initially devised as a scale to measure the experience of coercion upon being admitted to a psychiatric hospital. They argue that it measures a global experience of coercion and is not able to separate out the different forms of treatment pressure that may be used in a substance abuse setting. Despite this criticism the MPCS was used in another study that considered the prevalence of coercion in determining entry into a drug and alcohol treatment centre. Using this scale they found one third of 260 patients who had cocaine addiction described feeling coerced to enter treatment. In summary, the use of the MPCS remains controversial when applied to the substance abuse population.

Despite a variety of different coercive techniques being employed in this area their utility and evidence of improved outcome remains inconclusive. The majority of studies suggest that coercion improves treatment outcome. For example, a study that found legally coerced patients with cannabis dependence had less psychological distress and were more likely to complete treatment than patients who were not coerced. In contrast, another study found that there was no difference in outcome between the coerced and non-coerced groups. Finally Simpson and colleagues found that the non-coerced group compared to the coerced group in their study had the better outcome. Determination of outcome is likely to be context and treatment specific. Additionally illnesses of addiction have their own unique characteristics quite different from a population of patients presenting with acute medical needs. What this research does suggest is that in certain contexts and conditions coercive treatment may be a useful intervention to treat substance abuse.
In summary, this selected overview of the substance abuse literature pertaining to coercive treatment has shown that both informal and formal coercion can be applied to treat sufferers of addiction. It is not clear to what extent either formal or informal coercion interventions improve outcomes. Techniques such as the Johnson technique and contingency contracting have been developed to assist clinical treatment and have formalised coercive processes. How these types of interventions might translate to medical care is not certain.

COERCION AND EATING DISORDERS

As with the substance abuse field, a broad literature surrounds the use of coercive care to treat eating disorders. With particular relevance to this study is that when eating disorders are severe they are often treated on medical wards providing some theoretical overlap with other general medical patients. Compulsory treatment for eating disorders can use both formal and informal coercive mechanisms to enforce treatment. The focus of this part of the literature review is on the informal aspects of the admission rather than the formal (Mental Health Act) coercive process that are sometimes used in this population of patients. The most recent literature has been selected to provide the reader with a current overview of the area without providing a completely comprehensive review.

Patients suffering with eating disorders are often admitted to medical wards when their illness is severe. The challenge for the clinicians treating them concerns how to preserve autonomy while using a paternalistic approach. These admissions can be contentious due to the coercive processes driving the admission. Parallels with other medical patients exist in the fact that they are admitted to a medical hospital often on a quasi-voluntary basis. For example, in one study almost one third of the patients treated voluntarily felt coerced and another two thirds were not certain as to whether they could freely leave the hospital.
However, there are some important features that might attract greater levels of perceived coercion in patients with eating disorders than medical patients. Firstly, some eating disorders such as anorexia nervosa are ego-syntonic leading to a greater reluctance to cooperate and be treated in hospital. Secondly, eating disorders are characterised by a rigid and inflexible thinking style which may interfere with the acceptance of treatment options. While it is possible medical patients can present with similar characteristics these factors are not a defining part of the illness profile as with anorexia nervosa. This would suggest they are less likely to be present.

The type of eating disorder diagnosis appears to impact on the patient’s experience of coercion. One study showed patients with anorexia nervosa reported higher levels of perceived coercion during care than did patients with bulimia nervosa. This might be explained by the ego dystonic nature of bulimia nervosa and the drive to therefore seek and accept help. In contrast patients with anorexia nervosa tend to have limited insight into their condition and are therefore more likely to feel treatment is coerced upon them. Lack of insight such as in conditions with delirium or dementia can also be a problem in medical patients with cognitive limitations perhaps attracting a greater sense of coercion as a result.

Over time patients with eating disorders often change their views about the necessity of the admission. This is shown in a study where almost half of the patients with anorexia nervosa who initially disagreed with being admitted to hospital later acknowledged the need to be admitted. This finding parallels a study of psychiatric patients half of whom changed their view of the need for admission some weeks after the event. The reason for this change is uncertain but has been suggested to relate to the extent of therapeutic engagement, improving cognition due to not being as starved, and the possible influence of peers. The
authors of this study conclude by supporting the concept of coercive care in treating anorexia nervosa but qualify this with approaching each case individually and the primary focus should be on maintaining a good therapeutic alliance. This conclusion seems a reasonable position when thinking about the treatment of medical patients who are reluctant to receive care.

Paralleling the general psychiatric literature the therapeutic relationship has also shown to be important in eating disorders. A qualitative study that investigated the views of 29 patients with anorexia nervosa showed that the quality of the clinical relationship was the most important factor in the perception of coercion. When choices were restricted or limited in a coercive manner, if carried out within a trusting relationship, then coercion was not evaluated as negative by the participants. This has implications in the medical setting as it appears the depth of the therapeutic alliance is the key variable which dictates the extent of perceived coercion reported by patients. Where the alliance is strong, compulsion could be considered to be acceptable care and where it was weak compulsion was negatively valued and considered coercive.

The age of admission appears to be another important factor in agreeing to treatment in this population. Younger patients (minors under 18 years of age) disagreed more with admission to hospital than the older patients (above the age of 18) although this was not statistically significant. The sample size was quite small (139 patients, with 35 minors and 104 adults), therefore requiring a large difference to reach statistical significance. Guarda and colleagues did not provide exact details of the age range of the participants in their study although I would assume patients presenting with eating disorders are likely to be much younger than general medical inpatients. Due to the discrepancies in likely average age between eating disorder patients and medical patients this result is unlikely to be meaningful
in a medical population. It is therefore difficult to conclude from this particular study what impact age might have on compliance with treatment in a general medical population.

In summary, patients with eating disorders are an important population to consider when making comparisons with general medical patients. This is because patients with eating disorders receive treatment in a general hospital when the illness is severe and in the case of patients with anorexia nervosa are often reluctant to receive treatment, hence inviting a degree of coerced care. Most importantly, this part of the review has highlighted the therapeutic relationship, the type of disorder (bulimia versus anorexia) and the timing of when patients were questioned in relation to the admission as important factors that affect the perception of coercion and agreement with admission. While not fully comprehensive of all studies considering coercion in an eating disorder population it has identified some important themes that overlap with other patient groups.

**Coercion and Medicine**

While psychiatry has investigated the perceived coercion in some detail, this has been scarcely explored in a medical setting. This is despite the fact that coercion in medicine has been described as “rampant and used with little thought”\(^\text{125}\) A focus on coercion outside of psychiatric care was proposed in 2008, where it was recognised that coercive treatment may be present in such settings as aged care homes and medical hospitals.\(^\text{126}\) Geller also described coercive care as not being unique to psychiatry and outlines its presence in Emergency Departments, Primary Care and Nursing Homes.\(^\text{125}\)

As longevity increases, the average age of patients entering hospital is also rising, which places particular challenges on the healthcare system.\(^\text{127}\) The ability of patients to make decisions is often compromised by illness, loss of sleep, pain and sometimes isolation,
increasing the likelihood of experiencing coercion. Alongside these more acute factors come concern around the physical and mental changes that occur with age that may impact upon autonomy. For example, dementia, characterised by a progressive impairment in various cognitive domains, can have a significant impact on an individual’s autonomy to make healthcare decisions. Reduced decision making capacity may have an impact on how care is understood and received.

The vulnerability of older adults to alterations in cognitive functioning increases the potential for coercive care. In addition, in my experience older adults are often not as well educated, and less likely to be aware of the technological advances in medicine making them less able to be fully informed. These factors can lead to a sense of helplessness promoting the likelihood of undue influence from others such as family, friends and healthcare professionals. For these reasons it seems even more important to attend and listen to the wishes of the patient, thus reducing the likelihood of coercion and promoting an individual’s autonomy.

The question of the clinical appropriateness of coercive care is contentious and there has been very little research examining the extent and delivery of such care in a general hospital setting. During the EUNOMIA (European Evaluation of Coercion in Psychiatry and Harmonization of Best Clinical Practice, acronym: EUNOMIA) study it was realized that coercive measures can occur in non-psychiatric institutional settings. As a result of this realisation and as an aside to the EUNOMIA project, three areas of research were investigated in Spain. The first focus looked at coercive measures in general hospitals in non-mentally ill patients, the second prison inmates with mental disorder and the third intellectually disabled patients living in care homes. The results of the first two of these studies were presented at
the World Psychiatric Thematic Conference. Coercive Treatment in Psychiatry: A Comprehensive Review Dresden, Germany. 6–8 June 2007. It does not appear that this research has been formally published but the abstract for the oral presentation at this conference describes using an observational study format to looked at five general hospitals to gain knowledge of coercive measures used in these institutions. This study considered “involuntary admission, non-wished stay, non-wished medication or treatment, seclusion, chemical coercion and no information” as coercive measures. The researchers then developed a stereotypical patient profile of those patients who seem most at risk of being coerced in a general hospital. This profile consisted of the following elements ” age 71–80, lives alone, confused state, with neurological or respiratory disease, applied in the first 48 hours, by nursing staff, with a low perception of coercion, during the night, without patients' and/or relatives' opinion, without information.”

The only other study investigating perceived coercion in medical care was conducted in Brazil. Taborda and colleagues compared the levels of perceived coercion between psychiatric and non-psychiatric (medical and surgical) patients admitted to hospital. The non-psychiatric population consisted of both elective and non-elective presentations to hospital. In total, 58 medical and 83 surgical patients were interviewed, and a translated version of the MacArthur Admission Experience Survey was used to collate information about the level of perceived coercion, procedural justice and negative pressures subscale. While the psychiatric patient group reported higher levels of coercion, almost half of the non-psychiatric patient group reported experiencing some coercion.

Psychiatric illness and medical illness are perceived as quite different in regards to decisional capacity and the vulnerability to coercion. This bias has been shown by producing
a series of vignettes incorporating either psychiatric illness or medical illness, and asking the participants (institutional review board members considering research proposals) to comment on decisional capacity, risks and coercion. Psychiatric patients were perceived as more vulnerable to coercion with less decision making capabilities in both the less and more severe categories than the medical equivalents. This thinking might be part of the reason that little research focussed on perceived coercion has occurred in a medical setting.

Summary of the literature

Research investigating the perception of coercion has principally evolved within a psychiatric setting. The discovery that perceived coercion could be independent of legal status and also existed in a minority of patients who were voluntarily admitted to psychiatric hospitals indicated it may have implications in other clinical areas. The original Macarthur studies have provided the platform and research tools necessary for continued investigation of perceived coercion in a variety of clinical settings. A selected focus on eating disorders and substance abuse in relation to the perception of coercion has shown how this concept is understood and used in different disorders. Only very limited research has investigated the concept of perceived coercion in a general medical setting.

JUSTIFICATION FOR THIS STUDY

Medicine should always be striving to optimise the quality of healthcare delivered to patients. The subjective accounts of patients’ experiences are an important part in helping to shape a health service that can provide personal care. The complexity of current hospital systems with the layers of staff and specialisation may detract from the personalisation of care and lead to a greater sense of coercion. Furthermore, the appreciation from psychiatric
studies that many voluntary patients perceive coercion\textsuperscript{56,57} questions the extent to which perceived coercion is inherent with admission to any type of health institution. The importance of this study in the literature is emphasised by the fact only one other study has measured perceived coercion at medical admission.\textsuperscript{75}

This study has theoretical value in being able to assist in comparing a non-psychiatric population of patients with previous studies of psychiatric patients. This is important in helping understand if there is a baseline level of perceived coercion on admission to any health institution. The use of formal coercion is well established in psychiatric care but less is known about informal coercion. As formal coercion is seldom used in a medical setting this study will shed light into understanding how informal coercion may be experienced by medical patients. Ultimately this may assist in setting guidelines and rules around the use of informal coercive mechanisms, highlighting where it might be appropriate and where it crosses into potential abuse.

Optimising the autonomous wishes of patients, the levels of satisfaction with clinical services and validation and respect during the admission are likely to reduce the overall experience of perceived coercion.\textsuperscript{77} Understanding the theoretical relationship between autonomy and coercion in a real world setting may provide opportunities to enhance the patient experience in the future. Enhancing and meeting the patients’ preferences for autonomy are similarly likely to reduce the experience of perceived coercion.
Aims and research questions

The overall aim of this study is to quantify the extent of perceived coercion experienced by patients when admitted to an acute medical ward in a New Zealand tertiary hospital. Additionally the study aims to identify the clinical and demographic characteristics of the subset of patients who feel most coerced.

A further aim is to consider how autonomy preference is reported in a New Zealand hospital. This study aims to investigate the relationship between the patients’ preference to make “autonomous” medical decisions and their proclivity to feeling coerced at the time of admission.

RESEARCH AIM A.

1. What proportion of patients feel coerced when admitted to a medical ward of a general hospital?

2. What are the socio-demographic factors that might contribute to a perception of coercion in a sample of patients recently admitted to an acute medical ward?

RESEARCH AIM B.

To understand and investigate how much autonomy NZ medical patients desire when admitted to hospital.

1. How much desire for making decisions and information about their health do a sample of recently admitted New Zealand medical patients report?

2. What clinical and demographic factors correlate with a medical patients’ desire to make decisions and receive information about their condition?
**Research Aim C.**

To investigate the association between autonomy preference and perceived coercion in a general medical setting. It is hypothesised that those participants who value more control in managing their illness will be more likely to perceive the admission process as coercive.

1. What relationship is there between autonomy preference and perceived coercion in a sample of medical inpatients recently admitted to hospital?

The following section outlines the method employed to answer these research questions.
CHAPTER 3: METHODS

Method

This chapter is divided into four parts. In part one the general design, setting and sample are discussed. Part two contains discussion on the measures used. Part three outlines the analysis of the data. Part four describes the procedure and research method used to collect the data.

Part One: Design, setting and sample

Design

This is a cross sectional study of general medical inpatients admitted to the Medical Assessment and Planning Unit (MAPU) of a New Zealand tertiary hospital.

Setting

The MAPU is an acute medical ward of 18 beds providing a prompt, comprehensive assessment of acute medical patients within the first 48 hours of admission. It was chosen for this study because of the high patient turnover and variety of presenting medical conditions. In the last year, MAPU admitted 3903 patients. Of these 2218 (56.8%) were NZ European, 336 (8.6%) identified as Pacific islanders and 368 (9.4%) identified as NZ Maori. The remaining (25.2%) consisted of other ethnicities such as African, various Asian and other European categories.
Sample

Eligibility Criteria

Participants were to be selected from the stream of general medically ill patients admitted to MAPU on the days of data collection. All patients admitted except those placed into High Dependency Unit (HDU) beds were eligible for participation. It was assumed that the severity of illness was much higher in the patients in the HDU so they would be less able to complete the questionnaire. Patients were also excluded if they were unable to adequately communicate in English.

Identified participants were then randomly allocated a number and then ranked in numerical order. Participants were then approached by the author in sequential order from lowest to highest. Patients who did not complete the study included those absent from the bed at the time when approached, those who refused to participate and those whose cognitive impairment prevented completion of the questionnaire. These patients are defined as non-participants.

Sample Size and Power Calculation

The sample size calculation was based on a t-test comparing the mean Autonomy Preference Index (API) score between the coerced and non-coerced groups in a previous study.\textsuperscript{134} In terms of coercion, this study showed that approximately 20\% of a medical and surgical population scored at greater than two out of five on the perceived coercion scale. It was assumed that a difference of 10 points on the Autonomy Preference Index (API) would be a meaningful difference between the two groups. The standard deviation of the API is 12.6 points.\textsuperscript{49} Alpha was set at 0.05,\textsuperscript{135} and beta was set at 0.80.\textsuperscript{136} Based on these assumptions, a final sample size of 80 participants would be required to minimise type 2 errors.
Part Two: Measures

Each participant completed a questionnaire containing socio-demographic and clinical data including ethnicity, education and frequency of hospital admissions over the past five years. The New Zealand deprivation index was used to determine socio-economic status. This is a set of eight questions designed to elucidate the relationships between socioeconomic position and health outcomes. The Cronbach coefficient alpha of this scale is 0.81 indicating relatively high reliability when measuring the construct known as “deprivation.” The NZiDep takes 2-3 minutes to administer.

Admission Experience Survey

The MacArthur Admission Experience Survey (AES) was chosen to measure each participant’s perception of coercion. The AES was developed by the MacArthur Research Network on Mental Health and the Law. It was designed to assess the patient’s experience of admission to hospital. Since its development, it has been used widely primarily in psychiatric research and adapted for different cultures. Several multi-national studies have used this scale to measure coercion during hospitalisation. This scale has good retest reliability across time. This scale was selected so that comparisons of my data could be made with other studies.

The AES consists of a 15 item questionnaire yielding four subscales; perception of coercion at admission (perceived coercion subscale); the pressure placed on patients to be hospitalised (negative pressures subscale); the perceived level of fairness during the process of admission (procedural justice subscale); and the emotional reaction to the admission process (affective reactions subscale). The perceived coercion subscale consists of five items
with scores ranging from 0-5 with higher scores reflecting greater perceived coercion. The AES was adapted to fit with the population of medical patients surveyed by removal of Question 10 of the AES “I was threatened with commitment”. This reduced the scoring of the negative pressures subscale from a total of 6 questions to 5. The procedural justice scale scores ranged from 0-3 with higher scores reflecting high levels of procedural justice.

The Perceived Coercion Subscale has been found to have sound psychometric properties in measuring the extent of coercion during a hospital admission. This study found the Cronbach coefficient alpha of this scale is 0.90 indicating high reliability for the construct of coercion.

**Autonomy Preference Index (API)**

Patients’ desire to participate in medical decisions was measured using the API. The Autonomy Preference Index (API) was developed by Ende and colleagues in 1989 and it has become a well-established measure of autonomy. The API was initially validated in the United States of America and applied to general medical patients. It showed an internal consistency reported as alpha=0.82 and test re-test reliability as r=0.84. It consists of 23 items separated into an information seeking subscale and a decision making subscale. The information seeking component focuses on what the patient feels the physician should tell them. The decision making element focuses on what the patient thinks he or she should do when making healthcare decisions. Fourteen items use a Likert scale with responses ranging from “strongly disagree” to “strongly agree.” Reverse scoring was used for questions 1, 3 and 5 of the, preference to make medical decisions, scale. The scores range from 0 to 100 with the lowest score (0) representing the desire for the doctor to have complete control and (100) meaning that the patient wishes to have total control. The test re-test reliability over two weeks was 0.84 for medical decision making and 0.83 for information seeking.
validity was tested by comparing the scores of a highly motivated group of diabetic patients with the general population. The diabetic group scored significantly higher scores ($p<0.01$). Concurrent validity was assessed by the selection of a global statement about who should hold responsibility for medical decision making compared to the actual decision making scores ($r<0.54; p<0.0001$).

A comparison study between the API and the Health Opinion Scale, an alternative instrument I considered, recommended the API be used instead of the Health Opinion Scale where information seeking is the primary measure. The wide use of this measure in the literature allows for comparison between studies and across time. The original study claimed most patients could complete the scale in under ten minutes and without assistance.

Patient participation is further measured through the use of three clinical vignettes varying from an upper respiratory tract infection (mild disease) to hypertension (moderate disease) to myocardial infarction (severe disease). Patients are asked to consider their participation preferences in respect of these scenarios and who should make the decisions with responses ranging from “you alone”, “the doctor and you equally” and “the doctor alone.” The vignettes scores are then adjusted to measure out of 10.

**Mini-Cog**

The Mini-Cog was used to identify cognitive impairment. This involves a three item recall test for memory and a simply scored clock drawing test. An inability to recall any of the items in the memory test is considered positive for cognitive impairment. Scoring 3 out of 3 on the memory test indicates no cognitive impairment and the participant is not scored on the clockface item. If a score of 1-2 is found, out of 3 on the memory task then the additional clock face test is scored to differentiate the presence or absence of cognitive impairment. A normal
clockface was defined as all numbers being present in the correct sequence and position on the face along with the hands displaying the requested time. The Mini-Cog has a sensitivity of (99%) and specificity of (93%) in identifying cognitive deficits.\textsuperscript{142} Administration of the Mini-Cog takes less than three minutes compared to seven minutes for the Mini Mental cognitive assessment.\textsuperscript{142}

*Karnofsky*

The Karnofsky Performance Status Scale was used to assess the functional status of each participant. This scale was first used by Karnofsky to assess the functional status of cancer patients in the late 1940s.\textsuperscript{143} The scale has 11 points and ranges from 100 (normal functioning) to 0 (dead). It has been used widely to estimate functioning in a range of different conditions that includes but is not exclusive to kidney disease\textsuperscript{144}, HIV\textsuperscript{145} and osteoporosis.\textsuperscript{146} It relies on an observation by the researcher as to the functional status of the participant. It was chosen because it is easy and quick to administer and does not require the participant’s active involvement. It has good construct validity against two other measures of patient functioning.\textsuperscript{147}

*Feasibility*

A feasibility test was conducted by giving the questionnaire to a small sample of patients before commencement of the formal data gathering. Time to completion varied between participants but was not measured during testing. The author found assisting patients through the questionnaire was faster than leaving them to complete the questions on their own. Following the feasibility process the author was satisfied the questionnaire could be administered to medical inpatients in a reasonable time period (approximately less than 30 minutes for the longest application).
Selection of Instruments

The Coercion Ladder was considered as an alternative measure of perceived coercion. It was discounted firstly, because the MPCS (found within the AES) was considered to be better at discriminating lower levels of coercion. The Coercion Ladder has had only limited utilisation in other relevant studies.

The Health Opinion Survey (HOS) was considered as an alternative to the Autonomy Preference Index (API). A previous study had identified the API as more suitable than the HOS if the focus of the study is on the desire for involvement in decision making. The API has also had greater utilisation across a broader range of comparative studies.

Part Three: Analysis

Univariate analyses were used to describe the general characteristics of participants and non-participants.

The main analysis examined whether individuals with higher Autonomy Preference Index (API) scores were more likely to report coercion (Perceived Coercion Scale score of 2 points or more). The statistical associations between categorical variables were assessed using chi square tests. The Wilcoxon–Mann–Whitney two-sample rank-sum test was used to compare the perception of coercion to outcomes that were considered not normally distributed. Correlations were explored using Kendall’s tau-b (a non-parametric correlation coefficient) to test significance.

Further analysis used the perceived coercion score as a dependent variable. For the purpose of this analysis, data either missing or recorded as “don’t know” in the AES was considered the equivalent to a “no” in the scoring of the PCS. Scoring two or more in the PCS was taken as the cut-off to indicate coercion. Non parametric tests were performed using
the Wilcoxon–Mann–Whitney two-sample rank-sum test using the level of significance set at p<0.05. All statistical tests were conducted using SPSS statistics software.

Part Four: Procedure

Data were collected between 2 August 2010 and 4 May 2011. The days chosen to collect data were set throughout the working week (Monday to Friday) and no weekend days were used. The variation in days was used to reduce the chance of having participants always under the same medical team and therefore admitted by the same clinicians.

The study was approved by the Northern Region Ethics Committee and all participants gave written informed consent.

Participants were approached by the interviewer (AS) and asked whether they would be willing to complete a questionnaire on the amount of control they felt when being admitted to hospital. An information sheet detailing the aims of the study was provided and a written consent form was completed before participants began the interview. Participants either completed the questionnaire themselves in the presence of the interviewer or were asked the questions by the interviewer who completed the questionnaire based on their answers. This minimised the amount of missing data.

The interviews were not formally timed but took approximately thirty minutes to administer dependent on the speed of the participant including the initial approach, explanation and gaining informed consent. Occasionally visiting relatives were present during the interview and they were not asked to leave but requested to allow the patient to respond as best they could. The MAPU environment itself is a busy medical unit and often patients are separated only by curtains meaning conducting an interview was challenging at times due to the noise distraction.
CHAPTER 4: RESULTS

This chapter describes the results of the current study. Firstly it outlines the socio-demographic characteristics of the participant and non-participant groups. This is followed by the results of the perceived coercion and autonomy preference questionnaires and the associations between these two measures.

RECRUITMENT

Of the 153 patients who were eligible and approached to participate in the study, 86 (56%) patients completed the questionnaire. This group are defined as the participants. The non-participant group comprised of those patients who were eligible but not approached (due to random selection and the time constraints of completing the survey) and a further group who either declined to enter the study or were not at their bed when the interviewer attempted to gain informed consent for them to enter the study. Among the non-participants who were approached, 28 (18%) declined to enter the study and 35 (23%) were absent from their bed at the time of approach by the interviewer. Reasons for absence included already being discharged or undergoing clinical investigations at the time the interviewer was available. Four (3%) patients were unable to complete the questionnaire due to confusion and considered ineligible.
**Socio-Demographic Characteristics of Participants**

Table 2 summarises the key demographic data comparing participants to approached non-participants. Hypothesis testing has not been conducted between the two groups for most of the socio-demographic data. This is due to the relatively small sample size. Instead, confidence intervals have been provided to show the spread of the data and demonstrate the similarities between the two groups. Ethnicity was defined using Statistics New Zealand Ethnicity Classification System.149

Table 2. Demographic characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Participants</th>
<th>Non Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
<td>86</td>
<td>67</td>
</tr>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age – mean (95%CI)</td>
<td>65.69 (61.99, 69.39)</td>
<td>67.88 (63.52, 72.24)</td>
</tr>
<tr>
<td>Sex – male (%)</td>
<td>39 (45%)</td>
<td>31 (46%)</td>
</tr>
<tr>
<td>Average length of admission (95%CI)</td>
<td>7.83 days (6.31, 9.35)</td>
<td>6.73 days (5.32, 8.14)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European (%)</td>
<td>60 (70%)</td>
<td>44 (66%)</td>
</tr>
<tr>
<td>Maori</td>
<td>15 (17%)</td>
<td>9 (13%)</td>
</tr>
<tr>
<td>Pacific</td>
<td>5 (6%)</td>
<td>8 (12%)</td>
</tr>
<tr>
<td>Asian</td>
<td>5 (6%)</td>
<td>5 (7%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

One 60 year old participant identified as transgender and was hoping to have gender reassignment from male to female. Although this participant identified as female, for the
purposes of the gender analysis this individual was included as a male since surgical reassignment had not occurred. It is difficult to know how gender orientation in this case may have influenced the perception of coercion. It was therefore felt the simplest solution was to rely on biological parameters to assign gender within the study protocol.

The participants’ length of admission ranged from 1 day to 42 days with a mean of 7.8 (95%CI 6.31-9.35) days. No significant difference was found between the average length of admission for participants and non-participants t(160)=0.952, p=0.342.

A school level or higher qualification was found in 63 (73.3%) of participants with 23 (26.7%) holding no school level qualification. The majority of participants (56, 65%) occupied group 1 of the New Zealand index of socioeconomic deprivation showing least deprivation. The index is divided into five categories with counts of 0, 1, 2, 3, or 4, and 5 or more out of 8 deprivation characteristics. The distribution of NZi dep scores is shown in Table 3.

Table 3. New Zealand index of socioeconomic deprivation scores

<table>
<thead>
<tr>
<th>NZi deprivation score</th>
<th>Number of deprivation characteristics</th>
<th>Number of participants (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (least deprived)</td>
<td>0</td>
<td>56 (65%)</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>12 (14%)</td>
</tr>
<tr>
<td>4</td>
<td>3 or 4</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>5 (most deprived)</td>
<td>5 or more</td>
<td>4 (5%)</td>
</tr>
</tbody>
</table>

The majority of participants (55%) were admitted to the MAPU via the Emergency Department as opposed to directly from the General Practitioner. Participants’ recall of the
number of previous admissions to hospital in the last five years ranged from 1 to 20 separate admissions with a mean of 3.8 (95% CI 2.98-4.62).

The Karnofsky scale was scored following the interview. It was found to be difficult to assess the level of the participant’s functional ability while observing them during the interview and the researcher had little confidence in the scoring of the scale. As a result the scores of the Karnofsky scale were not used in the final analysis.
PERCEIVED COERCION

The mean perceived coercion score was 1.28 (95% CI 0.97-1.59), with a median score of 1.0. The distribution was negatively skewed with 37 (43%) participants reporting no coercion. The cutoff for measuring perceived coercion was arbitrarily set at answering two or more questions affirmatively (as defined by previous research) and was present in 30 (35%) participants. 49 (57%) participants described at least some coercion (one question or more answered affirmatively) and 17 (20%) participants experienced greater perceived coercion (at least 3 out of 5 questions answered affirmatively). Figure 2. shows the distribution of perceived coercion scores.

Figure 1. Distribution of responses for the perceived coercion sub-scale.
The mean negative pressures score was 4.76 (95%CI 4.67-4.85) with a median of 5.0. The majority of participants 72 (84%) reported no negative pressures. Figure 3. shows the distribution of negative pressure scores.

![Distribution of negative pressure scores](image)

Figure 2. Distribution of responses for the negative pressure subscale.
The mean procedural justice score was 0.56 (95%CI 0.37-0.75) (Fig. 4). The distribution was positively skewed with 58 (67%) scoring the maximum procedural justice score. Figure 4 shows the distribution of procedural justice scores.

![Figure 3. Distribution of responses for the procedural justice sub-scale.](image)

ASSOCIATIONS WITH PERCEIVED COERCION

The perception of coercion was not significantly associated with gender ($\chi^2$ (df 1) = 1.396, p=0.24) or age (Mann-Whitney U = 851.5, p=0.92). Socio-economic status (NZidep score) was not associated with perceived coercion (Mann-Whitney U=848.5, p=0.93). The educational
status of the patient as defined by those patients without any school level qualifications and those with school level qualifications or higher was not associated with perceived coercion ($\chi^2$ (df 1) = 1.02, p=0.31).

The referral source could potentially change the clinical journey for that patient in that some patients, who present to their GP first, bypass the Emergency Department and go direct to MAPU for further assessment and treatment. This has potential to alter the admission experience and was investigated to see if it had any bearing on the experience of coercion. The referral source (Admission via the Emergency Department or directly by the General Practitioner) was not associated with the reporting of coercion during the admission process ($\chi^2$ (df 1) = 1.18, p=0.28).

Repeatedly presenting to hospital for the same condition may influence how a patient feels about a further admission. To examine this in more detail, the number of admissions as recalled by each participant was compared to perceived coercion. The perception of coercion was not significantly related to the number of past admissions (Kendall’s tau-b = 0.037, p=0.67).
Autonomy preference: decision making

Participants showed a strong desire to be involved in making medical decisions with a mean score of 58.9 (95%CI 56.15-61.65) (where 0 indicates no desire to make medical decisions and 100 indicates a high preference to make medical decisions). The scores for decision making were normally distributed and are shown in Figure 5.

Figure 4. Distribution of autonomy preference index scores
AUTONOMY PREFERENCE: INFORMATION SEEKING

There was a higher preference for information seeking than decision making with a mean score of 89.3 (95% CI 87.36-91.24). See Figure 6.

Figure 5. Distribution of autonomy preference index scores
AUTONOMY PREFERENCE: CLINICAL SCENARIOS

Repeated measures ANOVA showed that there were statistically significant differences in the means of the three API scenario scores, $F(2, 170) = 370, p < 0.001$. Pairwise comparisons between scenarios suggested that all three groups had significantly different means ($ps < 0.001$; Figure 7.) Analysis with a non-parametric version of this test also indicated that scores were different between scenarios (Friedman’s test, $Q(2 \text{ df}) = 136, p < .001$).

![Figure 6](image)

**Figure 6. Decision making preferences across three clinical scenarios**

ASSOCIATIONS BETWEEN PERCEIVED COERCION AND AUTONOMY PREFERENCE

Perceived coercion and autonomy preference in the form of medical decision making were not significantly associated (Mann-Whitney $U = 787.5, p=0.63$). Nor was there a significant association between perceived coercion and the wish to seek information about healthcare (Mann-Whitney $U = 769.5, p=0.52$).
CHAPTER 5: DISCUSSION AND CONCLUSIONS

This study was designed to investigate the extent of perceived coercion and how this relates to autonomy preference in a sample of medical inpatients in a New Zealand setting. Part one considers the three research aims and each are discussed with reference to the relevant literature. The second part considers the methodological strengths and weaknesses of this study. The third part considers the implications of the findings and identifies areas of further research. The chapter finishes with the final conclusions.

PART ONE: REVIEW AND EVALUATION OF KEY FINDINGS

Research Question A1: Amount of coercion

What proportion of patients feel coerced when admitted to a medical ward of a general hospital?

Perception of coercion was reported by 35% of participants when recalling the admission process. Perceived coercion is defined by affirming two or more questions out of five on the MPCS. The only other study measuring perceived coercion amongst general hospital patients found rates of perceived coercion of around 20%. The discrepancy in these results might be explained by the different sample selection between both studies. Firstly Taborda and colleagues had a much younger age of participants (age range 20-55 years) compared to a median age of 66 (age range 18-90 years) in my study. Younger age has been shown to correlate with greater desire to make medical decisions about one’s health. Their study population may therefore have been less likely to report feeling coerced than an older population.
Furthermore in the study of Taborda et al 91 of the 141 medical/surgical patients were admitted for elective reasons as opposed to emergency (life threatening) treatment. Elective admissions are likely to involve a higher level of control and participation in medical decision making, thereby reducing the overall perception of coercion. All the participants in my study were admitted acutely and not for elective reasons. To break this down further they showed that the emergency (non-elective) non psychiatric (medical/surgical) patients scored 0.92 ± 1.16 on the PCS while the equivalent (medical/surgical) elective group reported less coercion scoring 0.75 ± 0.94. Importantly Taborda et al found the difference between these two groups was not significant (p<0.513). My study showed an overall PCS of 1.28 ± 0.31. The greater perceived coercion in my study might be accounted for by the recruitment of only non-elective presentations. Another factor that might contribute to this difference includes unknown cultural differences between New Zealand and Brazil in regards to the hospital admission process. Despite the differences in coercion between the studies they both demonstrate that it is relatively common for a minority of medical patients to perceive coercion during admission to a general medical hospital.

That coercion occurs during both psychiatric and medical admissions suggests there are similarities in the process of admission that contribute to the experience of feeling coerced. Firstly, admission to hospital is, where possible, avoided and when it does occur implies a seriousness of illness. One could postulate that whether it be a medical or psychiatric admission most patients would rather not be in hospital thereby raising the likelihood of feeling coerced in this cohort. Secondly, the process of admission to a psychiatric ward or medical ward is often similar. Once attention has been raised about medical or psychiatric need, various clinicians perform assessments, examinations and investigations to decide on
the most appropriate management. The decision to admit is made after initial assessment and involves interactions with multiple health professionals. If aspects of procedural justice are not observed during this process, then this may lead to coercion being perceived.

The rationale, understanding and consequences of coercive care remain uncertain in a medical context. By definition, coercion is associated with a narrowing of choice and is not generally considered as being in the best interests of the patient. Yet a broad conceptualisation indicates that “the care of all patients is full of various shades of persuasion and coercion.”

Coercive interventions are more likely to be justifiable where treatment efficacy is high and the consequences of non-intervention serious. In my study, the discovery that 35% of patients felt coerced may not necessarily be an unfavourable finding. Participants in my study were admitted for non-elective reasons suggesting the risk of non-intervention was serious and could lead to significant harm. Perhaps the admitting health care staff justified the use of coercion due to the risk presented if the participants were not treated and to ensure that participants received appropriate investigations and treatment.

The admission to hospital, a form of institution, might alone be enough to engender a sense of perceived coercion. The concept of institutions being restrictive, authoritarian and potentially coercive is not a new idea. Goffman in 1961 described the “total institution” in reference to various sociological structures that housed a grouping of people with similar presentations managed by another group defined as staff. His concept of “total institution” was fairly broad including psychiatric hospitals, care homes for the disabled, concentration camps and extending out into boarding schools and even monasteries and religious homes. Many of the principles in these institutions are shared. For example, the limitation to activity
designed to fulfil the aims of the institution. In the case of the hospital its aim is to improve
the health of the patients. Goffman’s sociological description of the institution lends itself to
understanding some of the basic principles underlying admission to hospital (an institution).
This provides a framework into how the institutional characteristics may then lead to coercive
care in some cases.

The actual coercion is driven from the interface between the employees of the institution
and the recipient. Goffman uses the description of the admission process to degrade and
debase an individual to conform to the regulations. While current hospital admission
processes do not act with such extreme practices there is still a need to conform and accept to
the systems processes. Long waits in the Emergency Department have not been uncommon
and, while unacceptable, may act as the rite of passage in some cases to entry to the hospital
system. This type of process and experience may predicate the development of the subjective
experience of coercion.

The idea of coercion being used in medical care tends to be judged negatively. While
coercive interventions are more likely to occur during a psychiatric admission, it seems
relatively high rates of coercion are still present during medical admissions. Rather than
simply assuming that the level of coercion should be reduced, an alternative view would be to
incorporate this concept into the quality of care. “Compassionate interference” has been
postulated as a method of regaining lost autonomy and provides a theoretical basis to justify
paternalistic care in some situations. Advanced by Verkerk, a bioethicist in the Netherlands,
it involves a relational concept of autonomy whereby the focus is on the relationship between
the caregiver and care receiver. Enhancing relationships can be a means of improving
autonomy by, for example, addressing self-esteem. Coercive care is incorporated into this
model where the longer term autonomy of the individual can be preserved even though short
term autonomy is threatened or absent. “Compassionate interference” remains a theoretical
construct only without measurement tools. The extent to which health professionals attribute
their actions to this model in regard to those patients who perceived high levels of coercion is
unknown. It is possible that this principle is being applied by health professionals and is
interpreted by the patients as coercion. Arguing against this is the fragmentation of clinical
care. Patients often see multiple clinicians and there is little chance to develop enduring and
meaningful relationships with clinical staff, particularly during an emergency admission. This
means the opportunity to utilise compassionate interference seems less probable with the
fragmented and short term contact with healthcare staff.

Rather than seeking to eliminate all coercion, an opposing view might welcome and
endorse the use of coercive care in certain clinical situations. Justifying the boundaries of the
use of coercive care and limiting the possibility of abuse are the challenges of taking such a
position. Is it possible to have a best practice standard for coercive treatment in medicine?
Without further study on the extent and type of coercion in a medical setting, it is not likely
that best practice standards can even begin to be devised. Furthermore attempts at doing this
in a psychiatric setting have been unsuccessful.¹⁵² Steinert and Lepping conclude that a best
practice standard “will probably never contain objective answers but are always dependent on
locations, traditions, historical contexts, attitudes and influences of stakeholders groups”.¹⁵² It
is likely that this is true of general hospital as well as psychiatric hospital care. Instead of a
practice standard they propose recommendations that are transparent and help to guide and
direct the use of coercive interventions.
The scarcity of research on perceived coercion in general medicine means it is difficult to assess whether 35% of patients reporting coercion is an acceptable rate. Perhaps this is the cost of running a modern healthcare system where patient flow, and low bed numbers place high demands on staff resulting in limited time to spend with each patient. Another way of framing this concept would be to ask whether one would expect 35% of patients to experience coercion if health professionals were not restricted by time. It has been proposed that poverty of time leads to paternalistic actions, rather than an absence of reasonable alternatives. Adding further weight to this argument one study showed that lack of clinician time spent with psychiatric patients is positively associated with the perception of coercion. It seems plausible that being able to spend longer with patients would provide a greater sense of validation improving procedural justice and thereby reducing the perception of coercion.

Enforced treatment of some patients admitted to medical wards can occur where the patient is deemed not to have capacity and the clinicians are acting in their best interests and have consulted relevant significant others who know the patient. This is usually done using the Health and Disability Code section 7(4). It is possible that many of the patients reporting coercive care did so correctly and this study has not accounted for the use of this legislation by clinicians when admitting patients to hospital. If a proportion of the patients were deemed not to have capacity and treated in this way then it would be expected that they might report feeling coerced at admission.

This study has shown that perceived coercion is prominent during admission to a general hospital. This has been measured from the patient’s subjective viewpoint. A previous study has also shown a minority of patients in a non-psychiatric (medical surgical population)
This study adds further evidence that perceived coercion is an important concept to consider during medical admission.

**Low perceived coercion**

The majority of studies conducted in psychiatric care have shown higher degrees of perceived coercion than found in this study.\(^{64,65}\) However, one study by Hoge \textit{et al} in the United States found much lower perceived coercion \((0.64 \pm 1.07)^{57}\) compared to my study \((1.28 \pm 1.49)\). The voluntary group in Hoge’s study were separated from the group who were uncertain about their voluntary or involuntary status (this group reported higher perceived coercion). It is curious that they should find such a low level of perceived coercion even though the sample population were considered voluntary. Voluntary patients, in their study reported that admission pressure came from family and friends before contact with services. This implies that the group of voluntary patients may have already accepted the need for admission so therefore did not feel undue pressure from the admission process and therefore reported lower perceived coercion. This low perceived coercion may reflect a selective group of voluntary unconfused patients. An alternative view proposes that it is possible to have less perceived coercion and that the systems used elsewhere are unnecessarily coercive. However, the fact this finding is isolated and a potential outlier from other similar studies suggests that it was more to do with the study design and population sampled than necessarily a repeatable finding. The extent family and friends exert pressure on medical patients to be admitted to hospital was not explored but it would be interesting to understand in light of the relatively high perceived coercion rates in this study.

**Perceived coercion and outcome**

The concept of coercive care implies that the patient is not consenting and that other people (often health professionals) are acting in what they consider to be the best interests of
the patient. Understanding the outcomes and consequences of perceived coercion is important in identifying what role it might play within healthcare.

There has only been very limited published research conducted considering the eventual outcome of such interventions and only in a psychiatric setting. Nevertheless this research may go some way to understanding the outcomes for this population and permit further discussions about how it might generalise to, for example, medical populations. One suggested consequence of perceived coercion is that the experience of perceived coercion leads to patients avoiding future follow-up care.\textsuperscript{20} The literature looking at outcome after the perception of coercion is mixed. A couple of studies have shown that perceived coercion does not negatively affect outcomes after discharge.\textsuperscript{65, 93} One proposal to explain this finding suggested that the reporting of higher perceived coercion was reflective of more awareness and insight and in order to avoid future coercive experiences motivated patients to do better thus improving social outcome.\textsuperscript{93} In contrast a Finnish study of 100 patients concluded that perceived coercion did have an impact on future engagement while legal status did not.\textsuperscript{153} To determine coercion this study used a structured interview and collated responses by participants indicating they had no choice or were resistant to the idea of admission. From this process, it is difficult to compare their results with studies that have used the MPCS. A study of 825 psychiatric patients that did use the MPCS with follow-up for a year after discharge showed perceived coercion did not alter medication adherence or engagement with services. One weakness of this study is that it used patient reports to assess medication adherence without evidence from corroborating sources.\textsuperscript{154}

In a different approach using mental health as an outcome measure, coercive incidents did not impact on either the voluntary or involuntary patients short term outcomes during
While the evidence remains mixed, on balance these studies suggest perceived coercion is not strongly correlated with better outcomes in psychiatric care. Justifying coercive care ethically would be more defensible if better outcomes were demonstrated. This would apply equally to a medical and psychiatric setting. The design of my study did not include follow-up either during the admission or post discharge. It would be of interest for future research to consider the longer term outcomes for those medical patients who perceived coercion.

**Perceived coercion distribution**

Despite a bimodal distribution being established in previous psychiatric studies using the PCS\textsuperscript{29,69,148} my study (of a medical population) showed perceived coercion as having a negative linear distribution. The bimodal distribution in the psychiatric literature indicates participants either considered coercion being present or absent with few participants reporting some coercion between these two extremes. This differs from my study which showed a gradual decline in the rate of perceived coercion as the coercion scale value increased. This indicates perceived coercion in a medical population is more on a continuum rather than a dichotomous all or nothing variable as suggested in the psychiatric literature. A similar negative linear finding was demonstrated in the only other study looking at a non-psychiatric population of subjects\textsuperscript{75}. The replication of this result in my study in a non-psychiatric population suggests that perceived coercion is experienced in a different way between psychiatric and non-psychiatric groups. One possible differentiating feature is the constant threat of compulsory treatment in psychiatry that may make psychiatric patients more sensitive to perceived coercion inducing a higher threshold for the perception of coercion which accounts for the bimodal distribution. Medical patients are less likely to be concerned
about the threat of compulsory treatment and therefore perhaps less sensitive to the idea of coercion.

Perceived coercion as a construct in research is often measured as a dichotomous variable. My research has shown that the distribution is dependent on the sample population. A further theoretical argument exists that coercion is a continuous variable across a spectrum of pressure. In this study, the cut-off for coercion was arbitrarily set at greater than or equal to two answers from the total of five questions in the MPCS. This reflects its use in other studies. This cut-off may have been influenced by the bimodal distribution in the original validation study of the MPCS. There is one other study that used the cut-off for perceived coercion as three or more questions affirmed out of five on the MPCS. Clearly the definition of whether coercion has occurred as being either greater than two questions answered in the affirmative or greater than three is essentially an arbitrary setting. The choice of using two or more in this study was influenced by the majority of previous studies assigning this cut-off.

Gardner in his original study of the MPCS postulated three hypotheses to account for the original bimodal distribution. Firstly, it was suggested that the five questions are too similar and that answering one affirmatively leads to others being answered in the affirmative thus giving an all or nothing response. The second explanation incorporated psychological mechanisms and supposed that once a certain threshold of coercion was reached that all answers would then show coercion. The third was that patients answered accurately reporting positively on situations that were coercive and negatively on situations that were not coercive. Another study hypothesised that the MPCS measured the emotional component of
the coercion in contrast to the more objective measure (factual) of what took place during admission and this accounted for a bimodal distribution.\textsuperscript{139}

A further concern about dichotomizing a continuous variable is the possible loss of statistical power.\textsuperscript{108} This leads to the question as to whether a more scalar measure would be more appropriate to measure this concept. At present, the two main tools to measure perceived coercion are the MPCS and the Coercion Ladder which is a visual analogue scale. A study that measured the experiences of coercion in 223 psychiatric patients using both the MPCS and Coercion Ladder showed both measures were similar across the population revealing a bimodal distribution for each measurement.\textsuperscript{148} They also found that while the Coercion Ladder is easier to administer and more straightforward to understand it does not perform as well in distinguishing lesser degrees of coercion.

The MPCS has been criticised as relying solely on the patient’s interpretation of events. My study has not considered the perspective of others such as admitting professionals or family members and their view of how much coercion was used at admission. One study looked at how clinical records of coercion corresponded with reported perceived coercion.\textsuperscript{156} Interestingly they found patients tended to report more perceived coercion than was documented in the medical notes. Additionally a proportion of patients entering medical wards have cognitive impairment either through delirium or dementia. Confusion about illness and the need for treatment is likely to promote a sense of coercion. While a brief cognitive screen (Mini cog) was used to identify these patients, removing them from the analysis did not alter the significance of the results in the smaller cognitively intact sample.

\textit{Perceived coercion and time}

Improving health and the passing of time may alter how patients perceive their admission to hospital. In this cross sectional study, participants were interviewed soon after their
admission to hospital without any further follow-up. With the benefit of hindsight, those patients who felt coerced could later alter their perception of the admission process and this would not be captured in this study. A variety of possibilities exist in how patients may later view the admission. Firstly, they may later feel that the admission was coercive and unnecessary, or coercive but necessary, or even coercive but be retrospectively grateful for the admission. Alternatively they could also report that they weren’t coerced at all. The psychiatric literature suggests that patients can change their mind about the perceived necessity of admission but their views on coercion do not change.\textsuperscript{98} My study did not account for the possibility of participants changing their position on the experience of perceived coercion as their health improved. This might be of interest to future research that investigates a medical population.

**Perceived coercion and procedural justice.**

In my study, coercion was found to have a negative inverse relationship to procedural justice. That is high levels of perceived coercion predicted low amounts of procedural justice. This finding replicates other studies that have found a similar relationship.\textsuperscript{157, 72, 158, 58, 64} Procedural justice is therefore an important concept for both psychiatric and medical patients. Procedural justice incorporates a range of different variables including a sense of validation, respect and fairness about the admission process. These principles are not unique to psychiatry and it is therefore not surprising that this strong association has been replicated in this study.

**Libertarian paternalism**

Potential acceptance of a background rate of coercion in institutional care (medical or psychiatric), questions the type of model used to justify the coercion. Sunstein and Thaler proposed the concept of soft paternalism or libertarian paternalism.\textsuperscript{159} They contend that not
only should people have individual autonomy but that choices can be framed or positioned to influence their decision making in order to make them better off. They describe this manipulation as “choice architecture”. They provide examples of the way food might be arranged in a cafeteria with healthy choices more available at eye level and unhealthier foods in more discrete positions. The hospital admission in some cases may reflect this soft paternalism. That is the choice to be admitted is more salient or prominent than not to be admitted. For example, in the work up to admission a history and examination are performed and investigations ordered. The time taken to do all of this and then await results firstly asserts the need for admission. In my experience, an open discussion about the potential advantages and disadvantages of admission seldom occurs and the assumption by health professionals is usually that the person will agree to be admitted. The decision for patients to decide against admission is therefore more difficult. If this theory is used in clinical practice then it might explain why 35% of patients in my study felt coerced.

**Research Question A2: Socio-demographic factors**

*What are the socio-demographic factors that might contribute to a perception of coercion in a sample of patients recently admitted to an acute medical ward?*

A range of socio-demographic factors were measured in this study and tested statistically against the perception of coercion. Age was not significantly associated with the perception of coercion. The comparison with other research in a psychiatric setting is mixed with one study showing a positive correlation between greater age and greater perceived coercion.\(^{65}\) In contrast, three other studies have shown no correlation between age and perceived coercion.\(^{148,160,77}\) In the Brazilian study investigating a non-psychiatric population age was not
found to be associated with coercion.\textsuperscript{75} Based on these results age does not appear to be a significant factor associated with perceived coercion either in psychiatric or non-psychiatric populations.

Similarly gender was not found to significantly correlate with perceived coercion and this matches two other psychiatric studies done using the MPCS.\textsuperscript{148,160} In contrast, one study of psychiatric voluntary patients showed an association with females more likely to experience perceived coercion than males.\textsuperscript{77} This was only at admission and not significant during treatment. More research into this area might be helpful in clarifying what effect gender has on the perception of coercion.

Socioeconomic status as measured by the NZidep tool did not show any correlation with perceived coercion. Of particular note in this study was that 65% of the participants were measured as least deprived by the NZidep scale. The authors of the scale mention that the scale is more accurate when measuring greater deprivation than less deprivation.\textsuperscript{137} Socioeconomic status is not readily comparable with the hospital data and therefore it is difficult to know how this finding compares to the usual socioeconomic status of medical patients.

Higher educational status has been shown in previous studies to be associated with greater perceived coercion.\textsuperscript{64,157,158} One hypothesis for this finding is better educated individuals are more aware of their rights and therefore more likely to feel coerced. My study did not show any correlation between education and perceived coercion. Age may have some impact on this result as an older population tends to have less formal education. For example, there are marked age differences between the psychiatric populations studied and my medical population. McKenna and colleagues study participants averaged 33.8 years and 41%
had no academic qualification. In my study, the average of participants was 65.7 years and 27% had no qualification. Despite clear differences in both age and education neither was associated with perceived coercion in either the psychiatric or non-psychiatric studies.

The findings of my study do not show a clear relationship between any of the socio-demographic variables and perceived coercion. A recent systematic study reviewing the psychiatric literature showed mixed findings in regard to socio-demographic factors with the majority of studies finding no association. My study was relatively small so the effect size for socio-demographic variables may not have been big enough to show significance. A future larger study may have more power in testing any socio-demographic associations with perceived coercion.

**Research Question B: Autonomy preference**

*To understand and investigate how much autonomy medical patients desire in a New Zealand hospital.*

**B1: How much desire for making decisions and information about their health do a sample of recently admitted medical patients report?**

Participants showed a strong preference to be given information about their health and make decisions about their healthcare as opposed to clinicians making decisions on their behalf.

Compared to the original studies using the Autonomy Preference Index, the participants in my study showed a greater desire to be involved in decisions about their healthcare and wanted more information about their condition. This may reflect the increased prominence and importance of patient autonomy in current healthcare since 1989 when Ende and colleagues first published their work. The shift to greater autonomy is perhaps driven by a
greater awareness and access to knowledge about health and illness than ever before. Despite this trend towards greater awareness of health and greater autonomy the health system still tends to operate with paternalism as its underlying ideology.\textsuperscript{161} The separation between the modern patient’s increasing desire for autonomy in a system that seems relatively inflexible, with an underlying paternalistic process remains a possible but unproven explanation for the reason 35% of patients felt coerced in my study.

My data is similar to other studies showing the preference to make healthcare decisions is normally distributed with a range of desired autonomy preferences.\textsuperscript{49,141} Clinically, patients seem to present with a wide range of different preferences for autonomy and the finding of a normal distribution for autonomy preference appears to capture this clinical observation. Previous research has demonstrated that autonomy preference is dependent upon a number of different parameters including the type of illness, severity of illness and the nature of the decision being made.\textsuperscript{162} Contrastingly, a German study by Hamann and colleagues investigating acute and chronic conditions showed with the exception of multiple sclerosis the type of illness (hypertension, schizophrenia, breast cancer and depression) did not affect autonomy preference.\textsuperscript{163} Instead of the condition, it was the individual’s internal values and characteristics that accounted for the majority of the variability within the autonomy preference measure. This finding helps substantiate the hypothesis that autonomy preference is an intrapsychic construct. They also found socio-demographic and illness factors were only very weakly associated with autonomy preference.\textsuperscript{163} Based on this research it seems likely that individual variation is the main contributor to the spread of autonomy preference in my study with only a minor influence from illness factors.
To account for illness and functional factors the Karnofsky scale was incorporated into the study design. Despite its relatively widespread use in a variety of different conditions I found estimating the functional ability of each participant very difficult in this study. This was because the encounter with each participant was relatively brief and did not focus on their clinical condition but rather the experience of admission. For example, I interviewed participants in their hospital cubicles and often did not have any idea how mobile they were by the end of the interview. Additionally participants suffered with a broad range of medical problems. Without a clear history of their condition and recent functional history I felt I could not do justice to scoring them on the Karnofsky scale. As a consequence the Karnofsky scale was not considered in the final analysis. In retrospect, taking more consideration of the functional disabilities might have been useful although this would have increased the length of time to administer the interview.

The desire to retain autonomy (by being involved in decisions about their health and having information about their health) is highly valued by patients in my study. This finding replicates previous studies using the API.\textsuperscript{49,50} As with previous studies participants expressed the greatest preference for information about illness followed to a lesser extent by the desire to participate in decision making. That is patients wish more to have information about their illness than they wish to be involved in making the decision.

Understanding the factors that contribute to making a medical decision is complicated. Deber and colleagues have postulated that there is a difference between making a decision to solve a medical problem (as a health professional does) to making a decision based on the life consequences of that decision (as a patient often does).\textsuperscript{164} For example, a clinician may need to decide how to treat high blood glucose either through dietary/lifestyle measures or
medication. This decision requires extensive clinical knowledge balancing the advantages and disadvantages in an attempt to optimise the blood glucose (the clinical problem). In contrast, the patient when confronted with the same clinical problem may make the decision based on the potential lifestyle impact (avoiding energy dense foods versus having to take medication everyday). If the problem is framed from a life consequence perspective (eg. taking daily medications or stopping eating cakes) the patient may feel more empowered to make the decision. If the problem is presented as the best treatment to reduce blood glucose (clinical problem) the patient may feel disempowered and defer to the clinicians judgement. This example illustrates how the problem is framed may influence the participation of the patient in the clinical decision. Autonomy preference may therefore not only depend on internal individual factors but also on how the clinical question is structured.

Individual preferences seem to provide the best explanation for the scatter of autonomy preference between participants. Identifying which individuals desire which level of autonomy preference is one of the keys to potentially improving satisfaction and possibly outcome in medical treatments. One relatively recent study provides some clues as to how the spread of autonomy preference is distributed in a medical and surgical population. The researchers divided the API questions up into active, passive or collaborative decision making. Active consisted of patients who responded to 1 and 2 on the API questions, collaborative 3, and passive 4 and 5. They found that 20% of their sample wanted active involvement in their decision making, and 80% wanted either collaborative or passive decision making. While these categories were not used in my study, a small minority of patients also reported that they wanted to maintain control of the medical decisions and would probably be in the active group in this study.
B2: What effect does the severity of illness have on a medical patients’ desire to make decisions and receive information about their condition?

The three scenarios incorporated within the API aimed to investigate how the severity of illness impacts on the desire to make medical decisions. Other studies show that as the severity of illness increases, the desire to make medical decisions diminishes and patients want medical staff to make more decisions on their behalf.\textsuperscript{49,50} Participants in my study showed they wanted most control in making decisions about an upper respiratory tract infection, next was blood pressure management and they wanted medical staff to take most responsibility when presenting with a myocardial infarction. The three scenarios clearly showed a significant difference in desire for autonomy dependent on the type of illness. Within each scenario however it is likely there is some individual variation as illustrated by the normal distribution of autonomy preference.

The use of clinical vignettes as a measure of exploring decision making preference has been criticised as quite removed from the way medical decisions are made in reality.\textsuperscript{161} My study and the original study using these clinical vignettes both show that as the seriousness of illness increases, patients want less participation in the decision making process.\textsuperscript{49} In contrast, an American study by Mansell and colleagues published in 2000 found as the seriousness of illness increases, patients wanted greater participation in medical decision making.\textsuperscript{162} This was a cross sectional survey of patients presenting to a Veterans affairs clinic. The design was structured around clinical vignettes. They also showed that prior experience of the actual illness resulted in a greater desire to be involved in the medical decision. The scenarios in the API have also been criticised because they address relatively minor illnesses eg. upper respiratory tract infection, and where the clinical scenario is more serious the decisions
requested are still relatively minor eg. deciding to take vital signs following myocardial
infarction or allowing visitors to come to hospital.\textsuperscript{162} A more recent study that considered how
much autonomy (in the form of consent) medical patients wanted during a variety of different
clinical scenarios revealed that even for the simplest procedure patients wanted to be
involved in the decision making process.\textsuperscript{165} They found that patients under the age of 65 had
an even greater desire to be informed and participate in medical decisions than their elder
counterparts. The interpretation of results through the use of vignettes in this study must be
treated with caution.

Medical decision making in current practice includes major decisions such as the decision
to stent coronary arteries or to have coronary artery bypass surgery. This type of decision is
argued to be quite different to the decision to have visitors present, as it brings with it the
possibility of mortality and the weighing up of significant risks. In most inpatient hospital
situations that I am aware of, the decision to have visitors is left to the patient so long as
patient care is not compromised by their attendance. It therefore seems surprising that
patients elect to have medical staff maintain control of this aspect of their admission when
the severity of their illness is greater.

In summary, by using clinical vignettes, my study showed that as the severity of illness
increases the desire to participate in medical decisions decreases. The use of clinical vignettes
has been criticised as not representative of actual decision making. The results of artificially
reducing complex decisions into simplified hypothetical situations must be treated cautiously
and not overly generalised.
Research Question C: Association between coercion and autonomy

What relationship is there between autonomy preference and perceived coercion in a sample of medical inpatients recently admitted to hospital?

The hypothesis that higher levels of autonomy preference would be associated with the higher perception of coercion was not confirmed. A number of possibilities could explain the lack of an association between autonomy preference and perception of coercion. To be autonomous is, in theory, to be free of undue pressures in making a decision. Some choices in life are made freely and others made within limitations, or even involuntarily. Coercion theoretically involves the restriction of choices yet despite these limits, in most cases, some choice still remains. For example, in the example “your money or your life,” despite the choices being unappealing, the threatened individual still does have some choice. The key problem here is that both choices were more freely available until the threat was made. However, if choice is still present despite being coerced, and if having choice is part of being free, then some sense of freedom may still be possible even when coerced. That is to say that it is possible to be coerced and still retain some freedom, and therefore autonomy. In my study, this would mean that even though some people felt coerced when admitted to hospital they also may retain enough perceived freedom to preserve their autonomous wishes. For example, being forced into a hospital admission as opposed to being treated at home (coerced) counterbalanced by active involvement in the treatment decisions (autonomous). This may account for the absence of an association between autonomy preference and the perception of coercion in this study.

An alternative explanation is that clinicians adapt their behaviour to suit the patient. For example, patients who have a strong autonomy preference may be less likely to be coerced as the clinician sees what they want and tries to be helpful. The adaptation by the clinician to
each patient reduces any potential association between autonomy preference and perceived coercion.

Another possibility explaining why coercion is not associated with autonomy preference involves separating the therapeutic relationship from the desire for autonomy. A poor therapeutic relationship between patient and clinician in a psychiatric setting has been shown to be an important component in feeling coerced. It seems likely that the therapeutic relationship is equally important in the general medical setting. In my study those participants who felt coerced may also have rated the therapeutic relationship with the admitting health professionals as poor. Despite a compromised therapeutic relationship, the preservation of autonomy may still be possible by attending to the patient’s preference to make healthcare decisions. Perhaps the importance placed upon serving individual autonomy in the clinical context occurs at the expense of the therapeutic relationship. Thus, the focus of the interaction for the treating clinicians is to strive to accommodate the needs of individual participant’s desire for autonomy rather than enhance the therapeutic relationship which may reduce the sense of coercion.

If the therapeutic relationship is a significant factor in the perception of coercion, then optimising this relationship may be one way to reduce the experience of coercion. Identifying and attending to patients’ individual preferences for autonomy is a possible way to improve the therapeutic relationship. The ability of clinicians to predict an individual patient’s desire for autonomy was investigated in a study of psychiatrists and neurologists and their respective patients. The API was used to examine the desire to make decisions. As with my study, they found most patients had a strong desire to participate in medical decision making. Interestingly, the clinicians were fairly inaccurate at predicting the amount of autonomy a
patient desired. In most cases, they overestimated thinking the patient wanted more autonomy than they actually did. One hypothesis for the reduced ability of doctors to accurately predict their patient's autonomy preference is that it is not stable through time. From the patient’s perspective, different diseases, severity of disease and the characteristics of the treating clinician were identified as factors that might influence different levels of desire for participation in medical decision making. They also suggested that patients and doctors rarely discuss autonomy preference. This is supported by research in a psychiatric clinical setting that patients and doctors seldom consider the autonomy preference of their patients. In regard to my study, it is conceivable that where a clinician underestimates an individual patient’s preference to make medical decisions greater perception of coercion could be experienced. While this was not confirmed by my study it leads to the question as to when and how clinicians should assess for autonomy preference in a clinical setting.

Participants who reported feeling coerced also reported experiencing increased negative pressures and a lack of voice in the admission process. It suggests a consistency of experience during the admission process indicating the concepts of procedural justice, negative pressures and perceived coercion are inter related. This has been well demonstrated in previous research in this area. From these results it can be inferred that autonomy preference is not directly associated with concepts such as validation, respect and fairness in the admission process. This can be derived from the fact procedural justice was significantly associated with perceived coercion and autonomy preference was not.

My research was designed to measure perceived coercion outcomes at the time of admission to hospital. While the questionnaire on perceived coercion (PCS) was specific to the timing of the admission, the autonomy preference index is a more general assessment tool
and not specific to any one particular decision or event. If the autonomy measurement was more precise in regards to the decision to be admitted to hospital perhaps it may have been more closely associated with the perception of coercion. For example, in my study those patients that reported feeling coerced may have experienced less autonomy in regards to the decision to be admitted but felt more autonomous in relation to other decisions.

Another possible explanation for this lack of association between perceived coercion and autonomy preference postulates that they are quite separate constructs and therefore not associated in a mirror image manner with each other. Coercion seems more interpersonal and relates to the interactions between staff and patients. Autonomy preference seems more intrapersonal or held within the personality of the individual. Support for this theory is found in a study by Hamann that postulated that the internal factors of the individual accounted for the variation in autonomy preference. As a result of these implicit differences it would seem logical that perceived coercion does not show a clear association with autonomy preference.

In reality it would appear that the total elimination of coercive care is neither possible nor practical. However, the understanding of when coercion is used is uncertain. It is also not clear to what extent other options are considered to reduce the perception of coercion. Furthermore it is not known whether the health professionals involved in the admission are aware of those patients who report being coerced into admission. Strong therapeutic relationships appear to reduce the perception of coercion amongst patients. Understanding what constitutes coercive care and how an admission is perceived by patients are important principles in maintaining good safe clinical care. Understanding and accepting coercion as a tool to be utilised in an ethical manner should perhaps be the focus of further research in this area.
In conclusion, there are a range of possible reasons why perceived coercion and autonomy preference are not closely associated with each other. One argument postulates that it is possible to have some autonomy within the confines of being coerced. A second possibility suggests a poor therapeutic relationship leads to the perception of coercion but again autonomy can still be adequately attended to despite the relationship strain. Thirdly evidence suggests that clinicians are often unaware of individual patient’s autonomy preference and therefore unable to adapt to avoid the possibility of perceived coercion. A fourth alternative is perceived coercion and loss of autonomy was experienced at admission, but subsequently the patients feel they have regained autonomy once they are resolved to being in hospital. Finally coercion could be considered to occur at an interpersonal level while autonomy is intrapersonal hence they bear no clear association as found in this study.

PART TWO: STRENGTHS AND LIMITATIONS OF THIS STUDY

Strengths
There are a number of strengths in this study. Firstly, this is only the second time in the literature that perceived coercion has been investigated in the medical setting and the first measuring only acute admissions. Moreover this type of study has never been conducted in a New Zealand setting. The key strengths of this study come from the research design. Firstly, the study used randomisation to select patients in a real world environment. All participants were recently admitted medical patients presenting with acute medical problems. The study was conducted in a large tertiary hospital and with little alternative acute private healthcare options. This means the sample group were closely representative of the patient medical population with few exclusion criteria. Interviewing patients within 48 hours of admission
meant the process of admission was still quite recently experienced reducing the impact of memory on the results.

The study was a cross sectional study that incorporated two widely used tools in the coercion and autonomy literature (MPCS, and the API). This provides an ability to compare results with other studies.

While a significant proportion of patients approached declined to participate this is not that surprising given the patients were admitted with acute medical problems and may not have felt well enough to answer questions. In comparison Taborda and colleagues gathered data across one year and do not mention a refusal rate of eligible participants. The participant and non-participant groups in my study were similarly matched in terms of socio-demographic factors.

The interviews were conducted by only one interviewer thus increasing the reliability of the study. The interviewer stayed with the participants until the survey was completed reducing the likelihood of non-responses and enhancing the patients understanding of the questions. Very few non responses were recorded within the recording of results. The interviews were of relatively short duration up to 30 minutes and the participants seemed to be able to concentrate for this period of time. This study used patient report to provide the data on perceived coercion which has been shown to have reasonable validity.

**Limitations**

There are a number of methodological limitations to my study. Firstly, the definition of coercion is open to interpretation and it can be confused with the unfavourable narrowing of choices in situations that are unpleasant or not expected. For most people, facing hospital admission represents a bleak choice between ongoing illness versus the need for assessment and treatment in hospital. For example, the statement “I felt free to do what I wanted about
coming into hospital” could capture the presence of coercion but also could be interpreted as a representation of bleak choices for those suffering with illness. The choice, however, remains voluntary and therefore not coercive, despite the negative and restrictive nature of the circumstances.

Secondly, a high percentage of possible participants were either absent from their bed or declined to participate in the study. This introduces the possibility of sample bias. The majority of participants who did not enter the study were absent from their beds at the time of approach; this could represent a number of different scenarios including undergoing further investigation elsewhere, recent discharge or social reasons. It is uncertain whether the attitudes of non-participants towards their hospital admission were different to those of participants.

Eighty six participants completed the survey. This is a relatively small sample and little could be made of the sub group analysis given the small groups. For example, analysing the ethnicity breakdown meant there were very few participants in some of the ethnic minorities limiting the ability to generalise the results to these specific populations.

This study was conducted in (MAPU) Medical Assessment and Planning Unit with patients who were in the acute phase of their illness. Chronic illnesses and long term conditions may not generalise as well to these results. Unfortunately the Karnofsky scale was not able to be used with any sense of accuracy and therefore the severity of illness was not able to be accounted for in the results. Severity and type of illness remain potential confounders not clearly accounted for by the study design.

As mentioned previously this study has not recorded from the clinical notes those patients who may not have had capacity at the time of admission and were treated under the
umbrella of the Health and Disability Code. If this had been done a separation between informal and more formal coercive practice and how patients responded to this differences might have been possible. A further limiting factor is that those patients who performed poorly on the Mini-Cog (n=16) were included in the final analysis. This group had cognitive deficits and therefore their responses should be treated with caution. The link between poor scores on the Mini Cog and understanding and completing the questionnaire is not clear. However inclusion of this sub group seemed more representative of a usual medical population and the analysis with this group excluded did not alter the significance of the results.

**PART THREE: IMPLICATIONS OF THE FINDINGS**

The current philosophical discourse in medical care is focussed around the promotion and protection of autonomy above all other principles. Despite this rhetoric, a closer analysis of practice reveals that paternalism is ever present. This study, measured the extent of perceived coercion during a medical admission to hospital. The perception of coercion is individually subjective and influenced by societal values, hence it seems to be a social construct. The background rate of acceptable societal paternalism is not clear but is likely to impact on these findings if known. To what extent coercion during admission to hospital is above the background rate of acceptable coercion is not known.

**Moral baseline**

The literature review highlighted the moral baseline as being important to understanding and interpreting coercion. The moral baseline underlying an action has been argued by Wertheimer to be a key principle in distinguishing a coercive from non-coercive act. A series of questions have been proposed to assist with the understanding of how paternalistic acts
can be justified.\textsuperscript{23} Applying these rules to the hypothetical situation of being admitted to a general hospital with a medical illness allows a greater understanding of the conditions which might promote the perception of coercion. Firstly, admitting a patient to hospital against their wishes or with only partial consent is a restriction on their overall sense of freedom and therefore autonomy. The harms that might come from the admission include potential medical investigations and treatments that carry some degree of risk depending on the clinical case. These need to be balanced against the avoidance of harms by the admission such as the deterioration of the clinical condition without medical intervention. In addition, the extent of the views and beliefs of the patient needs to be considered. This comes back to the theme of validation and the principle of procedural justice that has been shown to be closely aligned with the perception of coercion. The feeling of invalidation substantially increases the likelihood of coercion being perceived. The final question asks if all relevant alternatives been explored such as treatment in the home environment, assistance with family support or day hospital treatment.

Additionally Gert \textit{et al} propose further questions to address the individuality of each case\textsuperscript{23} (The questions can be found in chapter 1 page 10) In summary, the questions include how discrepant are the views of the clinician and patient about the potential harms of admission, and what level of rationality does the patient have in arriving at this position. Where the wishes of the patient and clinician are discrepant, or the clinician feels the patient’s decision making is irrational, then the patient is more likely to feel coerced during the hospital admission.

The difficulty with the moral baseline being a strong determinant to the perception of coercion is who sets the parameters for the baseline. In my opinion, societal expectations play
a significant part in determining the moral code. For example, when considering hospital admission the “sick role” described by Talcott Parsons remains an important sociological principle.\textsuperscript{19} When unwell various duties are excused on the principle that the person continue to attempt to get well, seek appropriate medical assistance, and comply with the medical system.\textsuperscript{19} In most cases the patient is adherent to the system and it would be in their best interests to conform and receive appropriate treatment. If, however, the patient departs from these sociological expectations such as not complying with medical treatment it places the clinician in a difficult position and sets the template for coercive interventions to be used.

**The system is coercive**

Medical illness restricts freedom and brings with it a series of decisions that patients have to grapple with. The first of these is whether to seek help for their illness. Once health professionals are consulted, they are guided by a sense of obligation and a duty of care to treat the patient. This obligation is encapsulated within a complex hospital system often involving multiple clinicians that can potentially lead to coercive care. While perceived coercion is more recognised and has been more widely researched in psychiatric settings due to the close association of compulsory care and forced legal treatment, little is known about the extent to which general hospital patients may perceive coercion.

In order to function effectively and attend to the needs of the majority, the hospital relies on systems and processes that can be impersonal and negate individual freedoms. This may be one reason that the perception of coercion has been reported by 35\% of the participants in my study. The hospital systems are burdened by ever increasing demands. The average length of patient stay has been decreasing.\textsuperscript{43} An increasing reliance on technology has meant even when in hospital much patient time is spent moving between investigations at the cost of patient and clinician contact time.\textsuperscript{43} I contend that one of the costs of advancing medical
technology and more complicated systems is the potential restriction on patient choice and the need to conform to the system to receive adequate care.

This research has shown a significant minority of medical patients experience some degree of coercion on hospital admission. Perhaps being admitted to any health institution non-electively brings with it a sense of perceived coercion for some people. If this is so, it has ramifications for the psychiatric literature as it suggests there is a baseline level of perceived coercion during any admission whether it be medical or psychiatric. The psychiatric research does not account for this possibility. A further research question to ask is therefore how perceived coercion differs amongst psychiatric and medical populations, and to what extent is being admitted to any institution coercive?

Being admitted to hospital can be a very challenging and disempowering experience. Hospital systems have developed, as medical care has advanced. Despite these advances the patient should remain the central focus of all treatments. Another way of thinking about medical care is from a patient centred perspective. What do patients expect about being admitted to hospital? A study that considered this question showed that respect, dignity and trust were the most important factors and had greater influence than the preference to be involved in medical decisions. These factors are woven into the concept of procedural justice which is closely associated with perceived coercion.

**Paternalism in medical care**

At times, all individuals have to accept some level of conformity or duress to enable the good functioning of society. For example, education brings with it a sense of coercion in the sitting of exams and assessments. There is a general acceptance that this is appropriate. Likewise hospital admission involves some restriction on freedoms and being embedded within the health framework is the expectation that patients will adopt the “sick role”. This
involves passing some degree of control to the relevant health experts. The medical system works with the “sick role” as its cornerstone principles. It is not therefore surprising that at times a proportion of individuals may feel too much control has been taken by the system and hence report a sense of perceived coercion.

Individual patients with impaired capacity due to denial or fear who find the hospital impersonal and uncaring are more likely to find decisions made about their treatment coercive. The focus on reducing the experience of coercive care needs to be targeted towards the way decisions are made, and involving patients as much as possible in the process. This would hopefully also help to address patient fear and denial of illness and help optimise capacity.

It also seems likely that there is a disjuncture between what is said and what is done in a clinical setting. This discourse is confusing and clouds the debate on the use of appropriate coercive mechanisms. Perhaps some forms of coercive care can be justified from an ethical perspective by using the restriction of autonomy (in treating someone medically unwell who does not wish to be treated) so that they may regain their future autonomy once well. This principle would apply to potentially reversible medical conditions such as delirium where appropriate treatment may allow a patient to regain their autonomy.

**Further investigation**

The key finding from this study shows perceived coercion is a significant factor during medical admission. A number of research questions arise from this discovery. Firstly to what extent is perceived coercion the same or different to that described in a psychiatric setting. The differing distribution of scores on the PCS (discussed in more detail in Research Question A) between these two populations suggests there may be differences in how coercion is perceived in different clinical settings. A comparison study between psychiatric and non-
psychiatric patients (similar to that conducted by Taborda and colleagues\textsuperscript{75}) but in a New Zealand setting would be a starting point in addressing this question.

Secondly another New Zealand study that investigated the patient journey through the hospital system found elderly patients were often reluctant to criticise the service received.\textsuperscript{41} This might be another reason that the extent of coercive care has gone relatively unnoticed in general medicine. Further investigation into whether patients are reluctant to challenge the system that is treating them might assist in making the patient journey through the hospital smoother.

The therapeutic relationship has been shown in a psychiatric population to have an important bearing on the perception of coercion.\textsuperscript{80} Further investigation of how the therapeutic relationship contributes to the perception of coercion in a medical setting would be interesting, to compare to the psychiatric literature considering this concept.

The perception of coercion involves the interaction between patients, health professionals caring for them and often family members. Previous psychiatric studies have considered the triangulated account of patient, health professional and family members in attempting to better understand the experience.\textsuperscript{34,171} Additionally the theoretical model of “compassionate interference” has been postulated as a method of managing patients reluctant to engage with healthcare services.\textsuperscript{151} The extent health professionals acknowledge, understand and describe the use of “compassionate interference” and how this might contribute to the perception of coercion would be an interesting qualitative study to conduct to understand the treating clinicians’ perspective.

The psychiatric literature is unclear about the longer term outcomes of coercive care.\textsuperscript{35} Nothing is known about the long term outcomes of patients who believe they were coerced
during a medical admission. Potentially, perceived coercion may influence the willingness of patients to seek health care in the future. This has broad implications for how healthcare is delivered, received, and what this means to longer term relationships with patients and their potential future health outcomes.

In summary perceived coercion is a concept that has been relatively well described in regard to psychiatric admission. This research shows its influence is also significant in clinical medicine and warrants further investigation.

**PART FOUR: CONCLUSION**

This study shows coercion does not just exist during psychiatric admission but exists in a wider healthcare context. While seldom acknowledged, coercive care plays an important role in current medical treatment. It can perhaps be justified in situations where the risk of non-intervention is serious, and treatment efficacy is well proven. Not all clinical situations meet such criteria and it therefore seems surprising that coercion occurs so often in a medical setting when informed consent takes such a prominent role in current medical thinking.

The perception of coercion is a subjective measure reliant on the patient’s recall of the admission experience. This subjectivity is likely to be influenced by societal factors such as the moral baseline that defines coercion, and the expected adoption of the “sick role.” Impersonal and time pressured hospital systems are also likely to contribute to the perception of coercion.

It is not known what an acceptable amount of perceived coercion might be during a general hospital admission. This is likely to be dependent upon the clinical parameters of each clinical case. However, some degree of coercion is probably inevitable in some clinical situations. Despite this keeping coercive care to a minimum should still be a goal of health
delivery. This study has shown the close association between procedural justice and perceived coercion. Potentially attending to the concepts of procedural justice is likely to assist in reducing the perception of coercion.

Autonomy preference has not been shown to correlate with perceived coercion in this study. Understanding to what extent patients wish to make decisions about their health however, does seem a reasonable goal for health professionals to incorporate in their clinical practice.
REFERENCES


36. Gillon, R. Ethics needs principles-four can encompass the rest-and respect for autonomy should be “first among equals.” Journal of Medical Ethics 29, 307–312 (2003).


86. Fukuyama, F. *Trust: the social virtues and the creation of prosperity*. (Free Press Publisher, 1995).


APPENDICES

APPENDIX 1: INFORMATION SHEET

Participant Information Sheet

How much control do people feel they have during admission to a general hospital.

Principal Investigator: Dr Adam Sims
Psychiatric Registrar in Consultation Liaison Psychiatry
Capital Coast District Health Board
Wellington Regional Hospital
Ph 3855999/ 9186610
Supervisor: Dr Sunny Collings, University of Otago,
Wellington, New Zealand

1. You are invited to take part in a study that will take about fifteen minutes of your time. Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part you will receive the standard care available in hospital.

2. I am trying to find out how much control people feel they have over their healthcare when admitted to hospital. I want to try to understand what affects the way people make decisions about their healthcare. I am hoping this research will show the level of choice people want to have when admitted to hospital in the future.

3. I have chosen to approach patients admitted to the Medical Assessment and Planning Unit (MAPU). A group of patients selected by chance by a computer will be asked to participate. I intend to survey eighty patients.

4. The survey will ask how much choice you wish to have when making decisions about your health and how much control you feel you have over your current hospital treatment. As an example of some of the questions in the survey you will be asked
   1. It was my idea to come into hospital (true/false)
   2. I chose to come into the hospital (true/false)

5. You will then be asked some questions about how you feel about making decisions about your health and how much choice you would want in a few different clinical situations.
6. You will briefly be asked questions testing your memory, concentration and asked general questions about your education, past health history and ethnicity.

7. The study will not affect your treatment while in hospital. The study is completed after you have finished the questions. You do not have to answer all the questions, and you may stop the interview at any time.

8. No material that could personally identify you will be used in any reports on this study. The survey is confidential and will not identify you when the results are analysed.

9. This study has received ethical approval from the Northern X Regional Ethics Committee ethics reference number NTX/10/06/055.

10. Please feel free to contact the researcher if you have any questions about this study.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:
Free phone: 0800 555 050
Free fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz
APPENDIX 2: CONSENT FORM

Consent Form

How much control do people feel they have during admission to a general hospital.

1. I have read and I understand the information sheet dated 05/07/2010 for volunteers taking part in the study designed to assess the level of control patients feel they have during a hospital admission. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

2. I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

3. I understand that taking part in this study is voluntary (my choice), and that I may withdraw from the study at any time, and this will in no way affect my continuing healthcare.

4. I have had this project explained to me by Dr Adam Sims.

5. I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study. I am aware that the exception to confidentiality will be if the interviewer has significant concerns about the safety of myself or others.

6. I consent to my data being used for a further study regarding the above subject.

7. I have had time to consider whether to take part in the study.

I _______________________________ hereby consent to take part in this study.

Date: ____________________________
Signature: _______________________

Full names of researcher: Dr Adam Sims
Contact phone number for researchers: (04) 3855999
Project explained by: Dr Adam Sims

I wish to receive a copy of the results. The results are not likely to be available until mid way through 2011. Yes □ No □
APPENDIX 3: QUESTIONNAIRE

Questionnaire

1. Which ethnic group do you belong to?

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand European</td>
<td></td>
</tr>
<tr>
<td>Maori</td>
<td></td>
</tr>
<tr>
<td>Samoan</td>
<td></td>
</tr>
<tr>
<td>Cook Island Maori</td>
<td></td>
</tr>
<tr>
<td>Tongan</td>
<td></td>
</tr>
<tr>
<td>Niuean</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td></td>
</tr>
<tr>
<td>Other eg (Dutch, Japanese, Tokelauan)</td>
<td></td>
</tr>
</tbody>
</table>

2. What is your highest secondary school qualification?

<table>
<thead>
<tr>
<th>Qualification</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>NZ School Certificate in one or more subjects or National Certificate level 1 or NCEA level 1</td>
<td></td>
</tr>
<tr>
<td>NZ Sixth Form Certificate in one or more subjects or National Certificate level 2 or NZ UE before 1986 in one or more subjects or NCEA level 2</td>
<td></td>
</tr>
<tr>
<td>NZ Higher School Certificate or Higher Leaving Certificate or NZ University Bursary / Scholarship or National Certificate level 3 or NCEA level 3 or NZ Scholarship level 4</td>
<td></td>
</tr>
<tr>
<td>Other secondary school qualification gained in NZ. Print what it is:</td>
<td></td>
</tr>
<tr>
<td>Other secondary school qualification gained overseas</td>
<td></td>
</tr>
</tbody>
</table>
3. Apart from secondary school qualifications, do you have another completed qualification? DON’T count qualifications that take less than 3 months of full-time study to get.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Print your highest qualification, and the main subject, for example:

qualification: TRADE CERTIFICATE: _______________________________
subject: ELECTRICAL ENGINEERING: _______________________________

5. How many times have you been admitted to hospital in the last 5 years?______

6. What was the main hospital department who cared for you? _______________

7. The following questions are designed to identify people who have had special financial needs in the last 12 months. Although these questions may not directly apply to you, for completeness we need to ask them of everybody.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months have you personally been forced to buy cheaper food so that you could pay for other things you needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, have you been out of paid work at any time for more than one month?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, did you yourself get income from any of these sources?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Domestic Purposes Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency maintenance allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transitional Retirement Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Independent Youth Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sickness/Invalids Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Orphans and Unsupported Child Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Widows Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months have you personally put up with feeling cold to save heating costs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months have you personally made use of special food grants or food banks because you did not have enough money for food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months have you personally continued wearing shoes with holes because you could not afford replacement?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months have you personally gone without fresh fruit and vegetables, often, so that you could pay for other things you needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months have you personally received help in the form of food, clothes or money from a community organisation (like the Salvation Army)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
"I now want you to read some statements about coming into the hospital this time. Please answer either "TRUE" or "FALSE" to each statement. Try to answer each question individually, no matter how similar it may sound to another."

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>False</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt free to do what I wanted about coming into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. People tried to force me to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I had enough of a chance to say whether I wanted to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I chose to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I got to say what I wanted about coming into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Someone threatened me to get me to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. It was my idea to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Someone physically tried to make me come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. No one seemed to want to know whether I wanted to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. They said they would make me come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. No one tried to force me to come into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My opinion about coming into the hospital didn't matter.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I had a lot of control over whether I went into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I had more influence than anyone else on whether I came into the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. How did being admitted to the hospital make you feel? Did it make you feel:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Angry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Sad.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Pleased.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Relieved.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Confused.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Frightened.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In this section we would like to know how you feel about some general health related issues. There are no right or wrong answers. We are only interested in you opinions

Please tick in the box which indicates how strongly you agree, or disagree with each statement.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree Nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The important medical decisions should be made by the doctor, not by you. You should go along with the doctor’s advice even if you disagree with it. When hospitalised you should not be making decisions about your own care. You should feel free to make decisions about everyday medical problems. If you were sick, as your illness became worse, you would want your doctor to take greater control. You should decide how frequently you need a check-up.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

I’m going to describe a few scenarios, and I want you to imagine you are the person in the story. Then I’ll ask you a few questions about what you would want in that situation

Suppose you developed a sore throat, stuffy nose, and cough that lasted for three days. You are about to call your doctor on the telephone. Who should make the following decisions?

<table>
<thead>
<tr>
<th>You alone</th>
<th>Mostly You</th>
<th>The Doctor And You Equally</th>
<th>Mostly The Doctor</th>
<th>The Doctor Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether you should be seen by the doctor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Whether a chest X-ray should be taken.

Whether you should try taking cough syrup.

Suppose you went to your doctor for a routine physical examination and he or she found that everything was all right except that your blood pressure was high (170/100). Who should make the following decisions?

<table>
<thead>
<tr>
<th></th>
<th>You alone</th>
<th>Mostly You</th>
<th>The Doctor And You Equally</th>
<th>Mostly The Doctor</th>
<th>The Doctor Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the next visit to check your blood pressure should be.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether you should take some time off work to relax.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether you should be treated with medication or diet.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Suppose you had an attack of severe chest pain that lasted for almost an hour, frightening you enough so that you went to the emergency department. In the emergency department the doctors discover that you are having a heart attack. Your own doctor is called and you are taken up to the intensive care unit. Who should make the following decisions?

<table>
<thead>
<tr>
<th>How often the nurses should wake you up to check your temperature and blood pressure. Whether you may have visitors aside from your immediate family Whether a specialist cardiologist should be consulted</th>
<th>You alone</th>
<th>Mostly You</th>
<th>The Doctor And You Equally</th>
<th>Mostly The Doctor</th>
<th>The Doctor Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

The next eight questions refer to your experiences with medical care.

<table>
<thead>
<tr>
<th>The next eight questions refer to your experiences with medical care.</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree Nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>As you become more unwell you should be told more and more about your illness. You should be kept informed about what is happening inside your body as a result of your illness Even if the news is bad, you should be well informed</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Your doctor should explain the purpose of any investigations, e.g., blood tests. You should be given information only when you ask for it. You should decide how frequently you need a check-up. It is important for you to know all the side effects of your medication Information about your illness is as important to you as treatment. When there is more than one way to treat a problem, you should be told about all the options.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Mini Cog Assessment For Researcher To Use Only

1. Instruct the patient to listen carefully and repeat the following

   APPLE, WATCH, PENNY

2. Administer the Clock Drawing Test

3. Ask the patient to repeat the three words given previously
4. 

   _______ _______ _______

Scoring
Number of correct items recalled _______ [if 3 then negative screen. STOP]
If answer is 1-2
   Is CDT Abnormal? No Yes
   If No, then negative screen
   If Yes, then screen positive for cognitive impairment

---

**Karnofsky Scale**

*Karnofsky Scale is used for grading functional status in patients*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>normal: no complaints, no evidence of disease</td>
</tr>
<tr>
<td>90</td>
<td>able to carry on normal activity: minor symptoms</td>
</tr>
<tr>
<td>80</td>
<td>normal activity with effort: some symptom</td>
</tr>
<tr>
<td>70</td>
<td>cares for self: unable to carry on normal activity</td>
</tr>
<tr>
<td>60</td>
<td>requires occasional assistance: cares for most needs</td>
</tr>
<tr>
<td>50</td>
<td>requires considerable assistance and frequent care</td>
</tr>
<tr>
<td>40</td>
<td>disabled: requires special care and assistance</td>
</tr>
<tr>
<td>30</td>
<td>severely disabled: hospitalized, death not imminent</td>
</tr>
<tr>
<td>20</td>
<td>very sick: active supportive care needed</td>
</tr>
<tr>
<td>10</td>
<td>moribund: fatal processes are progressing rapidly</td>
</tr>
<tr>
<td>0</td>
<td>dead</td>
</tr>
</tbody>
</table>
CLOCK DRAW TEST

1) Inside the circle, please draw the hours of a clock as they normally appear
2) Place the hands of the clock to represent the time: “ten minutes after eleven o’clock”