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RESEARCH

Perception of coercion of patients subjected to invasive medical procedure

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Abstract

The objective of this study was to evaluate the perception of coercion in hospitalized adults and elderly people subjected to invasive medical procedures. A quantitative cross-sectional study method, with a coercion perception scale, was used with 300 inpatients after surgery. The proportions and possible associations between groups, genders, elective procedures, urgency and degree of complexity were compared. Descriptive and inferential statistical analyzes were performed. The results indicate that most patients (82.7%) presented low perception of coercion, regardless of the degree of complexity of the procedures. However, this perception increased in cases of urgent procedures, when compared to elective procedures, regardless of age (p<0.0001). The perception of coercion was generally low, as most participants felt involved in the decision to perform the procedure. Respect for patients' autonomy was confirmed, as the medical team shared with them and their families the decision to operate, which was an appropriate result from the bioethical point of view.

Keywords: Aging. Decision making. Bioethics. Personal autonomy. Communication. Coercion. Surgical procedures, operative.

Resumo

Percepção de coerção de pacientes submetidos a procedimento médico invasivo

Este estudo objetiva avaliar a percepção de coerção em adultos e idosos internados submetidos a procedimento médico invasivo. Utilizou-se método transversal quantitativo, com 300 pacientes internados após cirurgia, com escala de percepção de coerção. Compararam-se proporções e possíveis associações entre grupos, gêneros, procedimentos eletivos, de urgência e grau de complexidade. Foram realizadas análises estatísticas descritivas e inferenciais. Os resultados apontam que a maioria dos pacientes (82,7%) tem baixa percepção de coerção, independente do grau de complexidade das operações. Porém, a percepção aumenta nos procedimentos de urgência, quando comparados aos eletivos, independentemente da idade (p<0,0001). A percepção de coerção, de modo geral, foi baixa, pois a maioria dos participantes sentiu-se envolvida na decisão de realizar o procedimento. Verificou-se respeito à autonomia dos pacientes, já que a equipe médica compartilhou com eles e a família a decisão de operar, resultado adequado do ponto de vista bioético.

Palavras-chave: Envelhecimento. Tomada de decisão. Bioética. Autonomia pessoal. Comunicação. Coerção. Procedimentos cirúrgicos operatórios.

Resumen

Percepción de coerción de pacientes sometidos a procedimientos médicos invasivos

Este estudio tiene como objetivo evaluar la percepción de coerción en adultos y ancianos internados sometidos a procedimientos médicos invasivos. Se utilizó un método transversal cuantitativo, con 300 pacientes internados después de cirugía, con una escala de percepción de coerción. Se compararon las proporciones y posibles asociaciones entre grupos, géneros, procedimientos electivos, urgencia y grado de complejidad. Se realizaron análisis estadísticos descriptivos e inferenciales. Los resultados indican que la mayoría de los pacientes (82.7%) presentaron baja percepción de coerción, independientemente del grado de complejidad de las operaciones. Sin embargo, la percepción aumenta en los procedimientos de urgencia en comparación con los electivos, independientemente de la edad (p<0,0001). La percepción de coerción, de modo general, fue baja, pues la mayoría de los participantes se sintieron involucrados en la decisión de realizar el procedimiento. Se verificó el respeto a la autonomía de los pacientes, ya que el equipo médico compartió con ellos y con la familia la decisión de operar, un resultado apropiado desde el punto de vista bioético.

Palabras clave: Envejecimiento. Toma de decisiones. Bioética. Autonomía personal. Comunicación. Coerción. Procedimientos quirúrgicos operativos.

Declaram não haver conflito de interesse.

The aging of the world's population is a reality [1]. Several factors are pointed out as responsible for increasing the survival of individuals. The following stand out among them: better basic sanitation; access to information, food and public health programs as well as new technologies developed and implemented in the health area [2,3].

Access to information has brought challenges to professionals as the volume of data is renewed with great speed. The World Health Organization (WHO) proposed in 2004 six international goals to promote patient safety, and one of them was to improve effective communication between health care professionals [4]. The implementation of these goals leads hospitals to seek internationally recognized accreditation systems, such as the Joint Commission International (JCI), which assesses implemented protocols and the need for improvements to meet international patient safety standards [5].

An important factor in security and communication is the consent process. Effective dialogue with patients and family members involves the adequacy of information, its objective and purpose, which needs to be properly recorded. The informed consent form (ICF) signed by the patient or his/her legal guardian, as well as by the doctor or other professional who obtains the document, should be included in the medical records. This is where decision-making begins.

Patient safety involves ethical issues, such as respect for autonomy [6-8], which implies freedom of thought, free from internal or external coercions so that the individual can choose the alternatives presented. Autonomy can be understood as a capacity to govern itself [8], but this right is not always respected, although it is ensured by the Brazilian Constitution [9] and included in the Human Rights of the United Nations (UN). This is evidenced in the large number of research on the subject, with data that become more critical when it comes to the autonomy of vulnerable groups, such as the elderly [10].

The WHO uses the chronological age and degree of development of the country where the individual resides as criteria for defining the elderly population, determining that the person aged 65 years or older is considered elderly in high income countries whilst in low income countries, the person aged 60 years or more is considered elderly [11-17]. This population is pointed out as vulnerable because of its susceptibility to disease, directly linked to the quality of information of a certain problem and the possibility of facing it [10-12]. To define the individual as vulnerable, some factors are considered, such as access to information, education, biological and behavioural aspects, beliefs and values [2,13].

Bioethics is a field of complex, shared and interdisciplinary reflection on adequacy of subjects involving life [18]. Bioethics aims to look at the patient in hospital daily life focusing both on his or her relationship with health professionals and the risks and consequences of medical acts for the individual, his/her family and society. One of the topics highlighted in bioethics are the terms of consent that aim to give information to the patient so that he or she decides whether or not to be voluntarily submitted to a given procedure, free from external pressure [19].

The progressive increase in the elderly population, associated with being categorized as vulnerable, has raised questions about its decision to perform invasive procedures, since they have been largely employed and trivialised. In this context, it is important to differentiate personal choices from decisions made through embarrassment and coercion of third parties [20-22]. Willingness may be affected by the partial or total restriction of the person's autonomy or by being a member of a vulnerable group. Sick people, because they are fragile, especially the elderly, are more easily manipulated in the process of obtaining consent [23]. Moreover, it is understood that because they are more fragile and vulnerable with the approach of death, the elderly would be more easily manipulated and convinced to authorise medical procedures.

Piaget defines *coercion as any relationship between two or more individuals in which an element of authority or prestige intervenes* [24]. According to the author, coercion *exists to the extent that it is suffered*, (...) *regardless of the effective degree of existing reciprocity* [25]. Therefore, the ICF is only valid if it is not signed under pressure [26], and it is necessary to identify whether there are differences associated with the perception of coercion of people according to the age group and whether the gender factor interferes with the results.

Several studies show that the elderly are, in many cases, victims of some kind of abuse by strangers or their own relatives, be the abuse financial, physical, sexual, emotional or simply disrespect to their stance, for example, in a situation that involves their own health [27-29]. From the perspective of humanization and comprehensiveness of care, one of the prerogatives of individualized care is to respect the patient's will regardless of his or her chronological age [30].

Several articles use the scale that assesses the perception of coercion in different groups, such as patients hospitalized for palliative care [19], elderly research participants on diagnosis of temporomandibular dysfunction [21], patients with type diabetes II [31], persons hospitalized with food restrictions [32], among others. In all cases the scale is adapted to the specific scenario.

Studies on perception of coercion in the elderly have gaps because they compare this population with each other and not with different age groups. In addition, no studies were found to consider how much the elderly perceive themselves participants in decisions about their health [21]. Would they have the same freedom as adults to decide or other variables, such as sex and schooling, also influence this process? Does the urgency of the invasive procedure change the way patients perceive coercion? Based on these questions, the aim of this study is to evaluate the understanding of coercion of adult and elderly patients regarding surgical interventions.

Method

This is a quantitative cross-sectional study with adult patients submitted to invasive medical procedures, hospitalized in surgical units of the Hospital de Clínicas de Porto Alegre (HCPA), Rio Grande do Sul, Brazil. Data were obtained between November 2016 and December 2017. People who agreed to participate in the survey signed specific ICF.

In the HCPA there are different accommodations for adult surgical patients hospitalized by the Sistema Único da Saúde (SUS) (Unified Health System): The two larger accommodations are in the units of the north wing (eighth and ninth floors), with 45 beds in 15 rooms; the distribution of rooms is by sex, being eight rooms for women and seven for men. The south wing units are different: the rooms have two beds and bathroom, and can be converted into men's or women's accommodations as per demand.

The sample had 300 patients, included by stochastic selection process, starting with the north wing, because it was the one with more beds. Demographic information was obtained such as years of schooling, gender and age, and the instrument on coercion perception was applied. The participants were classified into two groups: adults, aged between 18 and 59 years; elderly, aged 60 years or older. Everyone was able to choose to read and answer alone or receive help from the researcher to read the questions and write the answers dictated by them.

The inclusion criteria were: to be hospitalized by the SUS in surgical units up to five days after the invasive procedure, being an adult, being lucid and oriented, with the ability to communicate, be clinically stable and not be diagnosed with psychiatric alterations, Alzheimer's disease or other types of dementia. The characterization of lucidity, guidance and patient awareness was based on the information provided by the nursing team and recorded in the documents used for transfer of care on duty shifts.

The instrument for assessing the patient's ability to consent voluntarily was developed from the Admission Experience Survey, created by the MacArthur Research Network on Mental Health and the Law to assess coercion in psychiatric hospitalization [33,34]. In 2002, Taborda and collaborators [35] validated this scale for use in Portuguese and for clinical and surgical patients. The last adaptation was in 2010, when Protas [36] elaborated a version with five statements, with which the participant should indicate whether he/she agrees or disagrees.

Each negative response is evaluated as a level of coercion perception, ranging from zero to five. To reach the perceived degree, the amount of "disagree" responses is added; the higher the value, the greater the perception of coercion, which may be none (0), minimum (1), low (2), medium (3), moderate (4) or high (5). The research group was authorized by the author to use the instrument. In addition to the five questions, two open-ended questions were included: 1) Did you delegate to the doctor (asked the physician to decide) about doing the procedure or not? 2) Who helped you or influenced you most to decide to do the procedure?

The surgeries that the patients went through were classified according to the degree of complexity (low, medium or high), in order to evaluate a probable association between this classification and the perception of coercion. The data was stored, without direct personal identification, in a bank developed in Excel. Statistical evaluations were performed in the SPSS software, version 18, and the descriptions were presented in their measures of central tendency and variability. Descriptive statistical analyses included mean, median, standard deviation and interquartile range, according to the distribution of variables.

Inferential statistical measures were used, applying chi-square and Mann-Whitney tests, to verify possible associations or differences. For

dichotomous outcomes with logit link function, using as reference the category (answer) "disagree", the proportions of the groups "adults and the elderly", "female and male", "elective and urgent procedure" and "interaction" were compared. 5% (p<0.05) was defined as significance level.

The project included all regulatory requirements of the Conselho Nacional de Saúde – CNS (National Health Council) in CNS Resolution 466/2012 [37] and the other guidelines associated with research with human beings, being approved by the Research Ethics Committee of the HCPA.

Results

Of the 300 participants, 117 (39%) were male and 183 (61%) female. Age groups were divided into two groups: 166 (55.3%) adults, being 58 (35%) men and 108 (65%) women; and 134 (44.7%) elderly, of which 59 (44%) were men and 75 (56%) were women. There was no association between the two age groups and the sex categorization.

Regarding schooling, the variation in schooling time was from zero to 17 years among adults and from zero to 23 years in the group of the elderly. 8.78±3.74 years were obtained for the first group and 5.88±4.01 for the second when calculating the mean of the variable. The Kruskal-Wallis test showed that this difference was statistically significant (p=0.0001), unlike the association between schooling and gender, regardless of age group.

The perception of general coercion was low, representing 82.7% of the participants in this study. Among these, 39.7% did not notice any coercion; 28% noticed a minimum degree of coercion; and only 15% responded having low perception of coercion. The number and percentage of "agree" responses of each sentence that composes the scale were separated into two groups, adults and the elderly, verifying the correlation between them. There were no statistically significant results (Table 1), nor a significant relationship between the perception analyzed and the age of the patients, compared by age group or by gender.

Table 1. Coercion perception of adult and elderly patients undergoing invasive medical procedure (HCPA, Porto Alegre, Brazil)

Sum	Coercion Perception Degree	Adults	%	Elderly	%	General	%
0	None	62	37,3	57	42,5	119	39,7
1	Minimum	53	31,9	31	23,1	84	28
2	Low	25	15,1	20	14,9	45	15
3	Medium	11	6,6	12	9	23	7,7
4	Moderate	10	6	6	4,5	16	5,3
5	High	5	3	8	6	13	4,3

The evaluation of responses to each sentence of the scale demonstrates that the freedom to make a decision was the one that obtained the highest agreement, with 89.2% of adults and 88.1% of the elderly participants. On the other hand, the item with fewer concordant responses, with a frequency of 44% of adults and 51.5% of the elderly, was related to having had the idea of performing the procedure (Table 2).

Table 2. Distribution of answers "agree" to the questions of the Coercion Perception Scale, and degree of significance of the adult / elderly relationship (HCPA, Porto Alegre, Brazil)

Variable	Adults	%	Elderly	%	p
I felt free to do whatever I wanted about whether or not to do the invasive medical procedure.	148	89,2	118	88,1	0,909
I chose to go ahead the invasive medical procedure	147	88,6	115	85,8	0,594
It was my idea to have the invasive medical procedure	73	44	69	51,5	0,238
My decision had a considerable weight regarding the invasive medical procedure	141	84,9	114	85,1	1,000
I had more influence than anyone else on doing the invasive medical procedure	120	72,3	83	61,9	0,075
Mean	**125,8**	**75,8**	**99,8**	**74,5**	**0,875**

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It was observed that 24.2% of adult patients and 25.5% of the elderly stated that other people had more influence than they had on the decision. The questions *"Did you delegate to the doctor (asked him to decide) about whether or not to do the procedure?"* and *"Who helped or influenced you most to decide to do the procedure?"* aimed to better elucidate this aspect. The answers obtained were grouped as follows: patients themselves, doctors and family members. The first group totalized 60% of the answers, corroborating the other results; the second represented 33.3% of the participants; and the third 6.7%.

It is noteworthy that 18.8% of patients said they chose to delegate to the doctor the responsibility of deciding the appropriate procedure for their case, either due to the severity of the health condition or because they recognised not having enough knowledge to choose the best option. Regarding the type of procedure, 223 (74.33%) were elective and 77 (25.66%) were urgent. As for complexity, 34 (11.3%) were of low grade complexity, 206 (68.7%) medium grade and 60 (20%) high grade. The result was equivalent in the three groups, with no statistically significant association (X^2=2,71; p=0,2574 – NS) (Table 3).

Table 3. Patients' perception of coercion according to procedure complexity (HCPA, Porto Alegre, Brazil)

Sum	Coercion Perception Degree	Low	%	Medium	%	High	%	General	%
0	None	10	29,4	90	43,7	19	31,7	119	39,7
1	Minimum	10	29,4	60	29,1	14	23,3	84	28
2	Low	6	17,6	28	13,6	11	18,3	45	15
3	Medium	4	11,7	9	4,4	10	16,7	23	7,7
4	Moderate	2	5,9	10	4,8	4	6,7	16	5,3
5	High	2	5,9	9	4,4	2	3,3	13	4,3
	Total	34	11,3	206	68,7	60	20	300	100

A Mann-Whitney U test was performed to evaluate the relationship between coercion perception and elective or urgent surgery. A statistically significant difference (p<0.0001) was verified, with median (Md) equal to 1, lower than that observed in the emergency procedures (Md=2). This relationship was not influenced by the age of the participants or the degree of complexity of the procedure. It is noteworthy that patients undergoing emergency procedures were the only ones to report perception of moderate or high coercion. It is worth remembering that the terms of consent were included in all 300 medical records.

Discussion

Females prevailed in both groups, but in lower proportions than expected, because no significant difference was found, as in the literature on the subject, in which the majority of the adult and elderly population is female [2]. This finding is possibly related to how beds are distributed in the two largest surgical hospitalization units of the hospital, where most of the collections occurred.

It drew attention that the individual with the longest schooling time (23 years) was an elderly, while the adult with higher schooling time had 17 years of schooling. This did not alter the fact that the elderly in the research had a lower mean in this variable, which is statistically significant, compared to adults, regardless of gender. This finding reinforces information from the literature [2]. However, the shorter study time of the elderly did not alter their perception of coercion, differing from the research conducted with this age group in Paraíba, which presented a direct relationship between schooling and perception of coercion [21].

The fact that all participants have their ICF in the medical records suggests that there was respect for the right to information and non-discrimination, as they guide human rights, and that communication between professional and patient/family was effective, in addition to demonstrating commitment of the health team to its care activities, within the international quality and safety standards recommended by the institution.

It is worth remembering that when the patient is at risk of death, usually in emergency situations, the doctor should perform the necessary procedures, dispensing with formal consent. Even so, all patients had signed the ICF. This finding differs from the research conducted in 2016 in a Brazilian university hospital, where only

16% of the medical records of patients submitted to procedures had informed consent form [38].

The low perception of coercion in both groups suggests that participants felt respected for having their willingness preserved, regardless of age. This is reinforced by the prevalence of agreement with the statement that "they felt free to do whatever they wanted regarding the decision to perform the procedure or not".

The answers about "having been their idea to perform the procedure" exceeded expectations (44% of adults and 51.5% of the elderly), because, in general, this recommendation is from health professionals and not patients, except in aesthetic cases or for pain relief. Another data that positively surprised was the lack of relationship between the degree of complexity of the procedure and the perception of coercion.

These results allow us to infer that the doctor, after diagnosis, explained to the patient the possible alternatives, and the patients felt comfortable performing the procedure or not autonomously, free of external pressure, to the point of reporting that it was their idea. Electing the doctor to be responsible for defining treatment is also a form of decision, which demonstrates the patient's perception of respect for his or her autonomy to decide or not about the subject.

In fact, what the patient does in these situations is to autonomously transfer his or her self-determination to the physician, relying on the physician's judgment and professional qualification. This can also be understood as an indication that professionals do not trivialise procedures or the need to properly guide patients.

The grouping of responses to the question of who influenced the decision the most makes it clear that most patients felt involved in the decision making. It is noteworthy that the perception of coercion was significantly higher in emergency surgeries than in elective surgeries, regardless of age. This result was adequate and expected, because in urgent situations it is necessary to propose fast intervention after identifying the problem, and there is little time for the patient to assimilate information. It can be deduced that this stressor factor influences the patients' perception, since all who reported moderate or high coercion underwent urgent operations.

The results allow us to infer that personal treatment among professionals, patients and family members was safe and respectful, with clear guidelines, so that patients could decide on treatment, regardless of age. This posture enables individuals, even the elderly, to take control of their own lives, autonomously.

Final considerations

This study showed that the elderly actively participated in the decision-making processes about their health. The research identified that in most interventions, regardless of the degree of complexity, the decision was shared between patient, family and professionals, according to the principles of bioethics.

It was evident that the patients received guidance on the procedure and chose to perform it. In cases of urgency, however, the sick have not always had a choice, and the family or doctor is responsible for which conduct to take, which is the appropriate and expected action in urgent situations. Possibly this was the factor responsible for increasing the perception of coercion. In general, there was respect for the autonomy of patients and families.

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Participation of the Author's

Rosmari Wittmann-Vieira collected the data, did the bibliographic survey and formatted the article. Both authors conceived the study, analysed and interpreted the data, drafted the article and reviewed the final text.

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