Ethical dilemmas in drug treatments

Peter Tyrer, Jeanette Smith and Gwen Adshead

This is the first in a series of articles to be published in the *Psychiatric Bulletin* on ethical dilemmas in psychiatry. Each article will concentrate on a psychiatric sub-specialty or an area of special ethical concern. The articles will be aimed at practising psychiatrists, particularly trainees, who need to familiarise themselves with ethical issues. Each article will be based on a real life ethical dilemma experienced by the first author. The commentaries by Dr Gwen Adshead and Dr Jeanette Smith will then examine any relevant ethical concepts and, where appropriate, explore alternative approaches. It is hoped that the articles will be a useful introduction to the subject and provide answers to some of the practical ethical problems which face clinicians in everyday practice. A final article will summarise the main themes covered in the series and suggest how these could be developed and applied. The series was commissioned by Dr Jeanette Smith, Trainee Editor of the *Psychiatric Bulletin*.

A 45-year-old woman with a long history of schizoaffective symptoms associated with disruptive and antisocial behaviour refused to cooperate with out-patient treatment and particularly medication, having developed a strong distrust of psychiatrists. After discussions with the multidisciplinary team, the psychiatrist agreed to share treatment decisions with the patient and accepted her refusal of medication. This course of action is not always comfortable for professionals, especially when a patient challenges clinical judgement. However, this case illustrates how, by adopting a less paternalistic approach, the therapeutic alliance developed and, most importantly, the patient's health improved. The scenario described raises similar issues to those explored in the play *Whose Life Is It Anyway?*

Case vignette (*by Tyrer*)

I first saw Mrs A in 1989. She was referred to our community psychiatric team because she had failed to keep any out-patient appointments and refused drug treatment. On looking through the past records, the problem seemed a straightforward one. She was an isolated, divorced woman who had a long history of psychotic breakdowns since her early 20s after leaving university. She had been admitted to hospital on numerous occasions, usually involuntarily, through the agency of the police and, not surprisingly, she now mistrusted them. Over the years, her diagnosis on admission varied between schizophrenia and mania. On each occasion, she had responded well to antipsychotic drugs. However, following discharge from hospital, she made it clear that she would not take any psychotropic medication or attend out-patient appointments.

When I saw her with my psychologist colleague for assessment, we were therefore expecting the worst: that we would be recommending antipsychotic drug treatment which, in all likelihood, she would refuse and we would be forced to admit her to hospital at some point in the near, or medium, future. We were therefore pleasantly surprised to find an articulate, 45-year-old woman who had a variety of interests, particularly music and looking after her many fish in an aquarium. She was extremely suspicious of us and refused to disclose anything about her psychological functioning in case we immediately admitted her to hospital. She also made it clear that she would not take any psychotropic medications as, in the past, these had always made her feel very ill and she was convinced that they were really of no value except as agents of behavioural control. When the case was discussed at our multidisciplinary team meeting it was felt that her presentation was such that she ought to be given an opportunity to cope without drug therapy. However, in view of her history, I, as the medical member of the team, thought that further attempts ought to be made to give her adequate drug treatment in a lower dosage, to reduce the risk of relapse. After much argument, she agreed to take carbamazepine. However, I suspect she was only humouring me and, after a few months she stopped taking her medication and reverted to her standard position of total psychotropic drug abstinence.

It was then agreed that we would attempt to establish a therapeutic alliance without drug treatment. After I explained this to Mrs A, emphasising that it was against my training and better judgement, she became much more open and complimentary about the approach and attitude of our service. We organised a system of follow-up whereby she telephoned the service as

https://doi.org/10.1192/pb.18.4.203 Published online by Cambridge University Press

soon as she felt she was behaving in a way that might lead the police to think she was 'doo-lally-lally'. Fortunately she has sufficient insight to realise when she is becoming unwell and this arrangement has continued for the past four years. Nevertheless, when she does become ill, I feel I am betraying my training and principles. I think to myself "if only she would behave reasonably and accept medication for a few days, this would reduce her suffering from the illness and may, indirectly, improve her relationship with her neighbours". Her episodes of illness, I suspect, continue as before, but because she has more input at the time she is unwell, she retains a sufficient number of allies to prevent her from crossing the boundary into antisocial or dramatic behaviour that leads to admission. In the past four years she has had only one admission which lasted five days.

The experiences with Mrs A have taught me to be less arrogant. In particular, the view that the clinician is best placed to decide on the benefit and risk attached to a patient's particular treatment has been challenged. I now believe the decision should be shared more widely with the patient and that, when the patient feels strongly that the course of action is inappropriate then, provided that this view can be regarded as independent of the illness, it should be acknowledged and accommodated wherever possible. I suspect there are thousands of Mrs As throughout the country waiting for their fundamental wishes to be acknowledged in psychiatric treatment. Perhaps we could make a start by doing this, even though we may not abandon our beliefs entirely as I have done with Mrs A.

Comment (*by Smith & Adshead*)

It is questionable whether this case really poses an ethical dilemma, except on the micro level; the level of the individual. The author also talks about his principles, his training, and how he feels he had to abandon them. But on his account, he has made a good alliance with the patient that both of them value. She turns appropriately to him and his team for help which she then accepts. The benefits to her have been great. She has not had to be manhandled into hospital and she believes that her treatment team listen to her. Her antisocial behaviour that previously drew police attention has decreased. Furthermore, she has benefited society by not using scarce hospital resources. This is surely adherence to good medical ethical principles. After all, what is our training for if it is not to be the best doctor possible as defined principally by the patient? Principles in medical practice have little value if they lead one into disputes with the patient and result in the patient being unable to trust the doctor. However, perhaps one should also consider the alternative outcome to the case. Undoubtedly there are situations where, even with the best will in the world and an excellent therapeutic alliance, a person with a history of psychosis may relapse without medication with resulting harm to him or herself or others. This possibility should always be considered when deciding with a patient on the best treatment approach. Therefore another valuable lesson one can learn from the present case is the need to constantly review and carefully examine the patient's mental state so that action can be taken to prevent harm without delay if circumstances change and it becomes apparent that the patient is no longer competent to determine his or her own treatment. As in this case, difficult clinical decisions should be shared wherever possible and finally the reasons behind them should be clearly documented.

This case is an excellent example of how good practice, communication and understanding of medical ethics overlap. It is also a good example of how, as medical practitioners, we need never stop thinking and developing our ideas about practice, nor need we stop using our empathic imagination.

Peter Tyrer, *Professor of Psychiatry, St Charles Hospital, Exmoor Road, London W10 6DZ;* Jeanette Smith, *Senior Registrar, Fromeside Clinic, Blackberry Hill, Bristol BS16 1ED;* and Gwen Adshead, *Lecturer, Department of Forensic Psychiatry, Institute of Psychiatry, De Crespigny Park, London SE5 8AF*

https://doi.org/10.1192/pb.18.4.203 Published online by Cambridge University Press