ETHICS

"Because Something is Happening Here – But You Don’t Know What It Is – Do You, Mr. Jones?"

... there is rarely a better indicator of ethical conflicts in the clinical setting than when a CAP [child and adolescent psychiatrist] feels uneasy, unsure, and uncertain as to how to proceed.

Case: A 15-year-old female, admitted to a psychiatric inpatient unit, presented with suicidal ideation, nightmares, attention/concentration impairment, oppositional behavior, and threats to run from home. Following diagnoses of major depressive disorder, ADHD, significant parent-child tension, and a history of PTSD, she was treated with an SSRI, stimulant medication (which she had been receiving for the past year), and individual and family psychotherapy. One week after admission, the patient reported disturbing visions of dying people and animals. The CAP diagnosed an active psychosis, and treatment was initiated and maintained with a therapeutic dose of a second-generation neuroleptic. The patient's course, over a period of an additional two weeks, varied continuously and precariously. At that point, the patient’s parent withdrew consent for treatment for all psychotropic medications, asserting that they were harming the child and causing the aberrant behavior.

Discussion: Patients’ rights to confidentiality, rights stemming from the ethics-based principle of autonomy, not infrequently come into conflict with physician concerns about maintenance of patient safety. These concerns are based on the nonmaleficence principle, which places responsibility on the physician to ensure that harm does not befall the patient (Beauchamp and Childress 2001). This clash of principles is one commonly encountered during CAP training, in particular, in the ER setting. While the conflict between the two principles often leads to management and administrative problems, the choice of clinical approach is inevitably decided by the clear imperative of keeping the child patient safe. By contrast, the above case is one in which the CAP sensed the presence of additional, and possibly more fundamental, ethical conflicts, but felt stymied in defining and articulating them. One should note that there is rarely a better indicator of the presence

Author’s Note: The title for this piece is taken from Bob Dylan’s, “Ballad of a Thin Man,” from Highway 61 Revisited.

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After a hiatus of a year, the AACAP Ethics Committee returns to the AACAP News with a case submitted by an AACAP member. The child and adolescent psychiatrist (CAP) sensed the presence of ethical conflicts but had difficulty articulating them, other than the violation of patient rights to confidentiality inherent to the report of an ongoing case to a state child protection agency. Please read the case; then take time to note ethical issues you discern arising within it, only subsequently to return to the discussion below.
of ethical conflicts, in the clinical setting, than when a CAP feels uneasy, unsure, and uncertain as to how to proceed.

In this case scenario, a CAP provided treatment to a recently arrived inpatient after having first arrived at several psychiatric diagnoses. With the report of new and disturbing symptoms, i.e., visual hallucinations, another medication was added to the treatment regimen. Over time, however, the new treatment proved, at best, intermittently effective. With the case outlined in this fashion, what ethical disquiet begins to be sensed? The ethical underpinnings of biomedical care require that patients first be accurately diagnosed, with indicated evidence-based treatments to follow (Sondheimer and Jensen 2009; McClellan and Werry 2003). It is in this manner that, from the outset, the clinician engages in beneficent and nonmaleficent conduct. But when a treatment proves ineffective, what then? Does the ethical imperative change? It does not – the physician is duty-bound to continue beneficent and nonmaleficent intents and behaviors, commonly by reconsideration of the patient’s prior diagnoses and treatments.

But forces might stand in the way of doing so – they include several common candidates:

1) Pride – many individuals find it hard to admit to the commission of possible error – physicians are no more immune to this phenomenon than others.

2) Lack of breadth of knowledge and/or experience – even when considering alternative diagnoses and treatment options, other sensible possibilities or substitutions may not readily come to mind, particularly in the earlier years of practice.

3) Hierarchies – individuals or entities, e.g., supervisory or other administrative personnel, may seem to wield or actually demand greater power over clinical decision-making than the treating clinician.

4) Limited or absent collaboration – opportunities for consultation by a clinician with peers and/or supervisory personnel might be limited, due to the lack of available personnel, money, and/or time.

The AACAP Ethics Committee, in this summarized response, focused on these forces as possible contributors to lapses in clinical and administrative approaches to the case. Specifically, additional time for patient observation was recommended, in contrast to the introduction of a new class of medication, which appeared to be treating a new symptom rather than a defined disorder. Secondly, involvement of the CPS in the case by the hospital seemed an awkward choice, one guaranteed to alienate the family and bring treatment to a stop – and it did! Strikingly, pursuit of independent second opinions from peers and/or opportunities for case discussion and supervision seemed lacking, or possibly not even available to the clinician. Ultimately, the ethical imperative of beneficence underlies the creation of institutional atmospheres in which a practitioner is enabled, via education, supervision, and/or consultation, to provide optimal care for patients. In the setting of this case, the administrative structure may have been operating inadequately, indicating the need for adjustments and improvements in its functioning. In some suboptimal contexts, clinicians may simply sense lack of support; in others, they may feel constrained by their subservient positions from expressing conscious grievances.

While it is unclear which of the above factors in fact contributed to the case outcome, it is plainly evident that the CAP requesting input deserves commendation for having sensed an issue, feeling troubled by it, pursuing the matter in a useful venue in order to obtain feedback, i.e., via referral to the Ethics Committee and, perhaps most admirably, by entertaining the conceivability of a personal error in judgment but not permitting that possibility to interfere with obtaining feedback in a public setting. If we as professionals are to provide competent or optimal care for our patients, an ethical imperative, we need, in open fora, to discuss and learn from our inadequate efforts and failures as well as our successes.

References


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In 2008, AACAP Council agreed to add the requirement of one hour of education in ethics every two years as a marker/reminder of the importance of ethics and that it is intrinsic to all areas of practice.

This ethics column counts towards the AACAP ethics requirement for members.