Ethical Issues in the Treatment of Depression

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Sound ethical decision making is essential to astute and compassionate clinical care. Wise practitioners readily identify and reflect on the ethical aspects of their work. They engage, often intuitively and without much fuss, in careful habits—in maintaining therapeutic boundaries, in seeking consultation from experts when caring for patients who are difficult to treat or have especially complex conditions, in safeguarding against danger in high-risk situations, and in endeavoring to understand more about mental illnesses and their expression in the lives of patients of all ages, in all places, and from all walks of life. These habits of thought and behavior are signs of professionalism and help ensure ethical rigor in clinical practice.

Psychiatry is a specialty of medicine that, by its nature, touches on big moral questions. The conditions we treat often threaten the qualities that define human beings as individual, autonomous, responsible, developing, and fulfilled. Furthermore, these conditions often are characterized by great suffering, disability, and stigma, and yet individuals with these conditions demonstrate tremendous adaptation and strength. If all work by physicians is ethically important, then our work is especially so. As a service to *Focus* readers, this column provides ethics commentary on topics in clinical psychiatry. It also offers clinical ethics questions and expert answers in order to sharpen readers' decision-making skills and advance astute and compassionate clinical care in the field.

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Depression affects nearly 15 million adults in the United States each year. As the second leading cause of disability, depression is an illness that profoundly affects quality of life for individuals and creates significant socioeconomic burdens for society as a whole. Depression is also an important risk factor for suicide, an outcome that claims approximately one life in the country every 13 minutes. The clinical care of depression combines an urgency of crisis with the deeply experienced and pervasive feelings of hopelessness and sadness among patients, raising many ethical issues related to the need for patient safety, the appropriate treatment of disease, and the restoration of individual self-agency.

Against the backdrop of modern health care, where people receiving treatment for depression are predominantly seen in primary care clinics, recent developments in innovative therapeutics and methods of care delivery promise to raise many more ethical questions than answers. Some contexts for ethical tension are inherited, such as the split-care model of pharmacotherapy and psychotherapy in the treatment of depression, whereas others are completely novel, such as mobile health care and integrated care systems in disease management. Elements of therapeutic boundaries and alliance are being challenged in these settings. Last, research in new treatment modalities with distinct repertoires of benefits and potential harms, such as deep brain stimulation, suggests a continued role for ethical discussion in years to come.

In this commentary, we describe several clinical cases illustrating only a handful of these issues. We hope these cases pique our readers' interest in the application of ethical principles to practice and highlight the importance of ethical decision making in modern clinical care of patients experiencing this disorder.

Case 1

A 65-year-old male with no prior psychiatric diagnosis is brought by police to the emergency room for suicidal ideation. One hour earlier, the patient had called his wife, stating he was at the train tracks, "ready to say goodbye." She called 911 immediately out of concern for his safety, and police officers found the patient standing on the local train station platform. During his psychiatric assessment, the patient reveals that he had been feeling depressed and "hopeless" for the past three months, after he was hospitalized for his first heart attack. He lost ten pounds during this period, which he attributes to a loss of appetite. He spends most of his days lying in bed, unmotivated to leave the house. He reports difficulty falling asleep due to anxious and guilty ruminations, as well as poor concentration and low energy. He asks periodically throughout the interview if he can be released from the emergency room. He expresses frustration that the police stopped him from jumping and states that he plans to return to the train tracks tonight to end his life.

He has a history of coronary artery disease, hypertension, and hyperlipidemia, with a 40-pack-year smoking history. He denies any alcohol or illicit substance use. His medications include antihypertensive and antihyperlipidemic agents.

The mental status exam reveals a thin, elderly male, malodorous with poor grooming, who was cooperative in the

interview. He shows evidence of psychomotor slowing. Affect is withdrawn, with slowed but spontaneous speech. His thought process is linear and coherent. He denies experiencing hallucinations or delusions of paranoia or grandeur.

1.1 The psychiatrist should make which of the following initial clinical decisions in response to the patient's request for discharge?

A. The psychiatrist should hospitalize the patient involuntarily and deceive the patient about this decision—a response that reflects tensions between the ethical principles of beneficence and veracity.

B. The psychiatrist should hospitalize the patient involuntarily and inform him of this decision—a response that reflects tensions between the ethical principles of beneficence and autonomy.

C. The psychiatrist should explore whether the patient would consider voluntary hospitalization—a response that reflects tensions between the ethical principles of beneficence and autonomy.

D. The psychiatrist should discharge the patient because emergency resources are limited—a response that reflects tensions between the ethical principles of beneficence and justice.

1.2 The psychiatrist orders several lab tests, including a urine toxicology screen; a complete blood count; an electrolytes panel; and liver, thyroid, and renal function tests. These tests reflect the psychiatrist's adherence to which principle?

A. Compassion
B. Confidentiality
C. Justice
D. Nonmaleficence
E. Veracity

1.3 The patient's wife arrives at his bedside as the psychiatrist is completing her interview with the patient. The patient's wife asks, in front of her husband, if she can speak to the psychiatrist and share additional information about the patient before she leaves. What should the psychiatrist do next?

A. The psychiatrist should ask permission from the patient to speak to his wife.
B. The psychiatrist should announce to the patient that she will be speaking to his wife.
C. The psychiatrist should inform the wife that she cannot speak to her about the patient's care.
D. The psychiatrist should ask the wife to leave.

Answers

1.1 The answer is C. The patient does not wish to receive treatment; however, he clearly meets clinical criteria for a major depressive episode and continues to express self-harm intent. In this case, the physician's duty of beneficence, which prioritizes treatment of depression, conflicts with the patient's initial autonomous desire to end his life. The psychiatrist should explore this tension by providing appropriate education to the patient of his diagnosis and clinical options and exploring if the patient would accept voluntary hospitalization.

1.2 The answer is D. The psychiatrist has a duty to "first do no harm." This encompasses the imperative to ensure that medical issues are not left untreated and that any treatment plan (e.g., pharmacotherapy) will take the patient's medical issues into consideration and will not increase the risk of clinical harm.

1.3 The answer is A. The psychiatrist is respecting the duty of confidentiality toward the patient and seeks his permission prior to speaking with his wife. In some emergency situations, there may be legal protections for gathering clinical information without the patient's direct consent. However, if the patient is conscious and cooperative, it would be prudent for the physician to ask the patient for permission to speak with his wife first.

Case 2

A 19-year-old Hispanic female college student presents to her primary care provider (PCP) with depressed mood and anxiety. She is the first person in her family to attend college and describes intense fear of failing her classes and dropping out of school. Over the past semester, she has felt increasingly helpless against these fears and has not been able to experience any enjoyment of her typical extracurricular activities. She is sleeping ten to 12 hours daily and snacking between meals more frequently. She reports fatigue and difficulty concentrating on her coursework, resulting in several late assignments this semester. She denies experiencing suicidal ideation or hallucinations. She typically consumes four to six alcoholic drinks per weekend at campus parties, but she has been socially withdrawn during the past two months and denies using any alcohol, nicotine, marijuana, or illicit substances during this period.

2.1 The student's PCP starts her on fluoxetine for treatment of a major depressive episode but does not inform her of the potential risk of increased suicidality with this pharmacologic treatment. What ethical principle does the PCP fail to uphold?

A. Autonomy
B. Fidelity
C. Justice
D. Nonmaleficence
E. Veracity

2.2 The patient takes fluoxetine at a therapeutic dose for eight weeks. She denies experiencing side effects, but she has not noticed any change in her mood or anxiety and reports no changes in her sleep, appetite, concentration,

or energy level. She feels that she continues to struggle in school and social relationships. Her PCP notes that the patient was able to complete her semester with passing grades. What should the PCP do next?

A. The PCP should encourage the patient to continue her current treatment regimen, because her passing grades are an indication that she is getting better.

B. The PCP should encourage the patient to continue her current treatment regimen, because the patient's symptoms are unchanged and not severe.

C. The PCP should explore medication adherence and consider possible next steps in treatment, because the patient's symptoms are unchanged and continue to affect her daily functioning.

D. The PCP should explore medication adherence and consider possible next steps in treatment, because the patient is not being honest about her symptoms.

2.3 The PCP recommends that the patient supplement her fluoxetine treatment with individual psychotherapy. The patient finds a psychotherapist in private practice and begins seeing her once a week. The patient begins to feel improvement in her mood after several weeks and tells the therapist she is going to stop her medication because she thinks that therapy has been more helpful. What should the therapist do next?

A. Encourage the patient to stop her medication, to respect her autonomy.

B. Encourage the patient to continue her medication, to respect the PCP's most recent treatment recommendation.

C. Encourage the patient to discuss this with her PCP directly and discontinue her medications until a treatment decision is reached with her PCP.

D. Encourage the patient to discuss this with her PCP directly and continue her medications until a treatment decision is reached with her PCP.

Answers

2.1 The answer is E. The PCP has an ethical obligation to disclose, as truthfully as possible, the risks of treatment to this patient. In 2007, the U.S. Food and Drug Administration updated the black box warning on antidepressant labels with a notice of elevated risk of suicidality among young adult users ages 18 to 24 years. Failure to inform the patient of this risk would be a threat to the physician's duty of veracity.

2.2 The answer is C. The PCP should uphold fidelity to treatment goals and respect for the patient as clinical imperatives, which, in this case, means focusing on the patient's chief complaint (depressed mood and anxiety) and her report of continued struggles in academic and social settings. It is possible that the patient may be so severely ill that she is unable to notice or appraise her symptomatic improvements; however, given her continued clinical distress, the PCP would be well advised to seek additional clinical or collateral information before making a recommendation to continue the current treatment plan. Exploring whether the patient is actually taking her medication would be a prudent first step, and assessing whether antidepressant dosing should be increased or augmented (with other pharmacological agents, psychosocial treatment methods, or both) would be a sensible approach.

2.3 The answer is D. By encouraging direct discussion with the PCP and deferring medication changes until then, the therapist is appropriately recognizing the professional limits of her practice and upholding professional boundaries of her therapeutic relationship with the patient.

Case 3

A 53-year-old female was referred by her mental health provider to an academic interventional psychiatry clinic for treatment-resistant depression. The patient has a history of depressive mood and neurovegetative symptoms for two years, and she has been unresponsive to four different medication trials with concurrent cognitive-behavioral therapy (CBT). The patient also underwent a robust course of electroconvulsive therapy that did not alleviate her symptoms. The patient wishes to enter a deep brain stimulation trial, "because that's where my pain is—inside my head." She explains that she is aware of the potential risks of the procedure, including intracranial hemorrhage and brain damage; however, she has felt depressed for a long time and feels it is worth these risks for the chance to relieve her depression. "I want to enjoy the time with my grandkids before they grow old," she says. She believes deep brain stimulation works by "jumpstarting the brain."

On exam, she is a well-groomed, overweight female who appears her stated age, wearing a crisp cotton dress. Her attitude is cooperative. She shows evidence of mild psychomotor slowing. Affect is withdrawn, her speech is fluent with a slowed rate, and her thought process is linear. She denies experiencing hallucinations or paranoid delusions.

3.1 Does the patient exhibit the decisional capacity to consent to this research trial?

A. Yes, the patient has the capacity to consent to the research trial.

B. No, the patient lacks the capacity because she is unable to communicate a decision.

C. No, the patient lacks the capacity because she does not understand the risks and benefits of participation or nonparticipation.

D. No, the patient lacks the capacity because she does not appreciate her clinical situation.

E. No, the patient lacks the capacity because she is unable to rationalize her decision in a manner consistent with her values.

3.2 Deep brain stimulation is an invasive procedure that carries the risk of severe physical damage to the brain. What ethical principles shape the physician's decision to proceed with this novel interventional treatment for this patient? (Choose all that apply.)
A. Autonomy
B. Beneficence
C. Confidentiality
D. Justice
E. Nonmaleficence
F. Veracity

Answers

3.1 The answer is A. The patient exhibits all four cardinal features of decisional capacity: the abilities to communicate a decision, understand the risks and benefits of treatment and nontreatment, appreciate the clinical situation, and rationalize the decision in a clear and coherent manner. Although the patient's description of how deep brain stimulation works may not be completely accurate, it does not affect her capacity to make an informed decision to participate in the treatment. Furthermore, there is no evidence of a psychotic illness or severe cognitive distortion that would raise suspicion of impaired insight or judgment.

3.2 The answers are A, B, and E. The physician's decision to proceed with this interventional procedure reflects respect for the duties of autonomy, beneficence, and nonmaleficence. Balancing the potential benefits and risks of a novel procedure in the context of the patient's treatment history and her desire to proceed with the intervention are key components of the physician's decision-making process.

Case 4

A psychiatrist serves as a behavioral health consultant for an integrated care clinic run by a large health maintenance organization. During the clinic's weekly team meeting, a primary care doctor presents the case of one of her patients, a 54-year-old male with diabetes who is struggling with medication adherence. At his last visit, he screened positive for depression. She seeks guidance from the psychiatrist on how best to initiate treatment for this patient.

4.1 The role of the psychiatrist as a consultant in this setting involves which of the following ethical tensions?
A. Tension in patient autonomy, because the patient cannot participate in decision making regarding his care.
B. Tension in justice, because care is distributed differently in an integrated care model.
C. Tension in confidentiality, because the patient may not be aware that a psychiatrist is informed of his case.
D. Tension in fidelity, because the primary care doctor may not be faithful to the patient's treatment goals.

4.2 The psychiatrist meets the patient for an initial consultation. At the conclusion of the assessment, she discloses to the patient that his clinical needs do not require specialty mental health services, so he will be followed primarily by his primary care doctor, with peripheral engagement by mental health consultants. The patient expresses his desire to be followed by the psychiatrist for his mental health needs, because "the other doctor doesn't have time for these problems." What ethical conflict between patient autonomy and physician duty is being raised here?
A. Conflict with the physician's duty of beneficence
B. Conflict with the physician's duty of nonmaleficence
C. Conflict with the physician's duty of justice
D. Conflict with the physician's duty of veracity

Answers

4.1 The answer is C. For this patient, an ethical tension arises in confidentiality within the integrated care setting. The patient may not be aware that his clinical information has been disclosed to a psychiatrist who is acting in the capacity of a mental health consultant. Integrated care clinics may alleviate this tension by adopting several safeguards in practice, including obtaining informed consent from patients, obtaining separate release of information agreements for mental health information, and ensuring billing accuracy. In this case, there is no apparent tension yet in autonomy, justice, or fidelity, because these principles are expected to be upheld by the primary care doctor once she initiates the treatment discussion and plan with her patient.

4.2 The answer is C. The patient wishes to be seen by a mental health specialist even though his level of care is not severe enough to necessitate a formal referral. The patient's desires therefore conflict with the psychiatrist's obligation to distribute mental health resources in a fair and just manner across the clinic's patient population.

Case 5

A primary care physician notices that her 25-year-old patient appears more down, and a thorough evaluation and discussion with the patient confirms the diagnosis of major depressive disorder, moderate severity. The primary care physician discusses various treatment options, including CBT or a trial of an antidepressant medication. The patient prefers CBT but notes that she does not have the time to make therapy appointments. She adds, however, that she has

seen some online advertisements for a smartphone app offering a CBT intervention. The promise of doing CBT from "anywhere, at any time," is appealing, and the patient asks if this is a good plan. The primary care physician has not heard of CBT apps before but cannot see a reason why the patient should not use them, so the primary care physician agrees to let the patient use the app instead of seeing a therapist.

Two months later, the patient does not show up to her appointment. The primary care physician calls the patient and, after several attempts, finally reaches her. The patient reports she is feeling worse and now has little energy or motivation to leave the house. She recalls downloading a CBT app but thinks she stopped using it after three days. A clinic appointment is made and the patient is started on an antidepressant medication.

5.1 In originally respecting the patient's wish to pursue CBT instead of a medication, the primary care physician's decision was primarily governed by which of the following ethical principles?
A. Autonomy
B. Compassion
C. Fidelity
D. Justice
E. Nonmaleficence

5.2 In agreeing with the patient that using a smartphone app, which did not have a clinical evidence base, was an acceptable substitute for treatment, the primary care physician may have compromised which of the following ethical principles?
A. Autonomy
B. Compassion
C. Fidelity
D. Justice
E. Nonmaleficence

5.3 What should the primary care physician have done instead when the patient offered to pursue CBT through an app instead of seeing an individual therapist?
A. The physician should have insisted that the patient pursue CBT with an individual therapist.
B. The physician should have insisted that the patient choose medication instead of CBT.
C. The physician should have examined the app with the patient and decided on the basis of this user interaction alone whether it constituted appropriate treatment.
D. The physician should have examined and discussed the app with the patient, emphasizing her lack of clear clinical knowledge about mobile technology efficacy and privacy risks, and judged how using the app would fulfill the appropriate standard of care.

Answers

5.1 The answer is A. Both CBT and antidepressants have good efficacy and fall within the standard of care for moderate depression. The principle of autonomy supports accommodating patient preference while fulfilling the standard of care.

5.2 The answer is E. Although mobile technologies offer many promising new clinical tools, many such smartphone apps still lack strong clinical data, such as information on risks and benefits. In this case, the primary care physician had not heard of CBT apps and thus was unsure about their efficacy and safety. Similar to how medications should be prescribed, recommending treatments such as mobile apps without appropriate clinical knowledge can risk harm to patients.

5.3 The answer is D. The primary care physician is respecting patient autonomy by openly discussing a treatment alternative in which the patient has expressed interest, in the same way a physician would discuss an unknown herbal or supplemental remedy in response to a patient's inquiry. Because much is unknown about the clinical benefits, risks, safety, and privacy of most mobile apps, the primary care physician should raise these issues in an informed discussion with the patient prior to proceeding with any substitution. To fulfill the appropriate standard of care, the primary care physician should examine the app and judge whether use of the app aligns with treatment goals and expectations and, if so, how additional safeguards, such as increased communication with the patient between visits or increased frequency of visits, could protect against unforeseen consequences.

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