Laura Weiss Roberts, M.D., M.A.
Richard Balon, M.D.
John Coverdale, M.D., M.Ed., FRANZCP

Ethics Commentary

FUNDAMENTALS OF LIFE

Caring for patients involves understanding the ways in which they fulfill their physical natures. Balance in the basic drives of life, such as eating, sleeping, and having sex, is important to the quality of one's life. Imbalance in these fundamental domains, moreover, may reflect an underlying disruption in mental health or, alternatively, threaten mental well-being. Physiological dysfunction accompanying either illness or treatment may further upset this balance, interfering with the regulation of appetite, sleep patterns, or sexual interest and capacities. These dimensions of life are often very private and involve deeply personal concerns for our patients. Impulses, intimacy, image, and insecurities—these are the complex, overdetermined biological and psychological issues that arise. And as with other such sensitive considerations in psychiatric practice, certain values and bioethical principles are held especially dear in caring for these aspects of our patients' lives.

CARDINAL ETHICAL PRINCIPLES

The practice of medicine rests on the six cardinal ethical principles (1) of
-respect for persons (a deep regard for the worth and dignity of all human beings),
-autonomy (right to self-governance),
-beneficence (the duty to act in a way that provides the greatest positive consequences and the least negative consequences),
-nonmaleficence (a modern term for *primum non nocere*: "first, do no harm"),
-veracity (honesty or truth-telling), and
-justice (treating people fairly and without prejudice). Although these ideas seem very abstract, they can be applied in a manner that supports high-quality, clinically rigorous, and ethically sound decision making in everyday patient care.

UPHOLD APPROPRIATE STANDARDS OF CLINICAL CARE

Consider, for instance, the case of a 48-year-old woman who has been treated for major depression with antidepressants and benzodiazepines for several years. She has been morbidly obese her entire life and now weighs more than 360 pounds. She faces complications of obesity, such as diabetes mellitus and arthritis of knees and hips. She has spoken with her physicians about the option of undergoing bariatric surgery, which has been recommended for her. Her insurance company requires that she attempt to lose weight on her own during the next 12 months. She has tried several times without any success. Both she and her psychiatrist do not believe she can achieve significant and enduring weight loss without surgical intervention. Her psychiatrist, internist, and consulting surgeon agree that the patient's life and overall well-being are endangered by the delay in the surgical intervention because the complications of her obesity are progressing and she is becoming more depressed. The patient asks her psychiatrist to attest that she has tried to lose weight for 12 months and failed. The psychiatrist and internist discuss what they should do.

Although the physicians have a responsibility to be truthful (*veracity*) in their disclosures to the insurance company, they also have a responsibility to serve the health and well-being of the patient and uphold appropriate standards of clinical care. The principles of *respect for persons* and *beneficence* support the efforts of the physicians to honor the informed, *autonomous* decision of the patient to pursue bariatric surgery, because it is medically

CME Disclosure
Laura Weiss Roberts, M.D., M.A., Charles E. Kubly Professor and Chairman, Department of Psychiatry and Behavioral Medicine; Professor of Bioethics, Department of Population Health, Medical College of Wisconsin, Milwaukee, Wisconsin.

Dr. Roberts reports: *President, Board of Directors:* American Psychiatric Publishing, Inc.; *Editor-in-Chief*, Academic Psychiatry; *Owner, Investigator.* Terra Nova Learning Systems.

Richard Balon, M.D., Professor of Psychiatry, Wayne State University School of Medicine, Detroit, Michigan.

John Coverdale, M.D., MEd, FRANZCP, Professor, Menninger Department of Psychiatry and Center for Ethics and Public Issues, Baylor College of Medicine, Houston, Texas.

Drs. Balon and Coverdale report no competing interests.

indicated and may bring substantive benefit to the patient. Following the principle of *nonmaleficence*, the physicians believe that the risks of continuing with the medical and psychiatric issues related to her severe obesity are significantly greater than the risks of surgery at this point. Following these bioethics principles, the psychiatrist may appeal the decision of the insurance company and request a hearing to speed up the patient's request for bariatric surgery, knowing that this appeal is grounded in excellent clinical and ethical practice.

PROTECTING VULNERABLE PATIENTS

Consider a second scenario in which a male patient with bipolar disorder who is currently hypomanic is observed hugging another patient on an acute inpatient psychiatry unit. How do these ethical principles inform the care of this patient in this context? Although motivation cannot be ascribed to this observed behavior, sexual contact or contact that is designed to arouse or satisfy sexual feelings on inpatient psychiatry units is a serious concern because of the potential exploitation of vulnerable patients. Vulnerability is related in part to the acuity of a major psychiatric condition that potentially diminishes decision-making capacity and judgment about engaging in sexual relations. This vulnerability places special ethical obligations on psychiatrists related to the principle of *nonmaleficence*, such as anticipating risks and preventing harm from occurring to patients in a treatment setting. Adult patients with major psychiatric disorders are possibly also at greater risk of being physically and sexually abused than the general population and risk unwanted pregnancies and sexually transmitted infections (2–4). To this end, mental health professionals and administrators are obligated to protect vulnerable patients from harm and exploitation, i.e., fulfilling the bioethical principles of *beneficence* and *nonmaleficence*. One set of authors (5) has argued, in fact, that all sexual interactions between inpatients—an intentional therapeutic context—should be prevented.

Protecting vulnerable patients on inpatient units should be balanced by the ethical obligation of respect for persons, which encompasses respect for autonomy, and by our society's stance on protecting sexual freedoms (6). A potential conflict in this balancing has led to recommendations that sexual behaviors on inpatient units should be managed individually (6–8). Factors that might relate to the response of mental health professionals to such behaviors include the marital status of each patient involved, because spouses should be assured that patients will be protected in the hospital, the patient's mental and intellectual status, length of stay, psychodynamic factors, legal responsibilities, and the attitudes of staff (7). One important recommendation is that all staff members need to be adequately trained to manage these issues (9). Broad consensus (5–7, 9) exists that education should be provided to patients about responsible sexuality. Further, it is recommended that interpersonal relationships and institutional policies should be developed that inform on these matters and enable consistent, constructive responses while protecting vulnerable patients. These approaches are informed by all of the cardinal bioethics principles of *respect for persons, autonomy, beneficence, nonmaleficence, veracity,* and *justice*.

UPHOLD CLINICAL AND ETHICAL STANDARDS WHILE HONORING PATIENT AUTONOMY

A third example related to managing a patient's sleep needs helps to illustrate the difference between fulfilling clinical and ethical standards of care and gratifying a patient's request. This tension occurs commonly in clinical practice and can be confusing because of the apparent ethical ideal of honoring patient *autonomy*. In this case, a 42-year-old truck driver is evaluated for fatigue, tiredness, lack of energy, and poor concentration. He has been driving trucks for the last 20 years. He drives locally, short distances. His wife lost her job recently, and their income has decreased significantly. Thus, he got another part-time driving job, during the evening hours. His employers do not know about his other jobs. He admits feeling mildly depressed but denies suicidal or homicidal ideation. He sleeps on average 5 hours a night because of his two jobs. He wakes up frequently because he snores a lot. The patient refuses any workup, such as a sleep study. He heard from other truck drivers that "Adderall can do wonders, can keep me awake during the day, and then Ativan or Xanax can make me sleep like a baby. Doc, just give me a prescription for Adderall and Xanax, and I will be fine. We really need to keep me going, otherwise we may lose our house." In this situation, the patient's request is not in keeping with an appropriate standard of care—these interventions are not medically indicated. The physician should not provide the prescription medications but should offer accurate information to the patient about the risks inherent to fulfilling this request and work to find alternative approaches that will help the patient address his physical needs in relation to his work activities.

ENSURE PATIENT SAFETY AND DIGNITY

The therapeutic approach in a final example helps to demonstrate the meaning of the principle of respect for persons and the difficult conflicts that occur in endeavoring to fulfill all of the ethical imperatives of clinical care. A 15-year-old male adolescent is admitted to the hospital after a suicide attempt. He is severely depressed and still suicidal. He recently came to the realization that he is gay and is struggling to accept this, a situation made more difficult because his family is strongly religious and opposed to homosexuality. He feels that he cannot tell his parents about his homosexuality and feels depressed about it. He does not want his parents to know, saying "It would kill all of us." In this situation, what is the duty of the treating psychiatrist? Should the psychiatrist inform the parents about the primary issue of the adolescent's life?

This is a difficult case because it involves both the rights of the patient and his parents and the psychiatrist's fiduciary relationship with both. In addition, both action and inaction may increase risk for the patient. The most prudent course of action is to start an aggressive treatment of the patient's depression at an inpatient unit, combining medication and individual psychotherapy that addresses the issues of "coming out," followed by family sessions to explore the parents' attitudes and feelings, with a gradual move toward informing the parents and discussing their reactions and the patient's reaction and possible reconciliation. This approach places primacy on ensuring the safety of the patient first, i.e., *beneficence* and *nonmaleficence*, and this emphasis may require a delay in talking through the difficult issues pertaining to the young person's sexual identity and sexual life. *Respect for persons* requires that the care-giving psychiatrist serve the well-being of the patient, without judgment and with compassion, kindness, attention to privacy, and true regard for the patient's dignity.

Addressing imbalance or disruption in the basic drives of a patient's life, including deeply personal concerns related to eating, sleeping, or having sex, involves many ethical considerations. The cardinal ethical principles of respect for persons, autonomy, beneficence, nonmaleficence, veracity, and justice may help inform a therapeutic approach to such sensitive issues. Taking the time to reflect on the relevance of these principles in the care of an individual patient may foster greater empathy and illuminate critically-important aspects of the patient's experience that might otherwise go unnoticed or unattended. The quality of the therapeutic relationship, in turn, may be strengthened, enriching all of the dimensions of the patient's care.

REFERENCES

1. Roberts LW, Hoop JG: Professionalism and Ethics: Q & A Self-Study Guide for Mental Health Professionals. Arlington, VA, American Psychiatric Press, Inc., 2008
2. Coverdale J, Turbott S, Roberts H: Family planning needs and STD risk behaviors of female psychiatric outpatients. Br J Psychiatry 1997; 171: 69–72
3. Coverdale J, Turbott SH: Sexual and physical abuse of chronically ill psychiatric outpatients compared with a matched sample of medical outpatients. J Nerv Ment Dis 2000; 188:440–445
4. Miller LJ, Finnerty M: Sexuality, pregnancy and childrearing among women with schizophrenia-spectrum disorders. Psychiatr Serv 1996; 47:502–506
5. Ford E, Rosenburg M, Holstein M, Boudreaux T: Managing sexual behavior on adult acute care inpatient units. Psychiatr Serv 2003; 54:346–350
6. Welch SJ, Clements GW: Development of a policy on sexuality for hospitalized chronic psychiatric patients. Can J Psychiatry 1996; 41: 273–279
7. Keitner G, Grof P: Sexual and emotional intimacy between psychiatric inpatients: formulating a policy. Hosp Community Psychiatry 1981; 32: 188–193
8. Welch S, Meagher J, Soos J, Bhopal J: Sexual behavior of hospitalized chronic psychiatric patients. Hosp Community Psychiatry 1991; 42:855–856
9. Buckley PF, Weichers IE: Sexual behavior of psychiatric inpatients: hospital responses and policy formulation. Community Ment Health J 1999; 35: 531–536

NOTES