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Ethics Commentary

BIPOLAR DISORDER

CLINICAL SYNTHESIS

Ethical Considerations in the Treatment of Bipolar Disorder

Bipolar disorder is a serious and debilitating psychiatric condition involving recurrent episodes of depression and mood elevation that, broadly defined, affects up to 4% of the population (1). The management of patients with bipolar disorder may present unique ethical challenges for the clinician. For example, the impulsivity and impairments of insight and judgment that often characterize manic and mixed mood states may render patients unable to provide informed consent or to make rational decisions about their treatment. In addition, certain clinical presentations (e.g., irritability, grandiosity, and delusional thinking) may threaten to damage the therapeutic alliance. Furthermore, because of the relapsing-remitting nature of the disease, patients may at times feel well and question the need for continued treatment, potentially placing the clinician's treatment goals in conflict with the patient's decision-making autonomy.

In the face of such challenges, a treatment approach informed by core ethical principles, including beneficence, nonmaleficence, autonomy, respect for persons, veracity, and fidelity, will enhance the clinician's ability to provide compassionate and responsible care to the patient (2). This article presents three vignettes involving patients with bipolar disorder that serve to illustrate ways in which clinicians can apply these core concepts in complex clinical scenarios to facilitate ethically sound decision-making.

CASE 1: BENEFICENCE, NONMALEFICENCE, AUTONOMY

M.L. is a 30-year-old married woman with bipolar I disorder, currently euthymic, who comes in to see her psychiatrist for a routine visit, accompanied by her husband. M.L. states that she would like to try to become pregnant and wishes to go off her psychotropic medications during this process and throughout pregnancy. She has a clinical history notable for past psychotic depressive and manic episodes. Her psychiatrist is concerned about the potential destabilization of her mood and particularly about her risk for postpartum psychosis, if she discontinues her medications. He discusses his concerns with M.L. and her husband and outlines the risks and benefits of various mood-stabilizing agents during pregnancy, as well as the risks and benefits of being off medications during pregnancy. He strongly recommends that she continue treatment with what he considers to be a relatively safe medication in pregnancy. M.L. is able to express a clear understanding of the information provided yet still declines to continue treatment with psychotropic medications at this time. She states that she is willing to accept the risk of mood destabilization to avoid causing any harm to her child from the medications.

In providing ethically sound care to M.L., her

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psychiatrist must negotiate the tension between the core ethical principles of beneficence (the duty to "do good" for his patient) and nonmaleficence (the duty to "do no harm" to the patient and, in this case, to her potential child) (2). With respect to beneficence, the psychiatrist knows that mood-stabilizing agents offer M.L. the greatest chance of maintaining stable mood both during and after pregnancy, thus allowing her to maintain an optimal level of functioning and ability to care for her infant. On the other hand, the principle of nonmaleficence may dictate that M.L.'s psychiatrist avoid exposing her to psychotropic drugs to minimize potential harm to the fetus if she becomes pregnant (such as teratogenic effects or postnatal complications), as well as harm to the patient herself (such as gestational diabetes, which has been associated with treatment with certain second-generation antipsychotic drugs during pregnancy) (3). However, the principle of nonmaleficence might also drive the psychiatrist's recommendation of psychotropic medications to avoid harm to M.L. or her child should she become severely depressed or manic during or after pregnancy, with the associated risks of self-harm or infanticide.

The ethical concepts of autonomy and voluntarism may help guide the psychiatrist through this difficult and complex situation. Autonomy, or the right to make reasoned decisions for oneself (4), is closely tied to the concept of voluntarism, which encompasses the individual's capacity to make a free and deliberate choice without coercion (5). In determining whether M.L. has the capacity to make an autonomous, voluntary decision to consent to or refuse a proposed treatment, her psychiatrist must evaluate her ability to communicate a choice; understand the information presented to her regarding risks, benefits, and alternatives of treatment; appreciate the nature of her illness and the potential consequences of refusing treatment; and make a rational decision on the basis of the available information (6). In the case of M.L., the psychiatrist must evaluate her capacity for informed *refusal*, a concept that is often held to a higher standard than the capacity for informed consent (7). With respect to the latter, it is generally presumed that an adult individual is capable of making a reasoned and voluntary decision to consent to a treatment that has established benefit for his or her condition. However, when an individual refuses such a treatment, the concept of nonmaleficence necessitates an evaluation of the individual's decision-making capacity to avoid any potential negative health consequences of such refusal.

In this case, M.L. is able to communicate a clear preference (for no treatment with psychotropic medications), articulates a clear understanding of the information provided to her regarding the risks, benefits, and alternatives of such treatment, as well as the risks and benefits of refusing treatment, and offers a rational explanation for her decision (i.e., her wish to avoid exposing her child to potentially harmful effects of medications during pregnancy). Her psychiatrist determines that there is no psychosis or mania present that might impair her judgment or reasoning abilities. Weighing all of the above factors, he chooses to respect her decision to stop taking psychotropic medications. Together they agree to a close monitoring plan with weekly visits, and M.L. and her husband agree that they will consider resuming medications (or alternative acute interventions such as hospitalization and/or electroconvulsive therapy) if her condition destabilizes, particularly if there is any concern for the safety of the patient or her fetus.

CASE 2: RESPECT FOR PERSONS, NONMALEFICENCE

S.K. is a 67-year-old divorced man with bipolar I disorder, who has been followed by his psychiatrist for the past 5 years. Caring for S.K. has proven challenging at times, because he does not consistently follow his psychiatrist's recommendations for medication adjustments, follow-up visits, and initiation of psychotherapy. In addition, S.K. has demonstrated a tendency to stop taking his medications without consulting his psychiatrist, behavior that he would later attribute to multiple complaints of adverse effects that he had never previously brought up during clinic visits. The difficulties in the therapeutic relationship were further exacerbated when S.K. would experience episodes of mania, during which he would become hostile, paranoid, and verbally abusive toward his psychiatrist, calling her office several times per day with accusations that she was lying to him and poisoning him with medications.

The case of S.K. presents the particular challenge of maintaining a therapeutic alliance in the setting of nonadherence to treatment, combined with manifestations of the illness itself that can be alienating to the clinician. The negative countertransference that may result from such a scenario can lead over time to physician burnout and can increase the risk of patient abandonment. To avoid such unwanted outcomes and to continue to provide compassionate and competent care, the psychiatrist's approach to treating S.K. must be grounded in the core ethical principles of respect for persons (recognizing and honoring the inherent dignity of all individuals) and nonmaleficence (the duty to avoid

any harm that may come to the patient should the psychiatrist disengage from the relationship or terminate the patient's care) (2).

By acknowledging and seeking a better understanding of her own feelings of frustration and irritation engendered by her patient, S.K.'s psychiatrist was ultimately able to overcome the negative countertransference. She began to approach her interactions with S.K. with greater compassion and empathy for his suffering, bearing in mind the many interpersonal and functional losses he had endured as sequelae of his chronic illness. During their clinic appointments, she repeatedly reinforced positive behaviors and any progress he made toward improved self-care, while gently reminding him of the importance of collaborating with her and adhering to their agreed-upon treatment plan. He responded well to her empathic approach and, over time, was increasingly able to place his trust in her as an individual who authentically cared for his well-being. As the therapeutic alliance grew stronger, his treatment adherence substantially improved, and his previously debilitating manic and psychotic episodes became less frequent and less taxing on both S.K. and his psychiatrist. He also followed her recommendation to initiate weekly individual psychotherapy, which expanded his community support network and served as an important additional resource in his care.

CASE 3: VERACITY, FIDELITY

C.R. is a 54-year-old married woman with bipolar II disorder. She remains depressed despite adequate trials of two different mood-stabilizing medications, but several medication options remain that the psychiatrist believes have a reasonable chance of alleviating her depression on the basis of evidence from previous studies. The psychiatrist is also an investigator on a pharmaceutical company-sponsored clinical trial of an experimental medication for the treatment of bipolar depression. The company has offered the psychiatrist a bonus payment if he enrolls 20 patients in the study within the first year. C.R. is indeed eligible for the study; however, if one more trial of psychotropic medication fails, she will no longer be eligible for the study.

This situation illustrates the ethical dilemma that may arise when a clinician performs overlapping roles, the primary objectives of which may be in conflict with one another (4). In this case, C.R.'s psychiatrist functions not only as her doctor, whose goal it is to provide her with the most beneficial clinical care, but also as a researcher, whose clinical decision making is guided by the parameters of a study protocol. In addition, he is faced with a potential conflict of interest in his approach to her treatment. On one hand, he stands to benefit financially from enrolling her in the study, yet given the experimental nature of the study drug, he cannot be certain of the likelihood that she will respond to this treatment. On the other hand, if she tries an alternative, more evidence-based medication and fails to respond, she will no longer be eligible for the study and thus will lose the opportunity to potentially benefit from the experimental treatment.

The psychiatrist may feel tempted to overstate the expected benefit of the study drug to convince the patient to participate in the study. However, this action would be in conflict with the principles of veracity (duty to be truthful and avoid misrepresentations and misimpressions) and fidelity (obligation to remain faithful to the goals of treatment, in this case, alleviating her depression) (4). Patients with bipolar disorder, regardless of mood state, may be particularly vulnerable to the influence of their psychiatrist in deciding whether to participate in clinical trials and may overestimate the likelihood of receiving active treatment over placebo, as well as the likelihood that their condition will improve during treatment in the study (8). Thus, an approach to the informed consent process that emphasizes C.R.'s decision-making autonomy and reassures her that any refusal to participate will have no negative effect on her usual treatment, while carefully establishing her understanding of the study design and the risks and benefits of participation, is of critical importance in ensuring that the research study proceeds in an ethically sound manner.

The psychiatrist ultimately engaged in an open discussion with C.R. regarding the potentially promising, although experimental, nature of the study drug, compared with the more established evidence regarding potential risks and benefits of alternative treatments. He also discussed with C.R. the risks and benefits of being a participant in a clinical trial, for instance, that she will be blinded to the treatment she will receive and that she may potentially receive placebo instead of active medication, albeit with provision of treatment free of charge during the study. C.R. was able to verbalize a clear understanding of this information and stated that she wished to think about it some more; she was encouraged to seek her family's input. The next day, after discussing the matter with her spouse, C.R. called the psychiatrist and said that she would like to be part of a study, the findings of which could be of potential benefit not only to her but also to future patients. She expressed her willingness to enroll in the study, with the understanding that if her condition worsened, she could choose to with-

draw her participation and initiate a trial of a more evidence-based medication.

CONCLUSIONS

The episodic nature of bipolar disorder, its accompanying impairments of insight and judgment during periods of mood disturbance, and the potential for behaviors that may prove damaging to the therapeutic alliance all present the clinician with unique challenges in providing ethically sound, compassionate care to individuals with this disabling condition. By turning to core ethical concepts as guiding principles in clinical practice, clinicians can provide their patients with the highest quality of care grounded in honesty, integrity, and respect for individuals and their autonomy.

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Case Studies in Ethics: Bipolar Disorder

These case studies in ethics are adapted with permission from LW Roberts, JG Hoop: *Professionalism and Ethics: Q&A Self-Study Guide for Mental Health Professionals.* Arlington, VA: American Psychiatric Press, Inc., 2008, pp 167–169, 176–178.

A patient with bipolar disorder applies for life insurance. He signs a consent form for the release of his medical records to his insurance company, and the company subsequently requests a copy of his entire clinical record from the psychiatrist.

Which of the following is the most appropriate action for the psychiatrist to take?

A. Advise the patient of the need for confidentiality of treatment records.
B. Ask the insurance company if a treatment summary would suffice.
C. Comply with the request and send a copy of the entire record.
D. Explain to the insurance company the need for confidentiality of psychotherapy records.
E. Refuse to send the records, citing doctor/patient confidentiality.

Often insurance companies do not require complete psychotherapy records to determine coverage and are satisfied with a treatment summary including diagnosis, dates of treatment, and prognosis. Although patients have the right to waive confidentiality, they are not always cognizant of the full implication of the release-of-information forms they sign. When releasing confidential patient information for any reason, physicians should release only the minimum amount of information required for the particular situation. In addition to checking with the insurance company, it is also useful to discuss with the patient the implications of the waiver of confidentiality (1, 2). Answer: B

A psychiatrist working in a university mental health clinic has been treating a 45-year-old used car salesman for bipolar disorder and cocaine dependence. The patient presents for follow-up complaining of excruciating new-onset back pain and difficulty walking. The psychiatrist refers him to the university's urgent primary care clinic. The patient returns to the psychiatrist's office 4 hours later, saying that the primary care physician treated