Compulsively Moral: OCD, Ethics, and the Law

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Obsessive-compulsive disorder (OCD) is a potentially debilitating syndrome characterized by ego-dystonic obsessions or compulsions that cause marked distress and interfere with an individual's functioning (1). Symptoms may include intrusive thoughts, such as fears of contamination, or stereotypical behaviors, such as excessive washing, hoarding, repeated checking, or compulsive counting. Although historically classified among anxiety disorders, OCD symptoms may also manifest as psychotic delusions. It is important to distinguish OCD from obsessive-compulsive personality disorder (OCPD), an ego-syntonic condition characterized by rigidity, neatness, and perfectionism in which the patient often attempts to impose his preferences upon others. More than one in 40 Americans are estimated to suffer from OCD annually (2).

The diagnosis of OCD and related disorders and the treatment of patients with these disorders raise an idiosyncratic set of ethical questions. Because patients with OCD often do not pose an acute danger to themselves and others, therapies may be limited to voluntary interventions; but what is to be done when the patient's behaviors, such as hoarding, place the patient at risk of eviction or cause problems or distress for the person's neighbors? The well-intentioned therapist may struggle to determine where legal and ethical obligations begin and end. For example, rules governing confidentiality may limit the clinician's ability to advocate for patients in distress to access the supports or care they may need.

An interesting and understudied aspect of OCD involves the assessment and management of OCD among patients who belong to distinct, sometimes insular, religious or cultural communities. For example, how does one manage a patient who believes his compulsive behavior reflects a religious or cultural obligation?

The ethical challenges related to treating patients with OCD are likely to expand in scope, as novel therapeutic approaches (e.g., implantable devices) raise questions regarding who should have access to these interventions, who will care for the patients who receive them, and who should pay for them. Meanwhile, the 21st Century Cures Act of 2021 affords patients far more access to their medical data in real time, which will lead to new ethical and clinical challenges.

Case 1

Mr. A is a 26-year-old man who presents to the resident psychiatry clinic at the urging of his mother. Mr. A's appearance (i.e., long beard, uncut sideburns) is consistent with the traditions of his Chasidic Jewish community. In contrast, his mother, Mrs. A, does not wear traditional Chasidic Jewish clothing. Dr. Q attempts to interview the patient. Mr. A states: "Honestly, I really don't think I need to be here. But the Ten Commandments order us to honor our fathers and mothers, and my mother wanted me to come here. You should probably ask her to explain." With Mr. A's permission, Dr. Q interviews Mrs. A in private. She explains that her son, who lives with her, was not religious (Jewish by background, but not observant) until a year earlier, when his father was killed in an automobile accident. Shortly afterward, Mr. A quit his job as a high school history teacher and began attending a Chasidic synagogue. She does not object to his increased religiosity, but of late, she has become concerned that his behavior is not simply religious but seems, in her words, "abnormal." For example, she has overheard him in his bedroom reading the same passage from the Torah repeatedly for 12 hours straight, and when she asked why, he explained that he has to do so, "in case I've made a mistake and didn't realize it." He also washes his hands hundreds of times before and after eating while reciting the same blessings repeatedly. Mrs. A also reports that when she reached out to the rabbi at her son's synagogue to discuss the matter, Rabbi Z said, "Young men can often become a bit overzealous when they return to the Lord. It's nothing to worry about." Dr. Q asks Mr. A what his own thoughts are regarding his mother's concerns, and Mr. A says, "My mother just doesn't understand the importance of what I'm doing."

1.1. Dr. Q elicits further details that suggest that Mr. A's behavior is ego dystonic and that he has displayed other forms of obsessive-compulsive behavior since adolescence, such as ritualized counting and fear of contamination. Dr. Q believes that it would be helpful to speak with Rabbi Z to gain insight into the religious practices of Mr. A's community to help distinguish the degree to which Mr. A's behavior is indicative of a psychiatric illness. Which ethical value is

best reflected by Dr. Q's desire to speak with the patient's rabbi?

A. Moral relativism
B. Informed consent
C. Paternalism
D. Cultural competence
E. Autonomy

1.2. Dr. Q ascertains that Mr. A is unwilling to participate in psychotherapy but is amenable to pharmacological treatment. He prescribes fluvoxamine and sets up a follow-up appointment with Mr. A for the following week to assess how he is tolerating the medication. When Mr. A returns for this follow-up visit, his mother immediately follows Mr. A into Dr. Q's office and sits beside him on the couch. How should Dr. Q proceed?

A. He should allow Mrs. A to remain in the session, because Mr. A has implicitly consented to her presence and there is no reason to offend her.
B. He should allow Mrs. A to remain in the session, because Mr. A has diminished capacity as a result of his psychiatric illness.
C. He should exclude Mrs. A from the session permanently, because her presence is a clear violation of both HIPAA and the APA Code of Ethics.
D. He should suggest setting up a separate appointment with Mrs. A to discuss her own bereavement and offer her psychotherapy, as needed.
E. He should ask Mrs. A to step outside briefly and ascertain whether Mr. A would like her to be present for the appointment.

Case 1 Continues. At the second appointment, Mr. A reports that he has tolerated the fluvoxamine well and has been taking it consistently, but he is concerned about becoming dependent on the drug. Dr. Q offers reassurance and sets up a third appointment with Mr. A for the following month. In the interim, with permission from Mr. A, he contacts Rabbi Z and ascertains that Mr. A's religious preoccupations and behaviors appear to extend well beyond the normal religious practices of Orthodox Judaism. For example, Rabbi Z explains that it is important to read the passages from the Torah accurately but never necessary to repeat them for hours. When Mr. A returns, his mother explains to Dr Q that Mr. A stopped taking the fluvoxamine shortly after the second appointment and has forgone eating and drinking for the past 6 days. Mr. A acknowledges this, stating that he initially began fasting on a religious holiday, but he feared that he might have broken the fast in some way, so he is repeating the fast until he does it perfectly. Dr. Q asks Mr. A if he is concerned about the impact of his fasting on his health, and he responds, "Sometimes it is necessary to sacrifice health, and even life, in the name of perfection."

1.3. If Dr. Q decides to admit Mr. A to an inpatient psychiatric hospital on an involuntary basis, which of the following principles might justify his decision?

A. Autonomy
B. Deontology
C. Beneficence
D. Dual loyalty
E. Cultural humility

1.4. Dr. Q arranges for Mr. A to be transported to the nearest psychiatric emergency room for further evaluation, and he is soon admitted to the hospital involuntarily on the grounds that his refusal to accept fluids poses a danger to his life and health. He continues to refuse food and fluids, stating that he has a right to choose whether to engage in a religious fast. He also states that he recognizes that he might die, but it is a risk he is willing to take: "Why does it matter whether my fasting is motivated by OCD? Even if it is, it's still the Lord's will that I fast." Which of the following is the best ethical justification for administering nutrition and hydration over Mr. A's objection?

A. Decisional capacity is not relevant in cases of severe mental illness.
B. Mr. A's decisional capacity is impaired by his religious beliefs.
C. Decisional capacity can never justify rejecting nutrition and hydration.
D. Mr. A's decisional capacity is impaired by his psychiatric illness.
E. No proxy or surrogate has authorized withdrawal of nutrition and hydration.

Case 2

Mr. S is a 42-year-old man who schedules a consultation with you in your outpatient practice. He reports that, for many decades, he has been collecting books, newspapers, clothes, and food. He says he has been collecting items since he was in his 20s, stating, "Once I have something in my house, it is virtually impossible for me to get rid of it." When asked why he is unable to discard items, he appears anxious and says, "I'm afraid I might need it one day, and the thought of throwing out any item makes me panic." Mr. S lives alone in a small apartment and has always kept to himself. However, over the past several months, the apartment building manager has been receiving complaints from several of Mr. S's neighbors of foul smells coming from his apartment. Additionally, since he ran out of space for storage, he began leaving things on a shared balcony space, which has been annoying the neighbors. The building manager has requested to inspect the space, but Mr. S won't let anyone in. Most recently, the building's owner has threatened him with fines and states that his lease will not be renewed. Since the COVID-19 pandemic began, he has been working remotely from home. Mr. S tells you that his

coworkers are now also concerned because he is unable to set up his camera in any angle that does not reveal the extreme clutter around him.

2.1. Which of the following disorders would you want to screen for and rule out when making a diagnosis of hoarding disorder?

A. Major depressive disorder
B. Obsessive-compulsive disorder
C. Schizophrenia spectrum and other psychotic disorders
D. Prader-Willi syndrome
E. All of the above

Case 2 Continues. You diagnose Mr. S as having hoarding disorder and begin treating him with cognitive-behavioral therapy for hoarding disorder, focusing on education and goal setting, decreased acquisition of items, and exposure therapy (3). He tells you that the apartment complex is relentless with calls and notices for him to allow for inspection of his home. He tells you that he plans on suing the apartment complex, claiming psychological damages, and wants to know what circumstances might force you to release records or testify in court about the treatment for Mr. S's condition.

2.2. What is the term used to describe the physician's obligation in keeping information obtained from the patient from other parties?

A. Fiduciary
B. Confidentiality
C. Privilege
D. None of the above

2.3. If the patient goes ahead with suing his apartment complex for psychological damages, and the opposing counsel seeks to obtain the patient's medical records, will the patient be able to claim doctor-patient privilege in order to not have the records produced?

A. Yes, because doctor-patient privilege is absolute
B. No, because the lawsuit occurs in state court
C. Yes, because the patient has not explicitly waived the privilege
D. No, because there is a patient-litigant exception to privilege

Case 2 Continues. You continue to treat the patient for weekly psychotherapy. During one session, he asks you how he can obtain his medical records. You inform him that, in compliance with the 21st Century Cures Act, the hospital will now provide the medical record through an online secure portal, and the patient will be able to read clinical notes online without delay.

Discussion

On April 5, 2021, federal rules went into effect requiring health care organizations to share online access to a patient's medical record through secure portals. Almost all notes will be required to be shared "without delay" with patients on the portal, unless the notes fall into specific exempt categories. For example, the ruling allows physicians to withhold access to patients' notes if doing so "will substantially reduce the risk of harm" (4). Psychiatrists will need to make difficult decisions, weighing conflicting ethical principles such as autonomy and nonmaleficence, when determining whether and when information should be withheld from the patient. Questions that may arise include the following: Is this information sensitive enough to withhold it from the patient? If so, for how long should it be withheld? If seeing a patient through telepsychiatry, might it be better to wait to reveal certain information in person?

The so-called open notes model will present psychiatrists with other clinical and ethical concerns. Going forward, patients will far more easily be able to read their notes online, and they may do so frequently. For example, psychotherapy patients may go home and read their progress notes each week. It will be important for the physician to allow time in the session for discussing what the patient's thoughts and feelings are about reading the clinical notes. Although physicians should always be truthful in documentation, additional sensitivity to language used will be crucial. As the Latin phrase *verba volant, scripta manent* suggests, spoken words fly, written words remain.

2.4. According to the 21st Century Cures Act, which of the following note types will be automatically exempt from immediate positing on a secure online portal?

A. History and physical
B. Consultation notes
C. Laboratory report narratives
D. Progress notes
E. None of the above

Answers

1.1. The answer is D. Cultural competence generally refers to the skills needed to provide care to patients in the context of their own cultural beliefs and values (5). In this case, understanding the religious practices of Mr. A's community may prove helpful both in determining whether his condition is pathological and in establishing a trusting therapeutic alliance. One common framework for cultural competence, described by Paul Pedersen, emphasizes the importance of awareness, knowledge, and skills (6). Several recent models also incorporate a fourth feature, attitude, and additional emphasis has recently been placed on "cultural humility," an other-oriented and open approach to cultural difference (7). Cultural competence and cultural humility both differ from moral relativism (answer A), which argues for the universal acceptance of *all* culturally based moral differences and against the existence of any universal moral principles. Informed

consent (answer B) refers to the process of providing information to the patient so that he can make autonomous medical decisions rather than obtaining information about the patient. Obtaining collateral information with the patient's permission is not paternalistic (answer C), nor does it particularly promote the right to self-determination (answer E).

1.2. The answer is E. Confidentiality is an important component of the psychiatrist-patient relationship. A patient may not feel comfortable asking a partner or family member for privacy, especially in settings of duress or abuse. It is the physician's responsibility to ensure that the patient genuinely wants to speak in front of a third party, rather than assuming that the patient is amenable to a family member's presence (answer A). However, neither HIPAA nor the APA Code of Ethics prevent the physician from inviting Mr. A's mother back into this room for the session with his consent (answer C), although, in some instances, this may not prove ideal for the therapeutic relationship. Although Mr. A's capacity may be diminished because of mental illness regarding some decisions, capacity is decision specific, and nothing in the scenario suggests that his ability to decide whether he wants his mother to be present is impaired (answer B). Although it is not strictly unethical for Dr. Q to treat Mrs. A separately, it runs the risk of conflicts of interest arising between his duties to each patient, so it is not an ideal practice; treating two members of the same family outside of joint or family therapy is generally discouraged (answer E).

1.3. The answer is C. The involuntary commitment of psychiatric patients who pose an imminent danger to themselves is justified by the principle of beneficence, the duty of providers to protect a patient's welfare and interests (8). In this case, both the grave disability secondary to psychiatric illness and the acute threat to life caused by rejection of fluids might justify involuntary hospitalization. It is often viewed as a paternalistic approach in that it overrides the patient's liberty and wishes, which are embodied in the value of autonomy (answer A). Deontology, an approach to ethics often associated with the German philosopher Immanuel Kant, judges actions on their intrinsic merit, rather than their consequences, whereas involuntary commitment is usually justified with the consequentialist argument that abridging liberty in the short run saves lives (answer B). Dual loyalty refers to the obligation of the provider to serve the interests of two separate entities, such as the individual patient and society as a whole, which can sometimes come into conflict (answer D), but in this case, the psychiatrist is acting out of a direct fiduciary duty to the patient. Cultural humility is an aspect of cultural competence (answer E) that, in some cases, would favor deferring to the patient's wishes rather than overriding them.

1.4. The answer is D. Although some might contend that Mr. A appears to meet the formal requirements for capacity as initially outlined by Appelbaum and Grisso (i.e., expressing a clear choice, understanding relevant information, appreciating the situation and its consequences, and manipulating information rationally) (9), we argue that, in this case, the patient's OCD distorts his appreciation of the situation substantially enough and in such a way that it diminishes his capacity, which, in turn, justifies a decision to override his autonomy with regard to nutrition and hydration. In particular, the patient's inability to recognize his own illness (anosognosia) renders his appreciation of the situation less than fully accurate, although he may express a superficial understanding. In contrast, some patients with severe mental illness do retain capacity to make medical decisions (answer A), and medical patients with capacity are generally entitled to refuse all care, including artificial nutrition and hydration (answer C). Capacity assessments should be sensitive to a patient's religious beliefs, and the sincere beliefs of a religious community are not incompatible with decisional capacity in adults (answer B). In the United States, a surrogate or proxy cannot authorize the withdrawal of care for an impaired patient if the wish to cease care is based on preferences expressed while the patient's capacity was impaired by mental illness (answer E).

2.1. The answer is E. When making a diagnosis of hoarding disorder, it is important to rule out other disorders that may cause or contribute to hoarding behavior. One should assess for and rule out medical disorders such as traumatic brain injury or neurogenetic conditions such as Prader-Willi (answer D), which can be associated with hoarding behavior. Hoarding disorder is not diagnosed when the hoarding behavior is deemed to flow directly from decreased energy or motivation associated with major depressive disorder (answer A) or from obsessions (e.g., fear of contamination) or compulsions, as might occur in OCD (answer B). One should also rule out a psychotic process (answer C), such as paranoid delusions, that may be contributing to the hoarding behavior (1).

2.2. The answer is B. Confidentiality refers to the physician's obligation to keep information about the patient private. Although there are limits to confidentiality (e.g., the need to contact third parties out of concern for imminent self-harm), patients generally expect that their discussions with psychiatrist will remain private unless told otherwise or unless the patient gives permission to share information with another party. Privilege—(answer C) or, specifically, doctor-patient privilege—is an evidentiary rule applied in legal settings to exclude information and communication that occurred between a doctor and patient within a treatment relationship from being used in

court (10). Confidentiality is the obligation of the physician, whereas privilege belongs to the patient. If a patient requests that her records be produced for a court proceeding, the physician cannot "claim privilege" in order to not share the records with the patient. Privilege belongs to, and can be waived by, the patient. A fiduciary (answer A) is a person who holds a legal and ethical relationship of trust with another part and acts in the sole interest of that party. A fiducial relationship can exist only if the fiduciary abides by various ethical principles, such as confidentiality.

2.3. The answer is D. There are limits to both confidentiality and privilege. Most physicians are aware of the limits of confidentiality because of the nature of everyday practice (e.g., mandatory reporting, emergency situations requiring collateral information). However, the limits of privilege may be encountered less frequently in clinical practice. Under normal circumstances, a patient can claim doctor-patient privilege in legal proceedings. However, there are exceptions to the doctor-patient privilege (answer A), such as when a competent adult patient waives privilege. In this case, although the patient has not waived privilege (answer C), filing a lawsuit may create a patient-litigant exception to privilege (answer D). Such an exception is created if a patient chooses to file a lawsuit claiming psychological damages and the opposing party seeks to introduce the patient's medical record as evidence. Many would argue that it would be ethically appropriate to warn the patient that if the patient files such a lawsuit, there is a possibility that his record would be introduced as evidence or that the physician may be compelled to testify. It is important to know that doctor-patient privilege is different from the psychotherapist-patient privilege. The psychotherapist-patient privilege, described in the landmark U.S. Supreme Court case *Jaffee v. Redmond*, applies in federal courts, whereas the doctor-patient privilege is only valid in state courts (answer B), and the scope of doctor-patient privilege will vary in each jurisdiction.

2.4. The answer is E. One of the goals of the 21st Century Cures Act is to make medical records available to patients in a speedier and more effortless way than previously. Patients who receive their care in systems with electronic health records will be able to receive their records "without delay" and at no cost. The patient's full medical and psychiatric record will be available, and notes should be written with the understanding that patients may read them. There are some exceptions to the rule against "information blocking." For example, a physician may withhold information that he or she believes will "substantially reduce the risk of harm" (11). Withholding such information from the record is, in essence, a form of therapeutic privilege. Therapeutic privilege is an uncommon exception to informed consent whereby the physician withholds information from the patient if he or she believes that revealing such information would pose a severe psychological threat. Although it remains to be seen, the rolling out of immediately accessible notes may lead to an increase in claims of therapeutic privilege.

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