Ethical and Legal Aspects of Treating Bipolar Disorder

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Bipolar disorder is a serious mental illness that is characterized by severe, episodic fluctuations in mood that may be accompanied by psychosis. The illness was the 18th leading cause of disability worldwide in 2010, ahead of Alzheimer's disease and ischemic heart disease (1). Thirty to 60% of patients with bipolar disorder struggle with social or occupational functioning (2). The National Institute of Mental Health (3) reports that an estimated 4.4% of Americans will be diagnosed as having bipolar disorder during their lifetime. Individuals with untreated bipolar disorder are at substantially higher risk of suicide (4), violence (5), divorce (6), financial difficulties (7), and a range of other negative social consequences.

A variety of medications are available to treat the various manifestations and symptoms of bipolar disorder (8), the first of which was lithium in the 1950s. However, many medications have risks or side effects that may trigger distress, deter drug compliance, or cause medical complications. The teratogenic effects of antiepileptic drugs that have mood-stabilizing properties, such as valproate and carbamazepine, are among the most hazardous side effects. Balancing the potential benefits and the risks of such medications—and appropriately informing patients of these risks without discouraging essential care—frequently raises ethical challenges in clinical practice.

Another set of ethical challenges arise regarding the involuntary hospitalization and treatment of patients with bipolar disorder, particularly during acute episodes of mania or hypomania. These individuals do not often pose an imminent threat to the safety of themselves or others, but they are nonetheless engaging in self-defeating or destructive behaviors that may damage their personal relationships, jeopardize their employment and housing, and imperil their economic stability. Ethical norms regarding patient autonomy and legal standards for involuntary commitment often raise barriers to ensuring the long-term well-being of such individuals.

Case 1, Part 1

Ms. C is a 26-year-old attorney who presents to your outpatient practice at the behest of her parents. They accompany her to the appointment, and she agrees to allow them access to all protected health information. Ms. C explains that she had been hospitalized voluntarily the previous year because of an episode of acute hypomania and was diagnosed as having bipolar II disorder, at which time she was treated with lithium. She chose to discontinue the lithium 2 months prior to presentation at your clinic because she disliked the metallic taste it left in her mouth. Her mood has worsened since discontinuing the lithium and now she acknowledges feeling depressed and reports loss of appetite, lack of energy, insomnia, difficulty in concentrating, and shame over an instance of infidelity that occurred during her hypomanic episode. She denies any substance use. Her parents corroborate the details of her story.

1.1. You ascertain that Ms. C is neither experiencing suicidal ideation, violent ideation, or psychotic symptoms at present, nor has she ever engaged in self-harm or violence. You conclude that she does not pose an acute risk to herself or others, and you propose treating her with medication in conjunction with supportive psychotherapy on an outpatient basis. Ms. C responds by explaining that she is not willing to try medication again at this time but would be interested in talk therapy for her bipolar disorder. You determine that she is adamant about this choice. She is also very concerned that her treatment cannot interfere with her job at a prestigious law firm. Which of the following would be the most appropriate response to this request?

A. Persuade Ms. C to agree to voluntary hospitalization.
B. Hospitalize Ms. C involuntarily.
C. Prescribe Ms. C lithium because this is the standard of care.
D. Consult the literature to ascertain whether there are significant benefits to talk therapy without medication for patients in the depressive phase of bipolar II disorder.
E. Inform Ms. C that you cannot help her because to treat her with talk therapy in the absence of pharmacotherapy falls below the standard of care.

1.2. If you opt to treat Ms. C with talk therapy alone, on the basis of data from a recent study and after consulting with several thought leaders in the field who have

adopted this approach for medication-wary patients, you conclude that doing so can be justified based upon

A. The Right to Try
B. Implied consent
C. Therapeutic privilege
D. Informed assent
E. The respectable minority rule

1.3. Prior to starting talk therapy with Ms. C, you provide her with relevant information regarding the course of treatment, the potential risks, and you also review the potential downsides of not pursuing concomitant treatment with medication. She assures you that she fully understands everything that you have explained and provides her consent. This process is consistent with the principles laid out in which of the following cases?

A. *O'Conner v Donaldson*
B. *Tarasoff v Regents of University of California*
C. *Canterbury v Spence*
D. *Estelle v Gamble*
E. *Daubert v Merrell Dow Pharmaceuticals, Inc.*

Case 1, Part 2

Ms. C underwent talk therapy for 10 weeks and you were eventually able to persuade her to begin concurrent treatment with lamotrigine for bipolar depression. Her mood improved significantly over the next several months. She has now informed you that she eloped with a childhood friend with whom she recently reconnected and that, to her surprise, she is pregnant. You evaluate her for mania but find no indication that her sudden marriage was the product of psychiatric illness. At her request, you explain to her the potential risks of either continuing or tapering off the medication. She ultimately decides to continue lamotrigine.

1.4. Two months later, you receive a phone call from Ms. C's husband, Mr. D, who explains that he is concerned that his wife's psychiatric medication could cause their future child to have a congenital disorder. He also informs you that he is his wife's health care proxy and faxes you a copy of the document. "She told me she is taking a medication called lamotrigine and that she has nothing to worry about. I just want to be certain that is indeed the medication she is taking and that it is safe during pregnancy." How should you respond to Mr. D?

A. Inform Mr. D that you cannot discuss his wife's care without her permission.
B. Ask Mr. D what he knows about lamotrigine.
C. Only acknowledge that Ms. C is taking lamotrigine if you can confirm the validity of the health care proxy form and that the caller is the person referenced in the document.
D. Refuse to acknowledge that Ms. C is taking lamotrigine, but reassure Mr. D that you would never prescribe a medication that might cause birth defects.
E. Inform Mr. D that you cannot discuss his wife's care without corroborative evidence that he is the biological father of the fetus.

Case 2

Mr. X, a 19-year-old college student, presents to the psychiatric emergency department (ED) at a major urban hospital in the company of Ms. Y, the resident assistant at his university dormitory. She has persuaded him to come to the hospital because he has been acting oddly for the past several days: He is unable to sleep, he has been buying expensive jewelry for casual acquaintances in the dorm, and he recently apprised his roommate that the novel he is writing, which is now 700 pages long, has the potential to transform civilization. Upon arrival, he consents to a urinalysis and the results are negative for controlled substances. He also denies any history of psychiatric illness. On evaluation, his speech is mildly pressured and his affect is elevated. He states that he feels "better than ever before" and that he only came to the hospital because he wanted to humor Ms. Y. He states that he wants to return to his dorm to work on his novel. "Only 500 more pages and it will be longer than *War and Peace*," he says. "It's already better!"

2.1. On initial assessment, the evaluating psychiatrist, Dr. Z, suspects that Mr. X may be experiencing a manic episode of bipolar I disorder. Which of the following bioethical principles would prompt Dr. Z to agree to discharge Mr. X?

A. Justice
B. Beneficence
C. Autonomy
D. Cultural Humility
E. Utility

2.2. Dr. Z conducts a thorough psychiatric evaluation of Mr. X to determine whether involuntary psychiatric admission to the hospital is indicated. Which of the following would satisfy the legal and ethical standards for involuntary admission to a psychiatric facility in the United States?

A. Active mental illness and danger to oneself
B. Active mental illness and inability to care for oneself due to this illness
C. Active mental illness and capacity to consent to admission
D. Either A or B
E. Either A, B, or C

2.3. Further evaluation reveals that Mr. X is paranoid that his roommate, Mr. W, will read his manuscript while Mr. X is in the ED. "My ideas aren't ready for prime time yet," explains Mr. X. "Sharing them could endanger humanity. I'm not a violent person, but if Mr. W has read my manuscript, I will have no choice but to silence him." When Dr. Z asks Mr. X to clarify what he

means by "silence him," Mr. X responds, "I've already said too much." He refuses to address the issue further and will not answer questions about whether he has any intention of harming or killing anyone else. Dr. Z determines that involuntary admission to the psychiatric hospital is required. However, Dr. Z is uncertain as to the extent of his legal and ethical duties regarding this apparent threat to Mr. W. After Mr. X's involuntary admission to the ED, Dr. Z should

A. Call Mr. W to warn him of the implicit threat because doing so is required by *Tarasoff v Regents of University of California.*
B. Call Mr. W to warn him of the implicit threat because doing so is required by the expanded duty to third parties as established in the case of *Volk v DeMeerleer.*
C. Contact law enforcement to report Mr. X's statements because Dr. Z, as an agent of the medical system, has an obligation to protect Mr. W.
D. Not warn Mr. W or contact law enforcement because Mr. X's statements are too ambiguous to require such action.
E. Defer further action to the medical team on the inpatient unit.

2.4. Mr. X informs Dr. Z that "If I'm not out of here in 30 minutes, heads will roll. I'm not afraid to fight my way out of this place if I have to." Dr. Z fears that by advising Mr. X that he is going to be admitted involuntarily, Mr. X will become violent and require intramuscular medication or four-point leather restraints. Instead, Dr. Z decides to accompany Mr. X to the inpatient unit and inform him there in the hope that, once Mr. X sees that his admission is irreversible, he will not fight back or require escalated interventions. On the way to the inpatient unit, Mr. X asks, "Where are we going? You're not admitting me, are you?" and Dr. Z replies, "We're just going to another part of the hospital where it's quieter." By temporarily withholding information from Mr. X, Dr. Z is invoking

A. Implicit bias
B. Physician-patient privilege
C. Therapeutic privilege
D. Cultural competence
E. Cognitive restructuring

Answers

1.1. The answer is D. In order to decide whether to proceed with the care plan proposed by Ms. C, you need to know whether talk therapy for the depressive phase of bipolar II disorder is evidence-based and has support within the scientific community. You determine that some support for the efficacy of this approach does exist (9). It is not necessary for a mode of treatment to be the most efficacious or most widely utilized in order for it to be an acceptable form of care as long as the patient is made aware of other treatment options and demonstrates a meaningful understanding of the risks. No evidence suggests that Ms. C poses a danger to herself or others, or is gravely disabled, so no legal basis likely exists to involuntarily admit her to a psychiatric hospital (choice B). Although she might be eligible for voluntary admission, such an intervention at this time seems excessive and is an unnecessary use of resources when outpatient treatment appears to suffice in meeting her needs (choice A). Lithium is one of several medicines that has an established efficacy in treating the depressive phase of bipolar II disorder, but Ms. C has indicated that she is unwilling to take medication at this time. There is no ethical basis at present for overriding her decision (choice C). Although you may have the legal right to refuse to offer Ms. C the treatment option of her choice, you are not obligated to turn her away if she wishes to pursue therapy that is not optimal (choice E).

1.2. The answer is E. The respectable minority rule, also known as the two schools of thought doctrine, is a malpractice law principle that allows for certain treatments that do not meet the standard of care if "a 'considerable number' of respected and recognized medical experts support the approach" (10, 11). In this case, even though talk therapy alone for the depressive phase of bipolar II disorder may not conform to the accepted level of the standard of care, support does exist among thought leaders and in the literature. The Right to Try refers to a policy, now encoded in federal law, that allows patients with life-threatening conditions to pursue treatments that are not approved by the Food and Drug Administration when there are no clinical trials available (choice A). Implied consent is the principle that consent to treatment need not be explicit under certain circumstances, but can be inferred from other language or behavior (choice B). Therapeutic privilege (also known as therapeutic nondisclosure) refers to rare situations in which information may be withheld from a patient in order to protect that patient's welfare (choice C). Informed assent is a concept that has gained significant traction among pediatric researchers and that requires meaningful agreement by minors to participate in research even if they are legally not able to consent because of age (choice D).

1.3. The answer is C. *Canterbury v Spence* (1972) is a seminal federal court case in which Judge Spotswood Robinson articulated "a patient-centered standard of disclosure" that required informing the patient of all the risks that a reasonable patient would wish to know in order to render an informed decision (12). The informed consent process described in this case is now an expected aspect of clinical medicine. *O'Connor v Donaldson* (1975) is a U.S. Supreme Court decision that limited the state's

ability to confine nondangerous individuals (choice A). *Tarasoff v Regents of University of California* (1976) is a California Supreme Court decision that addressed the duties of psychiatrists with regard to the warning and protection of potential third-party victims of dangerous patients (choice B). *Estelle v Gamble* (1976) is a Supreme Court case that established the standards for a prison inmate to declare a violation of Eighth Amendment protection against cruel and unusual punishment for not providing necessary medical care (choice D). *Daubert v Merrell Dow Pharmaceuticals, Inc.* (1993) established the standards for admitting expert testimony in the federal courts (choice E).

1.4. The answer is A. Confidentiality has been a core principle of Western medical ethics for more than 2,000 years (13). The confidential nature of physician-patient interactions ensures that patients willingly share all private information that may be required for optimal care. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), state laws, and the canons of professional organizations transformed this principle into policy. The medical information of competent patients ought not be disclosed to others without the permission of the patient or certain overriding public policy concerns. What Mr. D knows about lamotrigine is not relevant to whether you are at liberty to share information with him; by asking the question, you may inadvertently imply that you are confirming that his wife takes this medication (choice B). Health care proxies, also known as health care powers of attorney, do not gain authority until a patient has either lost capacity or has authorized a designated proxy to act (choice C). Providing reassurance about whether the drug is not contraindicated during pregnancy is inappropriate as it might imply information about Ms. C's care. In addition, under some circumstances, it might be appropriate to prescribe teratogenic medication when the benefits outweigh the risks and the patient offers informed consent (choice D). Whether Mr. D is the father of the fetus is irrelevant to the question regarding his right to access his wife's medical information (choice E).

2.1. The answer is C. Autonomy is widely regarded as a central value in contemporary Western medicine (14). Since the 1960s, Western medical ethics has embraced the belief that patients should generally have the authority to render decisions regarding their own medical care. Discharging Mr. X upon his request would reflect this approach. Justice refers to the fair and equitable treatment of all patients, especially in such areas as access to care and allocation of health care resources (choice A). Beneficence, another principle in medical ethics, refers to the physician's duty to serve the patient's welfare or interests (choice B). Cultural humility is a self-reflective model of engagement with patients that emphasizes openness to the experiences of others over cultural competence (choice D) (15). Utility is a theory of ethics that prioritizes maximization of value and is often described as pursuing the greatest good for the greatest number (choice E).

2.2. The answer is D. Although standards for involuntary admission differ among the states, they generally require that patients have an active mental illness and also pose a danger to themselves, a danger to others, or be impaired by their illness to the degree that they may struggle to care for themselves on their own. This latter standard, sometimes referred to as "gravely disabled," is subject to a wide range of interpretations. A patient with an active mental illness and who poses either a danger to self (choice A) or an inability to care for self due to illness (choice B) will meet this standard. In contrast, a patient with an active mental illness alone does not necessarily meet this standard (choice C). In addition, many jurisdictions favor voluntary admissions for patients who have the capacity and are willing to consent to admission.

2.3. The answer is E. The goal of laws that require warning or protecting third parties is to do so with as minimal a violation of the patient's own confidentiality as possible. In this case, admitting Mr. X to the hospital involuntarily resolves any immediate danger. The inpatient team can reevaluate the danger posed by Mr. X at his time of discharge and then determine whether further action is indicated. *Tarasoff* is a state court ruling from California; obligations to warn or protect will vary in different jurisdictions. In any case, *Tarasoff* warnings are not indicated when the patient is not entering the community (choice A). Similarly, *Volk* is a state court ruling from Washington that imposed a foreseeability standard in duty-to-warn cases, but the principle has not yet been adopted elsewhere (choice B). Admitting Mr. X fulfills Dr. Z's obligation to protect Mr. W (choice C). Although Dr. Z will meet his ethical obligation by admitting Mr. X, it is worth noting that Mr. X's threats do not appear so ambiguous as to not require additional action upon discharge in jurisdictions that require additional steps. Had Dr. Z discharged Mr. X, such further action might well have been indicated (choice D).

2.4. The answer is C. Therapeutic privilege or therapeutic nondisclosure refers to the practice of withholding information from patients in service of their own well-being (16). Doing so runs against the dominant culture of contemporary Western medicine, which favors full disclosure in order to further autonomy. In this case, Dr. Z is exercising this privilege by concealing the admission plan from Mr. X temporarily in order to prevent the need for escalated interventions. Therapeutic privilege is frequently mistaken for testimonial privileges that are related to providing evidence in court, such as physician-patient privilege, which permits patients to prevent their doctors from testifying about private

conversations during their course of care (choice B). Implicit bias is a form of unconscious prejudice that may shape individual and collective decision making (choice A). Cultural competence is an expectation that physicians recognize both their own cultural values and understand the values and customs of the patients whom they treat (choice D). Cognitive restructuring is a tool used in psychotherapies, such as cognitive-behavioral therapy, in which patients learn to recognize and reshape distorted thoughts (choice E).

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