

Enforcing medical treatment under the Involuntary Treatment Order: An ethical dilemma?

Seth Delpachitra
Sixth Year Medicine
James Cook University

Seth has a particular interest in mental health and is currently investigating the role of neuroinflammation in cognitive decline.

Introduction: This case report aims to address the ethical issues and obligations of enforcing medical care onto psychiatric patients under the Queensland Mental Health Act 2000 Involuntary Treatment Order (ITO), and will also present Queensland’s legal standpoint and limitations on providing this care under the Act. **Case Presentation:** PF, a 47 year old male with a history of depression and recent diagnosis of Gleason 7 prostate cancer was admitted to the acute mental health unit following an intentional overdose of alprazolam. His risk to himself prompted the application of an ITO. Although PF was due for investigation of his recently diagnosed prostate cancer, he refused following his suicide attempt. **Conclusion:** Although an ITO allows for enforcement of psychiatric treatment, no legal allowances exist for enforcement of medical care. In situations where medical conditions may be indirectly detrimental to a person’s mental health, ethically-appropriate techniques should be employed.



Case Presentation

PF is a 47 year old male patient with a 28-year history of depression, who was admitted to the Acute Mental Health Unit (AMHU) at a Queensland hospital following a suicide attempt involving an overdose of alprazolam (14 x 0.5mg tablets). PF had experienced a number of life stressors in the several weeks preceding, having dealt with a divorce from his wife of 20 years due to adultery on her part, and a recent diagnosis of prostate cancer (Gleason Score 7). PF was living with his daughter at the time of presentation. This was PF’s first known episode of attempted suicide and self-harm.

Admission to the AMHU coincided with another appointment at the hospital for a bone scan to exclude prostate cancer metastases. It was PF’s belief that he had definitely developed metastatic cancer, and as such, he did not feel the need to have this diagnosis confirmed despite extensive counselling and discussion with his psychiatric management team.

During the initial assessment, PF seemed agitated yet withdrawn, refusing to provide a detailed history regarding his divorce. He had given a recent history of poor sleep, appetite and concentration. PF’s mood was clearly depressed and this was reflected in his affect. Although his thought form was largely intact, his view regarding his prostate cancer appeared to be a fixed, false belief manifesting as a delusion. Thought content was focused around his helplessness surrounding current events. He was particularly negative about the severity of his prostate cancer and was angry about the relationship breakdown with his wife. PF’s refusal to partake in prostate cancer staging and rather rely on his own beliefs about possible metastases demonstrated impaired judgement. Although PF was well aware of his depression and its effects, his refusal of psychiatric treatment was sufficient evidence that his insight was impaired.

Although PF was deemed to be very low risk for aggression or self-neglect, he was placed on an Involuntary Treatment Order (ITO) primarily due to his high risk of self-harm and suicide. His high risk of absconding further contributed to the need for involuntary treatment.

Legal and ethical obligations of the ITO

Part 3, principle 8a of the Queensland Mental Health Act 2000 states that “treatment provided under this Act must be administered to a person who has a mental illness only if it is appropriate to promote

and maintain the person’s mental health and wellbeing.” [1] There is no clear jurisdiction for enforcement of medical care under an ITO in Queensland, unless the medical condition is directly associated with the development of the mental illness. As a result, in cases where there is no direct association between the medical condition and mental illness, a complex legal and ethical dilemma presents itself.

Principlism, a widely used bioethical theory, refers to the use of a set of principles – autonomy, beneficence, non-maleficence and justice – in place of other moral theories. These provide a set of guidelines to combat moral problems that may occur in any medical practice, including psychiatry. [2] A key underlying tenet of this moral theory is that one should, to the greatest extent, retain the patient’s right to autonomy with regards to psychiatric and medical care. [3] Autonomy, in its most simple terms, refers to the right of an individual to self-determination; in this context, with regards to treatment of PF’s prostate cancer. Personal autonomy is regarded as a basic human right both in moral theory and legally under the Australian Human Rights Commission Act 1986. [4] In terms of autonomy, enforcement of medical treatment on a patient against their wishes is a direct breach of this principle; from this perspective, it would clearly not be acceptable to impose a bone scan on PF.

Beneficence refers to the provision of services that are of benefit to the patient. [3] In this case, provision of medical imaging for staging of prostate cancer was being proposed with the patient’s wellbeing in mind, in a situation where the patient may not have been able to reasonably make appropriate treatment decisions. A common criticism of the principle of beneficence is that it encompasses an outdated, paternalistic attitude towards patient care, with health professionals deciding what is in a patient’s best interests. Paternalism derives from the desire to avoid adverse consequences; the use of an ITO for patients who are thought to be clinically unable to make their own decisions is an example of this principle being enforced in an extreme fashion. Although PF should ethically retain his right to autonomy, his depressive state may impair his judgement about the consequences of not seeking treatment for his cancer. This raises the question as to whether this decision should be put into the hands of a person more able to provide an objective assessment on his behalf (in this case, the consultant psychiatrist).

A key influence upon the provision of medical care is non-maleficence;

that is, abstaining from any course of action that will cause harm to a patient. [3] Unfortunately, no procedure in medicine is without some degree of risk, and often a difficult choice must be made between benefits of a treatment and the risk of severe complications. Current literature suggests that the benefit of staging prostate cancer outweighs both the low risk of complications of a bone scan and the consequences of not performing the test. [5] Therefore enforcing this medical management to PF's case, although not completely free of risks or complications, would be considered 'non-maleficent' in that this risk is relatively low compared to not performing the scan.

Discussion

The current legal guidelines state that PF's prostate cancer cannot be treated involuntarily through the Mental Health Act; that is, PF should not be forced to participate in diagnostic testing and management plans regarding this illness. Although the prostate cancer may not have any physiological link to PF's mental illness, the diagnosis of this cancer was identified as a major contributor to PF's depression and suicidal behaviour. Given PF's current mental state, he did not appear to be able to make appropriate decisions regarding his psychiatric care. Such an assertion may also be applied to his judgement of general medical care. Using a principles-based ethical approach, although enforcement of prostate cancer management in a psychiatric patient breaches both patient autonomy and patient justice, this practice could be considered valid in that there is significant benefit with regards to the patient's health, with minimal side effects or patient discomfort.

A study by Schwartz, Vingiano and Perez [6] examined the attitudes of 24 psychiatric patients with regards to their involuntary treatment after discharge. The authors found that upon discharge, the majority of patients (seventeen out of the 24) were aware that their initial refusal of medication was a manifestation of their mental illness, and were happy with the decision made by the psychiatric health team to override their autonomy and place them on an involuntary treatment order. Patients who did not agree with the involuntary treatment decision often suffered severe mental illness with high levels of grandiosity and their response to treatment was less-than-adequate. This study may suggest that a paternalistic approach can be both beneficial and acceptable to patients in certain circumstances, namely, following an acute psychiatric episode. However, despite these findings, it remains difficult to overcome the ethical concerns regarding the overriding principle of autonomy. In most cases, other approaches to dealing with PF's situation would be available, such as involvement of family and friends in assisting with an explanation of the medical treatment needed to the patient, as well as providing support and assurance to the patient should they become distressed with the management plan. Intervening factors such as this would normally help to diffuse some of the ethical tensions which may arise in similar situations.

References

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- [3] Beauchamp TL, Childress JF. *Moral Norms. In Principles of Biomedical Ethics*, Sixth edition. Oxford. Oxford University Press, 2008. Pp. 1-23.
- [4] Australian Human Rights Commission Act 1986. Act No. 125 of 1896 as amended. Australian Human Rights Commission. 1 January 2010.

In the case of PF, management of the prostate cancer issues by the AMHU was ethically and legally appropriate given the circumstances of his admission; PF was given adequate advice from his psychiatric team and still refused to have the bone scan. In such a situation, methods may be required to ensure that the patient is aware of their medical conditions and are able to make appropriate decisions about their health care. For example, the incorporation of the patient's social supports may play a key role in providing emotional and social guidance, while assisting the patient to make a sound clinical judgement. In cases where support persons are unavailable, the pathway is wholly dependent on the urgency of the medical problem. If the physical health problem is deemed 'non-urgent' it may be necessary to first manage the patient's primary psychiatric complaint, until judgement is no longer impaired. Alternatively, if the physical health problem is 'urgent' then the importance of acute medical treatment becomes much higher, and a case-by-case decision needs to be made about the path of action that will lead to the best outcome for the patient. While PF's case raises an important ethical dilemma in its own right, above all else it highlights the more difficult dilemma that would have been faced if his need for investigation or treatment was more urgent.

Conclusion

The ethical issues associated with the use of the ITO are complex. Although from one aspect, enforcement of medical treatment is given with the 'best intentions' for the patient, patient autonomy must be upheld wherever possible.

In the mental health setting, patient autonomy is breached in situations where the said patient is not able to make decisions regarding management of their illness. This practice has been legalised through the Queensland Mental Health Act 2000, and other similar pieces of legislation throughout Australia and the world. However, the Mental Health Act does not reserve the same limitations for general medical conditions, unless they share a direct physiological relationship with the mental illness. Although this causes issues in the holistic treatment of psychiatric patients, it may prompt health professionals to either use other methods to ensure patients receive needed medical treatment through techniques such as involving patients' nominated next-of-kin, or delaying medical intervention until the patient's mental state has improved.

Consent

Informed consent was obtained from the patient for this case report.

Conflicts of Interest

None declared.

Correspondence

S Delpachitra: seth.delpachitra@jcu.edu.au

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