Ethical Issues in Psychopharmacology

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With thanks to Carl Salzman, MD

Disclosure

- Dr. Gutheil has authored or co-authored ca. 300 publications, some of which generate income.

DISCLOSURE

- DR. GUTHEIL HAS NO CONFLICTING INTERESTS WITH THIS PRESENTATION, BUT HAS WRITTEN EXTENSIVELY ON ETHICAL ISSUES IN A WIDE VARIETY OF LOCATIONS.

Ethics in Pharmacology

- Basics of ethics
- Pressures
- Binds
- Questions
- Extremes
- Risk management

Basics of ethical analysis

- **Ethical analysis begins as weighing goods versus harms**
- **More complex reality: competing goods**
- **E.g.: Involuntary commitment pits safety (public protection) against liberty**

Ethics in prescribing

- Welfare of the patient is foremost
- "*Primum non nocere*": as a first priority, do no harm.
- Fiduciary duty: place interests of "ward" before one's own

Pressures I

- From managed care/insurer
- Formulary restrictions
- Obligations to managed care agency/panel in tension with obligations to patients

Pressures II

- Best drug vs. required first drug
- Vanguard Managed care: have to use Zoloft first
- Fiduciary threat

Pressures III

- Pressures from staff to medicate patient:
- Nursing home or inpatient unit
- To quiet rambunctious or violent patient

Pressures IV

- **Pressures to accept risk of cardiovascular problems, stroke, death, especially in elderly**

Pressures V

- Pressures to medicate for symptoms not responsive to medication

Binds I

- Psychosis:
- Olanzapine -> risk of weight gain
- Haloperidol -> risk of tardive dyskinesia

Binds II

- **Benzodiazepines: good and effective drugs *but*:**

Binds III

- Risks of abuse, dependency, withdrawal, car accidents, cognitive impairment, memory loss, etc.
- Thus misperceived as "dangerous"
- One doctor has sign: "No klonopin prescribed here"

Ethics questions: unanswered

- When is polypharmacy justified and when is it malpractice?
- Symptom-based prescribing
- What about the big picture?
- E.g.: obsessions in paranoid conditions

Ethics questions II

- Diagnosing (and treating) Bipolar Disorder in 2 y.o.
- Prescribing for small children
- Riley case in MA

Ethics questions III

- How prevalent is true ADHD?
- Over-diagnosed, under-diagnosed or just right?

Ethics questions IV

- Performance enhancement
- Alertness enhancement
- Examples from audience

Ethics questions IV

- Kramer P: *Listening to Prozac ®*
- Concept of “better than well” though not ill

Extremes

- Medication to facilitate sexual misconduct
- "Ecstasy" case

Extremes II

- Anti-psychopharmacology division of anti-psychiatry movement

Extremes III

- **Peter Breggin: <u>some</u> writings imply all psychotropic medications are brain-damaging poisons**

Extremes IV

- Black boxes on, e.g., SSRI for teens
- Increased risk of death vs. data implying S.I. without actual death

Risk Management I

- Critical role of informed consent
- Not a form, a signature or a moment in time

Risk management II

- Informed consent is a process of openness and honesty extending throughout the relationship

Risk management III

- **A competent patient can consent to completely experimental treatment**

Risk management IV

- Off-label prescribing and dosing requires both informed consent and documentation
- Avoid surprise

Risk management V

- Patients can comply or fail to comply;
- Mis-dose or overdose
- Ignore your advice ->

Risk management VI

- **BUT: a patient cannot make you practice below your own standard of care or ethical threshold**

Risk management VII

- “Breaking up is hard to do”
- You may have to consider termination if pt. makes you give bad care

Risk management VIII

- Hierarchy of responses:
- Explore issue
- Solicit questions
- Check “outside sources” (e.g., Internet)

Risk management IX

- Explain possible contingent termination/referral
- Set deadline

Risk management X

- Explore referral potential
- Increase focus on issue
- -> becomes only topic
- Specify consequences

Risk management XI

- Offer possibility of return if attitude changes
- Terminate and refer

- **Thank you**