Jenny M. Young, MSW, MA, Bethan Everett, MBA, PhD

Cause of death: Schizophrenia?

A practical approach is needed to make an ethically justifiable decision about treating the physical illness of a patient with a mental disorder.

ABSTRACT: Patients who have both life-threatening physical illnesses and severe mental disorders may deny they are ill. Frequently such patients fall through the cracks in the health care system and do not receive appropriate medical care for their physical illnesses. We propose a decision-making process for these complex cases that is informed by an ethical analysis based on the principles of autonomy, non-maleficence, beneficence, and justice, as well as by a review of the literature and relevant legislation in British Columbia. This process is congruent with the law and can be used to make ethically justifiable decisions about treating the physical illness of a patient with a mental disorder when a cure or meaningful extension of life is possible. Mentally ill patients should not be allowed to die solely because they have a psychiatric disorder and are unable to make informed medical decisions or follow through on necessary treatment.

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Health care providers are often immobilized when presented with patients who have both serious physical illnesses and mental disorders, and who deny that they are ill. In these cases health care providers may be unsure what to do or how to carry out what they think is right, and may even avoid decision making until the patient's health deteriorates. Cases such as those described below (fictionalized cases based on actual situations) arise on a regular basis. These individuals challenge us because of health system structures, stigma, and our discomfort with involuntary treatment.

Two complex cases

Jamie has schizophrenia and is HIV-positive. He denies being HIV-positive, has no regular medical care, and does not take medication for his HIV infection or his schizophrenia. Without antiretroviral therapy, Jamie's life expectancy is likely to be 3 years rather than the 15 or 20 years he would live with treatment.

Chao-xing has schizophrenia and has been diagnosed with early-stage breast cancer. She is being held in hospital under the Mental Health Act, and the Public Guardian and Trustee is her health care decision-maker. Chao-xing has refused further testing and treatment for breast cancer because she does not believe she is ill. Despite having received consent from the Public Guardian and Trustee to undertake testing, Chao-xing's oncologist refuses to proceed. These kinds of cases are complex for several reasons:

- Individuals who are seriously ill both physically and mentally and do not recognize they are ill can be doubly vulnerable.[1] They may be reluctant to see physicians and have difficulty communicating about a medical problem.[2] Many have limited access to primary medical care[3] and face discrimination when they present to emergency departments for primary care.[4]
- Strong evidence indicates that inequalities exist in medical care for

Ms Young is a clinical ethicist with Providence Health Care in Vancouver, BC, and an adjunct professor in the Department of Occupational Science and Occupational Therapy at the University of British Columbia. Dr Everett is a clinical ethicist with Vancouver Coastal Health and a clinical professor in the Department of Physical Therapy, the Department of Obstetrics and Gynaecology, and the Department of Pediatrics at the University of British Columbia.

mentally ill individuals.[4-6] Serious mental disorders already carry a stigma[4] that may be compounded by a second diagnosis such as HIV.[7] There is widespread devaluation of people with serious psychiatric illness,[4] and health care providers may make assumptions about the quality of life experienced by these individuals, possibly biasing their medical decisions. Some studies show that even if medical visits occur, quality of care is substandard.[6]

- Psychiatric and medical health programs are separated at both the systemic and bedside clinical levels. Mental health care providers commonly do not engage with medical issues and medical care providers often do not incorporate mental health treatment into a care plan.[6]
- Many medical care providers are uncomfortable carrying out treatment against patients' wishes, especially if there is resistance. Practical issues can also arise regarding how to carry out unwanted treatment when the patient denies being ill, refuses medication, or is homeless.
- All provinces in Canada have legislation related to the treatment of patients with both physical and mental illness. In British Columbia two relevant pieces of legislation apply: The Mental Health Act[8] addresses treatment exclusively for mental disorders, while decision making for physical illness falls under the Health Care (Consent) and Care Facility (Admission) Act.[9] A common misunderstanding is that physical illness can be treated under the Mental Health Act.

Decision-making process

How can we approach cases such as Jamie's and Chao-xing's using an ethics perspective? We propose using a practical decision-making process congruent with the legislation of

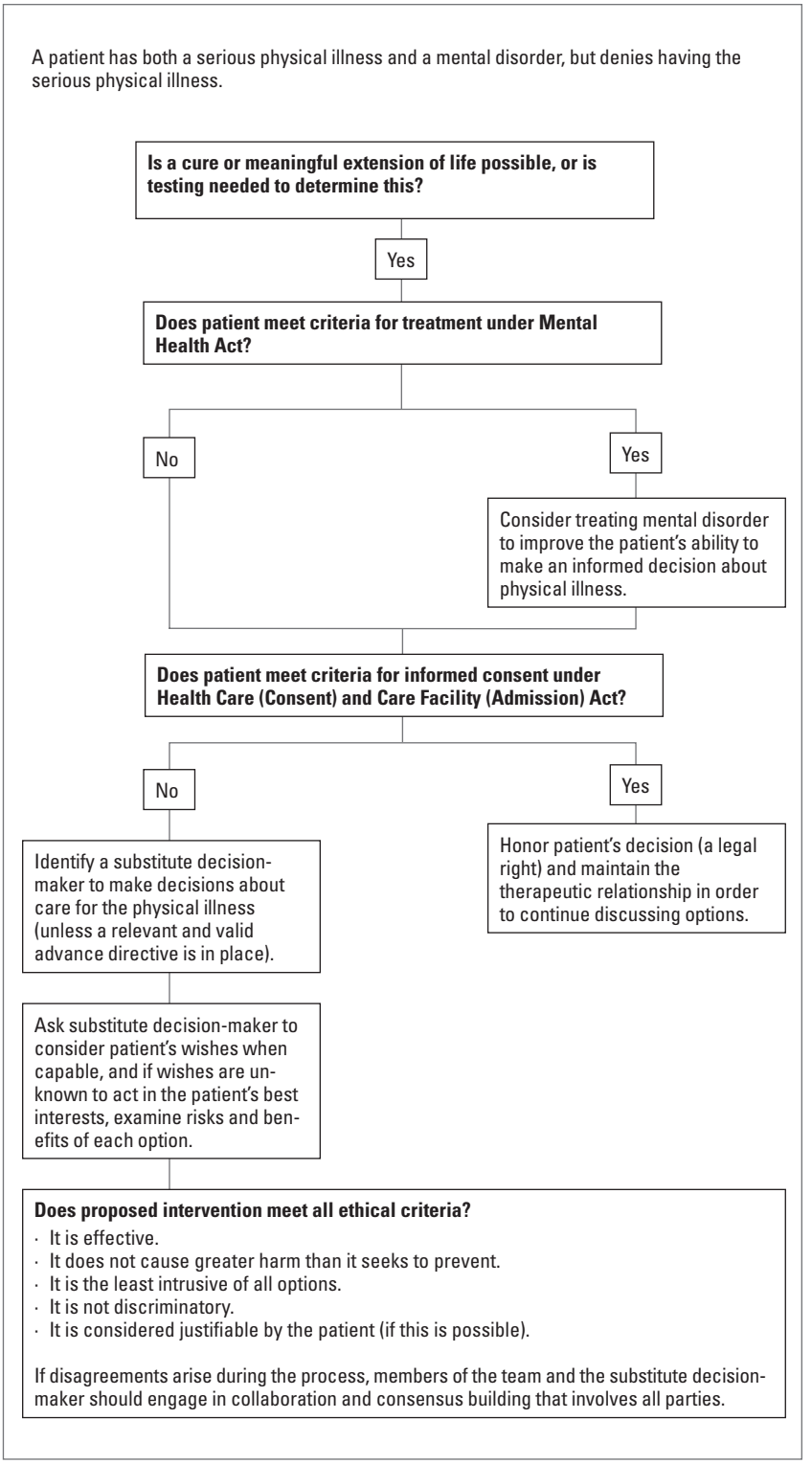

Figure. Ethical decision-making process for a patient with a serious physical illness and a mental disorder.

British Columbia that is informed by a literature review and an ethical analysis based on the principles of autonomy, non-maleficence, beneficence, and justice (**Figure**).

The first step in this process is to determine if a cure or meaningful extension of life is possible. If not, palliative care should be considered.

If a decision is made not to treat a physical illness in a patient with a mental disorder, the reasons for this decision must be clear and based on morally defensible criteria.

If a cure or meaningful extension of life is possible, or further testing is needed to decide this, the next step is to determine if the Mental Health Act criteria for involuntary treatment are met. If the criteria are met, treatment of the mental disorder should be considered with the goal of improving the patient's mental status so that making an informed decision about medical treatment is possible (i.e., patients can exercise their autonomy).

If treatment of the mental illness proceeds, the patient may become able to give informed consent regarding medical tests and treatments. If the patient understands the nature of the physical illness and treatment options, believes that this information applies to him or her, and is acting in an uncoerced manner, the patient's decision must be respected.

If the patient is not able to meet the above criteria for informed consent and a relevant and valid advance directive is not in place, the Health Care (Consent) and Facility (Admission) Act directs that a substitute decision-maker must be identified. This individual must first consider the patient's previous wishes when capable. If these wishes are not known, the substitute decision-maker is required to act in the patient's best interests by weighing the risks and benefits of each option with the goal of doing no harm and doing good. This is both a legal and an ethical requirement, and an exceedingly complex task at any time but notably more so when a patient does not understand and may well resist any decision made.

Ethical considerations

Despite the complexity of deciding on the best course of action, this task must be completed. A well-considered, ethically justifiable course of action must be chosen. To not do so is unjust because it leaves the patient responsible for a choice that he or she is not able to make.[10] The patient would, in effect, be denied care only because he or she cannot understand its importance. Jamie and Chao-xing are owed the same standard of care as those who are able to speak for themselves.

Although some may protest that treating Jamie and Chao-xing against their wills is coercive and an infringement of their autonomy and rights, depriving them of needed medical care may also be an infringement of their rights. To be clear, we are not saying that involuntary treatment is always desirable or permissible. Concern for the harms of involuntary treatment may, in fact, prevail in the decision-making process (e.g., intervention may not be the best option if there is an uncertain prognosis or an extensive treatment regimen is needed).

All options, including those that may be highly controversial, such as deceiving the patient, should be considered in complex cases. These options include not intervening and accepting that the disease will progress, using persuasion or incentives to encourage acceptance of treatment, involuntarily sedating the patient, and proceeding with treatment using covert means such as concealing medication in food. Certainly some of these options are not easy or ideal, and weighing the risks of harm and the possible benefits is challenging. The temptation to take no action may be great, but doing so without thought is indefensible. The decision to take no action medically *may* ultimately be best, but this can be determined only after careful consideration—not as a way to sidestep the challenge of deciding.

If a decision is made to provide medical care contrary to a patient's wishes, the proposed intervention should meet the following ethical criteria:

- It is effective in meeting the goals of care.
- It will not cause greater harms than it seeks to prevent.
- It is the least intrusive of all options.

- It is not discriminatory.
- It is considered justifiable by the patient (if this is possible).[11]

Interventions should also be proportional to the physical and psychological/emotional harms and the likely outcomes. If providing treatment for physical illness will make a significant difference to length of life, quality of life, or both, doing so has greater ethical justification.

Supportive strategies and other forms of accommodation during treatment, such as one-to-one companionship, a private room, or sedation, may be needed for interventions such as chemotherapy and dialysis.[12] These supportive strategies must be seen as essential components of care.[13] While not medical in nature, they are as lifesaving as transplants or ventilation because they provide the means for the treatment to be carried out successfully, and they should be accepted as equally valid. Not all patients require the same type of treatment, support, and accommodations. It is a fundamental tenet of justice that patients should each receive what they require to meet their health needs, not what their neighbors in different circumstances require.

There can be differences of opinion about what to do in complex cases. This is notably so when caring for a patient with both physical and mental illnesses, which usually necessitates a close working relationship between primary care, psychiatry, and other medical specialities, and often requires the input of an interdisciplinary team that includes experts in pharmacology, addictions medicine, ethics, social work, and law.[14] If disagreements persist within the team or with the substitute decision-maker, a process of collaboration and consensus-building that involves all the parties may prove useful.

Finally, imposing treatment against a patient's wishes may challenge the relationship between the patient and team members. All efforts should be made to establish and maintain a therapeutic relationship and ensure that clinicians have ongoing contact with the patient.

Summary

If a decision is made not to treat a physical illness in a patient with a mental disorder, the reasons for this decision must be clear and based on morally defensible criteria. Health care providers have a responsibility to help physically ill patients with mental disorders receive appropriate treatment, which may involve the use of supportive strategies and other accommodation. If a cure is possible, mentally ill patients should not be allowed to die solely because they have a psychiatric disorder and are unable to make informed decisions or follow through with necessary medical treatment.

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Competing interests

None declared.

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