

Bioethical procedure for decision-making in mental health[☆]



Procedimiento bioético para la toma de decisiones en salud mental

Dear Editor,

Psychiatric praxis often presents ethical dilemmas that professionals are unable to resolve using strictly clinical parameters. Some problems may arise due to confidentiality, the rejection of treatment or the use of coercive measures, etc.¹ Although several methodologies have been suggested,² they do not explicitly refer to psychiatric practice. We describe a bioethical methodology below that, although it is not a scientific method, does constitute a process for deliberation and assessment. It is based on *instrumental values* and *moral values*,³ the criterion for which is *prudence*.

It is first necessary to detect the *facts*. When we evaluate a clinical history we learn the diagnosis and treatment, etc., and we will specify whether the situation is acute or chronic. We will inform patients about different treatments and probabilities of success. More particularly we will inform them about drugs and psychotherapy, as well as electroconvulsive therapy, if applicable, given that although it has often been stigmatised, it is highly effective and efficacious in the case of some symptoms.⁴ Treatment therefore centres *on* and *is for* the person, and it focuses on their needs.

Secondly we identify the values, desires and preferences of the person. Although it is true that in patients with severe mental illnesses such as schizophrenia, *they may* find it hard to decide for themselves due to the intensity of their psychopathology, cognitive deterioration, lack of awareness of the disease (*insight*), etc., we know that schizophrenia does not *necessarily* reduce competence.⁵ Research into the evaluation of competence centres on a functional approach that studies cognitive processes: *reasoning*, *comprehension*, *appreciation* and *choice*.⁶ If the patient is not competent, we will have to check whether they have a document expressing their wishes for the future⁷ or if they have a legal representative. In the first case we must respect the document, while in the second case a decision must be reached by representation. Additionally it must not be presupposed that patients will not want to take part in decisions, given that a profile has been found that does wish to do so: a young person, with a high level of education, chronic symptoms, good cognitive skills for decision-making, dissatisfaction or distrust of treatments and/or professionals, and previous experiences of involuntary admission.⁸

Thirdly, all professionals have certain *duties*: to act according to duly analysed protocols or guides for good praxis.⁹ But there are also legal obligations: to gain informed consent, to respect the independence of competent patients, etc.

Subsequently the conflict in question has to be examined. It may arise between the patient and professional, the family and professionals or between professionals. One example may be the (of the "revolving door" type) who voluntarily rejects medication and in relapses presents behaviour that is self-harming or aggressive against others, so that compulsory outpatient treatment is requested. This requires a balance and ranking of the main ethical principles involved (independence, beneficence, justice and the absence of malice) in the ethical evaluation of the case.

This analysis has to specify the possible actions that can be taken, evaluating the advantages and disadvantages of each one while verifying that the wishes of those affected have been respected, as well as that the recommendations of guides and protocols have been applied. The final decision taken has to show that it really does have possibilities of achieving the proposed goal, that there are no morally preferable alternatives and that negative effects have been minimised. This therefore involves deliberating on the different courses of action, before reaching agreement that each intervention is *appropriate*, *good* and *just*.¹⁰

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