Ethical dilemmas during the treatment of patients with substance addiction

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Do you agree that ......

- the **therapeutic relationship** during the treatment of addicted patients are complex
- Poor motivation
- Third party involvement
- Legal issues
- Personality disordered
- Co-morbid psychiatric disorders
- Relapses
- Annoying defence mechanisms
- Social ‘poverty’
- Physical illnesses, STDs, pregnancies etc.
The complex Dr-Pt relationship

• Patients with a physical illness, mostly…
  – Experience their illness as threatening
  – Motivated by the need to ‘fight’ the illness
  – Wants the illness to end

• Patients with addiction
  – Experience their illness as threatening (at least deep ‘inside’)
  – Are painfully trapped between the dire results of this illness on their lives and the need to re-experiencing the drug effect.
  – Needs the effect of the drug to survive or feel ‘normal’
  – Motivated to keep the illness alive!

Ethical Issue
(Not)Respecting self-determination - autonomy
Example...

• The physician accepts patients with relapsing disorders – DM, hepatitis, ulcerative colitis, asthma, migraine and cancer – even with poor compliance!

• But the therapist may become very uncomfortable with failure to initiate sobriety, repeated intoxication and relapses - the very essence of the addiction (illness)!

Person – disease – therapist

“Do we really understand?”
This makes motivation....

• A difficult and challenging exercise!
• Should there be time limits?
• Should there be clear progress in motivational process? - unclear to me!
• What about regular relapses?
• What about patient decisions – controlled use - a process dictated by patient or the therapist?

What would the good moral action be? Respect self determination or stick to the program - “You are either desperate or you are full of nonsense!”
As therapist I.....

- like enthusiasm
- encourage myself to be resilient
- know the obstacles to sobriety
- have a core caring disposition
- must be on top of latest ‘best treatment’ skills
- must have unconditional acceptance for my patient? - We have to discuss this!
- must accept that even ‘best treatment’ can fail!
Anonymous wrote...

• “We counsellors have a lot of power! As authorities on this terrible disease of addiction, let us be careful to never use power for petty or vindictive ends. To never thoughtlessly reject a client. We can affirm our client’s sense of value, or we can damage them with a casual joke or comment at their expense. We can help them respect themselves, or we can tear down their self-esteem by treating them disrespectfully and unimportant. We have the power to do great good or great harm. Today, let me remember my power and take care to use it wisely!”
“Let us change that to....

• “As counsellors we touch the lives of others! As authorities on this terrible disease of addiction, let us carefully reflect on our attitude, knowledge, skills and insight into the complexities of addiction and specific client needs. To never thoughtlessly reject a client. Balance our scientific knowledge and developed skills with unconditional acceptance of the person as to accommodate his/her value systems as far as therapeutic possible. Always to be kind but firm. We can help them respect themselves, or we can tear down their self-esteem by treating them disrespectfully and as unimportant. We have the power to do great good or great harm. Today, let me remember my opportunity and take care to use it wisely!”
Ethical dilemmas of addiction

1. Respecting patient autonomy
   1. Capacity (understanding) (intellectual)
   2. Capacity (to react to that understanding) (Bio-psych-social component)
   3. Confidentiality
      • Third parties, work, family, community, legal issues
   4. Self determination – ethical debate on boundaries

Discuss the ‘good moral action’
Ethical dilemmas of addiction

2. The therapist patient boundaries
   1. When to start therapy – patient motivation
   2. When to stop therapy – Patient can not start sobriety
   3. When not to stop therapy – the complexity of the patient therapist relationship
Ethical dilemmas of addiction

3. Addiction science versus ‘traditional programs and therapists’
   – Define: “Registered addiction counsellor”
   – Programs: “One fits all!”
   – Ex- or recovering addicts as therapist
   – Special needs of the addicts/therapist relationship
   – Addiction and personality disorders
   – Addiction and co-morbid psychiatric disorders
Capacity

• Capacity (understanding) compromised by illness
  – Primary neuronal damage – alcohol dementia
  – Reward pathway changes – ongoing discomfort without the drug effect
  – Secondary infection, trauma, metabolic pathology
  – The psychology of the addictive process

• Capacity
  – Balance between understanding (intellectual insight) and the weight of the decision - bio-psycho-social and spiritual components
  – (Reminder) the seven ‘standards’ of competency

Ethical debate: Should addiction (this illness) render a patient with compromised understanding, then when should the ‘good therapist’ start treatment or until what stage should the therapist respect self-determination?
Patient Competence

1. Can communicate a decision
2. Understand immediate situation and consequences
3. Understand relevant information
4. Can reason
5. Can reason rationally
6. Give risk and benefit related reasons
7. Give a reasonable persons decision
Capacity to react to that understanding

- Emotion may render ‘understanding’ compromised
- Intoxication
- The ongoing neuronal pathway changes of addiction
  - Ability to ‘say no’ to harmful stimuli
  - Decisions motivated by past memory
  - Ongoing discomfort if drug effect not on board
- Inescapable lifestyle drives – sober lifestyle unknown
- Overwhelming need to escape emotional pain
- Surrendering to fatalism
Confidentiality

- Confidentiality as within a psychiatric hospital – but not all programs function within this standard.
- When can confidentiality be breached?
  1. Demand by statutory requirement – child/elder abuse, notifiable disease, if ordered by court – not lawyers or police or officer of the court.
  2. Justifiable in public interest – life of third party is at risk, emergencies
  3. With the informed consent of the patient
  4. When the therapist is the defendant or accused (info essential to the case)
  5. An overriding moral or legal duty/obligation to disclose – children, after death and other diverse situations
  6. HIV/Heb B status – Counsel, inform, get consent, if not communicate final decision to patient and make good notes.

    Always inform, ask for consent, communicate final decision and action, give only necessary information, make good notes and always weigh benefits burdens of actions.
Confidentiality

• What is so special about the addicted patient?
  – Often history of past abuse.
  – Often history of criminal behaviour – drug demand
  – Patient often ‘favour’ seeking – therapist exploiting
  – Third parties often ‘involved’ in every day lives of patients.
  – Third parties often involved in treatment
  – Therapists who are addicts in recovery must be aware of ‘sharing’ or ‘identifying’ too much with patients – could be inappropriate for that patient and ‘backfire’
  – ALWAYS discuss ‘group’ confidentiality – group obligation
  – ALWAYS discuss limitations of confidentiality early in treatment for it may strengthen trust and honesty not jeopardise.

Weigh respect for autonomy with that of duty to care and justice!

Should serious harm threatens the patient our duty to care should be priority!
Patient - Therapist Boundaries

• Very seldom that the patient would initiate Rx
  – Coerced into Rx by family, work and courts
  – Not so ‘voluntary’
  – Tail end of withdrawal
  – Should we accept ‘poorly’ motivated patients? – of course!

• When to stop therapy
  – Define unsuccessful or lack of progress, lack of insight
  – Define ‘unacceptable’ treatment behaviour
  – Group settings must have boundaries

• When not to stop
  – Slow process – but a process
  – Personality disorder makes group work difficult
  – How long is a mile?
Personal boundaries

• Unconditional acceptance as far as possible
• Respect differences – gender, age, culture, religion, tradition, social diversity etc
• Honesty and free sharing – but respect privacy – avoid unnecessary personal history and detail
• Beware of personal relationships!
• Beware of sexual exploitation
• Always kind but firm
• Each should take ownership of his/her behaviour
• Communicate personal boundaries early
• Communicate discomfort early
• Be aware of negative attention seekers, over valuation and over familiarity.

Know and avoid the cognitive, emotional and behavioural traps!
Addiction science versus ‘traditional programs and therapists’

• Science has broad us closer to outcomes based programs

• ‘Traditional programs’: Programs and therapists may get stuck in the past – Ideologies outdated – some of it had worked in the past. Some programs not balanced. rigid, inflexible and cannot be adapted.

• Therapists in recovery – “What worked for me must work for others.”

• Ethics: Bad sciences is unethical!
  – Programs should be accredited
  – Therapists should be qualified
  – Programs should be monitored
  – Addiction programs are in the realm of medicine (science) with the multi-professional team as treatment instrument.
Ethics of care

• Care is not merely the result of a program, it is not an outcome, it is the road travelled with your patient.

• Carefully reflect on the word ‘enable’
  – To equip the patient – encourage – empower
  – To ‘over’ Rx – to hang on for too long – to disempower the patient to take ownership of illness
  Indeed a fine balance!

• Allow the patient to take ownership of illness

• Discernment: The quality of being able to grasp and understand what is truly worth doing or what is best for the patient. Good moral human motive (insight) to act on the best needs of others.
Addiction treatment teams....

• Faces many novel, complex patient/illness issues.
• Often there are no clear treatment answers - we have to make value decisions.
• Should never get isolated – ongoing learning
• Touches the lives of very vulnerable people
• You are special people!

END