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Case Report: Ethical Dilemmas Faced by Psychiatrists When Assessmenting and Treating with a Ciminal History and Mental Illness

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ABSTRACT

Establishing the validity of information gathered from patients with antisocial tendencies can be challenging, particularly when no immediate corroborative sources of information are available, and a long-term history of criminal activity is suspected. With the advent of technology such as the internet, other means of gathering information is at the treating clinician's disposal. The handling of information gathered from non-certified sources of information is a delicate matter, and care should be taken in how this information is verified, disseminated and used to optimize the outcomes for the patient and other parties involved. Further, the treating clinician may be faced with obstacles in determining the true risk of harm by such patients to themselves and others, and subsequently, a range of conflicting ethical issues involved in the patient's management plan are raised. These include respect for the patient's confidentiality, maintaining equal treatment of the patient relative to other patients on the ward, ensuring that no harm comes to the patient, and a duty of care to external parties including the general public.

Key Words: antisocial personality disorder; corroborative information; risk of harm assessment; ethical; dilemmas.

A 52-year-old man voluntarily presented to a psychiatric unit in NSW, Australia after an unsuccessful suicide attempt. He reported a history of severe depression that developed following the resection of a frontal lobe meningioma a decade ago. He carried no personal identification and reported having no previous criminal record. He stated that he had relinquished all his belongings and all traces of his life at the time of admission.

Prior to the resection of his tumour, he held a high-ranking government position and noted that his planning and decision-making abilities had diminished after the operation, culminating in the loss of his job. He reported that this coincided with his father's death, and when his wife and sons abandoned him.

According to the history, this chain of events contributed to, and exacerbated his depressive symptoms. He maintained that treatment with several antidepressant medications and a course of ECT were ineffective, and that he first attempted suicide four years ago by cutting his wrists. He reported being physically abused

by his brother during childhood, and described his parents as Holocaust survivors who suffered from PTSD. On mental state examination, he did not feel that life was worth living.

Due to serious concerns about the risk of self-harm, and because of the lack of relevant medical records and means of identification, he was admitted to hospital for further evaluation and assessment.

Further investigation

In the absence of alternative sources of information, an internet search using the patient's name was undertaken by staff at the psychiatric unit. This yielded information from various Australian and international newspapers and blogs about a con-man of the same name from Australia, where scam victims described their experiences and were enquiring about his location.

An online article from four years ago in a reputable newspaper included a picture of a man whose first and last names matched those of the patient. Although the picture was not of high quality, it was possible to identify the patient as the man in the article. The article revealed that the man had a history of admitting himself to psychiatric units, claiming to have suicidal ideation and depression when his illegal money-making schemes (scams) were not generating income, or were attracting unwanted attention from the police.

Ethical issues, clinical judgements and corroborating the information

With this new information gathered from the internet, several corroborative questions were raised:

- How reliable was the article in confirming the patient's identity and his criminal activities?
- How much truth did the story relayed by the patient hold?

In addition, ethical practice issues pertaining to doctors' obligations in this situation were raised. Of particular importance was determining whether the patient could justifiably be held in a psychiatric unit under the Mental Health Act. In order to manage the patient's situation safely at this point, clinical and legal questions that would guide decision-making had to be answered:

- What was his current living situation and social network?
- Was he really depressed?
- Was he at immediate risk of self-harm?
- Was he suffering from a personality disorder, and if so, how had it been managed?
- What was he trying to gain from presenting to the hospital?
- Was he a person of interest to the police?

Perhaps the most significant ethical dilemma lay in determining whether the patient was an immediate or potential risk to others, as this would be directly affected by the clinical and legal judgements made at this point.

A psychiatric unit in Victoria, Australia where the patient had previously presented, as mentioned in the article, was contacted. The patient was found to have been diagnosed with depression, narcissistic and antisocial personality disorder, and a persistent pattern of admission to, and discharge from psychiatric units throughout NSW and Victoria. Contact was also established with the patient's brother, who verified the patient's identity and history of criminal activity. Further enquiries made to the Australian Federal Police (AFP) concerning the patient's legal status confirmed his involvement in domestic and international scams, including instances of masquerading as a medical student and a fighter pilot.

Diagnosis and management

While psychopathy per se is not a clearly defined clinical diagnosis, it is most strongly correlated with Antisocial Personality Disorder (APD) in DSM-IV-TR or Dissocial Personality Disorder (DPD) in ICD-10 (American Psychiatric Association, 2000; Hare, 2003; World Health Organization, 1992), both allowing the criteria for these disorders to be used interchangeably with that of diagnosis and assessment of psychopathy. The patient appeared to have displayed: 1) callous unconcern for the feelings of others, 2) a gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations, and, 3) incapacity to sustain relationships, though having no difficulty in establishing them. These fulfil at least three of the required traits for a diagnosis of Dissocial Personality Disorder (World Health Organization, 1992). The patient also displayed numerous Factor 1 personality traits found on the Hare Psychopathy Checklist-Revised (PCL-R), including glibness and superficial charm, pathological lying, cunning/manipulative nature, lack of remorse, lack of empathy, and the failure to accept responsibility for his actions (Hare, 2003).

Surprisingly, whilst the patient was caught repeatedly for his scams, victims rarely took any legal action against him. Some victims even expressed the belief that he would have been very successful had he utilized his intelligence in legitimate activities. Although the patient was questioned by the AFP within the unit, no charges were brought against him.

The more challenging question regarding the risk the patient posed to himself remained unanswered. He clearly fit the profile of a lonely male who was homeless and unemployed with no immediate social support. Under the State Mental Health Act, he was scheduled for two weeks on grounds of his high risk for suicide, and his long and persistent history of harm to others (NSW Mental Health Act, 2007).

The patient's management plan included:

- Thorough assessment of the presence of a mood disorder, with emphasis on depression

- Continuing antidepressants for two weeks and re-evaluating changes in mental state
- Organizing social support and safe housing prior to discharge
- Notifying other psychiatric units in the country about this man

It was determined that the use of psychotherapy, including CBT, was contraindicated due to the patient's personality disorder diagnosis (McGauley et al, 2007). The patient was subsequently weaned off the SSRIs initially prescribed, and advised to attend short-term psychological consults to develop practical methods for dealing with stressful events.

Discussion

It is rare for individuals with a criminal record and mental illness to present voluntarily and repeatedly to psychiatric units. This case highlights both conceptual and practical ethical dilemmas faced in forensic psychiatry, as well as in the assessment and management of patients with concurrent personality disorders and criminal behaviour.

The four principles plus scope approach provides a neutral framework for the analysis of these ethical issues (Gillon, 1994). The principle of respect for patient autonomy requires that consent and confidentiality of the patient be upheld. In this case, the reliability of the patient as a historian was questionable due to the lack of information that supported his allegations, and the patient only willingly admitted to his past actions after being confronted with evidence. While he was not provided the opportunity to consent to staff seeking alternative sources of information, details of his criminal activity may not have been revealed if external corroboration had not been undertaken. The ease with which personal information was obtained from various other sources including the AFP illustrates the privilege held by doctors, and the discernment required in accessing and handling confidential information. Patient autonomy has to be weighed against the prospect of unveiling information that would aid diagnosis or management, and decrease the risks posed by such patients to themselves, the public and staff. In this case, it would have been impossible to responsibly develop a reasonable management plan without further information.

Respect for justice requires that the patient be treated equally to other patients while upholding distributive, rights-based and legal justice. It is noted that the patient's history of criminal activity commenced only after resection of his tumour, making it possible that his change in behaviour is a sequelae of the frontal lobe lesion. Clinical and legal judgements with regards to whether the patient could be classified as being of 'sound mind', and hence, held responsible for his deceit and criminal activity, and whether he could be treated as equal to other patients are therefore relevant. In addition, although a significant amount of information was gathered from the internet about the patient, it was difficult to ascertain the reliability of this information. In this instance, this further complicated the psychiatrists' ability to clinically assess him with neutrality.

The principle of non-maleficence mandates that harm should not be done to the patient. In this case, the issue of preventative detention was raised. While the patient had a history of harming others, none of his victims had pressed charges against him in a criminal court, hence the dilemma of detaining the patient for the safety or benefit of others, or to report the patient's whereabouts to the police remained an ethical and legal question. While the legal issue was resolved via informing the police of the patient's admission, addressing the ethical dilemma involves weighing harm to the patient versus harm to his 'innocent' past and future victims (Adshead, 2000). This in turn raises the question of whose benefit takes precedence, and how to decide. The principle of beneficence is also difficult to uphold in the management of patients with psychopathic personality disorders, since treatment remains controversial, and conventional cognitive therapy and behaviour modification techniques have been found in some cases to facilitate a patient's ability to manipulate others (Harris & Rice, 2006).

The issue of scope relates to the fact that decisions made by psychiatrists affect third parties, and that they have a duty to protect these parties, although it remains unclear whether this duty extends to the general public. In this case, the patient was discharged without psychotherapy and enforced follow-up, and the relevant history suggests that he is likely to resume dishonest activities.

Conclusion

In patients with antisocial tendencies or other psychiatric complications, assessment of true risk of harm to self and others is challenging, and may present an ethical practice dilemma. If no corroborative information is available during initial assessment, and the validity of information provided by the patient is in doubt, other sources of information such as electronic media and criminal records can be investigated. However, it is critically important to ensure that a balanced judgement based on the consideration of ethical, clinical and legal issues is achieved, that will optimize the outcomes for the patient and other parties involved. These issues, which can entail a series of complex clinical judgements in individual cases such as this, include respect for the patient's confidentiality, maintaining equal treatment of the patient relative to other patients on the ward, ensuring that no harm comes to the patient, and a duty of care to external parties (e.g., the general public).

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In the past three years Dr. Malhi has served on a number of international and national pharmaceutical advisory boards, received funding for research and has been in receipt of honoraria for talks at sponsored meetings worldwide involving the following companies: AstraZeneca, Eli Lilly, Janssen-Cilag, lundbeck, organon, Pfizer, Ranbaxy, Servier and Wyeth.

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