

Four questions to guide clinical decisions

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Consider the facts, the patient's hopes and fears, and the concerns of others when making treatment recommendations

Psychiatrists often are asked to help medical colleagues deal with difficult patients. A typical situation involves a patient with a psychiatric diagnosis who refuses medical treatment. Asking 4 questions—adapted from the 4-quadrant model proffered by Jonsen et al^{1,2} for ethical decision making in medicine—will help you make pragmatic and helpful treatment recommendations.

1. What does psychiatry have to offer?

Consider all the psychiatric facts:

- Are you treating a well-established psychiatric syndrome or mere symptoms?
- What are all your treatment options?
- Which psychiatric treatment would be optimal?
- What is the prognosis for each psychiatric intervention, including no treatment?

2. What does the patient want? Patient-centered medicine tries to work out a competent patient's preferred course of action. Even for patients deemed incompetent and under court-ordered guardianship, find out what might be acceptable to avoid confrontations. For example, obtaining a guardian for a patient with dementia who refuses hemodialysis is pointless unless everyone involved is willing to restrain and sedate the patient 3 times weekly for the procedure.

3. What kind of life does the patient both hope for and fear? Quality of life features prominently in patients' minds. Make sure you know how each of the proposed psychiatric interventions might affect the patient's quality of life. Make explicit what the patient fears. For example, do not assume a patient

with human immunodeficiency virus/acquired immune deficiency syndrome who wants to continue to live necessarily wants or is willing to take antiretroviral medications.

4. Who and what else matters? Clinical decision making does not occur in a vacuum. Many stakeholders (people and "systems") will have legitimate concerns: family members will not take a patient back; hospital policies do not allow use of a particular drug; state laws must be obeyed. In addition, physicians have their own biases regarding what should or should not be done based on their worldview.

Asking these 4 questions in a structured way will not necessarily lead to "the solution." It will, however, ensure that important areas to consider are all made explicit, and all stakeholders and their concerns were heard. For a case study that illustrates how these questions could be used in practice, see this article at CurrentPsychiatry.com.

References

1. Jonsen AR, Siegler M, Winslade WJ. Clinical ethics: a practical approach to ethical decisions in clinical medicine. 7th ed. New York, NY: McGraw-Hill; 2010.
2. Sokol DK. The "four quadrants" approach to clinical ethics case analysis: an application and review. *J Med Ethics*. 2008;34(7):513-516.

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Visit this article at CurrentPsychiatry.com for an example of how these questions could be used in clinical practice

Psychiatric decision making: Applying the 4 key questions

Mr. A is a 55-year-old homeless man with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) who displays prominent disinhibition and witzelsucht—brain dysfunction marked by telling inappropriate or irrelevant jokes. He rarely misses clinic appointments and when acutely ill, seeks medical attention and cooperates with inpatient treatment. But he has a long pattern of poor adherence to HIV medications—in part as a result of being homeless—and mostly rejects outreach efforts (eg, visiting nurses to help with adherence); no arrangement has lasted more than a few months. Psychopharmacologic interventions have made no appreciable difference in Mr. A's frontal impairment. He declines further treatment with psychotropic medications but agrees to take antiretroviral agents.

After Mr. A is diagnosed with thyroid cancer, the medical team recommends a total thyroidectomy; a partial thyroidectomy with close follow-up and a potential second surgery is discussed as a reasonable alternative. Mr. A opts for total thyroid removal.

Mr. A's medical team asks you if he should be admitted to a psychiatric hospital to treat his disinhibition with the goal of improving his ability to adhere to a lifelong thyroid-replacement medication regimen.

Using the 4-Quadrant Method

1. What does psychiatry have to offer?

From the psychiatric viewpoint, the most critical feature is Mr. A's "frontal lobe syndrome" with elements of disinhibition, executive dysfunction, and impairments in persistence and long-term planning, likely secondary to severe past alcohol and drug use and long-standing, poorly controlled HIV infection. This neurocognitive dysfunction has been stable for many years, which argues against a progressive process that could be interrupted. Although further trials of psychotropics could be proposed, it is uncertain if any intervention could improve Mr. A's medication adherence. Even assuming a judge would authorize

an involuntary admission and compulsory treatment—which would be required in Mr. A's case because he has refused further psychiatric treatment—no psychiatric treatment would reverse his executive dysfunction in a reliable and timely manner. Better adherence to HIV medications might offer the best chance for improvement, but Mr. A would need to be in a supervised setting indefinitely, assuming such a setting exists and he agrees to be essentially immobilized.

One could argue Mr. A might be incapable of making some treatment decisions, but simply recommending and pursuing guardianship is not the purpose of this quadrant.

2. What does the patient want?

Mr. A's preference is not to take psychotropic medications because none helped in the past. His medical choice is clear: to have a total thyroidectomy. He is afraid of dying, explaining, "I don't want them to leave any cancer in there."

3. What kind of life does the patient both hope for and fear?

Although Mr. A generally rejects excessive intrusion into his life by the medical profession, he nevertheless takes HIV medications (albeit intermittently), wants surgery, and says he will take thyroid replacement medications. He is willing to tackle the issues he fears. He readily agrees to curative surgery for his thyroid cancer because he fears nothing more than dying of cancer.

4. Who and what else matters?

Besides the patient, the 2 people who matter most are the primary care doctor and the endocrinologist, who are concerned about Mr. A's ability to take thyroid replacement therapy reliably. Their shared concern is based on the patient's history of intermittent adherence to antiretroviral medications. Family does not figure in to Mr. A's situation, as it

usually does in cases such as this when family members are available to help the patient negotiate medical decisions.

Recommendation

The crux of the analysis is recognizing that a psychiatric intervention in the form of medication trials—even if a first-line treatment were clear—would be of uncertain benefit and involuntary psychiatric hospitalization would not accomplish the long-term goal of remediating Mr. A's executive dysfunction. In the final analysis, the patient's medical team accepted Mr. A's wish

for optimal medical treatment now, while accepting the uncertainty of his ability to follow through later.

Clinical outcome

Mr. A underwent a successful total thyroidectomy and is believed to be cancer-free. He continues to work with his infectious diseases doctor and endocrinologist; as expected, his adherence to thyroid replacement has been suboptimal. However, through occasional "loading doses," Mr. A has managed to remain only mildly hypothyroid with no clinical sequelae.