consent; however, permission must be received from a responsible clinical administrator. If the patient's condition was not life-threatening, the emergency physician could offer the patient admission to a hospital where a priest could be invited to discuss the patient's decision.

In conflict situations between a physician and a patient, the life of the latter depends on the ability of the physician to reinforce the need for medical intervention, the ability to avoid conflict situations, as well as the ability to obtain an informed consent from the patient or relatives for authorization of a medical intervention. The Ministry of Public Health of the Russian Federation has developed guidelines for providing medical care, formulated the standards of emergency care to children and adults in a variety of situations. They serve as a physician's practical guide. However, when fulfilling their duties, physicians must uphold ethical standards. The case-study method contributes to the improvement of professional competency, and the enhancement of responsibility of emergency physicians for the care provided, health and life of patients.

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## UNSOLVED ETHICAL PROBLEMS OF THE INVOLUNTARY PSYCHIATRIC CARE


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*Still, there are often situations which are moral-ethical dilemmas in establishing of relations between a doctor and a patient while providing psychiatric aid, however, strict regulation of this sphere by the law restricts providing effective aid to the patients, refusing treatment. As the mental disorders can violate the social functioning of the individual, purposiveness of behavior, the ability of critical evaluation of their condition and making correct decisions, the situation becomes a "problem" when a patient refuses treatment. In psychiatric practice, it can happen*

*when the patient's ability to understand the information, percept it efficiently, and make an informed decision causes doubt, it actualizes the problem of deteriorating mental state of a person suffering from a mental disorder, but the legal basis in involuntary psychiatric care is not sufficient. In order to study the complementarity of juridical, clinical and ethical regulators of psychiatric service`s work by means of case study we analyzed and researched 150 medical outpatient department cards of the patients which are provided with specialized psychiatric aid in outpatient hospital. The article describes typical cases when patients refuse meal thus showing inefficiency of juridical regulators, concerning psychiatric service. Therefore, there is a necessity of refining the law, concerning the reasons of involuntary hospitalization and renunciation while providing psychiatric aid.*

*Keywords: mental disorder, mental health care, the right of psychiatry, ethical issues in psychiatry.*

## НЕРЕШЕННЫЕ ЭТИЧЕСКИЕ ПРОБЛЕМЫ ПРИНУЖДЕНИЯ ПРИ ОКАЗАНИИ ПСИХИАТРИЧЕСКОЙ ПОМОЩИ

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*При оказании психиатрической помощи, по прежнему часто встречаются ситуации, являющиеся морально-этическими дилеммами установления оптимальных отношений между врачом и пациентом, а жесткая регламентация данной сферы законом, ограничивает оказание качественной специализированной помощи пациентам, отказывающимся от лечения в силу недостаточной способности понимать информацию, обрабатывать ее рационально, и принимать обоснованное решение, что значительно нарушает социальное функционирование личности, целенаправленность поведения, способность к критической оценке состояния своего здоровья и приводит в отдаленном периоде заболевания к неблагоприятным исходам для больного. С целью изучения комплиментарности правовых, клинических и этических регуляторов работы психиатрической службы*, с *помощью метода кейс-стади, нами были изучены и проанализированы 150 медицинских амбулаторных карт больных, получающих специализированную психиатрическую помощь в ГБУЗ «Волгоградский областной психоневрологический диспансер». В статье описываются типичные клинические случаи, иллюстрирующие неполноценность правовых регуляторов, важность дальнейшего совершенствования нормативных актов, регламентирующих работу психиатрической службы. Сделан вывод о необходимости пересмотра оснований для недобровольного оказания психиатрической помощи и порядка ограничения сферы принуждения при работе с лицами, страдающими психическими расстройствами.*

*Ключевые слова: психическое расстройство, психиатрическая помощь, право в психиатрии, этические проблемы психиатрии.*

Modern rate of development and transformation of health care dictates necessity of dynamic conformity of quality of mental health care and demands of permanently changeable modern society. Increases requirements to professionalism and ethical medical principles as guarantees for the protection of patients' rights [6, 12]. As the emergence and development of bioethics was largely a response to the "problem situation" in modern medicine, in deontological aspect of this problem, it is often seen in the "Bioethics" journal [2,3, 5,9, 12, 13]. This ethical challenge of the psychiatrist, as limiting range of physical coercion in providing of mental health care to the restrictions, determined by medical necessity, in some cases is difficult to be achieved. As the matter of fact, the greatest difficulty is noted, when the patient refuses treatment in situations which are not connected with the immediate danger to himself or others, as involuntary psychiatric care is strictly limited by the Law of the Russian Federation dated July 2, 1992 N 3185-I «On psychiatric care and guarantees citizens' rights in its providing"(the Act), articles 23, 24, 25, 29 [4]. The legislation, which has been significantly changed over the decade and is now regulating relations in the field of psychiatry, considerably enhanced procedures and regulations of work with mentally ill citizens [8, 9]. Gradually changing paradigm of relations "the patient-doctor" from "paternalistic" model to the "informed consent", which excludes the dominant role of the psychiatrist in solving the medical, social and living, moral and ethical issues, shows less effectiveness of the safety and conservation of patient's life. Considering the extremely wide range of nosology's in psychiatry, which are characterized as extremely serious changes in the psyche and the borderline states, the choice between paternalistic and non-paternalistic approach should be carried out strictly individually and based on an accurate diagnosis and may be changed in accordance with the patient's treatment and rehabilitation [7, 15].

As the mental disorders can violate the social functioning of the individual, purposiveness of behavior, the ability of critical evaluation of their condition and making correct decisions, the situation becomes a "problem" when a patient refuses treatment. In psychiatric practice, it can happen when the patient's ability to understand the information, percept it efficiently, and make an informed decision causes doubt, it actualizes the problem of deteriorating mental state of a person suffering from a mental disorder, but the legal basis in involuntary psychiatric care is not sufficient.

Uncommon situations where a psychiatrist, guided by moral and ethical principles in the interest of the patient, make a lot of effort to obtain consent to treatment,

but sometimes it doesn't happen. By receiving no consent for therapy, physician is clashed with a fact that there is a lack of legal basis for involuntary psychiatric care, in spite of a full awareness of the fact that the treatment of a mental disorder must be in the interest, first and foremost, of the patient. In order to study the complementarity of legal, clinical and ethical regulators work of psychiatric services, we used the method of case study analyzing 150 medical outpatient department cards of the patients which are provided with specialized psychiatric aid in outpatient hospital. There are revealed typical cases in which the patient is in need of psychiatric help, but did not give consent to it, and the doctor, in spite of the need for treatment, has no legal basis for involuntary psychiatric care.

**Case 1.** Female patient I., 16 years. For the first time applied to a psychiatrist in the outpatient hospital on the gastroenterologist's recommendation. Complained of depressed mood, irritability, tearfulness, fear gain wait, increased appetite.

Family psychiatric history is unremarkable. The patient is the only child in the family. Early development was without features, suffered frequent catarrhal diseases. She attended preschool institutions, adapted well. Went to school on time, good academic performance. Tells about the long conflict with the class teacher because of “the teacher was very picky to the individuality of the student", that`s why she plans to change the school. The patient describes herself as a shut-in person, "I find it hard to make contact", does not have any friends at school, has a friend on the social network, communicates well with only classmate, but only in social networks. She graduated from music school. In leisure time enjoys watching the teen series. The patient lives with her mother, parents divorced when she was two years old. There are no relationship with father. The relationship with mother deteriorated when the patient started purposely lose weight.

The mental state changed about a year ago, when she started to dislike herself, began to consider her body to be fat (having a weight of 55 kg with height 162 cm). In order to reduce the weight limit in food, "sitting on a diet", then "got frustrated and began eating everything". When overeating occurred she vomited, then the patient began to arouse vomiting purposely, sometimes several times in. In the same period of time, for the purpose of weight loss she took fluoxetine without prescription of physician, laxatives and diuretics, as a result she lost 10 kg over a month. There occurred weakness, constant anxiety, depressed mood, tearfulness, irritability. Drank bisacodyl 10 tablets once, every three days. Due to violations of intestinal discharge, weakness, she stopped attending school. On mother’s order the patient attended internists-physician ambulatory. Also was consulted by ophthalmologist: retinal angiopathy hypotonic type. Neurology: The syndrome of autonomic dysfunction. Endocrinology: diffuse goiter. Easy-fat protein deficiency. There was a gastroenterologist consultation. The diagnosis: superficial gastritis, bulbit, duodenal reflux. Gallbladder dyskinesia on hypotonic type. Irritable Bowel Syndrome. Amenorrhea within three months.

Because of the regular "breakdowns" and "overeating" inflicted self-cutting on the inner surface of the forearm, thigh, abdomen - "punishing herself". On mother's order turned to the mental outpatient hospital, the patient was hospitalized in psychotherapy department of a psychiatric hospital by her own consent. The mental state: right-oriented, neat appearance, low mood, voice is quiet. Complains of "bulimia" - overeating episodes, after which she caused vomiting, constant anxiety during the day, depressed mood and activity. Periodically notes bad sleep at night. Emotionally restrained. Thinking is logical and consistent. Judgments emotionally are dependent, immature. Memory and attention are not violated. Disorder of perception, suicidal tendencies does not exist. Configured for recovery, but at the same time talking about the undesirability of weight gain.

At the department she was examined by a physician: Protein-energy malnutrition II stage. Symptomatic hypotension. Chronic iron deficiency anemia. Psychologist: moderate violations of voluntary attention, the condition of clinical significant anxiety and depression, introverted personality, with a predominance inhibited character traits. At the department the patient adapted, communicated selectively as needed, mainly sit in her room with computer. In conversations she complained on constant hunger and the thoughts of food that are "necessary to restrain, suppress". The purpose of their treatment considered "remove the feeling of hunger", "cure bulimia". Ate about half portions of the main meals. During the treatment there was a decrease of anxiety, the sleep improved. Mental status in dynamic: in a conversation passively responds to the questions, does not show initiative, a distance in a conversation with the doctor,

benevolent. In an interview said that the information about the methods of weight loss she got from the internet, from a single virtual friend who has the same problem. Believes that no one understands her, family forces me to eat, "very afraid of getting even a kilogram". Thinking is consistent, with logical relations, judgment, superficial, infantile. Cognitive impairment is not revealed. Mood is decreased. BMI (body mass index) of 16, aims to lose weight up to 36 kg. Criticism to the state is extremely formal. Aggressiveness and suicidal tendencies are not revealed. Diagnosis: depressive episode of moderate severity with anorexia nervosa.

The patient oppressed by his staying in hospital, and ten days later, due to the categorical refusal of further treatment in the hospital, was discharged. Reported that she was determined to continue treatment in an outpatient department. However, the patient has not been visiting the outpatient department during year after discharge. Despite the presence of body weight deficit and the patient's wish to continue losing weight, we do not have enough legal basis to assist her in the voluntary order. Eating disorders of the International Classification of Diseases Tenth Revision (ICD-10) are considered borderline mental disorders in which there is usually no need for involuntary hospitalization [6]. However, the duration of the observation over 10 years with anorexia nervosa mortality is 30-40% [1] and increases with the duration of follow-up. The causes of death in anorexia usually due to undercurrents infections or suicide [16, 17]. In Russia, the death rate from anorexia nervosa was lower, as there are well-developed system of dispensary and involuntary hospitalization of patients with cachexia. Clinical and social importance of the disease is determined by the fact that it is typical for young people, extremely maladaptive pathology. Currently, reasons for the involuntary hospitalization of patients with anorexia nervosa and bulimia are considered expression of cachexia, which, on the one hand, is not always on the bulimic stage of the disease, and anorectic stage often pronounced a form, that prevents the placement of patients in psychiatric hospital due to the necessity of hospitalization in somatic hospital for vital indications.

Proper organization of mental health care, taking into account ethical and deontological principles in this case is not possible without addressing to the legal issues. Taking into account threat to the life, it is necessary to develop a clear indication for involuntary hospitalization of patients with anorexia nervosa. The criteria for involuntary hospitalization can be considered a medical condition: BMI, activity, body temperature, pulse, blood pressure, presence of edema, vomiting frequency, biochemical parameters: the level of potassium, calcium, iron, albumin, weight dynamics in the course of treatment, or mental (gross psychopathic behavior aggression, a complete rejection of food, episyndrome, delusions).

**Case 2**. Patient K, 65 y.o. Family psychiatric history is unremarkable. Grown up in a full family. There were no inadequate behavior or conflicts noticed in childhood. Studied at school well. After graduating from 8-th grade she obtained a profession of engineer. Had been working as an engineer for 57 years until retirement. Widow, has a daughter who lives separately with her own family. The patient suffers high levels of blood pressure. The first psychotic disorders have been noticed a year ago, when she began to feel “the insects crawling under her skin, unbearable itching”. She thought that fleas of homeless animals were the reasons of those symptoms. Also, she felt a mite bite. Because of these symptoms she consulted a dermatologist and got a treatment, however there was no result. To exterminate the insects, she started to use different materials: «I poisoned them with benzyl benzoate, peroxides, acid, e.c». Still there was no relief. Gradually, her physical and mental state started to worsen. She began feeling «not only the insects but movements but also changing location of them». She felt that «one of that insect fixed to her spine and started to grow up to 5 cm». Had a thought about getting rid of it by undergoing an operation. Refused day meal so that “not to feed the insects inside”. Lost weight up to 20 kg during two months. Numerously consulted infectious diseases specialist in Volgograd and Moscow. There were carried out a lot of expensive diagnostics but no infectious pathology had been revealed. MRT revealed thoracic spine osteochondrosis. Because of the patient`s strong belief in the origin of parasitic diseases, she threw out all carpets and clothes where, as she thought, all the insects might hide. The endless itching and moving inside was the reason of low mood and complete disorder of sleep. She started to notice that “the insects could crawl out of pores, saw their paws, pick them into the paper and carry them doctor”. After being consulted by a dermatologist and infectious disease physician, she was sent to psychiatrist. Mental Status

Exam: Consciousness is clear, oriented in space and time, cooperative, at the beginning of conversation the patient is anxious, apprehensive. Fixed on her state, insists on consultation of an infectious disease physician. Speech in form of monologue, bad mood, complains about the itching under her skin and the eggs parasites put there. Thinks they make ways across her body and eat her, come out of pores and should be weeded out. “I try to exterminate them myself, to crush on the door jamb”. She thoughts “one of them blew up but hadn`t become smaller”. Attention to unstable, memory is reduced. No sufficient loss of intellect has been revealed. No critical thinking. No aggressive and suicidal tendencies. The following diagnosis: organic dilusive schizotypical disorder. The patient stood strictly against hospitalization. The patient was persuaded into going to the hospital, considering her bad mood, depression, sleep disorder and loss of weight. It took a lot of time to persuade her and the next day she was highly angry and wanted to be discharged. Thus, the indications and reasons for involuntary hospitalization which are written in law are not enough, at times, to provide effective aid to the patients with mental disorders. The patients which refuse the psychiatric help at the onset of their disease are to face the harmful consequences and worsening of the disease and, in fact, disability. The core of the problem is that psychiatrist must be the only persons who take firm decision about hospitalization and no one can cancel or counteract their decision except relatives of the patient who this decision psychiatrist should discuss with, in addition, psychiatrist should give full information concerning a state of the patient, advantages and results of treatment. The patient must have a right to know an opinion about his disease from another psychiatrist and choose a mental hospital he prefers.

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