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Practical psychiatry: On therapeutic equipoise – Principles of a balanced approach to psychiatric treatments

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Abstract

Objective: There are many burgeoning treatments, and a large range of therapeutic options for 21st century psychiatry. This paper briefly comments upon considerations for balancing treatment to suit the patient, their illness, and their milieu.

Conclusions: Therapeutic equipoise, for psychiatric care, is an aspiration rather than a position easily achieved. In day-to-day clinical practice, there will be unexpected demands and barriers that cannot always be accommodated or surmounted. Psychiatrists can work collaboratively with patients, carers, and colleagues in conceptualising and care-planning to avoid extremes of therapeutic hubris and despair, and to adapt evidence-based care more effectively so that it is suited to the patient and their circumstances.

Keywords: psychiatric treatment, evidence-based medicine, therapeutic equipoise

Equipoise is a term that refers to the balance of interests or forces. Accordingly, we suggest that psychiatric therapeutic equipoise refers to the balance of interests and considerations in framing psychiatric therapy within the biopsychosocial model. Our usage is distinct from the other medical usage in clinical trials, where equipoise is used to describe treatments regarded as equivocal, that is, there is honest professional disagreement as to the preferred treatment for the condition.[1]

In providing healthcare, psychiatrists, like all physicians, have the ethical duty to act in the best interest of patients and *primum non nocere* – first, to do no harm. The Hippocratic oath exhorts physicians to '*apply the regimens of treatment according to my ability and judgment for the benefit of my patients and protect them from harm and injustice* (p.21–27)'.[2] There are a range of ways in which psychiatrists can consider the best interests and derive suitable treatment options for patients to confer upon. We outline some examples to guide framing of therapeutics. A patient's perspective can be considered from their narrative-based epistemology of their illness, within a socio-cultural context.[3] Psychiatrists understand illness using medico-scientific epistemology that encompasses consideration of aetiology, pathophysiology, diagnosis, formulation, prognosis, and treatment.[3]

Psychiatrists, as are all physicians, are responsible for health stewardship, that is, '*Doctors have an ethical and*

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professional responsibility to serve as stewards of healthcare resources. This involves caring for the resources available to improve health, avoiding wasteful expenditure and enhancing the safety and quality of the care in order to protect patients from harm while considering the resources that will be required to provide care into the future'.[4] Health economics informs health stewardship as a social science that provides guidance upon the use of finite healthcare resources, especially since the range of therapeutic interventions may exceed the resources available.[5] Indeed, there may be health stewardship dilemmas for psychiatrists in that they may reasonably seek to provide all the care possible for a patient, disregarding the costs, financial, opportunity, or otherwise.[6]

Of course, while understanding these principles, a practising psychiatrist, primarily engaged in face-to-face patient care, may not have time to consider all these aspects in framing care. We develop a framework, based on examples, that may assist psychiatrists to achieve a degree of aspirational therapeutic equipoise.

Principles of psychiatric therapeutic equipoise

There are a number of principles helpful in the formulation of treatment that seeks to achieve therapeutic equipoise:

(1) Accurate planning of therapy is predicated on understanding the patient's experience of their illness, and what type of help, for what impairments, is sought (aside from emergencies where there is a risk to the patient or others, where action may be necessary without such engagement).[3]

(2) Understanding the benefits, risks, and costs of proposed treatments, as well as discussing these with patients.[3] In considering patients' circumstances and socioeconomic status, there should be active discussion of the relative out-of-pocket and other opportunity costs for various treatment options. Out-of-pocket costs may lead patients to forgo treatment.[7] For example, while a medication may be recommended in clinical guidelines and on evidence-base, it may not be subsidised under the Australian Pharmaceutical Benefits Scheme, raising an out-of-pocket cost for the patient. Alternatively, a new therapy that requires inpatient care may only be partially or not reimbursed by a patient's private health insurer, again leading to out-of-pocket costs.

(3) Regarding innovative treatments, for which evidence is only beginning to burgeon, for example, psychedelic medications, be mindful that the existence of a treatment option sometimes drives physicians, and indeed society towards applying treatments as solutions, in an understandable motivation to ameliorate distress.[8] However, it is important to remain within the bounds of the evidence-base and to discuss gaps in knowledge about the effectiveness of treatment with patients. For example, a patient may express interest in psychedelic treatment for post-traumatic stress disorder, and the RANZCP guidelines for psychedelic treatment state, *'The clinical use of psychedelic substances should only occur under research trial conditions that include oversight by an institutional research ethics committee and careful monitoring and reporting of efficacy and safety outcomes'.*[9]

(4) While still empathising and understanding patients' distress, psychiatrists should also carefully discuss with patient as to whether there is an agreement as to whether a therapeutic intervention is needed. This is described as expectant management or watchful waiting: *'Closely watching a patient's condition but not giving treatment unless symptoms appear or change, or there are changes in test results. Expectant management avoids problems that may be caused by treatments such as radiation or surgery. It is used to find early signs that the condition is getting worse'.*[10] For example, a patient with recurrent depression may experience a significant drop in mood but has noticed that they have begun to recover, and therefore decides with their psychiatrist to delay or avoid any adjustments to their medication pending further progress.

(5) If a therapeutic intervention has been agreed upon with the patient, it remains preferable, wherever possible, to limit the number of concurrent interventions that may negatively interact, or simply make it difficult to discern what component of the interventions was effective. However, this is not a restriction on employing complementary modalities of treatment, for example, medication and psychological therapy for a moderate-to-severe obsessive-compulsive disorder.[11]

(6) Consistent with expectant management, subject to sufficient time, and relative stability of illness, treatments need time for patients and psychiatrists to evaluate their effectiveness. Even with urgent clinical circumstances, such as a severe psychosis, rapid turnover of treatments, and indeed multiple interventions, such as polypharmacy, will make it difficult to evaluate effectiveness. For example, a patient with a melancholic major depression with psychotic symptoms may benefit from antipsychotic treatment in addition to the antidepressants,[12] but the antidepressant effect may lag behind the antipsychotic treatment. In this case, it is reasonable to observe the effectiveness of the antipsychotic while considering alternative antidepressant treatment.

(7) Balance is dynamic. All the previous principles will need to be reconsidered in the light of new

information or developments, and treatment will then need to be re-balanced. For example, a patient may not respond to an atypical antipsychotic treatment, leading to consideration of switching or combination treatment, or if there has been lack of efficacy with two courses of antipsychotics at adequate dosages indicating treatment-resistance,[13] consideration of clozapine or other approaches.

(8) Effective treatment for a mental illness is developed through collaborative care planning with the patient and/or carer in shared decision making,[14] and often with much forbearance from the patient, and effort from the psychiatrist. This leads to the adage regarding careful collaborative consideration of any changes to effective treatment plans if there is no evidence of substantive side effects or harms from established treatment, *'If it ain't broken, don't fix it'*.

(9) Equipoise may nonetheless require gradually reducing treatment intensity, frequency, and duration, as for some patients an unhealthy dependency or side-effects may have developed upon either the therapist or treatment offered, leading to iatrogenic harm.

(10) Some patients with severe and persistent mental illness do not achieve their optimal level of mental health, psychosocial functioning, and quality of life, even with evidence-based treatment.[15] Equipoise-based therapy accepts that for some patients with severe mental illness, their symptoms can be intractable, requiring recalibration to develop shared, realistic goals of care. A collaborative approach aims at reducing harm, relieving suffering, and improving quality of life directly, working around irremediable psychiatric symptoms.[15]

(11) Psychiatrists' therapeutic equipoise can be restored through the learning and well-being function of peer review groups.[16] Enthusiasm about a novel treatment may be balanced by careful scrutiny of the accumulated evidence-base. Positive and negative countertransference reactions may be reflected upon, and patient-focused care re-established. New and more fruitful approaches are learned. Case conferencing and workgroups also enhance equipoise through balanced multidisciplinary discussion. Clearly, groups can challenge equipoise, and it is important to monitor if the work group is improving therapeutic optimism, individual well-being, and the psychiatrist's ability to deliver effective care.

Limitations

The above list is not intended to be comprehensive but rather to prompt consideration when relevant, for example, in the application of mental health legislation. Low-to-middle income countries may not have access to the full range of evidence-based treatments, and the psychiatrist may need to advocate for patients in the context of stigma and disempowerment. The internet has democratised medical information, reducing the perceived expertise gap between patients and psychiatrists. As psychiatric diagnosis is necessarily subjective, informed patients may have alternative views of diagnosis and treatment. Patient anosognosia, or lack of insight, can also pose challenges.

Conclusions

Equipoise is an aspiration and not an endpoint. In clinical practice, it can be difficult to achieve a perfect balance but remains useful as a guide to collaborative framing of treatment with patients. Day-to-day, an aspiration towards therapeutic equipoise is more feasible than a slavish adherence to all the potential considerations thereof.

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