

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

When Experiencing Inequitable Health Care Is a Patient's Norm, How Should Iatrogenic Harm Be Considered?

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Abstract

Inequitable care and outcomes experienced by persons with mental illness have long been exacerbated by stigma expressed by clinicians. This commentary discusses a case, considers physical and psychological dimensions of iatrogenic harm to patients for whom inequitable health care is the norm, and suggests how psychological iatrogenic harm can be recognized and addressed by clinicians.

Case

ST is a 45-year-old woman with a long-standing history of schizophrenia and violence. Occasionally, ST can respond appropriately to clinicians' questions. But she has been hospitalized in several organizations in the city several times for swallowing sharp objects, which require surgical removal, to which ST typically objects with fear and anxiety so great that she must be forcibly anesthetized. She has experienced several episodes of physical, chemical, and legal uses of restraints during her encounters with clinicians. She has not kept posthospitalization follow-up appointments and cannot adhere to prescribed medications without close supervision.

Most recently, ST swallowed a pen, underwent an initial surgery to extract the pen, and began recovering steadily until she noticed Dr L, a second-year surgery resident physician, to whom she said, trying to yell, "I never want any more surgery, ever!" Dr L approaches ST and sits with her, explaining that she will need at least one more surgery to check for bowel perforation. ST despairs, "No one cares about what I want. My decisions don't matter and have never mattered."

Commentary

Individuals with mental illness experience inequitable health care. They may be denied access to health services and left out of care decisions concerning both physical and mental health.¹ This inequity may partially explain why individuals with serious mental illness die 25 years earlier on average than those without serious mental illness.² One key driver of inequities in health and health care for individuals with mental illness is

stigma, which is characterized by social marginalization of an individual.³ Although it may manifest in interpersonal interactions, such as among caregivers of people with mental illness,³ it can also be embedded in institutions, policies, or clinical care structures in a more insidious and less visible manner.¹ Institutionalized stigma often creates the conditions for individual stigma to flourish in clinical care. In health care systems, stigma is associated with denial of care, substandard treatment, treatment delays, and physical and verbal abuse.⁴ Through clinicians' negative judgments and discriminatory comments or attitudes and through rigid treatment protocols, stigma can introduce iatrogenic harm to patients with mental illness.^{1,5}

While physical iatrogenic harm and care deficiencies resulting from mental illness stigma have been well documented, there is also a psychological dimension to iatrogenic harm. In qualitative research, people with mental illness have described the overt and covert psychological harm that they have experienced during interactions with health professionals.⁶ More generally, in interactions with others, people with mental illness have described encountering negative stereotypes, dismissiveness, overprotective or patronizing attitudes, and physical distancing.⁷ Research also suggests that health care professionals have a narrow view of risk of iatrogenic harm associated with care of people with mental illness and that they do not often consider psychological harm or involving patients in recovery-oriented approaches.⁸ In order to make meaningful progress in closing health disparity gaps and achieving health equity for individuals with mental illness, both physical and psychological iatrogenic harm must be addressed, particularly for patients with serious mental illness who are most vulnerable and for whom receiving inequitable care has historically been the norm.

Analysis of ST's Case

In caring for patients with mental illness who have historically received inequitable care, priority should be given to the ethical principle "first, do no harm."⁹ The use of **coercive practices**, such as physical restraint, chemical restraint, and legal force should be weighed carefully against their potential for inducing iatrogenic harm, including psychological iatrogenic harm, given evidence that such practices are associated with injury or even death.¹⁰ In the case of ST's emergency surgery to remove the pen that threatened her life, the do-no-harm principle may have necessitated that the surgery be performed. However, her history of untreated mental illness, clinicians' recurrent failure to meet her needs, and their only acting when she is experiencing a life-threatening emergency cannot be ignored moving forward. The interdisciplinary care team should consider using a **trauma-informed approach** to build rapport with ST¹¹; treating her underlying mental illness, including trauma and anxiety²; identifying drivers of intentional ingestion of sharp objects; and allowing ST voice and choice in her care to the greatest extent possible in order to do no further harm and repair the harm that has already taken place.

ST's clinical presentation, which her clinicians perceive as noncooperation and refusal to accept treatment, is likely driven by a history of traumatic health care experiences, stigma, and untreated mental illness. It is evident that interventions intended to promote ST's health have resulted in a pattern of psychological iatrogenic harm and disregard for patient autonomy that must be resolved before any additional surgeries take place. It can be challenging for clinicians to strike a balance between patient autonomy and safety for patients whose mental illness or behavior poses an immediate threat to themselves or others.¹² There are emergency situations when surgery or other interventions are necessary for a patient's survival. In these situations, options may be

limited or nonexistent for reaching an agreeable care plan based on respect and mutuality. However, following such emergencies, clinical teams should consider how crises that result in violation of patient autonomy can be prevented in the future and how to restore patient autonomy in the recovery period.

Addressing Iatrogenic Harm

Mental illness-related stigma can cause physical and psychological iatrogenic harm to patients when it contributes to violation of patient autonomy and when care decisions are determined by clinicians alone, leading to responses such as ST's assertion that "no one cares about what I want." To mitigate such harm, an approach grounded in the ethical principle of respect for autonomy must guide health care systems' care of patients who have a history of receiving inequitable care.¹³

Autonomy is a core ethical principle in health care that entails providing care that is acceptable to a patient based on their beliefs and values and that results in self-empowerment and self-actualization.¹² Patients with mental illness are not always perceived as competent to engage in shared decision making and thus may experience violations of their autonomy by clinicians.⁸ Importantly, iatrogenic harm to those with mental illness resulting from violation of their autonomy may be psychological in nature. Independently of patients' physical health outcomes, the risk of psychological iatrogenic harm must be considered when treating patient with mental illness, especially those who may be deemed legally incompetent to make their own health care decisions.¹² To operationalize respect for autonomy in challenging clinical interactions and to prevent psychological iatrogenic harm, clinicians should consider the following actions:

1. *Shared decision making.* Shared decision making between clinicians and their patients refers to patient-clinician agreement on the best course of treatment based on the patient's informed preferences about options provided by the clinician.¹⁴ In shared decision making, the clinician perspective is not given greater weight than the patient perspective, and there is a mutual, equitable, respectful, and dynamic process of reaching a shared decision.¹⁵ This approach can be applied in considering how to prevent emergencies, such as in the case of ST. Engaging with ST equitably to identify strategies to manage her mental illness and meet her psychosocial needs could reduce the likelihood of future emergencies.
2. *Interprofessional teamwork.* It is important for clinicians to use an interprofessional, **team-based approach** when caring for individuals like ST, recognizing that patients' complex needs require a team that includes physicians, nurses, social services, and family members. Interprofessional teamwork among health care professionals is associated with improved care quality, job satisfaction, organizational culture, and patient outcomes.¹⁶ By working as a team, clinicians can leverage interdisciplinary knowledge to resolve ethical dilemmas and mobilize resources to meet patient needs holistically.
3. *Challenging stigma, stereotypes, and bias.* Clinicians should work to challenge their own unconscious biases and stigma when they encounter cases like that of ST. Mindfulness—that is, focusing one's awareness on the present moment—about how bias and stigma might influence one's clinical interactions can be useful for countering implicit bias, increasing compassion, and practicing nonjudgment.¹⁷

By taking the above actions and prioritizing future prevention of crises that result in violation of patient autonomy, clinicians can reduce iatrogenic harm resulting from stigma against mental illness while improving both the quality of care provided and patient outcomes.¹⁸

Conclusion

Health care organizations have a responsibility to recognize the iatrogenic harm that arises from stigma against mental illness and to implement structures, care processes, and policies to eliminate stigma. These actions may include clinician stigma and bias training, establishing patient advocacy programs, promoting team-based care, and establishing processes for shared decision making. Because teamwork is essential to reducing stigma-related iatrogenic harm, clinical training programs should include strategies for interprofessional practice and for identifying interdisciplinary team members (eg, social workers, nurses) who can help resolve whole person needs. Clinical teams have a responsibility to recognize when iatrogenic harm has taken place, repair the harm, and take steps to prevent similar harm from occurring in the future. When iatrogenic harm in all its forms is understood and steps are taken to eliminate it, persistent inequities in health care that disproportionately harm vulnerable populations, including people with mental illness, can be reduced to achieve a more ethical, just health care system.

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Editor's Note

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Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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