ETHICS IN PSYCHIATRIC PRACTICE

Introduction

This report is drawn from presentations by South African experts at the recent Cipla-sponsored Neuroscience Academy meeting. Ethical dilemmas within psychiatric practice today are dealt with and best practice actions are proposed for today and the future.

Doctor burnout – causes, implications and management

A recent meta-analysis of published studies reflecting data across the world has shown that depression in medical interns and residents is higher than among non-medical professionals and reaches a mean prevalence of almost 30% with an annual increase of 0.5%.1

South African data are more than 10 years old and show that at least 20% of practising South African doctors had moderate symptoms of depression.2 Suicide rates are higher among male physicians than age-matched males in the general population (1.41), while female physician suicide rates, compared to females in the general population, are more than double (2.27).

Is suicide related to burnout? And is burnout equal to depression?

Professor Piet Oosthuizen, Durbanville addressed these issues in his presentation on burnout in doctors. The consequences of burnout are severe in terms of physicians’ physical and psychosocial health (Table 1).

“The term ‘burnout’, defined in 1976 by Maslach,3 is not a listed diagnosis in either DSM or ICD terms, which complicates interpretation and management of the condition,” Professor Oosthuizen pointed out.

A recent review of this condition, typified as mental exhaustion, is ascribed to excessive workload, loss of control in one’s profession, work/family conflicts and the culture of medicine itself, complicated by the physician’s personality, which is dominated by idealism, perfectionism and a sense of responsibility.4 Today, these factors are made worse by pressure to fulfil the ever-escalating requirements of others, competition to be better than others, a drive to increase income and a feeling that deserved rewards are being withheld.5 “Unfortunately the pathophysiology of burnout is still unclear; also, biomarkers are unreliable,” Professor Oosthuizen said.

A recent evaluation of burnout has shown overlap between depression and burnout, with 86% of school teachers identified with burnout also meeting...
the criteria for depression. A simplified causality of burnout was presented by Professor Oosthuizen in Table 2.

**Actions to deal with burnout in physicians**

In a spirited discussion, the audience pointed to a need for mentoring, particularly of junior doctors in training and those entering private practice for the first time.

The need for a fundamental change in medical training to be more supportive and less ‘bullying’ was recognised and is in line with a recent review of the extent of the problem in Australia and its suggested solutions.

**Dealing with funders and PMBs**

PMBs (Prescribed Minimum Benefits) currently discriminate against psychiatric conditions, despite the initial intention of the legislation, which envisaged an approach based on social solidarity principles that would provide for chronic conditions requiring comprehensive care (Medical Schemes Act 131 of 1998).

“The ideal of the PMBs is laudable as it provides a mechanism by which everybody who needs chronic care will get care, regardless of their age, state of health or the medical scheme cover option they are able to afford,” Dr Talatala noted. There are benefits for the medical schemes as beneficiaries receive good care on an ongoing basis and their general wellness improves.

However, competing stakeholders’ interests have led to court challenges to the actual regulations on how PMBs should be funded and utilised. These are aimed

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**Table 2. What causes burnout**

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<tr>
<td>Genetic risk interacts with stress</td>
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<td>This leads to burnout, which eventually becomes Major Depressive Disorder (MDD)</td>
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<tr>
<td>Chronic overactivation of the HPA-axis due to work-stress will eventually cause irreversible changes to the hippocampus and other areas of the brain to MDD</td>
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**Table 3. Psychiatric conditions provided for by PMBs**

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<tr>
<th>PMB Code</th>
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<tr>
<td>182T</td>
<td>Abuse of dependence on Psychoactive substance, including alcohol Hospital-based management up to 3 weeks/year</td>
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<tr>
<td>910T</td>
<td>Acute delusional mood, anxiety, personality, perception disorders and organic mental disorders caused by drugs Hospital-based management up to 3 days</td>
</tr>
<tr>
<td>901T</td>
<td>Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse Hospital admission for psychotherapy/counselling up to 3 days, or up to 12 outpatient psychotherapy/counselling contacts</td>
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<tr>
<td>910T</td>
<td>Alcohol withdrawal delirium; alcohol intoxication delirium Hospital admission up to 3 days leading to rehabilitation</td>
</tr>
<tr>
<td>908T</td>
<td>Anorexia Nervosa and Bulimia Nervosa Hospital based management up to 3 weeks/year or minimum of 15 outpatient contacts per year</td>
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<tr>
<td>903T</td>
<td>Attempted suicide irrespective of cause Hospital based management up to 3 days or up to 6 outpatient contacts</td>
</tr>
<tr>
<td>184T</td>
<td>Brief Reactive Psychosis Hospital based management up to 3 days</td>
</tr>
<tr>
<td>910T</td>
<td>Delirium: Amphetamine, Cocaine, or other psychoactive substance Hospital based management up to 3 days</td>
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<tr>
<td>902T</td>
<td>Major affective disorders, including unipolar and bipolar depressions Hospital based management up to 3 weeks/year (including inpatient ECT and inpatient psychotherapy) or outpatient psychotherapy of up to 15 contacts</td>
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<tr>
<td>907T</td>
<td>Schizophrenic and paranoid delusional disorder Hospital based management up to 3 weeks/year</td>
</tr>
<tr>
<td>909T</td>
<td>Treatable Dementia Admission for initial diagnosis; management of acute psychotic symptoms – up to 1 week</td>
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particularly at Regulation 10, which stipulates that PMBs must be paid for from the ‘risk benefits’ and not from a member’s day-to-day benefits, and Regulation 8, which requires PMBs to be paid in full.

There are currently 270 chronic conditions covered by the PMBs. The psychiatric conditions and their medical management are listed in Table 3.

In many instances, the medical management provided as a minimum standard is inappropriate; for example, schizophrenia should and can frequently be managed on an outpatient basis.

Also, there has not been any review of the PMBs since initiation some 10 years ago, despite the initial stated intention of biannual review. Similarly, there are shortcomings with regard to standards for unipolar and bipolar depression treatment, also the management of psychiatric consequences of other medical conditions such as HIV.

The current situation is tenuous. “Nonetheless, the best outcome within the system is for the psychiatric health professional to understand what is included in the PMBs, understand individual scheme limitations and whether the hospital in which you work has entered into any fixed PMB arrangement,” Dr Talatala advised. “As a profession, we should charge appropriately and not overcharge just because a condition is a listed PMB,” he stressed.

With regard to becoming an individual designated service provider (DSP), Dr Talatala concluded: “Most agreements that Psychiatry Management Group (PsychMg) has received are reasonable to sign.” PsychMg is the arm of the South African Society of Psychiatrists that looks after the interests of private psychiatrists.

**Family law in psychiatric practice**

The health care professionals should get more directly involved with legal decision making when it comes to children and adolescents. Currently the psychiatrist and other health care practitioners act only as expert witnesses. This is time consuming and expensive. Currently a movement towards letting the expert be more part of rulings, is not only necessary, but also already being implemented.

Clinical interventions in children/adolescents are based on biopsychosocial models that include understanding that problems within a family system act as stressors in the development of child and adolescent mental disorders.

The new *DSM*-5 sets out to update disorder criteria to more precisely capture the experience and symptoms of children and relate these also to adulthood and later years, reflecting a new lifespan approach to mental health. “This *DSM* also points to medical professionals becoming more involved in working with parents and, in the face of divorce/separation, with the family lawyer/advocate,” Dr van der Westhuizen said.

In order to fulfil ‘damage control’ and protect the rights of children in a dysfunctional family system, an interested group of professionals is advocating that ‘parenting plans’ should be instituted when parents separate, as it may be many years before divorce is instituted and parenting plans become mandatory.

“It is important also to note that psychiatrists have a legal obligation to report abuse/neglect of a child,” Dr van der Westhuizen concluded.

**The ethical dilemma of confronting established medical practices**

Professor Tim Noakes’ presentation was based on evidence he has collated supporting the concept that it is not dietary fat that causes the problem of obesity and related disorders, but rather the high dietary intake of carbohydrates. This raises the ethical dilemma of advising patients to take a certain course of action against currently accepted medical advice.

Professor Noakes pointed out that insulin resistance underlies the common diseases of type 2 diseases, obesity, hypertension, gout and atherogenic dyslipidaemia (Figure 1). “Of importance, is that insulin resistance is also associated with dementia,” he noted. The role of insulin resistance in developing disease points to the role of high dietary carbohydrate intake.
In speculative discussion with the audience, he suggested that putting a patient on a high-fat diet prior to giving weight-gaining antipsychotic medications may be an intervention that will reduce future weight gain.

The approach of restricting carbohydrates and increasing fat in the diet, thereby reducing weight, can ‘cure’ some patients with type 2 diabetes. This implies that when advising patients about chronic conditions probably related to insulin resistance, the approach by the clinician should be nuanced to include the possibility that lifestyle changes with a diet restricting carbohydrates and raising fat intake could be beneficial.

References

8. Latest DSM www.dsm5.org