Original Article

Dilemmas in Private Psychiatric Practice

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ABSTRACT

Background: A practicing psychiatrist faces dilemmas on a number of occasions, in deciding the best course of action he/she needs to undertake while treating a patient. At times, this choice may not be in accordance with the ethical and moral principles and may in fact appear to violate patient’s autonomy and rights. Aim: To study the nature of psychiatric practice by the practicing psychiatrist in the areas of admission, discharge, consent, physical restraint, electroconvulsive therapy (ECT), certification, treatment, suicide and psychotherapy. Settings and Design: Cross-sectional observational study. Materials and Methods: Forty-eight psychiatrists gave consent to participate in the study. A special proforma was prepared, which addresses the common dilemmas in the clinical psychiatric practice. All the psychiatrists were given specially designed profoma and were requested to fill the proforma with appropriate answers. Statistical analysis was done using SPSS software. Results: There were 42 male and 6 female psychiatrists. The age of the psychiatrists ranged from 28 to 65 years with a mean of 43.08 years. The mean duration of practice of these psychiatrists was 14.81 ± 11.07 years. Question and answers related to admission, discharge, consent, physical restraint, ECT, certification, treatment, suicide and psychotherapy are discussed. Conclusions: The present standard and practice especially in private psychiatric set-up does not conform to the rules, recommendations, and regulations suggested by Mental Health Act 1987, Mental Health Authorities and various guidelines of practice. Indian Psychiatric Society and other professional bodies need to take steps to prepare guidelines for a good psychiatric practice.

Key words: Ethics, dilemmas in psychiatry, mental health act, private psychiatry

INTRODUCTION

Psychiatry has grown rapidly in the last few decades. Ethics is much more relevant in psychiatry, as the line of demarcation between normal and abnormal is hazy and the appropriateness of psychiatric diagnosis and treatment can be easily questioned. Psychiatry entails many ethical dilemmas. Ethics related to psychiatry is of recent origin. It was in the year 1970 that the American Psychiatric Association (APA), for the first time, appointed a committee to develop a code of ethics. Subsequently, in 1977, the World Psychiatric Association developed a code of ethics which is known as the “Declaration of Hawaii.”[1]

Indian psychiatric society (IPS) adopted its ethical code in 1989. After a committee appointed by it prepared the recommendations for a code of ethics for psychiatrists in India, the draft was approved by IPS at its annual conference in 1989, held at Cuttack, Orissa. Most of the recommendations are general ethical principles for handling any patient but not specific to psychiatric patient, and there have been no revisions since then.[1]

A practicing psychiatrist faces dilemmas on a number of occasions, in deciding the best course of action he needs to undertake while treating a patient. These dilemmas
may be related to admissions, discharges, consent process, certification, off-label use of drugs or use of drugs without patient’s knowledge, use of procedures like electroconvulsive therapy (ECT), etc.

There are a lot of factors which make one select a particular way. At times, this choice may not be in accordance with the ethical and moral principles and may in fact appear to violate patient’s autonomy and rights. Most of the time, a particular way would have been chosen keeping in mind the patient’s welfare, the economic status, family’s plight, accessible and available psychiatric services, etc.

Many times, during informal discussions, psychiatrists express concern about the rigid rules and how actually they harm the patient if strictly adhered to and how they are not suited to our country, especially when involving practices in smaller towns and places.

We decided to study the pattern of practice that is prevalent in private psychiatric practice. We wanted to find out whether the practice adhered to ethical and legal principles in force in India.

**MATERIALS AND METHODS**

The study sample consisted of psychiatrists practicing in geographically contiguous areas of western Maharashtra and northern Karnataka, involving about 12 districts. It is expected that about 100 psychiatrists with Diploma/MD/ DNB qualifications are practicing in this area. Some are in full-time practice. Amongst them, some have their own nursing home licensed by mental health authority. Some admit patients in nursing home owned by others but licensed by state mental health authority (SMA). Some are attached to medical colleges teaching UGs and PGs and may or may not practice outside. A special proforma was made by the principal investigator (PI). The PI, after discussion with four of the other practicing psychiatrists who have at least 10 years of private practice experience, framed the questions and prepared a questionnaire. The questionnaire included 57 questions, most of which were of yes/no type and few were fill in the blanks. The questions were under the following subcategories: admission related, discharge related, physical restraint related, ECT related, certification for fitness, treatment related, suicide related and psychotherapy related. Sixty-five psychiatrists were approached and those who were willing to participate were given the questionnaire and asked to fill the form. They were asked to fill exactly how they practice rather than just filling up the ideal answers. They were also informed that their identity would not be revealed. Forty-eight psychiatrists participated in the study. The data were entered into Statistical Package for Social Sciences (SPSS) software and analyzed.

**RESULTS**

Psychiatrists’ age ranged from 28 to 65 years with a mean age of 43.08±11.36 years. In the study group, 42 (87.5%) were males and 6 (12.5%) were females; 14 had MD qualification, 18 were Diploma degree holders, 14 had both MD and Diploma degree and 2 had Diploma and DNB degree. The mean duration of practice of these psychiatrists was 14.81±11.07 years. Twenty-six (54.2%) of the psychiatrists had in-patient psychiatric services and 22 (45.8%) were having outpatient services; among these, some were attached to teaching medical colleges.

**Admission related**

The practicing psychiatrists feel that 38.5% of the admissions were on voluntary basis and the rest 62.5% were involuntary admissions. Psychiatrists having in-patient care admitted the patient after obtaining their consent. Six (12.5%) psychiatrists admitted the patients without any attenders and these patients are kept in a locked facility. Only 5 (10.42%) psychiatrists have occasionally utilized section 19 of mental health act (MHA) 1987 to admit patients against their will under section IX. All the psychiatrists having in-patient care admit the psychotic patient against his/her will, and consent of the relative is obtained.

**Discharge related**

Thirty-two (66.7%) psychiatrists discharge a patient admitted as a voluntary patient when he/she requests discharge. Thirty (62.5%) discharge the patients as “Discharge against Medical Advise” if insisted. Fourteen (29.4%) would not discharge him/her and continue the treatment till they are satisfied. Thirty-two (66.7%) would do the above if the family member of the patient also feels that he/she should not be discharged.

**Physical restraint related**

Twenty (41.7%) psychiatrists feel that they often physically restrain the patients and 14 (29.17%) psychiatrists do not physically restrain the patients. Twenty-four (50%) psychiatrists have fixed protocols or standard operating procedures (SOPs) about the use of restraints. Eighteen (37.5%) feel that patients can be restrained up to 4 hours, 4 (8.33%) feel that patients can be restrained up to 24 hours or more, and 4 (8.33%) feel that the period may vary and did not specify the number of hours. Twenty-two (45.8%) restrain the patients using cotton strips or bandages, 4 (8.33%) using available rope, 6 (12.5%) using saree or cloth, and 2 (4.17%) did not specify. All the psychiatrists obtain the consent from the relatives before physically restraining the patient but only 10.42% document it.
Electroconvulsive therapy related
All the psychiatrists inform relatives about ECT and consent is taken from them. Thirty-eight (79.2%) inform the patient that he/she would receive some injection and take consent. 20.84% occasionally inform the patient about ECT and take consent. Only 10.42% take consent for each ECT, and 89.58% take consent for the whole course of ECT. On an average, a practicing psychiatrist gives 5.54±1.65 ECTs and the maximum reported is eight ECTs in an episode. All the psychiatrists continue medication during the ECTs irrespective of the type of medications.

Certification for fitness
Thirty-eight (79.2%) give fitness certificate when requested. All of them mention the nature of mental illness in the certificate. All of them feel that it is right to give certificate if a patient is on drugs but in remission. Ten (20.8%) psychiatrists feel that it is good to inform the employer on their own. Twenty-four (50%) psychiatrists inform employers about patients’ fitness and the medications, especially when the patient is employed in jobs like Public Transport (Driver), Electrician and Security Personnel carrying lethal weapons, and rest of the psychiatrists leave the choice to patients and their families.

Treatment related
All the psychiatrists make their patients aware that they are on psychotropic agents. Forty-four (91.7%) explain the nature of drugs. Twenty-eight (58.3%) practice poly pharmacy. Thirty (62.5%) consider selective serotonin reuptake inhibitors (SSRIs) better than tricyclic antidepressants (TCAs) for treating depression. Fourteen (29.2%) consider typical antipsychotic drugs better than atypical antipsychotic agents in treating psychosis. Sixteen (33.3%) think that most patients need more than the prescribed dose. Eighteen (37.5%) use drugs in conditions for which they have not been cleared by the drug regulatory authorities (off-label use), and all of them explain this to patients and relatives.

Related to use of drugs without the knowledge of the patient
Thirty-four (70.8%) have prescribed drugs to be given without the knowledge of the patient on relative’s request, especially when they were convinced that the patient has no insight but needs to be treated. Thirty (62.5%) feel that it is justified to do that. All of them feel that it is usually antipsychotics which are prescribed in such a manner. Four (8.3%) use the drug disulfiram without patient’s knowledge.

Related to treatment guidelines
Thirty-four (70.8%) are aware of the treatment guidelines. They are aware of IPS, APA, National Institute for Health and Clinical Excellence (NICE), Maudsley guidelines. These psychiatrists agree with the guidelines issued most of the time and feel that they are useful in practice. Rest of the psychiatrists feel the guidelines are not practical and useful.

Suicide related
All the psychiatrists advise admission to patients who express suicidal ideas or who have attempted suicide. Twelve (25%) psychiatrists report suicidal attempt made by patient to the police.

Psychotherapy related
Thirty (62.5%) use psychotherapy of various types as indicated. Rest of them do not use psychotherapy because it does not pay well (12.5%), 22 (45.8%) feel that they do not have time, 14 (29.2%) feel that they are not trained or skilled in psychotherapy, 18 (37.5%) feel that it is difficult to employ a psychotherapist, and 2 (4.2%) do not believe in psychotherapy.

DISCUSSION
The laws in relation to mental health are Indian Lunacy Regulation Act of 1853, The Lunacy Act of 1890, The Indian lunacy Act of 1912 and Mental Health Act 1987. Other associated acts include Narcotic Drugs and Psychotropic Substances Act 1985, Persons with Disability Act 1995 and Care and Protection of Children Act 2000. The Erwady tragedy showed very clearly that the 1987 Act and the State Mental Health Rules, 1990, appear to have made little impact on the ground realities. It was felt that the lack of implementation of the MHA was the main reason for Erwady tragedy and the strict implementation of the law was the answer.[2]

Of the health conditions contributing to the disability adjusted life years (DALYs), of the top 10 conditions, four are mental disorders.[3] There is large scarcity of mental health professionals in India. The figures are worrisome, especially given the number of mentally ill. The average national deficit of psychiatrists is estimated to be 77%; more than one-third of the population has more than 90% deficit of psychiatrists.[4] The figures for psychologists, psychiatric social workers and psychiatric nurses working in mental healthcare are equally inadequate.[4] With this wide gap it is difficult to implement the available mental health acts strictly.

A study by Kala et al. involved 1890 private psychiatrists to delineate the characteristics of private sector psychiatry in India. The study reports only about the demographic details of the psychiatrists, and no mention has been made about the nature of their practice.[5] In the current study, psychiatrists feel that 62.5% of the
admissions in psychiatry are on involuntary basis. As per the MHA, the application has to be given by the relative to the doctor and at least two doctors should certify that he/she is mentally ill and needs admission. This is a difficult situation because most of the private practice involves a single psychiatrist with the help of some supportive staff. About 29.4% psychiatrists in this study would not discharge their patients and would continue the treatment till they are satisfied. This is ethically incorrect, but most of the times, the patients are not aware of the psychiatric illness and it would be difficult to convince the patient or family members about the nature of illness. But once the patient improves, the family members feel that doctors’ decision was correct to continue the treatment. Most of such incidents happen during the first episode or during first admission when families are not aware of the existence of such illness. A study showed that 83% of patients who lacked the initial capacity to give consent, gave retrospective approval once the patient was better clinically. About 12.5% of psychiatrists admit patients in locked wards. Care should be taken that at least one attender/security personnel is constantly present to observe the patients, otherwise incidents like Ervady tragedy may repeat.

About half of the psychiatrists use physical restraint during the treatment, and as per the report, many have the SOPs for physical restraint. There needs to be some consensus standard guidelines about this procedure. The details of the physical restraint should be documented, namely, reasons for restraint, duration, nature of material used and how frequently vitals are monitored. It is inhumane to keep the patient tied for a long period and may lead to secondary injuries. ECT is a medical procedure and requires prior consent. Ideally, consent should be taken before each ECT, but very few (10.42%) follow it. Most of the time, psychiatrists do not reveal to the patient that he/she is going to receive ECT. 79.2% tell their patients that they will be giving some injections and later carry out ECT procedure. In a study involving patients who received ECT, more than 50% patients were not aware of the details of ECT, even at the end of the course, though they were not unhappy about receiving ECT, but their relatives were aware of the ECT. All the psychiatrists continue medications during ECT course. Sometimes psychiatrists prescribe drugs without patients’ knowledge and usually antipsychotics are prescribed. Some (8.3%) used disulfiram without patients’ knowledge. This may lead to serious adverse reactions and should be curtailed. About one-third of the psychiatrists do not practice psychotherapy because of the following reasons: it does not pay well; they do not have time; they feel that they are not trained in psychotherapy; it is difficult to employ a psychotherapist; and few of them do not believe in psychotherapy.

It is the first study to look into the nature of private practice and whether it adhered to ethical and legal principles. The limitations of the study include: (1) small sample size, just around 1% of the whole psychiatrist community; (2) heterogeneous group of psychiatrists; and (3) questionnaire is not standardized.

CONCLUSIONS

The current study throws light on the ground realities of practice. The present standard and practice, especially in private psychiatric set-up, does not confirm to the rules, recommendations, regulations suggested by MHA 1987, Mental Health Authorities and various guidelines of practice. Admissions and ECT appear to be more problematic areas in private practice. Practice of psychotherapy is neglected and drug treatment appears to be the only choice other than ECT. There is a need to improve standards of private practice in psychiatry. Since the present study involves a small sample of private psychiatrists and is confined to a small geographic area, the findings cannot be generalized. IPS and other professional bodies need to take steps to prepare guidelines for good psychiatric practice.

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How to cite this article: Patil NM, Nayak RB, Bhogale GS, Chate SS. Dilemmas in private psychiatric practice. Indian J Psychol Med 2011;33:149-52.

Source of Support: Nil, Conflict of Interest: None.