



Bijlage 5b (engels)

Ethics in a multidisciplinary guideline on depression in The Netherlands

Version 30 september 2010

Noks Nauta, on behalf of the workgroup
n.nauta@nvab-online.nl

Table of contents

1. Introduction
2. Aim of this chapter
3. Fundamental questions
4. Dilemmas in practice
5. Dealing with dilemmas in practice
 - 5.1 Moral Deliberation
 - 5.2 Norms and values
 - 5.3 Consideration
6. Recommendations
7. Literature
8. The workgroup



Made possible by a grant from ZonMw, The Netherlands organization for health research and development.

1. Introduction

This chapter was written within the context of the project Ethiek in Richtlijnen bij Arbeid en Gezondheid (EiR-A) (Ethics in Guidelines for Labour and Health). The project has been financed by ZonMw (Netherlands organization for health research and development) within the framework of the KKCZ program and ran from 1 January 2009 till 30 June 2010.¹

The main question studied in the EiR-A project was: How can a multidisciplinary guideline provide a structure in situations in which both curative care and care concerning labour and health are provided^{2 3}, and where, as a result, moral differences in insights play a key role? How can the moral quality of advice and assessment be assured, in particular through effective attunement⁴?

The point of departure of this chapter is that users of this multidisciplinary guideline for Depression will encounter situations in practice for which the guideline offers no direct assistance. In evidence-based medicine, it is assumed that in addition to scientific evidence, other considerations also play a role in the choices made. Koerselman and Korzec (2008) refer to the clinical experience of the individual practitioner and cite 'patient values', referring to Sackett, the founder of Evidence-Based Medicine. Koerselman and Korzec are of the opinion that deviating from a guideline will also need to be justified and they propose that ethical reasons, if these are relevant, should also be specified.

In their report, Berg et al (2001) draw attention to the 'political, economic and justice considerations that often influence decisions at the clinical level, and conclude: "An evidence-based guideline is not automatically value-based".

In this chapter these other considerations are looked at in more detail, specifically in relation to ethical aspects.

This chapter can also be used in conjunction with the Verzekeringsgeneeskundig protocol Depressieve stoornis and the NHG standaard Depressieve stoornis (Insurance medicine protocol for Depressive disorders and the NHG (Dutch College of General Practitioners) standard for Depressive disorders.

2. Aim of this chapter

The aim of this chapter is to assist users of this guideline:

- a. in raising awareness of dilemmas in ethically sensitive situations when treating, supervising, and assessing people suffering from depression in the context of labour and health;
- b. in signaling ethical dilemmas, especially at an early stage,⁵ that play a role in these situations;

¹ For more information about the whole project and the related products, please go to www.NVAB-online.nl, after October 1, 2010.

² The EiR-A project concerns ethically sensitive situations in which labour and health play a role. The principles described in this chapter are not limitative and may be placed in a wider context in practice.

³ When we refer to labour in this text, this also includes unpaid labour such as voluntary work and informal care.

⁴ For the answer to the questions: 'What is moral?' and 'What is ethics?' please refer to the relevant textbooks in this field. A short description of values and norms is given in section 5.2.

⁵ The word 'dilemma' suggests a choice between two alternatives. However, we use the term in a broader context: a situation that often, in the first instance, resembles the question: shall I do something or not?; shall I do A or B?, but where closer investigation reveals that more than two alternatives are possible.

- c. in finding/specifying ways of dealing with these dilemmas.
- d. in bringing the subject of the dilemma more into the open among other care providers *and* among the patients/clients, by being better able to specify and describe the elements of the dilemma and the possible options.

By the nature of the topic, this chapter does not contain any simple solutions. Its aim is to inspire people and to motivate them to become more aware about the dilemmas in ethically sensitive situations and to improve people's ability to deal with them.

3. Fundamental questions

The fundamental questions that are posed in this chapter are:

- Which ethical dilemmas and/or ethical issues with regard to depression occur in practice and which overarching elements can we observe that recur within them?
- In which way could professionals deal with these dilemmas in practice?

We will now answer these questions, and conclude with recommendations from the workgroup responsible for writing this chapter.

4. Dilemmas in practice

Table 1 shows a schematic overview of issues that may play a role in the treatment, assessment and support of clients with a depression. The content of the table is the result of reading literature, collecting case studies from the practices of occupational physicians and insurance physicians, and collecting case studies from the practices of members of the workgroup.

In the literature we found several case discussions on this theme in the Netherlands (Faas, 2006; Faas, 2008; Weel, Kelder, Faas, 2005). Additionally, we conducted an orientational search in Pubmed using the keywords Depression, Ethics and Work, and all related MeSH terms. This produced 73 articles, from which 14 were selected based on their title, and studied in more detail.

Before the workgroup started their investigation, an inventory was performed among a group of occupational physicians and insurance physicians concerning which dilemmas they encountered when working with clients with a depression. Subsequently, in the research part of the EiR-A project, interviews were held with various professionals, in which they were asked about their own dilemmas.

The next step involved the members of the workgroup specifying which dilemmas they were familiar with from their own experience. This inventory resulted in a number of themes. Some themes from the 14 articles that were not specified by the workgroup members were added to these.

The workgroup divided the themes into seven main topics: (1) vision of the client; (2) collaboration, (3) diagnostics, (4) treatment; (5) assessment of capacity to work, (6) self-reflection of the professional and (7) the context in which the client finds him/herself. (The aim of this inventory was not completeness; the emphasis was on becoming aware of the themes.) The third column of table 1 lists the questions that professionals often ask themselves. These are not necessarily always questions with an overt ethical content, but when looked at in more detail an ethical issue is often

revealed that is worthy of closer investigation and where more than one alternative is possible (or where even several options present themselves).

It appears that dilemmas occur frequently within the context of multidisciplinary collaboration and attunement, which is why that specific cluster/main group is situated directly after the cluster 'vision of the client'. The workgroup has consciously and explicitly chosen to include 'collaboration' as an important value.

According to Verplaetse, "Collaboration is sometimes risky, and demands a measure of willingness on the part of all parties, but everyone can benefit from collaboration. The moral call to collaborate can thus be seen as a special form of 'doing good'. Collaboration also refers to a form of 'justice' in which everyone participating in the cooperative relations that make living together possible, adopts their rightful place and is willing to bear the corresponding responsibilities.

Table 1
Elements of dilemmas encountered in practice with clients with a depression, accompanied by relevant themes and questions

Main topic	Themes	Questions
Vision of the client (and/or close relatives/friends) or collaboration of professional with client (shared decision making)	Client and care provider are situated at the same level in terms of their relationship hierarchy Room for own vision with regard to diagnosis and treatment	To what extent is the client given the space and time to introduce his/her own vision with regard to the diagnosis and the treatment? Does the client have enough information (including written info) to be able to have a voice in the decision? Including regarding the working and side effects of medication in relation to work? What does 'leadership' of the professional entail?
	Meaning of the diagnosis for the client	What is the meaning of the diagnosis for the client and his or her life?
	Vulnerability of a client with depression	Is adequate attention paid to the vulnerability of the client? Is the client able to actively cooperate if his/her self-image is low and he/she is vulnerable?
	Choice of treatment	What if a client makes a therapy choice that is different from the therapy that is the professional's first choice?
	Side effects and other drawbacks of treatment	Does the professional realise well enough that each treatment has its side effects? Is it possible to empathise with the client in such a way as to understand how the client will react to a treatment proposal?
	Sharing the diagnosis and problem analysis and reporting in general with the client	Does the client agree with the diagnosis and the problem analysis? In what way can the professional discuss with the client what is included in the report and what is not?

	Confusion about procedure concerning labour and health can evoke fear	What does an occupational physician or insurance physician do? Has this been communicated clearly enough? Does the client have adequate knowledge?
	Trust in the care provider	Can I as a client (or as a professional) trust the (other) professional? To what degree do you as a professional influence the trust that the client has in the other professional?
	Client's own opinion of fitness for work	What if the client does not consider himself/herself fit for work? What if the client chooses a therapy that perhaps reduces the chance of his/her capacity to work? What does the client need to be able to improve the work situation?
	Diversity	How much space is given to a client who has another vision (on people) or who is from a different cultural background?
	Coping	How to respond to a more passive coping style or when a client for example considers that the cause is genetical in nature, and therefore cannot be changed? Do we still choose to activate?
Attunement and collaboration of professions/ disciplines, including employer	Joint responsibility for effective care	Are thoughts and ideas shared by all parties? Is the client given the same consistent messages?
	Responsibilities, rights, duties, tasks and goals	Who is responsible for what? What are the rights and duties of all parties, including that of the client? Is everyone aware of what everyone else is doing, and is this clearly defined? What goal is being aimed at: recovery from complaints or recovery of functioning? Employer is responsible for the care of a sick employee but is also responsible for the colleagues that do <i>not</i> go on sick leave. How does this happen in practice? What role does the occupational physician have in this?
	Effect for client	Is it possible to chart the pros and cons of attunement/collaboration for the client?
	Discussion about the diagnosis	Do all parties share the same definition of 'depression', 'depressive complaints' and 'depressive disorder'? Does everyone use DSM-IV?
	Discussion about the treatment	Does everyone use the same guidelines? What is the best treatment, viewed from each other's perspective? When is an anti-depressant prescribed and when not? If one is prescribed, which one? What if a client chooses a therapy that is different from the professional's first-choice therapy?

	Assessment of work possibilities	Does a recovery from complaints also mean a recovery of functioning? Is the professional also alert to a recovery of functioning? To what extent is the occupational physician under pressure of the employer?
	Keeping each other up to date and information exchange	Do people keep each other sufficiently up to date in the case of referrals? What should be done if the client does not want information from the psychologist to be made available for the occupational physician (fear of information reaching employer)? Is the occupational physician or insurance physician able to make accurate statements without access to info from the treating physician?
	Time investment	What should be done if there is no time for attunement or collaboration?
Diagnostics (not directly in relation to collaboration)	Depression, depressive complaints, depressive disorder	Is use of the DSM-IV accepted? When do we use the terms depression, depressive complaints or depressive disorder, what are the objective criteria? (In this respect, a shift over time can also be observed.)
	Overlap with other conditions	In the case of an overlap with personality disorder, is a depression still diagnosed?
	Shift in notion of 'depression'	Everyday problems of life are not the same as a depression, or are they?
	Consequences of diagnosis	Is there an awareness that the diagnosis of depressive disorder can also lead to disempowerment (I am sick, so...)? Is there an awareness of the consequences of including the diagnosis in the EPD (Electronic Patient Dossier)?
	A missed diagnosis as a result of the client wanting to avoid losing face	Is enough space provided during the consultation to allow the client to talk about feelings of depression?
	Own resistance and prejudices	What feelings do you yourself experience when hearing the client's story and in the case of psychological complaints in general?
	Use of questionnaires	What are the pros and cons of using questionnaires for supporting the diagnostics for the various parties?
	Occupational factors that play a role in the causes of depression or a worsening of the depression	What role do stress, discrimination, and injustice at work play in causing or worsening a depression? To what extent is it an occupational disease?
	Cultural aspects, notion of sickness as experienced by people with a non-Dutch background	Should the same diagnostic criteria be used with people from a different cultural background? How should other cultural backgrounds be dealt with?
Treatment (not directly in relation)	Choice of treatment that is offered	How are the diagnostics used to choose a treatment?

to collaboration)	Consequences of a treatment proposal	Is there an awareness that the prescribing of anti-depressants can lead to disempowerment (I swallow pills, so I am sick.)?
Assessment of capacity to work	Notion of sickness is not objective	When do we talk of someone being sick? How is the quality of life determined? What happens if the client demands explicit confirmation of 'being sick'? To what extent does sickness form an illusion of certainty?
	Assessment of capacity to work in relation to diagnosis	How direct is the relation between the diagnosis (distinction between depressive complaints, depression, depressive disorder) and the workload capacity?
	Cooperating with treatment	Are clients allowed to refuse anti-depressants? Does this mean that they are not cooperating in the process of their own recovery?
	Social context	To what extent is it justified to allow the social context to be taken into account?
Self-reflection on the part of the professional	Dealing with criticism of others, providing criticism to others, own (personal and professional) attitude with respect to psychological complaints	To what extent do you accept the criticism of others and do you criticise others? Are you aware of your own prejudices in the field of psychological problems/depression? Would you allow people with psychological problems to transfer to a colleague who has more affinity with psychological problems? Is it acceptable to take into account subjective notions like gain from illness and burden of suffering?
Context	Taking the context into account (partner/family; work: colleagues and employer)	What weight is given to contextual factors in the assessment of capacity to work? And how much weight is given to work factors when considering the treatment? How much weight is given to the contribution of others, such as partner, children? How much weight is given to the contribution of employer and colleagues? How is professional confidentiality dealt with towards third parties (openness versus negative prejudices about depression)?

5. Dealing with dilemmas in practice

5.1 Moral deliberation

The workgroup considers that the intercollegial – and preferably multidisciplinary – approach to discussing dilemmas in practice has the ability to raise the levels of care. As a result, the practice of self-reflection – being aware of how we deal with our own attitudes, opinions, 'biases' in the personal and professional context – will be

stimulated. There are also indications that discussing ethical dilemmas increases the job satisfaction of employees in the care sector and that they experience less stress, and become more enthusiastic about their work (Bauduin & Kanne, 2009). One of the ways in which it is possible to open up a dilemma for discussion is a 'method of moral deliberation'. Several methods exist for this, all of which consist of a plan of action for systematic ethical reflection (Manschot & van Dartel, 2003; Steinkamp & Gordijn, 2003). When working with these methods, it is strongly recommended to work with a trainer who has had a specific training in them. The tasks of this supervisor/trainer are to facilitate the process, to guide the group through the steps in a structured manner, and to initiate and maintain a dialogue within the group, so that they work in a manner based on an investigation of the facts. The supervisor/trainer then tries to foster an attitude of investigation among the participants, free of any prejudgements. The session concludes with a list being drawn up of actions to be taken (who does what, when).

In the world of occupational physicians and insurance physicians, use is made of a (simplified) action plan based on the Nijmegen method of Moral Deliberation. This structured process of case discussion consists of five steps in which the following are identified:

- a. Facts
- b. Choices
- c. Values per alternative and based on various perspectives
- d. The weighting of the values
- e. A choice for an alternative, with argumentation,

Each case discussion has its own characteristics and specifics, ensuring that the weighting always has a unique character.

5.2 Norms and values

The basic norms, also known as fundamental principles, that are predominantly used in the medical world are: doing good and causing no harm, justice and respect for autonomy. All four refer to a moral obligation to promote important values that are worth striving for. This applies especially to the values of wellbeing (including health), autonomy and justice. (Beauchamp & Childress, 2001; Bolt et al, 2007) Additionally, values such as honesty and carefulness are also often mentioned, and therefore (initially) the moral obligation to act in accordance with them.⁶ In the doctor's oath and in many professional codes this is referred to explicitly. In the health sector (explicitly mentioned in the GGZ (Netherlands Association for Mental Health Care) but also of great importance outside this sector), attention and trust are also vital aspects.

We will go into more detail here of the basic norms mentioned above.

Doing good and causing no harm: this norm prescribes that the value of 'wellbeing', including health, should be promoted. But workforce participation, and many other material and immaterial values can also be included here. If we decide on a specific choice, we need to ask ourselves what the consequences of this choice will be for the wellbeing of the person concerned.

Respect for autonomy concerns above all giving the client space/not imposing restrictions on the client: in other words, does the client have the option to reject the

⁶ The personal experiences of several workgroup members when giving courses on moral deliberation for occupational physicians and insurance physicians.

advice given, does the client have a voice in the proceedings? How much space is made available to the client? Additionally, there is the question of self-determination: to what extent is someone with a depression able to be autonomous, and does he or she have an adequate mental capacity? Is someone in such a condition – in which a low self-image and vulnerability often play a role – able to accurately oversee the implications of a specific choice? In what aspect and to what degree are we able to consider people with a depression as having sufficient mental capacity?

The actions of professionals must also be respected: do they always have the freedom to take their responsibility? Is the professional actually able to act according to professional standards? Is the professional able to freely choose an alternative, without experiencing any form of coercion on the part of a client, employer or other party?

The norm of *justice* is always present in questions of labour and health, because the question of the justification (validation) of a sickness allowance often plays a role: do people receive the allowance that is rightfully theirs (morally and legally)? In our society, a political choice has often already been made to allocate allowances on the basis of earning capacity, but that can be considered as unjustified, or can turn out to be unjustified in specific cases. Justice then means ensuring a fair distribution. Justice always is accompanied by an element of comparison. Similar situations should be treated equally, but dissimilar situations should be treated differently. From the point of view of the physician: would I act the same in a similar situation? And if I were to act differently, what justifies that difference? Justice, finally, also has a formal side: procedures should be well thought out, so that all clients have an equal and fair chance of access to the care, social services and public resources available.

Honesty means: do I stick to the facts? Am I telling the truth, am I not concealing anything? It is also often about transparency. Am I telling the client everything that I have written in my report?

Carefulness is concerned with the way in which, for example, information – confidential and otherwise – is dealt with, and more generally with carefully designed procedures, so that everyone knows where they stand; they assure safety and protection within (occasionally bureaucratic, anonymous) systems. Carefulness is also concerned with: am I using all the available information? Should I request additional information?

Attention can be regarded as the way in which people present themselves to the client. The attention should be focused on the client/patient and their interests. Attention also implies that the patient is listened to.

Trust means that people feel comfortable enough to be able to discuss sensitive issues with each other. This applies both when care providers communicate with each other and within the patient/care provider relationship. Trust is not something that is automatically present; rather, it grows within a relationship when experiences are seen and felt as being positive within the collaboration. When a breach of trust occurs, regaining that trust can be difficult, in which case, more positive experiences are required.

Our proposal is also to give attention to the value of '*collaboration*'. The workgroup considers (see also at 4) '*collaboration*' as a special form of doing good, an appropriate way of promoting wellbeing: a better quality of treatment, assessment, and support also in terms of ethics. Which is why we also ask ourselves to what extent a certain choice does justice to desired, morally motivated collaboration.

5.3 Consideration

The workgroup considers that the discussion of a case study in which an ethical dilemma plays a role, has specific value. Using a method of Moral Deliberation – which provides the necessary structure – can give professionals the framework they need. The choice for a specific treatment – once the weighting is complete – is partly influenced by the vision that prevails concerning, for example, the importance of work (participation in paid and unpaid work). Depending on the perspective that is adopted, certain values will weigh more heavily than others, and certain norms will be situated higher in the hierarchy. Normally these aspects remain implicit and unspoken. The importance of the discussion is that participants are invited to be explicit about it, so that the choice can be explained and justified.

If moral dilemmas are analyzed more often, when a new dilemma is discussed, less time is required to acknowledge which moral values conflict with each other and from which perspectives conflicts can occur.

In order to be able to justify a choice, we need adequate information. This means that the evidence on the effectiveness of treatment methods plays an important role. The most recently acquired knowledge on this topic can be found in the multidisciplinary guideline on Depression.

It may occur that recurring and overarching problems are encountered during the case study discussions. These deserve to be studied at a more structural level. Some of these overarching questions are listed in table 1 in the third column; for example (but certainly not exclusively) questions about responsibilities, definitions, function recovery, and questions that also merit attention from the legal viewpoint such as the transfer of information between professionals.

Based on actions prompted by these questions, the care required can be improved structurally. When certain types of dilemmas occur more often, it may make sense to formulate a written point of view about them.

6. Recommendations

1. Adequate time should be reserved for holding a moral deliberation. A trained supervisor will be required to ensure that the ensuing discussion is productive.

2. When treating, supervising or assessing a patient with depression, the first question to ask is always how much autonomy this individual can handle. Or, does this person need more support due to his/her vulnerability, and should the expectations of him/her being able to take matters into their own hands not be too high?

3. Think about which dilemmas play a role in the case study within the context of labour and health. The table listing frequently occurring elements from dilemmas noted from practice may prove helpful here.

4. Discuss at regular intervals with a group of colleagues dilemmas that play a role in people with depression, preferably in a multidisciplinary context. Use a method of moral deliberation and (in addition to the values already known in the context of medicine) focus attention on the importance of 'collaboration'. In other words, try to

establish the correct relations and harmonisation of responsibilities. Assess each case study: did the discussion lead to an improvement in the decision-making process and in the choice itself? And pose the question: in what aspect do joint discussions have a positive effect on everyone's personal raising of awareness and ethical (self)-reflection?

5. Discuss a dilemma preferably also with the client, and where possible with a close relative or friend of the client. These individuals can then think along about what the best option might be, from their own perspective.

6. At regular intervals, as a result of a case discussion, reflect on whether overarching aspects exist which can be taken into account by making structural changes. Think about formulating a standpoint on issues raised by the same dilemmas recurring frequently.

7. Literature

Dorien Bauduin & Mariël Kanne. Tijd voor reflectie. Praktische ethiek in psychiatrie en rehabilitatie. Amsterdam: SWP; Dordrecht: De Grote Rivieren, 2009.

Beauchamp TL, Childress JF. Principles of Bioomedical Ethics, 5th edition. New York/Oxford: Oxford University Press, 2001.

Berg, Marc, Niek Klazinga, Ben van Hout, Van 'evidence based' naar 'value based': normatieve overwegingen bij richtlijnen voor "Passende medische zorg" (Een KNMG-project), in: Ingebouwde normen, Marc Berg en Annemarie Mol (red.), Utrecht, 2001.

Bolt LLE, Verweij MF, Delden JJM van. Ethiek in praktijk. Assen: Van Gorcum, 2007.

Faas WA, Kantonrechter verplicht werknemer medicijnen te slikken. Het hek van de dam? TBV 2006; (14): 38-39.

Faas WA. De kwaal erger dan het middel: een geval van genezingsbelemmering. Hoogste tijd voor een richtlijn? TBV 2008 (16); 3: 110-112.

Koerselman GF, Korzec A. Voorstel voor een checklist bij het afwijken van richtlijnen. [commentaar] Ned Tijdschr Geneesk 2008 (152):1757-1759.

Henk Manschot en Hans van Dartel. In gesprek over goede zorg. Amsterdam: Boom, 2003.

NHG standaard Depressieve stoornis, 2005. In revisie.

Norbert Steinkamp and Bert Gordijn. Ethical case deliberation on the ward. A comparison of four methods. Medicine, Health Care and Philosophy 2003 (60): 235-246.

Jan Verplaetse. Het morele instinct. Amsterdam, uitgeverij Nieuwezijds, 2008.

Verzekeringsgeneeskundig protocol Depressieve stoornis. Gezondheidsraad, 2006.

André Weel, Marja Kelder, Noks Nauta. Praktijkdilemma's voor Bedrijfs- en Verzekeringsartsen. Houten: Bohn Stafleu van Loghum, 2005

8. The workgroup

The workgroup that put this section together consisted of:

Mw dr I. (Ina) Boerema, Trimbos Instituut, deputy project manager for multidisciplinary guidelines for depression and fear
Mr. drs P.G. (Paul) Brock, insurance physician, UWV
Ms. drs I. (Inge) den Besten, researcher, ErasmusMC
Ms. drs A. (Aly) van Geleuken, psychologist, till 1 October 2009 head of Depressiecentrum, Fonds Psychische Gezondheid; since 1 October 2009 manager of development, research and implementation at Praktijkondersteuning Zuidoost Brabant
Mr. drs D. E. (Dick) Kleinlugtenbelt, sociologist and philosopher, head of quality and policy staff member for ethics, GGNet and his own bureau for philosophy
Ms. dr J. (Jolanda) Meeuwissen, psychologist, senior scientific researcher Trimbos Instituut, project manager multidisciplinary guidelines for depression and fear
Mr. drs P.J. (Pieter) Molenaar, mental health psychologist, Human movement scientist and scientific researcher, Indigo Gezond werken
Ms. dr A.P. (Noks) Nauta, occupational physician and psychologist, NVAB,(sub)project manager for EiR-A and chairperson of the workgroup
Mr. dr E. (Eric) van Rijswijk, family physician
Mr dr J. (Jan) Spijker, psychiatrist

The workgroup came together on three occasions, as well as holding discussions via email. A draft text was drawn up, and presented on 25 February 2010 to a group of potential users in a practical trial, consisting of a family physician, two occupational physicians, one insurance physician, a first-line psychologist, an ethics expert and two people from the perspective of the patient. The text was then adapted as a result of the findings.

Translation from Dutch into English: Kumar Jamdagni (Language Matters)