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THE ETHICS OF HEALTH SCIENCES ACADEMICS INTERVENING IN STUDENTS WITH SUSPECTED PSYCHIATRIC ILLNESS IN SOUTH AFRICA

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the Degree of Master of Science in Medicine (Bioethics and Health Law)

Johannesburg, 2020

Declaration

I, Nabeela Sujee, declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Masters of Science in Medicine (Bioethics and Health Law) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



On 30 day of March 2021 in Johannesburg

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SENATE PLAGIARISM POLICY: APPENDIX ONE

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Dedication

For those who believed in me, pushed me and never stopped supporting me, thank you for the unwavering love and strength when I forgot how to love and be strong.

For all the students I have encountered, mentored and taught, for the students who have shown me perseverance and resilience. You have given me a fierce purpose and taught me not to give up.

For myself, for showing up when it was most difficult to do so and for ensuring this work reflects who I am and what I stand for.

"The strongest people are not those who show strength in front of the world but those who fight and win battles that others do not know about." – Jonathan Harnisch



Abstract

Psychiatric illness has become a major topic of concern in the university setting. There have been numerous calls for academics to intervene and address the rise of psychiatric illness amongst the students. It is imperative that interventions are normatively analysed so as to ensure they are ethically justified. This research focuses on health science academics' role and how their roles and responsibilities are associated with the call to intervene when a student is suspected to have psychiatric illness. I will argue that it is ethically unjustifiable for health sciences academics to intervene when they suspect a student to have psychiatric illness. I argue that direct or indirect interventions take a paternalistic approach, which is ethically unjustifiable as the student is an autonomous individual capable of rational decision making. Secondly, interventions are not within the role and expected responsibilities of the health sciences academic.

I will explore the consequences that interventions may have on the student and health sciences academic, and their relationship. I argue that the negative outcomes outweigh the positive outcomes which further support my argument that it is ethically unjustifiable for a health sciences academic to intervene when they suspect a student has psychiatric illness.

Finally, I propose that the academic still has a duty of care for the student and this duty of care can assist the academic in supporting students with suspected psychiatric illness in an ethically justified manner.

Acknowledgements

A special and heartfelt thank you to my supervisors, Ms Lizeka Tandwa and Mrs Shirra Moch, you have not only guided me through this process but ensured I felt supported and encouraged. I could not have asked for a better duo to hold the same enthusiasm and compassion for my project as I do.

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Finally thank you to my amazing team of colleagues and friends in the Division of Clinical Associates who not only supported and motivated me throughout but allowed me to dedicate time to this project despite the strain and workload.

Foreword

This project has held a special place in my heart for a while. It is a topic that has come about due to my many encounters with students who have psychiatric illness and either have come to me for help, to debrief or just needed a shoulder to lean on and an ear to listen.

In the past three years, this has become more important to me due to numerous increased encounters with students who have sat in my office crying due to diagnosed psychiatric illness, attempted suicide or psychosocial stressors. I have felt emotionally burdened and for the most part burnt out with carrying this load and this topic became more pertinent for me to take further.

It is a project that I hope will provide perspective into the role of the health sciences academic and the ethical duties we have towards students.

It is aimed to help all the academics who, like me, have tried to put up boundaries to protect emotions while still acknowledging the role they play, considering the needs of the student and caring for the student in front of them while always considering the best outcome for the greater patient population in the South Africa healthcare setting.

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Abbreviations and Acronyms

HPCSA – Health Professions Council of South Africa

WHO – World Health Organization

ZPD – Zone of Proximal Development

Chapter 1: Introduction

1.1. Background Literature Analysis and Critique

“I really do believe that if we do not commit to working together towards addressing the mental well-being of students, and putting an end to student suicide, our collective futures may be compromised” (September, 2018, pp 2). This is a statement made by the Dean of Student Affairs at the University of Witwatersrand in 2018, after multiple suicides of university students were being reported. This underscored numerous matters that need to be explored including questioning the responsibility placed on academics to intervene when these issues arise (Bantjes *et al.*, 2017).

Psychiatric Illness is a diagnosed illness and is defined as a “mental illness collectively to all diagnosable mental disorders — health conditions involving significant changes in thinking, emotion and/or behaviour and distress and/or problems functioning in social, work or family activities” (American Psychiatric Association and Parekh, 2018, pp 1). The phrase psychiatric illness is used in this research as this term directly refers to a diagnosed psychiatric illness, whereas mental health, used in some literature is inclusive of general social stressors, however, the term mental illness and mental health may be quoted in some references as these terms are often used interchangeably.

Psychiatric illness in this research is referred to as being ‘suspected’, this means that the university student may have not been diagnosed with a psychiatric illness by a health professional yet and may not have sought help. The academic only suspects that the student has psychiatric illness when they observe characteristics that may meet the criteria of a psychiatric illness, this may include social withdrawal, behaviour changes and risk factors associated with psychiatric illness. Psychiatric illness in students has raised concerns in various academic institutions in South Africa as students who have psychiatric illness may go unnoticed and untreated, with this only being addressed after multiple suicides being reported in students at university (September, 2018).

1.1.1. Psychiatric Illness in South Africa

The Lancet Commission reports that in countries where human dignity and rights to healthcare were compromised, there has been a call to improve the services for people who are affected by psychiatric illness (Patel *et al.*, 2018). It is understandablethat the South African Depression and Anxiety Group stated that due to the history ofapartheid in South Africa, which had a negative effect on the emotional, environmental and demographic issues, 1 in 6 South Africans suffer from anxiety, depression or substance-use problems (and this does not include more serious conditions such as bipolar disorder or schizophrenia) (Stein *et al.*, 2008; The South African College of Applied Psychology, 2018). The historical context of South Africa not only predisposes people to psychiatric illness but apartheid had also ensured that due to the racial discrimination, gender inequality, political and criminal violence and poverty, these contributed to social disparities in access to healthcare which ultimately lead to a lack of treatment for such illnesses (Stein *et al.*, 2008). The Lancet Commission further reports that early detection is vital to appropriate treatment and recovery amongst people with psychiatric illness (Hancock, 2018; Patel *et al.*, 2018). This is why it is important to be aware of psychiatric illness in this context, as well as ways to respond to and/or address it.

1.1.2. Psychiatric illness amongst university students in South Africa

One factor that affects the mental health of people is the education and schooling environments. A study done at Stellenbosch University in 2015 by Pharma Dynamics showed that of 1337 university students from various backgrounds, almost 12% experienced significant forms of depressions ranging from moderate to severe symptoms and 15% reported severe symptoms of anxiety (Freeman, 2018; Pharma Dynamics, 2018). Psychiatric illnesses have since been perceived to be taken more seriously amongst university students especially with the high crime rate and the sexual violence that occurs in academic institutions. (Mortier *et al.*, 2018).

The results of a study done involving high school and university students in South Africa in 2004 explored the prevalence of psychosocial issues amongst black students, this study related alcohol and tobacco use to social stressors such as low social support, poor interpersonal relationships, and home environments amongst others (Peltzer, 2004). The study results showed that where there is a low prevalence of healthy behaviour there is a subsequent higher prevalence (29,5%) of psychological

and depressive symptoms (Peltzer, 2004). This particular finding and the time at which the study was done is concerning as the South African Depression and Anxiety group reports statistics in 2018 state that 1 in 4 university students are diagnosed with depression and more than 20% of 18 year olds have had suicide attempts (Freeman, 2018). It is concerning that over time, the findings of the Peltzer study have not changed substantially when considering the rate of depression and anxiety symptoms amongst students (Freeman, 2018; Njilo, 2018).

The reported incidents of psychiatric illness amongst university students have been increasing and this correlates with the increase in suicide attempts (Wynaden *et al.*, 2014). The escalations of suicide attempts as compared to 2004 can be linked to undiagnosed psychiatric illness (Freeman, 2018). The South African Depressions and Anxiety group reports that depression and anxiety may be experienced by university students, without them knowing it. Students are not equipped to cope and handle some of the challenges that they face (The South African Anxiety and Depression Group, 2019). The surge of reports of psychiatric illness have resulted in discussion that academic institutions have a responsibility to find solutions to address these concerns (Njilo, 2018; The South African Anxiety and Depression Group, 2019).

Various South African universities have made headway in starting some intervention strategies to address these issues. The University of Witwatersrand has since increased their counselling services available to students as an effort to address the problems facing students (Njilo, 2018). The University of Cape Town, in August 2018, drafted a student mental health policy that seeks to enable the university to fulfil not only educational responsibilities but an additional responsibility to student's well-being (University of Cape Town, 2018). Stellenbosch University has joined a global study, called the 'Caring Universities project', this study "aims to unpack mental health issues facing university students" (Bantjes et al., 2017, pp 1). This demonstrates that there is an effort to firstly, understand the root causes of the issue, the possible triggers and to address the rise of psychiatric and psychosocial issues amongst university studentsin South Africa by finding solutions for it. These efforts that are being initiated may helpto alleviate the burden on institutions as well as students affected. It is noted that these efforts may not be enough, but it is a start in the right direction (September, 2018).

A study involving nursing students in Kwa-Zulu Natal showed that some of the key factors contributing to tension and anxiety amongst students include stress and time-management (Langtree *et al.*, 2018). Academic content and commitments can also be seen as a stressor; this is particularly relevant to the context of this study as it alludes to high pressure work environments. The clinical setting comes with its share of strenuous situations and is a high pressure work environment, this is in addition to course content being taught to students which includes patient assessment and management inclusive of patient care (Stillwell, Vermeesch and Scott, 2017).

Psychiatric illness in universities is not limited to South Africa, a study done at Makerere University in Uganda explored the prevalence of depressed mood and suicidal ideation amongst its students, the results and showed a 16,2% prevalence rate of depression amongst their first year students (Vuga *et al.*, 2006). The study attributed many of the problems to be linked to high levels of poverty, loss of traditional social support and the HIV/AIDS epidemic (Vuga *et al.*, 2006); these are similar to the problems the students in South African universities face. The study however, did not look into interventions or recommendations for these issues raised.

Psychiatric illness proves to be a challenge at higher education institutions, the studies describe the prevalence rates of suicide, psychiatric illness and stressors, these rates are alarmingly high and there is a need for a strategic intervention to decrease these rates and put preventative measures in place (September, 2018).

1.1.3. Educational aspects in Health Sciences Education

Academics or lecturers are amongst those who provide support for their students (Langtree *et al.*, 2018). Theories of teaching and learning allow academics to understand the roles of an academic and an institution of higher learning. The central theory that encourages a versatile academic can be found when looking at the theories that fall under the umbrella of Transformative Learning Theory. The Transformative Learning Theory is the essence of adult education and is most applicable as it encourages the academic to teach in such a way that helps the students become autonomous thinkers (Mezirow, 1997a). An autonomous thinker in educational theory is an individual who has autonomy, that is they are rational thinkers and are able to make their own decisions without coercion or external influence (Mezirow, 1981; Rachels and Rachels, 2015b). This transformative teaching is done in various ways,

it includes involving additional theories which fall under transformative learning, such as Vygotsky's zone of proximal development. This sociocultural theory emphasises the importance of social interaction in the students' learning experience (Shabani, 2010). This social interaction is further explored in experiential learning theory, where the focus is on students to learn through practice and experience (Kolb and Kolb, 2005).

These theories are even more so applicable in the health sciences faculty where the health sciences academic teaches through interactions with students and patients, both in a classroom and clinical setting. This makes the role of the health sciences academic different from that of academics from other faculties since health sciences academics fulfil their roles as teachers and at the same time they are healthcare professionals, who are expected to encourage student well-being and overall patient care, sometimes simultaneously.

Health sciences academics teach and work together with students to treat patients, the duality of their role creates teaching dimensions that are specific to health sciences academics (Maudsley and Strivens, 2000). Health sciences academics are required to ensure that students learn good professional behaviour to become competent colleagues (Karnieli-miller *et al.*, 2010). There is a subsequent ethical obligation on the healthcare professional to impart ethical ideals while being a role model to the student.

This leads academics to at times feel a sense of responsibility towards the student and therefore might be inclined to identify suspected psychiatric illness in health sciences students (Bergman, 2004; Gholami and Tirri, 2012; Owens *et al.*, 2012; Gulliver *et al.*, 2018).

The manner in which a health sciences academic may identify and subsequently address suspected psychiatric illness may be in the form of various interventions taken. The term intervention in this project will refer to the manner in which an academic suggests and provides assistance to students with suspected psychiatric illness, this being in the context of a medical intervention. This is defined as an act of intervening or interfering in an individual's life with the intention of altering the outcome. In medicine, an intervention is usually seen as something done to help treat or cure a condition (Shiel, 2018). The interventions that are alluded to throughout this essay range from approaching a student that is suspected to have psychiatric illness and suggesting counselling or a medical consultation for them, referring them to

psychiatrists to possibly going a step further and providing medical assistance for them.

There are 2 types of interventions referred to as direct intervention which may also be referred to as a targeted intervention, and indirect intervention. Direct interventionsare described as interventions where students are directly approached based on specific criteria observed or screened for and referred to seek further medical advice,Indirect interventions are those that seek to provide non-targeted and universal support to a group of students with the aim of providing mechanisms to cope with or prevent stressors and illnesses in general (Stein *et al.*, 2008; Kaffenberger and O'Rorke-Trigiani, 2013; The Association for Child and Adolescent Mental Health, 2019).

These various interventions and possible approaches raise ethical concerns ascurrently there is no specific guidance as to what health sciences academics are expected to do. It is important to interrogate whether health sciences academics should be intervening at all when a student is suspected to have a psychiatric illness (September, 2018). It is important to compare the health sciences academics role to the role they may undertake when intervening, and evaluating whether this is ethicallyjustified. The interventions which raise ethical concerns, are those that may compromise the autonomy of the students in question.

1.2. Research Question

Is it ethically justifiable for health sciences academics to intervene when students are suspected to have psychiatric illness?

1.3 Rationale for the Study

Academics in health sciences are placed in a peculiar position as they are healthcare professionals as well as academics. They are expected to be mentors and role models and, therefore strive to have the students' best interests at heart while treating patients (Gholami and Tirri, 2012). This may lead to specific views or approaches towards what should be done when a student is suspected of having a psychiatric illness, especially if there is concern that it might affect their studies (Stillwell, Vermeesch and Scott, 2017). This study will focus on undergraduate students and the academics associated with undergraduate teaching only. This is due to the close contact teaching that occurs at this level and the literature highlights the alarming rate of suspected psychiatric illnesses amongst undergraduate students (Njilo, 2018; Pharma Dynamics, 2018).

Despite the alarming rate of psychiatric illness and suspected psychiatric illness amongst health sciences students (Pharma Dynamics, 2018), there are no clear and accepted interventions to address these concerns (Bantjes *et al.*, 2017). There is a further need to normatively assess the consequences these interventions may have for the student. Once this question is addressed, the next question to be answered is whether it is ethically justified for health sciences academics to intervene when students are suspected to have a psychiatric illness? If yes, which interventions can be considered as ethical and what are the reasons for this. There are research studies which have been conducted both locally and internationallywhich seek to find solutions and possible interventions for addressing or possibly preventing psychiatric illness in academic institutions, however there are no definitiveanswers to the questions posed (World Health Organization, 2004; Thomas *et al.*, 2011; Bantjes, 2018; Malboeuf-Hurtubise *et al.*, 2018). Studies done by Garlow et al and Stillwell, Vermeesch and Scott have analysed the impact stress has on university students and have not thoroughly investigated possible interventions for addressing suspected psychiatric illness nor have they looked specifically into the health sciencesfield (Garlow *et al.*, 2008; Stillwell, Vermeesch and Scott, 2017).

There is a need to normatively assess the specific role of health sciences academics, particularly since health sciences education is unique and includes many factors within the clinical environment which influence teaching and learning. It is important to further explore the ethics, principles, consequences and values of any intervention before deciding ifit may be implemented.

1.4. Thesis Statement

It is ethically unjustifiable for health sciences academics to intervene when students are suspected to have psychiatric illness, except in cases of direct intervention that is intended to protect the student from harming themselves or others, or in cases of indirect intervention strictly voluntary basis, and academics have a duty of care towards the student.

1.5. Research Aim

To defend the thesis that it is ethically unjustifiable for health sciences academics to intervene when students are suspected to have psychiatric illness, except in cases of direct intervention that is intended to protect the student from harming themselves or others, or in cases of indirect intervention strictly voluntary basis.

1.6. Research Objectives

1) To describe the roles and responsibilities of health sciences academics in South African institutions.

2) To normatively assess the interventions and approaches health sciences academics take towards students with suspected psychiatric illness.

3) To normatively assess the impact of possible consequences that may arise from interventions health sciences academics take towards students who are suspected to have psychiatric illness.

1.7. Research Design

This is a purely normative study. **I seek to establish what the moral obligations of health sciences academics in these situations are.**

1.8. Research Methods

This is a purely normative study and does not include research participants. No new or existing data was collected or analysed. **I seek to establish what the moral obligations of health sciences academics in these situations are** by using philosophical and bioethical research methods to define, explore, evaluate and critically analyse the arguments in this component of the study. My arguments critically discuss arguments defending my thesis statement as well as counter-arguments that may arise. Desktop searches were conducted using search engines such as Google Scholar and webpages such as Wits Libguides, PubMed, Wiley Online, Science Direct, Research Gate, The Lancet etc., and included the use of primary sources such as Beauchamp and Childress: Principles of Biomedical Ethics, Kuhse and Singer: A Companion to Bioethics, Rachel and Rachels: The Elements of Moral Philosophy, Paolo Friere: Pedagogy of the Oppressed, newspaper clippings etc. The keywords used include: psychiatric illness, South African Universities and psychiatric/mental illness, suicide amongst university students, adult learning theories, transformative learning, power dynamics in higher education, duties of academics, moral code for academics, code of conduct for healthcare professionals, ethics in psychiatric illness/mental illness, interventions for psychiatric/mental illness, impact of psychiatric/mental illness, health sciences students, autonomy in mental health, paternalism in education, paternalism in healthcare, duty to care, ethics of care, medical students, health sciences/medical academics/educators, consequences of psychiatric interventions, consequences of mental health interventions in tertiary institutions.

1.9. Overview of approach taken to answering the question

a) Firstly, I explore literature on the general ethical and legal obligations placed on academics in health sciences in South African institutions. This has been explored through educational theories and how education has changed for the health sciences context. I have specifically looked at Mezirow's Transformative learning, Vygotsky's zone of proximal development, Kolb and Kolb's Experiential Learning theory and Wenger-Trayner's Communities of Practice (Mezirow, 1997a; Maudsley and Strivens, 2000; Hedegaard, 2005; Kolb and Kolb, 2005; Merriam, 2008; Wenger-Trayner and Wenger-Trayner, 2015). I have analysed specific responsibilities that academics have, either directly or indirectly, through the educational theories. I compared these roles and responsibilities of the health sciences academic to that of the general academic and the healthcare professional. There is a duty to mentor students on the part of the academic, to stimulate learning and foster a good environment, empower leaners to be autonomous thinkers and competent professionals (Mezirow, 1997b; Whitcomb, 2006; Karnieli-miller *et al.*, 2010; Owens *et al.*, 2012). I have used these general obligations to evaluate literature that guides academics in addressing incidents where students may be suspected to have psychiatric illnesses (The Association of UK University Hospitals, 2017; Wartman, 2017). These guidelines have been evaluated by analysing the values that inform them, this can include moral codes (Bergman, 2004), as well as code of conduct that are aligned to healthcare professionals, academics and higher institutions; these include the Health Professions Council of South Africa's guidelines for the management of the impaired student, the Health Professions Council of South Africa's Code of Conduct for Healthcare professionals, and the Coalition of National Health Education organizations': Code of ethics for the health education profession (Coalition of National Health Education Organizations, 2011; Health professions council of South Africa, 2014; Health Professions Council of South Africa, 2014; University of Cape Town, 2018).

b) I analyse current approaches academics take when intervening when a health sciences students is suspected to have psychiatric illness (Stillwell, Vermeesch and Scott, 2017). These approaches have been analysed using literature on how academics have tried to intervene if at all and compare it to general ethical principles. The ethical arguments include respect for autonomy, a look at what constitutes

diminished autonomy, paternalism in this case (Provost, 2008; Davies, Marie and Cooper, 2009; Smeyers, 2010; Beauchamp and Childress, 2013; Sjöstrand, Eriksson and Helgesson, 2013). I also analyse these approaches using the values that are attributed to academics in the health sciences faculty, these include the core competencies expected of a healthcare professional as outlined by the HPCSA which include communicator, collaborator, healthcare advocate, scholar, professional, leader and manager (Health professions council of South Africa, 2014). This assesses whether there is a basis for the approaches used, their relevance for the context and if they are linked to ethical and legal obligations placed on academics in the health sciences (Salam *et al.*, 2013; Mortier *et al.*, 2018). I described how various interventions may alter the autonomy of an individual thereby resulting in diminished autonomy. I evaluated this using transformative learning theories which includes the shift in the power dynamics in academic institutions (Mezirow, 1997a). An important aspect being the responsibility placed on the adult student and assessed the importance of upholding autonomy to achieve these learning goals. I explored the ethics of care and discuss the impact care has on the student and the health sciences academic, I considered the place caring has in health sciences education and particularly discuss the duty of care that an academic should have towards students and how this is underpinned by the responsibilities of a health sciences academic.

c) I have used the consequentialist theory of Utilitarianism to defend the thesis that the interventions taken are morally unjustifiable when students are suspected to have psychiatric illness. The firstdiscussion explored the relevance of consequentialism in general and thereafter specifically discussed the application of utilitarian theory in the context of interventions.The consequences that were looked at include the impact on the health sciences student and the academic using rule utilitarianism. This included the impact on the relationship between the health sciences academic and student, the possibility of stigma, discrimination and the vulnerability of the student as a suspected psychiatric patient in the education setting (Lossius, Legernes and Pedersen, 2019). The consequences also analysed the importance of resilience and what may impact the development of it, such as how an assumed diminished autonomy can affect resilience building in health sciences students and subsequently health sciences professionals (Browning *et al.*, 2007; Jadaszewski, 2017). I explored the impact that would result from the health sciences academic intervening, and how this contributes to their

overall emotional burden, workload, and whether or not this has affected their primary role and responsibilities. I normatively analysed the consequences caring will have on the student and the health sciences academic. I compared whether the consequences of the interventions and the consequences of caring and established whether or not each yields good or bad outcomes and whether they contributes to overall happiness and ultimately mental health and well-being for the health sciences student and academic (Davies, Marie and Cooper, 2009; Ovseiko *et al.*, 2014).

1.10. Ethics

An ethics waiver has been granted by the Wits Human Research Ethics Committee.

1.11. Research outcomes

I have attempted with this research to create recommendations for possible ethically justifiable methods for supporting health sciences students and alleviating the burden on health science academics.

I will further research the duty to care in academics and the impact it may have on students and academics to inform future policies.

I will further research the impact psychiatric illness has in health sciences students and how this further impacts them once they have graduated, as well as the impact this has on health science academics.

1.12. Limitations

The limitation of this study includes the paucity of literature on specific studies on interventions done in students with suspected psychiatric illness in health sciences. This limitation has been mitigated by exploring general interventions done for suspected psychiatric illness in other healthcare settings as well as other fields within higher education and applying it to the health science education context.

1.13. Overview of chapters

Chapter 1 – Introduction

In the introduction I have described the rationale for this study, the aim and objectives of the study and discussed the argumentative strategy that will be used to defend the thesis statement.

Chapter 2 – Role and responsibilities of health sciences academics

This chapter discusses the various roles and responsibilities placed on an academic in a health sciences faculty. It describes the general roles of academics which are underpinned by theories of teaching and learning. It describes how this translates into the health sciences environment and how the role and responsibilities can determine ethical decision making.

Chapter 3 – Normative analysis of the interventions taken for students who are suspected to have psychiatric illness.

This chapter discusses the interventions that are taken when a student is suspected of having a psychiatric illness. It normatively analyses each intervention, and considers the ethical principles and the role of the health sciences academic in these interventions. It explores the impact the duty to care has on the student and the health sciences academic.

Chapter 4 – Consequences and ethical concerns of interventions taken for students with suspected psychiatric illness.

This chapter focuses on the specific consequences for each intervention discussed in Chapter 3. I explore the consequences on the health sciences student and the academic. This chapter examines the ethical concerns for each consequence and compares it to the duty to care. It assesses whether or not a specific intervention and the duty to care yields good or bad outcomes, ultimately analysing if the outcomes makes it an ethical intervention and approach or not.

Chapter 5 – Conclusion and Recommendations

This chapter concludes the research and reiterates that position that it is ethically unjustifiable to intervene when students are suspected to have psychiatric illness and it underscores the importance of the duty to care that an academic should have towards the student. I also provide recommendations on how health sciences academics ought to assist students with suspected psychiatric illness.

Chapter 2: Roles and Responsibilities of Health Sciences Academics

"Whether in the face of the most everyday slights and bruises in the school classroom, or in the face of great evils that haunt our world today, which intrude on our college seminars, the obligation of the moral educator is to heed his or her own sense of 'I must care' by nurturing the 'I must care' of the student" (Bergman, 2004, pp 161).

In this chapter I address objective 1) of the research, which is to explore the roles and responsibilities of the health sciences academic. I first describe the roles and responsibilities placed on the health sciences academic and the promotion of student autonomy and resilience, which is associated with outcomes of education theories. I then discuss various relevant theories of teaching and learning and relate them specifically to health sciences education, this is focused on transformative learning which includes Vygotsky's Zone of Proximal Development (ZPD), experiential learning – communities of practice amongst others.

2.1 Roles and responsibilities of the health sciences academic

A role can be described as positions individuals hold when in a team or part of a process, whereas responsibilities refer to specific tasks or duties and obligations that an individual is expected to complete as a function of their roles. The responsibilities in a given role must be fulfilled and the individual can be held accountable for their responsibilities in a team or project (Collaborative Justice, 2013).

Academics are placed in a position to teach and influence emerging professionals and researchers and therefore it is reasonable and expected to hold them to a high moral standard (Cleary *et al.*, 2012). Academics generally have two roles, they are educators and researchers. An academic's primary responsibilities are to teach, be an educator and foster a good learning environment as well as contribute towards curriculum planning and assessment. In a tertiary institution academics are also expected to contribute towards research outputs (Whitcomb, 2006; The Association of UK University Hospitals, 2017; Kaufman, 2019). The role of researcher is not going to be discussed here, instead the role of the educator will be the focus as it illuminates the issues of the ethical dilemma in question.

The health sciences academic is unique when compared to other academic professions as they have responsibilities towards healthcare services as well as academic responsibilities towards students and education outputs. Some health sciences academics have clinical responsibilities if the individual is employed in the healthcare field, such as a joint appointee. A joint-appointee in the health sciences faculty refers to a healthcare worker who is employed by the National Department of Health and an academic institution, this individual has both academic roles and clinical service duties to carry out. These roles may need to be carried out simultaneously, as is evident in the case of clinical teaching which takes place in the clinical environment (Whitcomb, 2006; Kaufman, 2019). The additional role placed on the health sciences academic which comes from their profession as a healthcare worker is also important as they are placed in a unique position to effect positive change to improve the healthcare system through role modelling and teaching (Dharamsi *et al.*, 2011).

It is important the roles and responsibilities of the academic align well with the advancements of education and importantly health sciences education. This should be clear to all who enter the field of health science education such that students receive quality education promoting a culture of self-directed learning and encourage emphasis on moulding critical thinking skills. The Coalition of National Health Education Organizations has a specific document guiding academics in the health education field (Coalition of National Health Education Organizations, 2011). This code of ethics document directs health sciences academics to six main responsibilities: Responsibility to the public, the healthcare profession, the employer, the delivery of health education, responsibility in research and evaluation and in professional preparation. This document is an example of what should be implemented in all health sciences faculties such that educators are aware of what is expected of them. It is what is deemed close to a gold standard for health sciences academics, noting aspects that are missing and will be discussed, it is inclusive of the core values needed in the health sciences educational context.

The fundamentals of health sciences education is to train the next generation of healthcare workers to meet the demands of an ever changing healthcare system (Dharamsi *et al.*, 2011), the first responsibility in the code of ethics for the health professions education is the responsibility to the public, this ensures priority is given to promoting “health and well-being of individuals and the public while respecting both

the principles of individual autonomy, human rights and equality" (Coalition of National Health Education Organizations, 2011). Section 1 of the Code of Ethics for Health Education Profession is applicable here, it describes allowing individuals to make informed decisions, provided that these decisions do not pose a risk to the health of others (Coalition of National Health Education Organizations, 2011). This is a vague statement and is not clear what constitutes a decision that may pose harm to others. It is an important section to explore as this speaks directly to intervening when a student is suspected of having psychiatric illness. This is discussed further in chapter 3.

The second responsibility is the responsibility to the profession (Coalition of National Health Education Organizations, 2011). This emphasises the duty placed on the health sciences academic to uphold the professional values and code of conduct for their respective profession, this includes patient care, respecting the rights of individuals and ensuring continuous learning (Health Professions Council of South Africa, 2008; Health Professions Council of South Africa, 2014). This responsibility is also important in experiential learning theory and Vygotsky's ZPD, as role modelling allows the student to aspire to uphold the same conduct (Kaufman, 2019). This is discussed further in chapter 2.2.

The health sciences academic also has a responsibility to the employer, the academic institution, and this emphasises professional conduct, upholding integrity and values of the institution.

One of the core responsibilities of an academic is their responsibility in the delivery of health education. This is the academics duty to contribute to curriculum reform and the development of professional standards (Coalition of National Health Education Organizations, 2011; Dharamsi *et al.*, 2011; Mukhalalati and Taylor, 2019). Section 5 of this responsibility is worth noting: Health Educators promote the adoption of healthy lifestyles through informed choice rather than by coercion or intimidation (Coalition of National Health Education Organizations, 2011).

The academic's responsibility now includes both teaching responsibilities and mentorship. This may bring in thehealth sciences academics role as a healthcare worker in assisting with 'lifestyle

changes' that may promote growth of the student. (Mezirow, 1997b; Hedegaard, 2005; Kolb and Kolb, 2005; Kaufman, 2019).

The responsibility to produce research and evaluation will not be explored here. The next responsibility to discuss is the responsibility in professional preparation. This highlights educational theories where the academic has a responsibility to create a learning environment relevant to the student and to the lesson objective (Rogers, 2010). This responsibility requires the academic to not teach in isolation of medical theory but also to include aspects which provide a quality education that aims to benefit the profession and the public (Coalition of National Health Education Organizations, 2011).

The responsibilities required by this code of conduct, specifically the responsibility of educating, are informed by educational theories. The approaches to education have a theoretic basis which guide the way in which this responsibility is achieved. In short, the code sets out the expectations and the education theories indicate how to best meet the expectations and outcomes of teaching and learning. Education theories also assist in framing the student and health sciences academic relationship by highlighting the responsibilities of the student as well.

The focus on health sciences academics can be elucidated by making a comparison between general academics (or academics who are not health sciences academics) and health sciences academics. Table 1 below describes the responsibilities of the general academic, the healthcare practitioner and the health sciences academic. It is important to note the health science academic has the responsibilities of a general academic and health practitioner at the same time. The general academic and health sciences academic have more teaching responsibilities than the healthcare practitioner would have. The healthcare practitioner has more responsibilities towards patient care and healthcare service delivery whereas the general academic does not have this responsibility. The health sciences academic has a combination of the general academic responsibilities and the healthcare practitioner responsibilities as outlined below.

Table 1: Responsibilities of general academic, the healthcare practitioner and the health sciences academic

	General Academic	Healthcare Practitioner	Health Sciences Academic
Core teaching responsibilities	Develop learning objectives for the course/ lesson. Develop curricula, course assessment strategies and facilitate learning in a classroom or laboratory setting	Guide a student that rotates through their clinical environment based on specific objectives that a student brings from their course. Act as a mentor for students who may rotate through the clinical environment.	Facilitate learning in classroom setting and clinical work environment, develop curricula, course assessment strategies. Develop learning objectives for the course/ lesson. Act as a role model for students while in clinical field.
Service responsibilities	Serve in institutional committees and use research output to serve the professional and general society.	Primary responsibility is to the patient population, ensuring patient-care, assessment and management.	Fulfil dual responsibility of serving professional and institutional committees and serve the patient population through ensuring patient care and public health goals.

There are core competencies which the healthcare professional is expected to maintain, these include being a: Professional, Communicator, Collaborator, Leader and Manager, Health Advocate and Scholar (Health Professions Council of South Africa, 2014). These additional roles are placed on them in the academic institution (this being educator and researcher (Hope, 2013)).

As outlined in Table 1, the healthcare professional takes on the role of academic and in turn also become a role model for the students (Cleary *et al.*, 2012). Each role assigned to a health sciences academic has responsibilities and the interaction within each environment emphasises the various characteristics needed in order to meet these expectations. The health sciences academic has a dual responsibility to ensure the best quality of care for the patient and create a conducive learning environment for the student (Ovseiko *et al.*, 2014). It is anticipated that these various roles can be blurred during different interactions with students, colleagues and patients. For

example, if a student requests medical advice due to the health sciences academic's role in the hospital as a healthcare professional. This would result in a combination of the roles of a health professional and health sciences academic.

New and developing theories of teaching and learning have redefined old responsibilities and created new ones which are placed on the academic and specifically the health sciences academic. These responsibilities are now inclusive of academic and health professional as described in Table 1. It is important to describe the theoretical framework that undergirds the responsibilities placed on academics and specifically health sciences academics.

2.2 Theories of teaching and learning in Health Sciences

"We need only attend to our own mind, body, spirit, and emotions and the sociocultural and material contexts in which we ourselves learn to recognize the potential of this expanded vision for our adult students" (Merriam, 2008, pp 98).

The conception of adult learning is evolving, academics are becoming more conscious of different learning styles that students use and the importance of self-directed learning, this places a burden on the educator to be more cognisant of the individual student's context and the learning environment best suited for it (Mukhalalati and Taylor, 2019). It is important in the health sciences field because of the healthcare needs of the country are constantly changing and the constant advances in medicine. There is a responsibility on health sciences academics to constantly be up to date with developments in health sciences and include the developments in teaching (Maudsley and Strivens, 2000).

New and developing theories of teaching and learning encourages a mind shift from didactic lectures to a more inclusive method of teaching to allow the student to become self-directed and ensure they understand the importance of being a life-long student in the health sciences field (Koons, 2004). Furthermore, they require effort from the educator to be more conscious of learning environments and how it can influence the student once in the workplace (Merriam, 2008). In this subsection I use the term educator instead of academic as that is the primary role focused on in the theories of teaching and learning.

There are various theories that are used to describe learning, each theory explained and summarized in Table 2 below discusses the theory definitions and objectives, the responsibilities of the student, the responsibilities and role of the educator and the implication it has on the student's future practice (Kaufman, 2019).

Table 2 Summary of theories used in health sciences education

Theory	Description	Responsibility of the student	Responsibility of the educator	Role of the educator	Implications for practice
Transformative Learning	Emphasis is placed on teaching methods that encourage autonomous thinking, rational decision-making and critical reflection.	Become a team-player, be self-reflective, critical and more aware of their original frames of reference and listen to new perspectives to gain new problem-solving skills.	Create lesson plans and objectives that encourage critical reflection, teamwork and allow the student to participate in lesson through meaningful discourse.	Facilitator	Student becomes autonomous thinker, is able to be self-directed and make independent rational decisions.
Sociocultural Theory as described by the Zone of Proximal Development	Learning is achieved through discourse and collaboration with others.	Develop problem-solving skills, work collaboratively in an effort to become independent decision makers.	Create lessons and objectives that encourage team work, collaborative effort and allow for a shift in student development from passive to a more active and engaging learner.	Facilitator, mentor	Student develops through learning from others, maintains autonomy whilst appreciating collaborative learning and mentorship.
Experiential Learning	Learning is achieved through activities that require students to immerse themselves in experiences and observations. Students need to engage in the experiences/process and reflect on it to enhance learning.	Student to engage and actively participate in the process to enhance learning. To develop critical reflective skills.	Create a learning environment that is based on experience to meet objectives and promote growth.	Facilitator, mentor, role-model	Student becomes self-directed, a lifelong student and a reflective practitioner.
Communities of Practice	Students learn in various communities who have a shared interest that promotes increasing knowledge of a topic.	Students contribute to the work of the community, developing tacit attitudes and skills by exposure to the work environment.	Organize learning experiences that place students in relevant communities of practice that enhance their growth and professional identity.	Facilitator, mentor, role-model	Student forms part of community of practice, understands importance of lifelong learning and learn

		Develop teamwork, lifelong learning skills.			importance of teamwork.

A paradigm shift in health sciences education has occurred, from a behaviourist teaching method to a more transformative and inclusive method of teaching (Mezirow, 1997b; Kaufman, 2019). Jack Mezirow's Transformative learning theory is inclusive of Lev Vygotsky's description of the zone of proximal development (ZPD) and experiential learning which is inclusive of communities of practice. As described in Table 2, each theory has core responsibilities of the student and educator and emphasises the role of the educator to remain that of a facilitator of learning, while potentially becoming a mentor and role model in a specific teaching setting.

Transformative learning theory is defined as the essence of adult education, this is due to its emphasis on helping the student become an autonomous thinker (Mezirow, 1997a).

The outcomes of transformative learning: student autonomy and resilience

The word autonomy refers to the ability to self-rule, that is to make a decision for oneself (Beauchamp and Childress, 2013; Rachels and Rachels, 2015b). Respect for autonomy is one of four principles used in Principlism which is described as an ethical framework to ethical decision making. The other principles are beneficence, non-maleficence and justice, specifically distributivejustice. An autonomous choice is that which is done freely without coercion or externalinfluences. In order for an individual to be seen as autonomous they must have libertyand agency (Rachels and Rachels, 2015b). Liberty means they are free from controlling factors and agency refers to the capacity of the individual to make an intentional action. For an individual to have autonomy they should have both aspects.Beauchamp and Childress propose three conditions to be present for autonomous choice: intention, understanding and non-control (Beauchamp and Childress, 2013).

It is important that academics understand the importance of respecting the autonomy of the students. In order to understand respect for autonomy it is important to look at its original thought, Immanuel Kant's respect for person's. Kantian theory falls under deontological theory, which is a rule-based theory (Rachels and Rachels, 2015b). This is described as morality being grounded in reason. One of Kant's most important

claims is that of a “maxim” – a maxim refers to the general rule. Kant claimed that an action that is moral is that which is done for the sake of obligation, this action should then always be carried out. Thereby it becomes a general rule - a maxim. Kant considered human beings to be valuable, and have dignity. He said that humans have “intrinsic worth” because they have the capacity to make their own decisions, free from coercion. Kant further believed human beings should be treated as “an end” and not as a “means” only, this means that you should treat human beings with respect, promoting their well-being and respecting their rights (Rachels and Rachels, 2015b).

In later years Beauchamp and Childress looked at the term Respect for Autonomy (Beauchamp and Childress, 2013). This is different to Respect for persons in that this definition ensures that an individual’s autonomous choice is respected. It is respecting the individual’s choice to also hold views and opinions and take actions that are in line with their personal views, opinions or beliefs.

An individual with the capacity to make decisions is still able to change their mind and opinions (Behrens, 2018). This occurs when they have a new perspective and they can now make a decision based on new information. Reflection and critical thinking are required and since the decision is not made through direct coercion the individual still maintains their autonomy. This is where the concept of respect for autonomy comes in (Beauchamp and Childress, 2013).

Furthermore, respect for autonomy is not merely an attitude but must be acted upon, in such a way that it enables the individual to make an autonomous choice. (Beauchamp and Childress, 2013). Autonomous actions are the outcome of deliberations and choices by rational agents as persons, in the moral sense, an autonomous individual is seen as an individual who is capable of self-rule and self-governance (Varelius, 2006; Beauchamp and Childress, 2013). This can further be described as an individual who is able to reason, deliberate and make choices that are free from control and interference (Beauchamp and Childress, 2013; Behrens, 2018).

A student should be recognised as an autonomous thinker if they have both the capacity and the agency to make their own decisions independent of controlling influences (Rachels and Rachels, 2015b). Transformative learning is centred on students developing these abilities to be autonomous thinkers. Students come with a ‘frame of reference’, this refers to the habits of mind an individual has and the learning

that takes place aims to shift and change those perspectives through discourse. Through their training a student is meant to learn critical thinking and problem solving skills, and use new perspectives to change or strengthen original frames of reference (Mezirow, 1981, 1997b). The decision to change their perspective based on processing and integrating new information, and be critical and self-reflective is what makes the student an autonomous thinker (Kaufman, 2019). This ensures they challenge their original thought process (frames of reference) with the knowledge gained in the learning environment to create new frames of reference which assist with their critical reflective skills.

These discourses in the learning settings encourage student empowerment, which aims to strengthen the health sciences student abilities as they prepare to be health professionals. Developing strength in the student evokes autonomous thinking and enable the student to be more confident, communicative and improves their problem solving skills and become an effective team player (Mezirow, 1997b)(Kaufman, 2019).

There is a shift in the power dynamic, where traditionally the educator was expected to provide all the resources and learning, in transformative learning, this shifts to allow the student to take ownership of themselves, their growth and their learning. The power dynamic shift is also described in social constructivist theory. Social constructivism is a learning theory that is based on the understanding that knowledge is co-constructed and that individuals learn from one another. This collaborative learning encourages teamwork and discourse (Vygotsky, 1978). It emphasises that development cannot take place without having both the social and cultural contexts (Kaufman, 2019).

Lev Vygotsky, a social constructivist, developed a theory where he described the zone of proximal development (ZPD). This theory emphasises that experienced practitioners can guide novices to perform at a level that they would not have achieved if left unaided. (Hedegaard, 2005). ZPD encourages independent problem solving and thereafter gives opportunity for collaborative thinking to reach a new potential development level, this new development level is reached by expert guided problem-solving (Kaufman, 2019).

The educator's responsibility (in social constructivism, under the transformative theory umbrella) is to ensure the teaching method includes self-reflection and critical thinking

for the student (Mukhalalati and Taylor, 2019). The educator has a responsibility to encourage critical thinking, develop problem solving scenarios that promote discourse and challenges student's assumptions. This environment should be free from coercion and promote autonomous thinking. The educator's sub-role becomes a facilitator and mentor (Hedegaard, 2005; Kaufman, 2019). This type of learning can be achieved through case based learning where a student engages with a real patient case or simulation training where the student is placed in a simulated workplace environment to learn a skill set. Mezirow believed that learning is volitional and should be curiosity based, and mentor assistance ought to enable the student to be discovery-driven and self-reflective (Kaufman, 2019).

The mentorship relationship that is built incorporates Vygotsky's ZPD and through experiential learning as outlined in Table 2 allows the health sciences academic to play a vital part in developing the student as a professional. It is important to ensure boundaries are maintained to uphold ethical conduct within the institution (Cleary *et al.*, 2012). These boundaries protect both the academic and student, playing a significant part in ensuring that there is no inappropriate behaviour nor a breach of boundaries.

The experiential learning theory developed by David Kolb is a transformative theory, based on the foundations of John Dewy and Kurt Lewin who deduced that learning is conducted on the basis of experience (Kolb, 1984). Learning is a process, and is important to engage students in a process that enhances their learning. Experiential learning theory describes learning as a process which draws out beliefs and ideas so it can be tested to generate new and refined ideas, thereby saying learning is re-learning (Kolb and Kolb, 2005). This incorporates Vygotsky's ZPD as a student exposed to experiences learns how to adapt to it such that they are prepared the next time, thereby contributing to their development (Shabani, 2010).

In Experiential Learning theory, it is the responsibility of the student to develop skills needed in an environment, to adapt to various experiences and critically reflect on those experiences to create new ideas and problem solving skills (Rogers, 2010). Table 2 lists these responsibilities. The purpose of this method is to allow the student to take responsibility for their learning and take initiative to become a reflective

practitioner and develop the ability to synthesize information and experiences (Rogers, 2010).

In an experiential learning space, the educator takes the role of a mentor, role model and facilitator of learning, these roles are listed in Table 2. The educator has a responsibility to respect the students experience, create a setting that is hospitable for learning, make the learning conversational to enhance development in the student. It is important to create this space to encourage reflection so that the student critically reflects and then actively changes their methods to improve their learning/ problem solving skills (Kaufman, 2019).

Experiential Learning Theory allow for the student to become part of a community of practice. A community of practice includes student interactions in different groups or 'communities' (Rogers, 2010). These communities range from the university environment, interdisciplinary activities and most commonly workplace teaching. These communities have a shared interest and hold joint activities to share information around that interest (Wenger-Trayner and Wenger-Trayner, 2015). A community of practice enables individuals to take collective responsibility to foster knowledge and relate this to their performance. These communities are not limited by formal structures (Wenger-Trayner and Wenger-Trayner, 2015). Each community of practice has a role in the training of the health sciences student.

The student has a responsibility to take initiative such as those listed in Table 2, in these communities of practice in order to gain knowledge they need to improve their performance and knowledge base. The responsibility of learning is on the student and once again, the power dynamic shifts between educator and student (Kaufman, 2019). The student develops their own professional identity.

It is the academics responsibility to ensure that each community of practice has something to offer the student to contribute to the learning experience (Wenger-Trayner and Wenger-Trayner, 2015; Kaufman, 2019).

Each theory contributes to and holds value in the development of a competent healthcare professional. The roles of the educator described range between facilitator and mentor. It is easy to see where an educator may feel responsible for the student's learning and additionally their well-being as they promote the growth of the student (Owens *et al.*, 2012).

The aims of transformative learning, the ZPD and experiential learning theories that the development of an autonomous thinker and ultimately a self-reflective and independent practitioner, and the role of the educator is to ensure this is promoted. A description of the responsibilities and theoretical frameworks of learning is essential in understanding the nature and the academic and student relationship and its intended outcomes. It is clear that the autonomy of a student is a priority in these approaches to learning. This informs the way in which academics should interact with their students. If a student is suspected of having a psychiatric illness, this suspicion does not warrant a disregard of their autonomy because this would counter the aims of adult learning as discussed above (unless in extreme circumstances discussed later in this report).

The educational theories provide a basis for understanding the role of the health sciences academic. This emphasises the health sciences academics' role as a facilitator of learning and at times a mentor and role model. A health sciences academic may have, in the past and due to older educational approaches, resorted to specific interventions in an effort to support a student as they believe they have the best interests of the student, this would have been in instances of directly approaching and medically advising students who would not have consented to this approach. This is described as a direct intervention to suspected psychiatric illness and is discussed further in chapter 3.

Experiential theory explains the opportunity a health sciences academic may have to support a student. This is due to teaching in a setting comfortable for the health sciences academic (the clinical setting). The role of mentor and role model to the student is due to them working closely with students during ward rounds and clinical teaching. This environment may lead to the health sciences academic feeling comfortable to approach a student with suspected psychiatric illness. However, as described above, in the teaching and learning process there is no room for such an intervention because it would counter the aims of transformative learning. This is because university students are understood to be independent agents who arecapable of making choices/self-governance. It then follows that if students are understood to be autonomous thinkers, they should be accepted as autonomous beings, meaning that their autonomy generally is acknowledged and respected. For example, in an event where a student is unwell or is suspected to have psychiatric

illness, they still have autonomy, therefore there is no place for an intervention that counters this.

It is challenging for the student to adapt to the clinical environment without any specific training for the field intended (Browning *et al.*, 2007). The clinical environment comes with more than just patient conditions and management. There are elements of pressure, stress, emotional trauma, increased workload, professional and personal roles amongst others (McCann *et al.*, 2013; Salam *et al.*, 2013). This demonstrates the need for resilience training in health sciences education (Baldini *et al.*, 2014). Resilience can be defined as the skill to adapt to a new or challenging situation (Forbes and Fikretoglu, 2018). There is a need to develop 'resilience-promoting' environments to ensure healthcare professionals have the skills needed to be competent and perform at their best for the patient and the larger healthcare system while still being able to maintain their well-being (McCann *et al.*, 2013; Baldini *et al.*, 2014). Transformative learning theory promotes resilience when implemented and practised effectively. The teaching is centred on the biopsychosocial approach when consulting with a patient, this approach looks at the holistic patient and treats all aspects of the patient, the medical and psychosocial assessments. The approach is to teach students to understand what Hippocrates means when he says "It is more important to know what sort of person has a disease than to know what sort of disease a person has" (Wartman, 2017, pp 12). This additional approach calls for broader and much more elaborate (or even multi-dimensional and conscientious) ways of teaching and learning.

The competencies a student needs to have to be the type of professional the healthcare system needs are outlined in the Health Professions Council of South Africa Code of Conduct and guidelines for good practice (Health Professions Council of South Africa, 2008). These competencies include upholding/improving the standard of patient care, upholding and safeguarding patient rights as well as responsibilities, maintaining principles of confidentiality, professionalism amongst others (Health Professions Council of South Africa, 2016).

In conclusion, the health sciences academic has a responsibility in the execution of educational theories to promote student autonomy and resilience (Mezirow, 1997; Chen *et al.*, 2010). This should be done by promoting a culture of teaching and

continuous life-long learning in students (Kaufman, 2019). In doing so an academic becomes a mentor and role model for the students and ensure they reach the competence expected of their profession (Coalition of National Health Education Organizations, 2011). They have a duty not only to the students, but also to their various educational institutions, the healthcare system, the community at large as well as their profession (Manthorpe and Stanley, 1999).

It is further evident that the lines become blurred once the academic either becomes a mentor or has to support a student with a non-academic issue, this could also be attributed to the role of academic merging with the role of healthcare professional (Manthorpe and Stanley, 1999).

The theoretical approaches to teaching and learning demonstrate the health sciences academic has a responsibility to facilitate learning, provoke discourse ensuring the student develops the identity and competence of a professional (Kaufman, 2019). The academic has a responsibility to do this in a manner that ensures the student becomes an autonomous thinker, able to make good decisions using problem solving skills and use critical reflection for growth and improvement.

This is an ethical obligation to ensure the next cadre of healthcare workers are equipped with skills and have the capabilities to be competent professionals who will be able to make rational and independent decisions. The increase of psychiatric illnesses amongst university students has given rise to the question of how an academic should approach a student who they suspect to have psychiatric illness. These interventions are normatively analysed in the next chapter.

Chapter 3: Normative analysis of the interventions taken for students who are suspected to have psychiatric illness.

“Universities are increasingly diverse environments with opportunities to enhance knowledge development and cultural enrichment. For this enrichment to occur and for individuals to reach their learning potential, health and well-being must be enabled. Health is much more than the absence of disease, and includes mental health” (Wynaden *et al.*, 2014, pp 343).

There is an expectation from institutions and communities on academics to intervene when there is a student who is suspected to have a psychiatric illness. This is important to ensure the well-being of the student and future professional, it is also vital for competence in a healthcare field. Students may have inherent psychiatric illness without clinical/academic triggers, however, there is argument that the healthcare environment comes with many triggers that may aggravate a health sciences student with suspected psychiatric illness these triggers may include, but are not limited to, trauma patients, patients with psychiatric illness or terminal illness, an aggressive patient and high-pressure working environments (Storrie, Ahern and Tuckett, 2010).

In this chapter I address objective 2) of the research, I normatively assess the interventions and approaches health sciences academics can take towards students with suspected psychiatric illness.

I first define the term intervention and its context for this project, thereafter I discuss various interventions and approaches taken by academics (health sciences and those in other fields). I define the various ethical theories and principles that apply to each intervention and normatively analyse each intervention described. These theories and principles include respect for autonomy and specifically look at what constitutes diminished autonomy, paternalism and ethics of care. Finally, I use this ethical analysis to evaluate the roles and responsibilities placed on health sciences academics to determine if these interventions align with the various codes of conduct the health sciences academic should abide by.

3.1 Interventions used for students with suspected psychiatric illness

3.1.1 Direct Interventions

Direct intervention ranges from an academic observing and identifying a student who is suspected to have a psychiatric illness (Stein *et al.*, 2013), and thereafter referring a student to a registered health professional to generally screening all students and then identifying students at risk based on specific criteria or risk factors (Stanley and Manthorpe, 2001).

Both methods include a level of observation of key signs and symptoms of psychiatric illness, such as social withdrawal, a decline in academic performance or more serious symptoms of suicidal ideation and manic behaviour, and thereafter approaching the student to be screened and/or treated for psychiatric illness. (Chafouleas, Kilgus and Wallach, 2010; Muriungi and Ndetei, 2017; Gulliver *et al.*, 2018). These interventions involve the training of staff to detect these signs and symptoms early, this staff member can be an academic or a support staff based on the institution (Gulliver *et al.*, 2018). Direct intervention is a strategy that when implemented, allows the academic to pick up symptoms and confirm a student with suspected psychiatric illness, which is more often than not a recognized symptom that meets the criteria of a psychiatric illness and approach the student to either counsel or refer them to the relevant professional to seek help and possible treatment (Costello, 2016).

For example, in the first method an academic may use is to observe/identify signs of withdrawal, sudden and concerning behavioural changes, sudden change in marks/grades, e.g.: a student who had consistent marks having a sudden drop in marks, or not showing up for assessments at all and/or being flagged as an "at risk" student, they would directly approach the student regarding these concerns and suggest possible treatments or referral. It is imperative to note that the student must first consent to be screened and to be referred. The second method entails the academic providing a screening tool (may be in the form of a questionnaire or activity) and identifying these risk factors from that. The risk factors include those described in chapter 1, such as emotional trauma, psychosocial stressors or even go as far as symptoms of a psychiatric illness. Thereafter, they would select students at 'risk', and suggest treatment or referral for these students (Stein *et al.*, 2008; Costello, 2016; Das *et al.*, 2016; Tomlin, 2018).

This can be seen as the academic being extra vigilant and observant in the classroom or in the case of a health sciences academic, in a clinical setting when training students as well (Manthorpe and Stanley, 1999). Due to the mentor role that the health sciences academic may take on when including the student in a clinical practical environment, the health sciences academic may unintentionally detect such symptoms that meet the criteria for a suspected psychiatric illness. It is therefore imperative to examine whether direct interventions as described above can be ethically justifiable. This is explored in subsection 3.2.

3.1.2 Indirect Interventions

Indirect or universal interventions are aimed at groups of students and do not only focus on students who may be suspected to have a psychiatric illness (Stanley and Manthorpe, 2001; Stein *et al.*, 2013; O'Reilly *et al.*, 2018). These interventions aim to support students to cope better with or without suspected psychiatric illness, reduce the risk of or prevent students developing psychiatric illness. These interventions require academic staff to be trained in the prevention strategies as well as to ensure these strategies are included in curriculum reform.

The prevention strategies can be confused with the screening methods mentioned in the direct interventions above. The differentiating feature between the screening method above and an indirect intervention is that a screening method specifically looks

for risk factors for psychiatric illness or suicide risk, whereas the indirect intervention is aimed at universal prevention strategies. The direct intervention is responsive, whereas indirect interventions are preventative.

The use of psycho-education has proven to have good outcomes in the school-based system. Psycho-education includes teaching stress-coping strategies to students and training academics in these strategies and techniques to best equip students with these skills (Muriungi and Ndetei, 2017). This allows students to take responsibility for themselves, their personal well-being and their growth and equips them with basic skills for effective decision making regarding their lifestyle choices (Muriungi and Ndetei, 2017).

Stress-reduction courses are another means of indirectly intervening. In these courses students find ways to reduce or deal with triggers to specific psychiatric illnesses such as anxiety and depression (Stillwell, Vermeesch and Scott, 2017). This is therefore a preventative intervention (Costello, 2016).

It is proven that universal interventions are effective for students who are suspected to have psychiatric illnesses. These preventative measures aim to improve social and emotional competence (Stein *et al.*, 2013). A whole group approach that has proven to have some good outcomes include the “Mindfulness” strategy (Malboeuf-Hurtubise *et al.*, 2018). This strategy encourages individuals to be more aware, it is described as the method in which an individual pays particular attention to situations, acts purposefully and without judgement in their thought processes (Malboeuf-Hurtubise *et al.*, 2018). This includes the values of compassion and respect, it is a universal prevention approach and can be useful in the health sciences context where thought process is important when it comes to dealing with patients (Ciurria, 2016).

It is evident that most indirect interventions impact the affected student or are aimed at prevention, these prevention strategies have a wide variety of themes and includes multidisciplinary approaches (Kaffenberger and O’Rorke-Trigiani, 2013; Fazel *et al.*, 2014). The prevention interventions that are taken aim to not only improve social and emotional competence but also reduce socio-economic inequality and encourage resilience (Stein *et al.*, 2013; Fazel *et al.*, 2014). Resilience as discussed in the previous chapter, improves the individual’s ability to cope with traumatic experiences, both personal and in the workplace (Ramalisa, du Plessis and Koen, 2018). A

healthcare professional requires resilience in order to be effective, confident and competent in their specific work environment (Browning *et al.*, 2007). There is little relation and evidence to support a correlation between resilience and prevalence of psychiatric illness, but there are various strategies aimed at building resilience strengthening an individual's confidence and decision making, and ultimately aims to reduce the prevalence of psychiatric illness in healthcare professionals (Grant and Kinman, 2014).

3.1.3 Reporting of the impaired student

The Health Professions Council of South Africa's guideline for the management of the impaired student emphasises the student's competency and fitness for the health sciences profession, this protects the public and ensures a student who is treating patients are mentally and physically fit to do so (Health Professions Council of South Africa, 2014). It is a duty of the academic, the institution and the regulatory body to act when a student is deemed 'impaired' which can be the case when a student has observed or confirmed psychiatric illness. The way in which the student is assessed is unclear in the guideline, it merely states that the report of concern can be lodged bythe student themselves, the lecturer or a colleague. This can be done by an observation and then reported to a senior colleague for advice.

The Health Professions Council of South Africa's guideline for the management of the impaired student describes the reporting as follows

1) A concern or report is lodged, this concern is based on an observation by the student themselves, the lecturer, clinical staff or fellow students.

2) This concern is thereafter presented to the dean or committee of the university that resides over such matters.

3) The student is then called in to assess these concerns and either validate or deny them.

4) The student seeks help and psychiatric evaluation as needed, adheres to treatment and follow up plan or the student denies these observations/concerns and is advised to see student support.

5) The student is adherent to treatment plan and succeeds in their academic career, deemed fit for clinical practice.

6) The student is not adherent to treatment plan and eventually is reported to the HPCSA and deregistered. (Health Professions Council of South Africa, 2014)

This process is effective in ensuring competent healthcare practitioners are sent into the clinical setting. There is an obligation on the health science academic to report an impaired student. This is not an intervention that is taken to assist the student directly but is a means to ensure safety of community and patients and is a measure put in place to safeguard this.

3.2 Ethical analysis of the interventions and roles of the academic

As discussed in Chapter 2, there are conditions that make an individual autonomous, in other words having liberty and agency. An autonomous individual is best described as someone who is has good insight and judgement in order to identify a decision that is either good or bad for them and act accordingly to what is deemed most appropriate for them (Varelius, 2006).

An autonomous individual is therefore in a position to give informed consent to a treatment plan or decision made. Informed consent is gained when the autonomous individual is fully aware and appreciates the risks, benefits and outcomes relevant to the choice they're agreeing to or decision they make (Dhai, 2008).

This is a similar thought to transformative learning theory, as this theory promotes autonomous thinking and encourages the educator to facilitate learning in such a manner that the student becomes capable of rational, independent decision making (Mezirow, 1997b).

Therefore, health sciences academics have a responsibility to promote autonomous thinking in the student. This implies they should respect the autonomy of the student. Any intervention done in an effort to assist this student must take their autonomy into account. If it is not maintained or promoted, if the intervention is done through coercion or by disrespecting the student's opinions or beliefs, the action is ethically unjustifiable.

Important to note that respect for autonomy has prima facie standing, this means that it is based on the first impression until proven otherwise (Beauchamp and Childress, 2013). If it is applied to suspected psychiatric illness in a student, if the student is proven to be a risk or danger to themselves or others then their autonomy would be justifiably restricted. (i.e.: reporting of the impaired student).

An individual is required to have the cognitive skills to be able to make independent judgement and decisions. There are factors that may affect the individual's capacity to make rational decisions. This refers to an individual who has diminished autonomy (Beauchamp and Childress, 2013).

Diminished autonomy

The autonomy of an individual is diminished when they are deemed incapable to make a decision for themselves, this means the individual may make a decision through coercion or influence by others and/or lacks the cognitive ability to make an independent decision (Beauchamp and Childress, 2013; Rachels and Rachels, 2015b). This renders them unable to give informed consent. Examples of such individuals are prisoners, children and people who are seen as mentally incapacitated (i.e. severe psychiatric illness) (Varelius, 2006).

It is argued the decisions of an individual can be overruled when the individual is assessed to have diminished autonomy. An individual with diminished autonomy in the case of psychiatric illness will need to be assessed as being cognitively challengedas well as having poor insight and judgement in order for decisions to be made on their behalf (Sjöstrand, Eriksson and Helgesson, 2013). This can be described as a paternalistic action.

Beauchamp and Childress define paternalism as taking a decision to override an individual's preferences on the basis of beneficence or non-maleficence (Beauchamp and Childress, 2013). In simple terms it can be explained as the manner in which a father may claim or attempt to supply the needs to adjust/control the life of their child. The father acts in a manner that he believes is in the interest of the child's welfare (beneficence) and either prevents or mitigates harm to the child (non-maleficence) (Beauchamp and Childress, 2013). Similarly, in medicine, a healthcare professional may at times become paternalistic in an effort to help their patients lead healthier lives. However, in healthcare, this approach can be viewed as authoritative as the

healthcare professional assumes what they believe is the patient's best interest and may not be what the patient wants.

Paternalism may be either soft or hard paternalism. Soft paternalism is an approach taken in an act of beneficence or non-maleficence, this is usually where the individual may not have a full degree of autonomy (may not have one or more of the three conditions stated above). Hard paternalism is when a person's autonomous choice is usurped to mitigate or prevent harm, this is where the individual is capable of making a rational decision, is aware of the consequences but their autonomy is restricted and a decision is made for the individual. Paternalism may also include coercion in order to get an individual to agree with the decision. It is important to note that often, paternalism in the clinical setting is seen to be acceptable when an individual is assessed to be incapable of making their own decisions (Beauchamp and Childress, 2013).

In the case of a direct intervention where students are being observed/identified and/or screened for risks of psychiatric illness, the first ethical issue is that of assuming diminished autonomy of an autonomous individual. The autonomy of the student is may still be intact and cannot be assumed to be diminished without a full medical or psychiatric consultation. This is not the responsibility of the health sciences academic. Thus a student, despite being suspected of having a psychiatric illness, cannot be considered as having diminished autonomy as it is not proven or properly assessed (Beauchamp and Childress, 2013; Craigie, 2015; Rachels and Rachels, 2015b; Vereenooghe *et al.*, 2018). An intervention taken towards this student by a health sciences academic becomes one that is paternalistic in nature, goes against the role and the responsibilities of the academic, which is to facilitate learning, encourage independent decision making and ultimately autonomous thinking. Not only does a paternalistic approach assume that the student has diminished autonomy, paternalism also causes diminished autonomy by restricting or interrupting the student's liberties. Therefore, a direct intervention in assuming diminished autonomy, and taking the health sciences academic out of their role is not ethically justifiable.

In the case of screening students for suspected psychiatric illness it is important to note that a university space is not a healthcare centre and directly approaching a student based on a criterion does not fit with the role of the academic nor the

expectations a student comes with of an academic institution. The health sciences academic has a role to facilitate learning and be a role model, they are not healthcare workers for students in this teaching environment. Therefore, an action where an academic is required to screen students goes against their primary role of empowering students to be problem solvers and critically reflect. This action removes the student's independent decision making capacity and is unjustifiable. The assumption that the student lacks the agency to carry out an action infringes on the respect for their autonomy and is ethically unjustifiable (Roubaix, 2017).

As established, the university student enters the environment with presumed autonomy intact. Any intervention which coerces the student, or is done on their behalf restricts their autonomy or assumes a diminished autonomy. The student is therefore not making decision for themselves and assumed to be incapable of self-governance.

However, as stated earlier, this is not true for the student who is assessed as impaired and poses a harm to themselves or others. In this case, the student does not have substantial autonomy and soft paternalism would be indicated in an effort to prevent harm (i.e.: reporting of the impaired student). Soft paternalism in this case prioritises non-maleficence, for the benefit of the student and the patients if the student works in the clinical setting, this makes the reporting of the impaired student ethically justifiable.

A paternalistic approach to the student forces the roles of the academic to become interchangeable between educator and healthcare professional. (Manthorpe and Stanley, 1999). These dual roles are not permissible in line with what is expected of the health sciences academic in an educational role. The role of clinician allows for the academic to teach students in this clinical setting while delivering a service to a patient population. It is within these roles where a health sciences academic may be prone to be observant of a student's behaviour through their clinical eye, but acting on this is unjustifiable. This action assumes that the student becomes the patient and this is not the case in a teaching environment where the student is there to learn and not be assessed as a patient.

Full autonomy and paternalism cannot coexist and academics have a responsibility to encourage student empowerment and make intentional actions based on independent decision making. Paternalism restricts the development of competent, resilient healthcare professionals.

Indirect interventions can be seen as an additional tool to use in the educational curricula and students would be required to consent to being involved in such a teaching method, especially when it is aimed at reducing personal stress and decreasing the likelihood of developing a psychiatric illness. An alternate view is that this type of intervention is regarded as part of the curriculum and if implemented as such, informed consent may not be needed as students may be afforded the opportunity to opt out of such a class or session. This reduces the effectiveness of this intervention if many students do not attend these classes, and an effort might be made to make these classes compulsory (Kaffenberger and O'Rorke-Trigiani, 2013). The student's right to choose is infringed upon, even if done in a consultative manner, such an intervention, if forced can ultimately restrict students' autonomy, as individuals and as a collective. Students attend university lectures to learn and acquire skills relevant to the course or programme they are registered for. Content specific to the course is what they expect and choose to engage with. To have non-content related topics such as preventative measures for stress and anxiety is uncalled for and may offend students. In a classroom setting some but not all may find this information important or useful. This means that those who do not need this information will be forced to receive information they do not expect and do not need. It is for this reason that indirect interventions can contentious and ethically unjustifiable as well.

It would also be arbitrary and even unfair to have indirect interventions for health sciences students only, because their lecturers have experience with dealing with cases of psychiatric illness, while students in other disciplines and faculties do not have the same access to information.

Indirect interventions may allow the health sciences academic to maintain their role as educator and the approaches may be less paternalistic towards these students (Smeyers, 2010; Tucker, 2016). However, it is argued that it is still not within the health sciences academic stated responsibilities to provide such an intervention as it is not in line with a teaching method or content in a curriculum. The health sciences academic's role is to facilitate learning of a topic and allow students to be empowered to be independent thinkers who can problem solve and critically reflect, this additional teaching responsibility to teach stress reduction skills amongst others, can be out of the health sciences academics expertise and this may need to be done by a more relevant department within the institution (Dharamsi *et al.*, 2011; Kaufman, 2019).

There are various interventions academics and institutions have taken in order to support and assist students who are suspected to have a psychiatric illness. The ones that prove most effective and do not infringe on the autonomy of the individual include indirect interventions which consist of preventative measures such as stress reduction, psycho-education and resilience training. These interventions allow students to make their own choices and be accountable for their well-being. It maintains the students' responsibility to equip themselves with skills to be independent decision makers and ensures they are autonomous thinkers. However, I still maintain that it is not the responsibility of the academic to undertake this task and the student in turn does not sign up for these lessons, this forced inclusion in the curricula is ethically unjustifiable.

Direct interventions may prove effective in addressing the illness, as they target the students who are assumed to need support the most but this intervention disregards student's autonomy when the academic becomes invested in treating the student. However, the question also comes in as to if the student in fact does not have a psychiatric illness then the trust between the academic and student is now broken, and the relationship is in turn affected. This goes against what Kant views as being important when dealing with other human beings, and this is to value the intrinsic worth of the individual, their dignity and rational mind and ultimately ensures a respect for persons. The role from academic to healthcare professional transitions rapidly and a paternalistic approach is clearly seen in the manner in which direct intervention needs to occur (Sjöstrand, Eriksson and Helgesson, 2013). This paternalistic approach disregards the autonomy of the student, the role of the health sciences academic and is ethically unjustifiable.

However, it is argued that a health sciences academic should display care towards the student. Care is defined as "a set of relational practices that foster mutual recognition and realization, growth, development, protection, empowerment, and human community, culture, and possibility" (Owens *et al.*, 2012, pp 393). Transformative learning theory emphasizes the importance of the health sciences academic to empower students, encourage growth and using Vygotsky's ZPD through human interaction promote development (Hedegaard, 2005; Kaufman, 2019). This therefore, brings in the duty to care in the health sciences academic.

Ethics of care

“As we build an ethic on caring and as we examine education under its guidance, we shall see that the greatest obligation of educators, inside and outside formal schooling, is to nurture the ethical ideals of those with whom they come in contact” (Bergman, 2004, pp 149)

Carol Gilligan, feminist theorist, identified two modes of thinking – ethic of care and ethics of rights and justice (Beauchamp and Childress, 2013; Rachels and Rachels, 2015a). Gilligan maintained that men embrace ethics of rights and justice whereas females display an ethic of care that is centred on responsiveness, empathy, an understanding of the needs, and the need to prevent harm. This demonstrates that the ethic of care is centred on caring and taking care of others (Rachels and Rachels, 2015a).

In education, I focus on Bergman who discusses ‘caring for the ethical ideal through Nel Nodding’s perspectives on moral education (Bergman, 2004) and Owens et al. who expand on Nodding’s ethic of care in teaching (Owens *et al.*, 2012). In education the educator is seen as the “one caring” and the student is the “cared for”, Nodding’s describes this as the teacher being in a position to empower the student through caring for them (Owens *et al.*, 2012). Nodding’s says education that is moral must include care. This means the ethical ideals are nurtured and includes the academic responding to their own sense of ‘I must’ by asking, ‘what are you going through?’ (Bergman, 2004). In order to do this, there must be three characteristics.

Nodding’s describes these three characteristics in caring for the student in such a way that the educator is able to be connected to the student and therefore, can lead to empowerment of the student. These are engrossment, commitment, and a motivational shift to the cared-for student. Engrossment is described as acceptance of students feeling, and being inclusive of students and their experiences. Commitment reflects that there is nothing more important than caring for the student. This means the educator makes an effort to understand the student’s feelings and their shared experiences. Finally, the motivational shift to the cared-for student is described as the educator understanding what motivates the student, there is a shift from focusing on self to focusing on the student, and the educator would teach in a way to allow the student to connect to peers, patients and be motivated to become competent in their profession (Bergman, 2004).

Caring in education

These characteristics are also seen prominently across transformative learning theory and there is a duty established for the health sciences academic to care for the student ensuring they are empowered and can develop by using “frames of reference” to enhance learning (Mezirow, 1997a). A health sciences academic would not be successful in implementing such transformative learning unless they care about the student’s success.

There may be argument that caring goes beyond the roles and responsibilities of the academic, however, as seen in the characteristics Nodding’s describes as well as their alignment with transformative learning theory, it is within the role of the academic. This duty to care for the student, should therefore, not be confused with a paternalistic approach, the care displayed ensures the student is ‘cared for’ in a manner that is ethical and does not infringe upon the student’s ability to make an independent decision. Instead caring encourages the student to share experiences so they ultimately make independent decisions.

The duty to care is seen in the teaching methods and interactions with students, and not intervening outside of their role as an academic. The health sciences academic would create learning opportunities where the students will share feelings, utilize shared experiences to enhance their learning. They will share their feelings and allow a motivational shift so that they are becomes empowered. This type of teaching covers what Nodding’s describes as caring for the ethical ideal (Bergman, 2004; Owens *et al.*, 2012).

This is crucial as it allows the student to take ownership of their decisions, as well as feel comfortable to reach out when they need additional help. It ensures the academic maintains their role and respects the autonomy of the student. Caring for the student in the manner as described above is ethically justified.

The ethical duty to care is not to be confused with the legal term of duty of care. In legal terms the duty of care is described as acting in a manner that avoids risks of foreseeable injury to others (Claus and Yost, 2010). It is, however important to discuss this duty as when a student enters a university, the university has a relationship with the student that is governed by a social contract. This contract places a legal obligation on the institution to care for that student and support the student (Sladdin, 2018). This

is seen as a common law duty of care. Common law is defined as an unwritten law that is set by the courts due to unusual judgements where the outcome was not decided on solely on statutes or constitutional laws (Segal, 2020). In the university setting it is important that the university put measures in place to support students and their staff.. It is imperative that with the rise of psychiatric illness amongst university students, that universities note the obligation placed on them of the duty of care. Therefore, it is the institution (the universities) who must be held to the duty of care as seen in common law (Claus and Yost, 2010).

In conclusion, the rising numbers of psychiatric illness in the healthcare profession is a call for an intervention that uphold an individual's autonomy, this includes their capacity to make informed and independent decisions. An intervention that respects their autonomy is vital. No intervention, both direct and indirect must be carried out by the health sciences academic and as discussed earlier. Instead there is an ethical duty to care through mentorship and teaching methods is important in empowering the student to seek help for themselves and get support from the academic to do so. Finally, it is also important to explore the effect that interventions and the duty to care have both on the student and the health sciences academic and whether that can be grounds for further ethical debate These consequences are discussed next.

Chapter 4: Consequences and ethical concerns of interventions taken for students with suspected psychiatric illness.

“You are free to choose, but you are not free to alter the consequences of your decisions” – Ezra Taft Benson.

The World Health Organization has conducted a global survey which discusses the prevalence of mental disorders amongst college students. Amongst the results from the survey, is identifying the need for individualised support and intervention for these students (Auerbach *et al.*, 2018). These interventions need to have the desired outcome in order to minimise negative effects psychiatric illness has on the individual (Seroalo *et al.*, 2014; Burns, 2017).

In this chapter I address objective 3) of the project and evaluate the possible consequences arising from the interventions academics take towards students with suspected psychiatric illness. I use utilitarianism, a type of consequentialist theory, to investigate each intervention and thereafter assess whether these interventions yield good or bad outcomes and if this contributes to overall happiness and well-being of the student, the academic and ultimately the healthcare system (Davies, Marie and Cooper, 2009; Ovseiko *et al.*, 2014; Auerbach *et al.*, 2018).

I evaluate the various interventions discussed in the previous chapter using two main themes, the consequences of the interventions on the student and the consequences these interventions have on the health sciences academic. I first discuss the direct outcome the intervention has on the individual with suspected psychiatric illness and the immediate effect it may have. I discuss the broader impact the intervention may have, this includes the impact on the relationship between the academic and student as well as the stigma and discrimination that may arise towards individuals with suspected psychiatric illness (Schachter *et al.*, 2008; Winzer *et al.*, 2018). I evaluate the impact the intervention has on the resilience of the health sciences student and whether or not it will affect their future practise once part of the workforce (World Health Organization, 2004; Browning *et al.*, 2007; Grant and Kinman, 2014).

I explore the consequences intervening has on the health sciences academic and compare it to the consequences the duty to care may have. This is explored using the

roles and responsibilities placed on the academic, determined by educational strategies and theories. I discuss the consequences interventions have on the responsibilities of the academic as well as additional burdens these interventions bring.

Utilitarianism

Consequentialism is an umbrella term encompassing theories that focus on the morality of an action based and consequences. Utilitarianism is one of the most prominent theories of consequentialism. A utilitarian focus is on the individuals' well-being. This well-being is determined by the happiness, pleasure, satisfaction that an individual will experience as a result of the action. The main ethical principle within utilitarianism is the concept of utility (Beauchamp and Childress, 2013; Rachels and Rachels, 2015c). This principle asserts that an individual ought to do the action that produces the maximal amount of happiness. In other words, one must do the greatest good for the greatest number. Bentham and Mill have conceived the concept of utility in a more hedonistic manner – this means that the main focus is on happiness or pleasure (Rachels and Rachels, 2015c).

Recent utilitarians propose that the concept of utility is broader; the action done should produce the greater good for the individual and it should promote the intrinsic value of the individual, inclusive of the individual's preferences (Beauchamp and Childress, 2013). There are two types of utilitarianism; act or classical and rule or practical utilitarianism. Act/classical utilitarianism has three elements, the goodness of an action is determined by the consequences of an action(s) only, the good action results in the greatest happiness for the greatest number of people/beings, everyone's happiness is equally considered. Rule utilitarianism considers the consequences of adopting the rules and thereafter decides whether this yields good or bad outcomes (Beauchamp and Childress, 2013; Rachels and Rachels, 2015c).

When exploring intervening in a student with suspected psychiatric illness, using act utilitarianism, the intervention is only ethical justifiable if it maximizes the happiness for the greatest number, this means that an action is only justifiable if the outcome is the most positive for the academic and the student.

An act utilitarian would ensure that any intervention done ensures the maximum happiness and if it does not, then it cannot be justified. A rule utilitarian will look at the

intervention and the rules guiding the intervention, to determine if the rule results in positive outcomes and happiness. It is important to note the outcome must be positive for the greatest number involved in the decision being made for it to be seen as ethically justifiable.

An act utilitarian would ensure that any intervention done ensures the maximum happiness and if it does not, then it cannot be justified. A rule utilitarian will look at the intervention and the rules guiding the intervention, to determine if the rule results in positive outcomes and happiness. It is important to note the outcome must be positive for the greatest number involved in the decision being made for it to be seen as ethically justifiable.

In this chapter I use act utilitarianism to analyse the consequences and utility interventions have on the health sciences academic and the student. An act utilitarian assesses the overall outcomes of each intervention and analyses whether they yield good or bad outcomes. In simple, an act utilitarian will first analyse the justifiability of the intervention (direct and indirect) based on whether or not it yields overall happiness for the maximum number, thereby assessing it to be ethically justifiable or not.

4.1 Consequences of the intervening when health science student are suspected to have psychiatric illness.

The first direct intervention includes an academic identifying students who are at risk for psychiatric illness or students who have symptoms or signs of suspected psychiatric illness and referring them for further counselling or treatment (Stein *et al.*, 2013; Mcallister *et al.*, 2014).

The benefit of this intervention is that the student is supported and the referral to counselling may benefit the student academically and socially. This may prevent the student from underperforming academically and even ‘dropping out’ (Mcallister *et al.*, 2014). Based on these outcomes, the well-being and overall happiness of the individual is promoted by this intervention.

The student will be capacitated in dealing with their psychiatric illness through such an intervention, this will improve their overall well-being and academic performance, which could result in a confident, competent student in the clinical field. This would ultimately lead to developing the student’s resilience. It is argued that ensuring an

individual who has emotional support results in increased resilience (Ramalisa, du Plessis and Koen, 2018).

However, as discussed in the previous chapter this intervention is paternalistic, the student would have been observed without their knowledge breaching their privacy and a decision is made on behalf of the student (Beauchamp and Childress, 2013).

Trust between individuals is based on comfort and a sense of loyalty each individual has for the other (Halligan, 2008; Gholami and Tirri, 2012). The health sciences academic would build trust in the relationship with the student through mentorship and teaching. A direct intervention infringes on the individual's rights of self-governance, by identifying students as 'at risk' from information given by the student or observed by the academic. This may lead to a break in the trust between the health sciences academic and the student. This break in trust, damages the relationship between the academic and the student. Once this trust is broken, a student may hesitate to confide in an academic and may be less likely to seek help with challenges should they arise. If other students become aware of this, they may also not trust the academic because of how they related with their colleague.

This breach in trust with this specific intervention, leads to the student not being able to trust an academic with information that can assist them with their well-being in the future. Despite the benefit the intervention has, if not addressed properly, such a paternalistic intervention has negative effects on the student. This manifests in challenges with trust and future relationships. This does not have overall happiness in the individual. There are concerns that since the academic directly approaches the student and referred them, there may be a resultant discrimination towards the student based on the outcome of the referral, this is seen in how individuals act towards psychiatric illness. The competence of the student might be further questioned and the academicmay feel the need to ensure the student is okay in order for them to be competent in a clinical environment. The student may in turn become restricted in how they interactwith the academic as the trust is now broken and they may feel a level of discriminationtowards them.

The paternalistic approach towards the student can leave the student feeling dependant on the academic or any other mentor for support and guidance. This dependence has to be separated from that of a general mentoring role the academic usually takes. This approach may leave the student searching for that support once

they are in the working field, and may not take the responsibility for their own well-being as they are accustomed to someone else assisting them with it. This can lead to a decrease in resilience of the health sciences student once they are in the working field. This goes against the goals of transformative learning theory in that the student is no longer capacitated to critically self-reflect nor independently problem solve (Mezirow, 1981; Kaufman, 2019). This does not support the view that resilience is increased or strengthened through this intervention.

Direct interventions would cause the health sciences academic to take on a paternalistic approach, this approach will place a burden on the health sciences academic, it will inevitably cause emotional strain and burnout. The health sciences academic almost takes on a parental role towards the student, this shifts the relationship between the student and academic. It ultimately leads to a break in the trust a student has for the academic, this power dynamic shift negatively affects the academic in that the academic now has an overwhelming sense of additional responsibility towards this student. This is ethically unjustifiable and is not a stated duty of the health sciences academic to carry out (Mezirow, 1997b; Kaffenberger and O'Rorke-Trigiani, 2013; Kaufman, 2019).

Applying the concept of utility (Rachels and Rachels, 2015c), this direct intervention has more risks than benefit, it has the potential to negatively impact the student and the academic. It does not increase the overall happiness of the student and therefore is an intervention that cannot be ethically justified.

Screening, as a direct intervention can be done in institutions with an opt-in option or it may be compulsory for all students to do once they get accepted in an institution (Pen and Caine, 2010). There has been little evidence to support such an intervention for suspected psychiatric illness, however the screening methods that have been used are those aimed at preventing suicide in adolescents and assessing risk for psychiatric illness (Garlow *et al.*, 2008; Chafouleas, Kilgus and Wallach, 2010; Pen and Caine, 2010).

The screening technique can be effective in identifying students who need support and possible referral where there is a case of suspected psychiatric illness (Garlow *etal.*, 2008; Pen and Caine, 2010). This may provide institutions with necessary information to better help and support a student. It is aimed at preventing self-harm orattempted suicide. Once a student is assessed to be at high risk, they can then be referred to the

appropriate level of care to get the help needed. This may be in the form of counselling services or psychiatric treatment.

An intervention where a student that is required to go through a screening process to detect risks for suicide or depression and anxiety decreases the autonomy of the individual by taking away their choice to be assessed for risks and thereafter request an intervention (Garlow *et al.*, 2008; Chafouleas, Kilgus and Wallach, 2010). This will result in the student not being empowered enough to make rational, independent decisions, it goes against educational theories and therefore does not yield a positive outcome.

It can be argued that the positive outcomes which may result include the student getting the support and help they need to succeed (Winzer *et al.*, 2018). A student who does prove to have higher risk for a psychiatric illness or suicide attempt will needto be referred to the appropriate level of care for assistance or treatment. This will allow the student to get the support needed to cope and function better in the environment, this positive outcome results in overall happiness of the individual (Garlow *et al.*, 2008; Davies, Marie and Cooper, 2009; Rachels and Rachels, 2015c).

However, the student did not sign up for such screening approaches when enrolling at an academic institution. The primary goal of education is to facilitate learning and create the environment that is conducive for learning, and this would go against the aims of educational theories. The student may in turn become restricted in how they interact with the academic as the relationship is now affected.

There is argument that this type of intervention may result in discrimination arising towards students who have suspected psychiatric illness (Kiuhara and Huefner, 2008). This is because there is possible exposure of students who are suspected to have psychiatric illness. It is possible that these students are put on treatment, should the suspicion be confirmed and they are diagnosed with a psychiatric illness. This required medical intervention causes fear that there may be an increase in the stigma towards these individuals as the psychiatric illnesses are labelled as ‘disorders’ (Kiuhara and Huefner, 2008; Burns, 2017). A student who would be identified and advised to seek help for their suspected illness may feel like this might put them in a different category as compared to students who do not have these risks. There may be fear of being discriminated against and/or ostracised, which may prevent the student from seeking the necessary help. This could also affect the student’s ability to engage freely in

lectures and on site clinical training.

There is a further argument that in cases where the screening technique is anonymous and the decision is left to the student to decide to seek help without any face-face evaluation or counselling may lead to an impaired student being allowed in the healthcare system. This poses a threat to patient care and competency of the student. This could lead to the student displaying obvious signs which meet the criteria to be reported as an impaired student, the repercussions of this become more strict and affects the students future (Health Professions Council of South Africa, 2014).

Finally, this type of screening intervention has an impact on overall resilience of the student. The screening intervention is seen to yield good outcomes as it is effective in discreetly identifying, referring and supporting students who have suspected psychiatric illness. A preventative approach to maintaining mental well-being is argued to indirectly promote resilience, due to the student getting the support and the treatment needed. This strengthened resilience leads to a more confident, mature student who is capable of coping in the ever changing healthcare system (McCann *et al.*, 2013; Grant and Kinman, 2014).

The next type of intervention to be discussed are the indirect interventions. These refer to the stress coping strategies and a more universal approach at prevention for students who could be suspected to have a psychiatric illness (Stillwell, Vermeesch and Scott, 2017). These interventions are less specific to the individual student and aim to capacitate students with the skills needed to cope with stress, deal with their own risk factors that can induce stress or trigger a suspected psychiatric illness and to prevent these episodes from recurring (Stanley and Manthorpe, 2001; Stillwell, Vermeesch and Scott, 2017).

These strategies uphold the autonomy of the student without coercing or forcing the student to seek treatment for any suspected psychiatric illness. This intervention can therefore be seen as having good outcomes in the overall well-being and happiness of the student. This removes the stigma and discrimination associated with psychiatric illness and seeking help for it as there may be universal strategies applicable to all students, and will equip all with necessary skills to cope (Ramalisa, du Plessis and Koen, 2018).

These strategies do not identify specific students it is reported that implementation of these strategies have decreased the number of incidents reported that are related to

students having suspected psychiatric illness (Ramalisa, du Plessis and Koen, 2018). The reduced reports of incidents related to suspected psychiatric illness can lead to a focus change for academics, as it would now allow academics to focus directly on resilience training for these students.

Indirect interventions may result in the student feeling a reduced agency, meaning it removes their capacity to make their own choices. This is due to the shift in the power dynamics and the student will not feel as though they truly have the capacity to make a decision for themselves, as this approach will now make the decision for them. This potentially influences the relationship between the academic and the student, looking at educational theory where the focus is placed on students being held accountable and being empowered, this type of intervention done by the health sciences academic potentially reduces the development of this.

Indirect interventions that are optional, where the student may opt-out of a class or session that aims to promote mental well-being and provide preventative strategies may yield good outcomes for the student as the student is not left feeling disempowered and is still given a choice. However, a student that chooses to attend may gain the skills intended and those who don't might be concerned about being discriminated against for choosing not to do so. This does not ensure overall happiness for all students.

Furthermore, it is not the responsibility of the academic to provide these strategies and this added theme in curriculum development do not align with educational outcomes for the degree. A health sciences academics primary responsibilities are to teach students to become empowered and include educational objectives that are aligned with the content necessary to meet them, the addition of preventative strategies for mental health are not in line with the academics' duties and therefore is not ethically justifiable.

In conclusion, direct intervention yields some good outcomes, in that it allows for students to get assistance for their suspected psychiatric illness, however it assumes a diminished autonomy and the paternalistic approach taken is ethically unjustifiable.

The obligation on the health sciences academic to intervene in students who are suspected to have psychiatric illness is an additional role placed on this individual. This burden on the health sciences academic adds an additional responsibility to observe, counsel and possibly diagnose this student. The roles discussed in chapter 2 and 3 describe the significant impact the health sciences academic has on the training and mentoring of the student, any addition to these roles may cause the health sciences academic to take a paternalistic approach towards intervening when a student is suspected of having a psychiatric illness.

The duality of these roles place strain on the health sciences academic as there is an expectation to advocate for patients, students and the healthcare system.

Indirect interventions also yield some good overall outcome for the student and attempts to ensure the students overall well-being and ultimately happiness is preserved, however, it has a ripple effect on the relationship between the academic and student, it reduces the development of the student to be empowered. Indirect interventions force additional responsibilities being placed on the academic, this results in the academic needing more time to draft lesson plans, reform curricula and be equipped with the necessary skills in order to implement them. This will have a negative impact on the overall happiness of the health sciences academic. This therefore, is ethically unjustifiable.

Furthermore, this expectation placed on the health sciences academic assumes the academic should be responsible for the overall well-being of the student (Owens *et al.*, 2012). It is important to therefore, explore who should be responsible for such interventions being implemented as well as who then takes responsibility should anything go wrong when an academic may implement them. The student is registered at the academic institution, and this institution has a responsibility to ensure strategies are in place to support students (Bantjes, 2018; Njilo, 2018; September, 2018). This is discussed in the conclusion and subsequently the recommendations in chapter 5.

The arguments show that when a health sciences academic takes the responsibility of intervening when they suspect a student has a psychiatric illness, it does not increase

or promote the overall happiness of the academic or the student. Therefore,when a health sciences academic goes beyond their role as educator to a student, it negatively affects the trust in the relationship between student and academic, it placesadditional responsibilities on the academic, out of their formal teaching responsibilitiesmaking intervening ethically unjustifiable.

4.2 Consequences of the duty to care

As described earlier in chapter 3, the health sciences academic has a duty to care for the student in such a manner that they are empowered. There is an innate responsibility to care, as their role as healthcare professional requires a level of care for their patients. The role modelling that results also assists with allowing the students to see what a patient care should be like.

The care displayed is in the form of supportive teaching, ensuring students feelings and providing learning opportunities that allow the student to feel motivated and encouraged.

The health sciences academic displaying care to the student does not take them out of their role and therefore does not add responsibilities on them other than what is expected as outlined through transformative learning theories. This results in their workload being the same and them not being burdened with additional tasks that the interventions would require.

There risks posed with caring, include that the traditional forms of teaching do not embrace this, and therefore, there is argument that caring may bring about additional burden. However, as Nodding's describes, there must be ethical caring (Bergman, 2004). This is because ethical caring promotes empowerment of a student and caring within the student. In addition to feeling motivated to care, in ethical caring this may not always be present and therefore one must include feeling for our "ethical selves" (Bergman, 2004, pp 152). This means one must care for own and the other's ethical ideals, this makes caring ethical.

Furthermore, caring does not negatively impact the relationship between the academic and the student and therefore has an overall positive outcome and increase in happiness as the academic is empowering the student, caring on the side of the academic is ethically justified.

In conclusion, a health sciences academic directly and indirectly intervening when they suspect a student has a psychiatric illness is ethically unjustifiable as it produces an overall negative outcome and decreases the happiness for both the student and the health sciences academic. These negative outcomes include a decrease in resilience, decision – making capacity in the student, it negatively affects the trust between the

student and academic, changes the role of the academic and increases/ adds to the responsibilities of the academic.

However, the duty to care and the outcomes of ethical caring that the health sciences academic would display positively affects the student and the academic. This leaves the student feeling empowered, does not change the role of the academic and does not increase/ add to their responsibilities. The duty to care is ethically justifiable and therefore encouraged.

Chapter 5: Conclusion and Recommendations

"The ethics of psychiatric therapy is the very negation of the ethics of political liberty. The former embraces absolute power, provided it is used to protect and promote the patient's mental health. The latter rejects absolute power. Regardless of its aim or use" – Thomas Szasz

5.1 Conclusion

This research aimed to show that it is ethically unjustifiable for a health sciences academic to intervene when they suspect a student may have a psychiatric illness. The objectives of this research were to describe the role and duties of health sciences academics in South African institutions, to normatively assess the interventions and approaches health sciences academics take towards students with suspected psychiatric illness through the impact on individual autonomy and the use of paternalism and the ethics of care. Finally, to normatively assess the impact of possible consequences, that may arise from interventions health sciences academics take towards students who are suspected to have psychiatric illness and comparing it with the duty to care for students. This was done using the consequentialist theory of utilitarianism.

South Africa has a long history of post-traumatic stress and political unrest. These past injustices have left a trail of undiagnosed psychiatric illness amongst the survivors of these injustices (World Health Organization, 2004; Lund *et al.*, 2008). This has subsequently had an effect on students entering higher institutions, wherein psychiatric illnesses can be triggered by stress, high workload and the intense clinical environment (Ramalisa, du Plessis and Koen, 2018) amongst other psychosocial factors.

This rise in suspected psychiatric illness is concerning and it now falls on the institution to develop support structures to address this problem (Njilo, 2018). The primary source of information to best understand the needs of the students are the students themselves and also the academic who is teaching these students (Bergman, 2004). This causes it to be perceived that it is the responsibility of the academic, who has direct contact with students at a higher institution, to address these concerns.

It is imperative that the role of the academic is clear, that the responsibilities are outlined and achieving the objectives and goals of teaching and learning remain a priority. The role of the health sciences academic is unique when compared to a general academic and this shows that the health sciences academic has more responsibilities to students and to the healthcare setting. However, in the academic setting, the general and the health sciences academic have the same responsibilities. This makes interventions that are taken by a health sciences academic for students who are suspected to have psychiatric illness more questionable.

Interventions that have been tried in an attempt to decrease the prevalence of psychiatric episodes amongst university students have not proven to be very effective and there are various strategies that need to be explored further (Kaffenberger and O'Rorke-Trigiani, 2013). The health sciences academic, being in the healthcare setting, is prone to observations regarding certain criteria for suspected psychiatric illness, however the health sciences academic ought to maintain professional boundaries and not conflate the two roles they occupy.

Consequences resulting from these various interventions will have an effect on the student and the health sciences academic. These interventions will change the goals of teaching and learning theory and the role and responsibilities of the health sciences academic.

Teaching in health science education is premised on the theory of transformative learning where the students autonomy is preserved (Mezirow, 1997a). This is aimed to develop their identities as healthcare professionals in an ever changing medical field. This enables the students to experience the clinical space and adapt to the healthcare system. Transformative learning and use of Vygotsky's ZPD encourages student empowerment and the development of autonomous thinking, the student is responsible for their own learning and the academic facilitates this process (Hedegaard, 2005; Kaufman, 2019). This is demonstrated in experiential learning theory where the academic facilitates learning in an environment to ensure the student develops the ability to be independent decision makers and become critically reflect to form new perspectives (Kolb, 1984). These teaching theories put the responsibilityon the academic to make learning more practical and clinically relevant so that students become engaged and competent in the content, are able to be rational and

independent problem solvers, become self-reflective, self-directed students and finally develop their own resilience (Thomas *et al.*, 2011; McCann *et al.*, 2013; Kaufman, 2019).

In order to ensure a student has these qualities, the health science academic has to be observant of the student in the classroom and the clinical field. An observant academic mainly focuses on the training and assessment of the student, however, the health science academic observations could possibly go beyond this. This is due to their profession being in the health sciences and the need to notice behaviour characteristics and concerns in patients. These observations may be both academic and healthcare related in the health sciences academic space. These dual roles can cause internal conflict for the health sciences academic as there is now an added burden to treat a student.

The academic takes on the role of educator in the assessment of the student, but may also be a mentor to the student in the clinical space in order to role model the core competencies expected of the student (Shabani, 2010; Kaufman, 2019). This mentorship role that the academic takes on creates a relationship between the health sciences academic and the student, and a bond based on trust and mutual respect (Owens *et al.*, 2012). The health sciences academic may notice some behavioural traits or concerning features in the student that may mean the student is not fit for the clinical space, it now becomes the duty of the academic to report this as the student could be determined to be an impaired student (Health Professions Council of South Africa, 2014). The values that the academic would base this action on would be for the interest of the profession and the patient population (Coalition of National Health Education Organizations, 2011; Health Professions Council of South Africa, 2014). The outcome is one that assists the student and ensure the safety of the patients the student may encounter as well.

It is argued that the autonomy of the student will be assumed to be diminished when they are reported to higher authorities without their consent. However, if the student is suspected of having a psychiatric illness, they are more than likely unable to make an informed decision and their capacity to do so may be diminished (Beauchamp and Childress, 2013). This gives the right to the academic who is not only concerned for the student's wellbeing but also concerned about the student being a risk to others,

and the patients in the clinical teaching environment, to act on behalf of the student to get them the appropriate help (Gulliver *et al.*, 2018). This is a moral obligation and not seen as an intervention where a student is forced into treatment for their suspected psychiatric illness. Therefore, this type of reporting strategy is ethically justified.

A student who has a suspected psychiatric illness requires specific treatment and therapy in order to be competent in the clinical field, if not deemed impaired. The treatment they would undergo and coping mechanisms that a student would learn would make the student able to persevere in situations and ultimately become more resilient (McCann *et al.*, 2013). This outcome can be achieved provided that the process to get the student this help does not make the student feel discriminated against, nor should it take away their dignity (Bramesfeld *et al.*, 2007; Winzer *et al.*, 2018). This treatment can only be done by a healthcare professional who is trained in treating psychiatric illness and not by the health sciences academic whose role is not inclusive of this for the student.

Direct intervention of approaching the student based on individual concerns assumes that the student has diminished autonomy, it becomes paternalistic as it takes away their choice to seek help, this removes the need for consent and is ethically unjustifiable (Rachels and Rachels, 2015b).

The consequences of direct interventions include infringing on the autonomy of the student, negatively affecting the trust built in the relationship between student and academic and increasing the likelihood of stigma and discrimination towards the student, resulting in decreased overall happiness in the individual. This intervention goes against the role of the academic as defined by teaching and learning theories, as it enables the academic to become paternalistic and act out of their role as educator. It causes the academic to intervene in a manner that mandates them to act as a healthcare provider to the student. It is my argument that this action makes the intervention of the academic intervening in this manner ethically unjustifiable.

The preventative indirect interventions taken where a student is not specifically identified or identified as having a suspected psychiatric illness allow for most students to seek support for their challenges. This alleviates the burden on the academic to take on the paternalistic role in addressing the student directly and it providespreventative therapy to students who may be more at risk of developing a psychiatric

illness (World Health Organization, 2004; Bantjes *et al.*, 2017). The outcome of these strategies are aimed to allow the student to be empowered and take responsibility with the hope of making rational decisions for their own well-being. However, these strategies are not what the students attend class for and this additional aspect may also affectthe relationship between academic and student and cause a power dynamic shift. However, should these indirect interventions be implemented in a manner that is an opt-out option, it could be seen to be ethically justifiable. The issue still remains that the student has a potential to be discriminated against due to “opting out’ and it is not aligned with educational practices. This would not increase the individual overall happiness and is not ethically justifiable.

The role of the health sciences academic is to promote a culture of learning, to ensure the student is fit for the healthcare setting, to maintain a standard of patient care and ensure confidentiality and dignity of the student and patient (Coalition of National Health Education Organizations, 2011). The additional role on the academic would be to screen and create strategies for prevention, in addition to teaching responsibilities. This decreases the overall happiness of the academic and therefore ethically unjustifiable.

However, I argue that an academic does have a duty to care for the student. This ethical caring should be aligned with the goals of transformative learning, in that it ensures the student’s experiences contribute to their learning, that the student feels empowered to be held accountable for their decisions and therefore can seek the help they need without the need for an intervention.

In conclusion, it is unethical to assume a student’s autonomy is diminished without a proof of a psychiatric illness in the student. This assumption will lead to health sciences academic taking a paternalistic approach to intervening when they suspect a student has a psychiatric illness, going against the goals of teaching and learning theories. This places an additional role on the academic and goes beyond the role of educator for the student making intervening (both directly and indirectly) based on suspicions ethically unjustifiable. These interventions also cause a disruption in the relationship that is built between the academic and the student and decreases the trust that is formed. Ethical caring for the student does not have these outcomes and allows the

trust to be maintained, the role of the academic to remain as such and the student to be left feeling empowered and supported.

It is therefore evident that my thesis statement holds true and it is ethically unjustifiable for health sciences academics to intervene when students are suspected to have psychiatric illness, except in cases of direct intervention that is intended to protect the student from harming themselves or others, or in cases of indirect intervention aimed at helping a broad group of students and offered on a strictly voluntary basis and academics have a duty to care for students.

5.2 Recommendations for ethically justifiable interventions when students are suspected to have psychiatric illness.

1) On the basis of the rise of psychiatric illness amidst university students it is my recommendation that universities work together with students to implement strategies that will support students with psychiatric illness. These strategies should be undertaken by relevant university structures such as counselling units and supportive structures, not the academics. These strategies should be inclusive of helping students to understand the overall benefits of these strategies and that it is ethically justifiable and does not assume diminished autonomy nor take on a paternalistic approach. It is my view that the responsibility falls on the academic institution to create and implement more effective counselling units and support structures.

2) The duality of the roles of the health sciences academic, making their primary role unclear at times, require universities to design and adopt clear codes of conduct for academics when there is a need to intervene if a student has psychiatric illness. I recommend that a guideline including specific codes of conduct for health sciences academic should be created and serve to assist with teaching and learning as well as student support.

3) I recommend that based on the stigma and concerns around discrimination for students who are suspected to have psychiatric illness, further research needs to be done which focus on student perceptions of the interventions.

4) I further recommend that empirical research is done that focuses on health science academics perceptions of their role and their role in the carrying out of interventions

taken towards addressing student who are suspected to have psychiatric illness.

5) On the basis that health sciences academic have a duty to care for the student, I recommend that there be guidelines, workshops that dedicate time to teaching academics about ethical caring and how it can be achieved through teaching.

6) Finally, on the basis of the ethical duty to care that academics should have towards students, I recommend universities place supportive measures and workshops to educate and empower both university students and staff on the implications this has.

References

American Psychiatric Association and Parekh, R. (2018) *What Is Mental Illness ?*, *Psychiatry.org*. Available at: https://www.psychiatry.org/patients-families/what-is-mental-illness (Accessed: 14 March 2019).

Auerbach, R. P. *et al.* (2018) 'WHO World Mental Health Surveys International College Student Project: Prevalence and Distribution of Mental Disorders', *Journal of Abnormal Psychology*, 127(7), pp. 623–638.

Baldini, L. L. *et al.* (2014) 'The clinician as neuroarchitect: The importance of mindfulness and presence in clinical practice', *International Journal of Emergency Mental Health and Human Resilience*, 16(122), p. 122. doi: 10.1007/s10615-014-0476-3.

Bantjes, J. *et al.* (2017) *Global study aims to unpack mental health issues facing university students*, *UCT News*. Available at: https://www.news.uct.ac.za/article/-2017-05-11-global-study-aims-to-unpack-mental-health-issues-facing-university-students (Accessed: 1 March 2019).

Bantjes, J. (2018) *Managing student mental health*, *Life @Stellenbosch*. Available at: https://www0.sun.ac.za/lifesu/en/features/mental-health (Accessed: 26 March 2019).

Beauchamp, T. L. and Childress, J. F. (2013) *Principles of Biomedical Ethics*. Seventh Ed. Oxford University Press.

Behrens, K. G. (2018) 'A critique of the principle of "respect for autonomy", grounded in african thought', *Developing World Bioethics*. Blackwell Publishing Ltd, 18(2), pp. 126–134. doi: 10.1111/dewb.12145.

Bergman, R. (2004) 'Caring for the ethical ideal : Nel Noddings on moral education', *Journal of Moral Education*, 33(2), pp. 149–161. doi: 10.1080/0305724042000215203.

Bernstein, B. (2003) 'Social class and pedagogic practice', in *The Structuring of Pedagogic Discourse*, pp. 63–93.

Bramesfeld, A. *et al.* (2007) 'How do patients expect the mental health service system to act ? Testing the WHO responsiveness concept for its appropriateness in mental health care', *Social Science & Medicine*, 65, pp. 880–889. doi: 10.1016/j.socscimed.2007.03.056.

Browning, D. M. *et al.* (2007) 'Difficult Conversations in Health Care : Cultivating Relational Learning to Address the Hidden Curriculum', *Academic Medicine*, 82(9), pp. 905–913.

Burns, J. K. (2017) 'Social and ethical implications of psychiatric classification for low- and

middle-income countries', *South African Journal of Psychiatry*, 20(3), p. 6. doi: 10.4102/sajpsychiatry.v20i3.589.

Chafouleas, S. M., Kilgus, S. P. and Wallach, N. (2010) 'Ethical dilemmas in school-based behavioral screening', *Assessment for Effective Intervention*, 35(4), pp. 245–252. doi: 10.1177/1534508410379002.

Ciurria, M. (2016) 'A virtue ethical approach to decisional capacity and mental health', *Philosophical Psychology*, 29(3), pp. 462–475.

Claus, L. and Yost, R. (2010) 'A Global View of the University's Duty of Care Obligations', *University Risk Management & Insurance Association Journal*.

Cleary, M. *et al.* (2012) 'Ethical conduct in nurse education: Creating safe staff – student boundaries', *Nurse Education Today*. Elsevier Ltd, 32(3), pp. 320–324. doi: 10.1016/j.nedt.2011.02.013.

Coalition of National Health Education Organizations (2011) *CODE OF ETHICS FOR THE HEALTH EDUCATION PROFESSION*.

Collaborative Justice (2013) *Teamwork Exercise : Discussion of Roles and Responsibilities*, *Center for Effective Public Policy*. Available at: https://www.collaborativejustice.org/how/tools/structure/structure-ex1.htm (Accessed: 29 July 2019).

Costello, E. (2016) 'Early Detection and Prevention of Mental Health Problems: Developmental Epidemiology and Systems of Support', *Journal of Clinical Child and Adolescent Psychology*. Routledge, 45(6), pp. 710–717. doi: 10.1080/15374416.2016.1236728.

Craigie, J. (2015) 'A fine balance: reconsidering patient autonomy in light of the UN convention on the rights of persons with disabilities', *Bioethics*, 29(6), pp. 398–405. doi: 10.1111/bioe.12133.

Das, J. K. *et al.* (2016) 'Interventions for Adolescent Mental Health: An Overview of Systematic Reviews', *Journal of Adolescent Health*, 59(2), pp. S49–S60. doi: 10.1016/j.jadohealth.2016.06.020.

Davies, S., Marie, K. and Cooper, D. E. (2009) *A Companion to Bioethics Blackwell Companions to Philosophy*. 2nd edn. Edited by H. Kuhse and P. Singer. Wiley Blackwell.

Dhai, A. (2008) 'Informed consent – 2008', *South African Journal of Bioethics and Law*, 1(1), pp. 27–30. doi: 10.7196/SAJBL.5.

Dharamsi, S. *et al.* (2011) 'The Physician as Health Advocate : Translating the Quest for Social Responsibility Into Medical Education and Practice', *Academic Medicine*, 86(9), pp. 1108–1113. doi: 10.1097/ACM.0b013e318226b43b.

Fazel, M. *et al.* (2014) 'Mental health interventions in schools in high-income countries', *The Lancet Psychiatry*, 1(5), pp. 377–387. doi: 10.1016/S2215-0366(14)70312-8.

Forbes, S. and Fikretoglu, D. (2018) 'Building resilience: The conceptual basis and research evidence for resilience training programs', *Review of General Psychology*, 22(4), pp. 452–468. doi: 10.1037/gpr0000152.

Freeman, M. (2018) *Suicide in university students likely tied to undiagnosed mental conditions*, *News24*. Available at: https://www.health24.com/Medical/Depression/Life-stages-and-depression/your-child-and-mental-health-20181010 (Accessed: 1 March 2019).

Garlow, S. J. *et al.* (2008) 'Depression, desperation, and suicidal ideation in college students: results from the American Foundation for Sucide Prevention College Screening Project at Emory University', *Depression and Anxiety*, 488(June 2007), pp. 482–488. doi: 10.1002/da.20321.

Gholami, K. and Tirri, K. (2012) 'Caring Teaching as a Moral Practice : An Exploratory Study on Perceived Dimensions of Caring Teaching', *Education Research International*, 2012. doi: 10.1155/2012/954274.

Grant, L. and Kinman, G. (2014) 'Emotional Resilience in the Helping Professions and how it can be Enhanced', *Health and Social Care Education*, 3(1), pp. 23–34. doi: 10.11120/hsce.2014.00040.

Gulliver, A. *et al.* (2018) 'University staff experiences of students with mental health problems and their perceptions of staff training needs', *Journal of Mental Health*, 27(3), pp. 247–256. doi: 10.1080/09638237.2018.1466042.

Halligan, A. (2008) 'The importance of values in healthcare', *Journal of Responsible Social Medicine*, 101(10), pp. 480–481. doi: 10.1258/jrsm.08k019.

Hancock, M. (2018) 'Prevention , detection , intervention : the big wins for mental health', *The Lancet*. Elsevier Ltd, 392(10157), pp. 1499–1500. doi: 10.1016/S0140-6736(18)32269-4.

Health professions council of South Africa (2014) *Core competencies for undergraduate students in clinical associate, dentistry and medical teaching and learning programmes in South Africa*, *Medical and Dental Professions Board of the Health Professions Council of*

South Africa. Available at: http://www.hpcsa.co.za/uploads/editor/UserFiles/downloads/medical_dental/MDB Core Competencies - ENGLISH - FINAL 2014.pdf.

Health Professions Council of South Africa (2008) 'Hpcsa: Guidelines for Good Practice in the Health Care Professions; General Ethical Guidelines for Health Researchers', 9(May), pp. 1–12.

Health Professions Council of South Africa (2014) *Guidelines for the management of impaired students*.

Hedegaard, M. (2005) 'The zone of proximal development as basis for instruction', in Daniels, H. (ed.) *An Introduction to Vygotsky*. 2nd editio. London and New York: Rout, pp. 223–247.

Hope, A. (2013) 'The role and place of the academic is changing – and it's a good thing', *The Guardian*, pp. 3–7. Available at: https://www.theguardian.com/higher-education-network/blog/2013/nov/13/academic-job-changing-flexibility-university.

Jadaszewski, S. (2017) 'Ethically Problematic Value Change as an Outcome of Psychotherapeutic Interventions', *Ethics and Behaviour*, 27(4), pp. 297–312. doi: 10.1080/10508422.2016.1195739.

Kaffenberger, C. J. and O'Rorke-Trigiani, J. (2013) 'Addressing Student Mental Health Needs By Providing Direct and Indirect Services and Building Alliances in the Community', *American School Counsellor Association*, 16(5), pp. 323–332.

Karnieli-miller, O. *et al.* (2010) 'Medical Students ' Professionalism Narratives : A Window on the Informal and Hidden Curriculum', *Academic Medicine*, 85(1), pp. 124–133.

Kaufman, D. M. (2019) 'Teaching and Learning in Medical Education: How Theory can Inform Practice', in Swanwick, T., Forrest, K., and O'brien, B. C. (eds) *Understanding Medical Education:Evidence, Theory and Practice*. Third Edit. Hoboken, NJ: Wiley Blackwell, pp. 37–70.

Kiuhara, S. A. and Huefner, D. S. (2008) 'Students With Psychiatric Disabilities in Higher Education Settings', *Journal of Disability*, 19(2), pp. 103–113.

Kolb, A. Y. and Kolb, D. A. (2005) 'Learning Styles and Learning Spaces: Enhancing Experiential Learning in Higher Education', *Academy of Management Learning & Education*, 4(2), pp. 193–212.

Kolb, D. A. (1984) *Experiential learning: experience as the source of learning and*

development. Prentice Hall.

Koons, D. C. (2004) *Applying Adult Learning Theory to Improve Medical Education*. University of Connecticut.

Langtree, E. M. *et al.* (2018) 'Factors causing stress among first-year students attending a nursing college in KwaZulu-Natal , South Africa', *AJHPE*, 10(2), pp. 90–95. doi: 10.7196/AJHPE.2018.v10i2.993.

Lossius, T., Legernes, E. and Pedersen, R. (2019) 'International Journal of Law and Psychiatry " A plea for recognition " Users ' experience of humiliation during mental health care', *International Journal of Law and Psychiatry*. Elsevier, 62(December 2018), pp. 148–153. doi: 10.1016/j.ijlp.2018.11.004.

Lund, C. *et al.* (2008) 'Mental health policy development and implementation in South Africa : a situation analysis Phase 1 . Country Report Table of Contents', *Mental Health and Poverty Project*, (January), pp. 1–352. Available at: http://www.who.int/mental_health/policy/development/SA Country Report - Final Draft Jan 2008.pdf.

Malboeuf-Hurtubise, C. *et al.* (2018) 'A Mindfulness-Based Intervention for Students With Psychiatric Disorders in a Special Education Curriculum: A Series of n-of-1 Trials on Internalized and Externalized Symptoms', *Frontiers in Education*, 3(September), pp. 1–22. doi: 10.3389/feduc.2018.00097.

Maudsley, G. and Strivens, J. (2000) 'Promoting professional knowledge , experiential learning and critical thinking for medical students', *Medical Education*, 34, pp. 535–544.

Mcallister, M. *et al.* (2014) 'Staff experiences of providing support to students who are managing mental health challenges: A qualitative study from two Australian universities', *Advances in Mental Health*, 12(3), pp. 192–201.

McCann, C. M. *et al.* (2013) 'Resilience in the health professions: A review of recent literature', *International Journal of Wellbeing*, 3(1), pp. 60–81. doi: 10.5502/ijw.v3i1.4.

Merriam, S. B. (2008) 'Adult Learning Theory for the Twenty-First Century', *New Directions for Adult and Continuing Education*, (119), pp. 93–98. doi: 10.1002/ace.

Mezirow, J. (1981) 'A critical theory of adult learning and education', *Adult Education*, 32(1), pp. 3–24.

Mezirow, J. (1997a) 'Transformative Learning : Theory to Practice', in *New Directions for Adult and Continuing Education*. Jossey-Bass Publishers, pp. 5–12.

Mezirow, J. (1997b) ‘Transformative Learning : Theory to Practice’, *New Directions for Adult and Continuing Education*, (74), pp. 5–12.

Mortier, P. *et al.* (2018) ‘Suicidal Thoughts and Behaviors Among First-Year College Students: Results From the WMH-ICS Project.’, *Journal of the American Academy of Child and Adolescent Psychiatry*. Elsevier, 57(4), pp. 263-273.e1. doi: 10.1016/j.jaac.2018.01.018.

Mukhalalati, B. A. and Taylor, A. (2019) ‘Adult Learning Theories in Context: A Quick Guide for Healthcare Professional Educators’, *Journal of Medical Education and Curricular Development*, 6, pp. 1–10. doi: 10.1177/2382120519840332.

Muriungi, S. K. and Ndetei, D. M. (2017) ‘Effectiveness of psycho-education on depression, hopelessness, suicidality, anxiety and substance use among basic diploma students at Kenya Medical Training College’, *South African Journal of Psychiatry*, 19(2), p. 10. doi: 10.4102/sajpsychiatry.v19i2.401.

Njilo, N. (2018) *Wits to increase counselling services capacity after third student suicide this year*, *TimesLive*. Available at: https://www.timeslive.co.za/news/south-africa/2018-10-25-wits-to-increase-counselling-services-capacity-after-third-student-suicide-this-year/ 1/2 (Accessed: 1 March 2019).

O’Reilly, M. *et al.* (2018) ‘Review of mental health promotion interventions in schools’, *Social Psychiatry and Psychiatric Epidemiology*. Springer Berlin Heidelberg, 53(7), pp. 647–662. doi: 10.1007/s00127-018-1530-1.

Ovseiko, P. V *et al.* (2014) ‘Improving accountability through alignment : the role of academic health science centres and networks in England’, *BMC Health Services Research*, 14(24).

Owens, L. M. *et al.* (2012) ‘The Ethic of Care in Teaching: An Overview of Supportive Literature’, *Quest*, 57(4), pp. 392–425. doi: 10.1080/00336297.2005.10491864.

Patel, V. *et al.* (2018) ‘The Lancet Commission on global mental health and sustainable development’, *The Lancet Commissions*, 392. doi: 10.1016/S0140-6736(18)31612-X.

Peltzer, K. (2004) ‘Stress, psychosocial symptoms, social support and health behavious amongst black students in South Africa’, *Journal of Child and Adolescent Mental Health*, 16, pp. 19–23.

Pen, J. B. and Caine, E. D. (2010) ‘Screening as an Approach for Adolescent Suicide Prevention’, 36(December 2006).

Pharma Dynamics (2018) *SA students more at risk of depression and anxiety than elsewhere*, *Pharma Dynamics*. Available at: https://pharmadynamics.co.za/student-

depression/ (Accessed: 26 March 2019).

Provost, E. (2008) 'Frontstage and Backstage Ethics in Mental Health: A Qualitative Case Study', *Journal of Law, Ethics and Intellectual Property*, 2, pp. 1–12.

Rachels, J. and Rachels, S. (2015a) 'Feminism and ethics of care', in *The Elements of Moral Philosophy*. 8th edn. McGraw-Hill International, pp. 147–158.

Rachels, J. and Rachels, S. (2015b) 'Kant and Respect for Persons', in *The Elements of Moral Philosophy*. 8th edn. McGraw-Hill International, pp. 137–146.

Rachels, J. and Rachels, S. (2015c) 'The Utilitarian Approach', in *The Elements of Moral Philosophy*. 8th edn. New York: McGraw Hill Education, pp. 99–125.

Ramalisa, R. J., du Plessis, E. and Koen, M. P. (2018) 'Increasing coping and strengthening resilience in nurses providing mental health care: Empirical qualitative research', *Health SA Gesondheid*, 23(0), pp. 1–9. doi: 10.4102/hsag.v23i0.1094.

Rogers, C. (2010) *Experiential Learning*.

Roubaix, M. De (2017) 'Dare we rethink informed consent ?', *South African Journal of Bioethics and Law*, 10(1), pp. 25–28. doi: 10.7196/SAJBL.2017.v10i1.507.

Salam, A. *et al.* (2013) 'Stress among Medical Students in Malaysia : A Systematic Review of Literatures', *International Medical Journal*, 20(6), pp. 649–655.

Schachter, H. M. *et al.* (2008) 'Effects of school-based interventions on mental health stigmatization: A systematic review', *Child and Adolescent Psychiatry and Mental Health*, 2(18), pp. 1–14. doi: 10.1186/1753-2000-2-18.

Segal, T. (2020) *Common Law*, *Investopedia*. Available at: https://www.investopedia.com/terms/c/common-law.asp (Accessed: 31 October 2020).

September, J. (2018) 'Campus suicide : Universities need to find ways to assist students who are passive in seeking help', *Daily Maverick*, pp. 1–5. Available at: https://www.dailymaverick.co.za/opinionista/2018-10-29-campus-suicide-universities-need-to-find-ways-to-assist-students-who-are-passive-in-see….

Seroalo, K. B. *et al.* (2014) 'A critical synthesis of interventions to reduce stigma attached to mental illness', *Health SA Gesondheid*, 19(1), pp. 1–10. doi: 10.4102/hsag.v19i1.800.

Shabani, K. (2010) 'Vygotsky's Zone of Proximal Development: Instructional Implications and Teachers' Professional Development', *English Language Teaching*, 3(4), pp. 237–248.

Sjöstrand, M., Eriksson, S. and Helgesson, G. (2013) 'Paternalism in the Name of

Autonomy', *Journal of Medicine and Philosophy*, 38, pp. 710–724. doi: 10.1093/jmp/jht049.

Sladdin, J. (2018) *Duty to care for student mental health has legal implications for universities*, *Out Law Analysis*. Available at: https://www.pinsentmasons.com/out-law/analysis/duty-to-care-student-mental-health-legal-implications-universities (Accessed: 29 October 2020).

Smeyers, P. (2010) 'Empathy ,Paternalism and Practical Reason: Philosophy of Education and the Ethics of Care Revisited', *Journal of Philosophy of Education*, 44(1), pp. 171–180.

Stanley, N. and Manthorpe, J. (2001) 'Responding to students' mental health needs: Impermeable systems and diverse users', *Journal of Mental Health*, 10(1), pp. 41–52. doi: 10.1080/09638230123777.

Stein, B. *et al.* (2013) *Interventions to improve student mental health*. Available at: http://www.rand.org/content/dam/rand/pubs/monographs/MG1200/MG1217/RAND_MG1217.pdf.

Stein, D. J. *et al.* (2008) 'Life time prevelance of psychiatric disorders in South Africa', *Br J Psychiatry*, 192(2), pp. 112–117. doi: 10.1192/bjp.bp.106.029280.LIFETIME.

Stillwell, S. B., Vermeesch, F. A. L. and Scott, F. J. G. (2017) 'Interventions to Reduce Perceived Stress Among Graduate Students : A Systematic Review With Implications for Evidence-Based Practice', *Worldviews on Evidence-Based Nursing*, 14(6), pp. 507–514.

Storrie, K., Ahern, K. and Tuckett, A. (2010) 'A systematic review: Students with mental health problems—A growing problem', *International Journal of Nursing Practice*, 16, pp. 1–6. doi: 10.1111/j.1440-172X.2009.01813.x.

The Association for Child and Adolescent Mental Health (2019) *School-based interventions*, *ACAMH*. Available at: https://www.acamh.org/topic/school-based-interventions (Accessed: 4 June 2019).

The Association of UK University Hospitals (2017) *Transforming healthcare through clinical academic roles in nursing , midwifery and allied health professions A practical resource for healthcare provider organisations*.

The South African Anxiety and Depression Group (2019) *The South African Anxiety and Depression Group*. Available at: http://www.sadag.org/ (Accessed: 26 March 2019).

The South African College of Applied Psychology (2018) 'The shocking state of mental health in South Africa', *The South African College of Applied Psychology*, pp. 1–12. Available at: https://www.sacap.edu.za/blog/counselling/mental-health-south-africa/.

Thomas, S. E. *et al.* (2011) 'Developing a program to promote stress resilience and self-care in first-year medical students.', *Canadian medical education journal*, 2(1), pp. e32–e36. doi: 10.2196/jmir.1827.

Tomlin, A. (2018) *Prevention and early intervention for youth mental illness: how should we focus our limited resources?*, *The Mental Elf*. Available at: https://www.nationalelfservice.net/...-intervention-for-youth-mental-illness-how-should-we-focus-our-limited-resources-mqsciencemeeting/ (Accessed: 4 June 2019).

University of Cape Town (2018) *University of Cape Town Mental Health Policy*. South Africa.

Varelius, J. (2006) 'The value of autonomy in medical ethics', *Medicine, Health Care and Philosophy*, 9(3), pp. 377–388. doi: 10.1007/s11019-006-9000-z.

Vereenooghe, L. *et al.* (2018) 'Interventions for mental health problems in children and adults with severe intellectual disabilities: A systematic review', *BMJ Open*, 8(6), pp. 1–12. doi: 10.1136/bmjopen-2018-021911.

Vuga, E. *et al.* (2006) 'Undergraduate student mental health at Makerere University , Uganda', *World Psychiatry*, 5(1), pp. 51–52.

Vygotsky, L. (1978) *Mind in Society.* London: Harvard University Press.

Wartman, S. A. (2017) *The role of the physician in 21st century healthcare*, *Association of Academic Health Centers*. Available at: www.aahcdc.org (Accessed: 16 April 2019).

Wenger-Trayner, E. and Wenger-Trayner, B. (2015) 'Communities of practice a brief introduction', *Wenger-Trayner*, April, pp. 1–8.

Whitcomb, M. E. (2006) 'The General Professional Education of the Physician', *Academic Medicine*, 81(12), pp. 1015–1016.

Winzer, R. *et al.* (2018) 'Effects of mental health interventions for students in higher education are sustainable over time: a systematic review and meta-analysis of randomized controlled trials', *PeerJ*, 6, p. e4598. doi: 10.7717/peerj.4598.

World Health Organization (2004) *Prevention of mental disorders: effective interventions and policy options*, *World Health Organization*.

Wynaden, D. *et al.* (2014) 'The Silence of Mental Health Issues Within University Environments : A Quantitative Study', *Archives of Psychiatric Nursing*. Elsevier Inc., 28(5), pp. 339–344. doi: 10.1016/j.apnu.2014.08.003.