Ethical considerations when treating patients with eating disorders

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In South Africa, the prevalence of eating disorders remains largely unknown. However with the unique, complex, social and political transformation of the country and increasing urbanization, it is anticipated that there will be an increased local risk of eating disorders.[1] Psychological, social, biological, cultural and familial factors play a role in the development of these ailments. Adolescence is a time of significant self-awareness, identity development and critical self-evaluation[2] and has perhaps been most impacted by socio-cultural changes in contemporary South African society.[3] It is usually during this developmental phase that, among females predominantly, body dissatisfaction and aesthetic concerns are raised and efforts to address these worries often result in dieting.[4,5] Western culture and the seductive emphasis on consumerism appear to have a powerful impact on the development of eating disorders.[6] Consequent assimilation of the associated Western value system, where physical appearance and self-worth are seemingly synonymous,[7] seems inevitable. The media plays a pivotal role in promoting and reinforcing the development of eating disorders as youngsters are faced with a barrage of media propaganda suggesting what is the ideal body.

Eating disorders are essentially psychological conditions, often associated with devastating medical consequences and share the core features of self-evaluation by weight perception and a desire to be thin.[8] They are classified as *Anorexia Nervosa*, *Bulimia Nervosa* and Eating Disorders Not Otherwise Specified. The diagnostic criteria of Anorexia Nervosa includes (i) body weight is maintained at less than 85 percent expected for age; (ii) a distorted body image; and (iii) an endocrine disorder typified by amenorrhoea. The self-induced weight loss criteria achieved by food avoidance, vomiting and purging. *Bulimia Nervosa* is typified by binge-eating large amounts of food and a subjective sense of loss of control. It is characterized by (i) a persistent preoccupation with eating; (ii) compensating for over-eating with behaviour to decrease calorie intake or expend calories, typically by self-induced vomiting, exercise and laxative abuse; and (iii) a morbid dread of becoming fat. Eating disorders are often severe conditions with elevated standardized mortality ratios and marked impairment. Anorexia Nervosa and Bulimia Nervosa both have a typical onset in late adolescence and early adulthood, mainly in young women, but are increasingly seen in young males.

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Eating disorders have a significant impact on oral health. The subtle changes in the mouth, which should be recognized by the general dental practitioner, may be early indicators of a serious underlying psychiatric condition. Recognition of these signs should result in earlier diagnosis, referral and instigation of management of both the underlying condition and the secondary oral conditions in their early stages.[8] Early recognition will result in more favourable treatment outcomes as failure to recognize the signs may lead to serious systemic problems, together with progressive and irreversible damage to the dental hard tissues. Dental erosion is the most common and dramatic oral manifestation of the chronic regurgitation typical of eating disorders.

Other oral manifestations include dental hypersensitivity, enamel erosion of lingual surfaces of the maxillary anterior teeth, which may also have a moth-eaten appearance of the incisal edges, raised restorations above eroded tooth structure, xerostomia, enlarged parotid glands, sore throat, mucositis, burning sensation of the tongue, bleeding gingiva and decreased salivary flow/enlarged salivary glands. In addition to the damage to dental hard tissues, the oral mucosa is also affected. Nutritional deficiencies impair repair and the regenerative potential of the oral mucosa. Trauma to the mucosa, particularly to pharynx and soft palate is a universally recognized sequela of eating disorders and is often caused by the insertion of foreign objects into the oral cavity to induce vomiting.[9,10]

Angular cheilitis has been reported and non-specific nutritional deficiencies and trauma have been implicated as aetiological factors. Angular cheilitis is a manifestation of chronic infection either solely by the fungus *Candida albicans* or sometimes by concomitant candidal and staphylococcal flora and is associated with both nutritional deficiencies and salivary dysfunction. Many of the manifestations of chronic oral candidiasis present as atrophic,

erythematous lesions of the oral mucosa and may be misdiagnosed as being of traumatic aetiology. All forms of oral candidiasis are associated with nutritional deficiencies – patients with eating disorders are nutritionally challenged individuals and would be expected to exhibit candidal lesions of the oral mucosa.[8] Oral candidiasis is an early clinical marker of systemic conditions such as HIV/AIDS, diabetes and sideropenia. However in nutritionally deficient individuals, such as those with eating disorders, oral candidiasis may raise a red flag of suspicion, especially as chronic oral candidiasis should not be present in healthy adolescents. Other oral mucosal manifestations include oral ulceration and glossitis[11] that are known to be related to hypovitaminosis B-12 as well as folate and iron deficiency states. Such deficiency states should alert the dentists to a potentially serious underlying problem.[11]

ETHICAL CONSIDERATIONS

Eating disorders arise from a variety of physical, emotional and social issues all of which need to be addressed to help prevent and treat these disorders. Early detection of eating disorders is important not only for the psychological and somatic outcomes but also for the oral and dental consequences. Dentists are often the first health care professional to whom individuals with previously undiagnosed eating disorders may present. In this regard the dental profession is ethically bound to be knowledgeable and informed and to assist with the secondary prevention of the disease.[12] Despite the serious consequences of eating disorders on physical and psychological health and well-being, they are often difficult to diagnose and more than half of all cases go undetected.[13] Many dental professionals and other health care workers prefer not to pursue their suspicions and do not engage with the patient for fear of losing the patient or misdiagnosing the condition. Such reactions are not in accord with ethical principles. Dentists should be socially responsible and act humanely in both professional and personal matters. If a patient presents with some of the classic oral signs of an eating disorder, a dental professional should, at the very least, discuss the dilemma with the patient. Practitioners should always regard concern for the best interests or well-being of their patients as their primary professional duty.

A medical referral may be necessary, even though when detected, patients are often averse to accepting treatment. The issue of patient confidentiality may then be raised. Seeking consent of patients to disclosure is part of good communication between health care providers and patients and is an essential part of respect for the autonomy and privacy of patients. With regard to access to health records, the National Health Act states that "A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user".

The ultimate act of beneficence will be in making the patient aware of their problem and to encourage and assist them to seek appropriate care and treatment to address the underlying psychological and interpersonal factors and to restore weight loss in a caring, humane manner. Treatment, with a stepped-care approach to determine the patient's needs, is most effective when it involves a multidisciplinary team including psychotherapy, behavioural healthcare, nutritional advice and medical and dental monitoring. The dental profession is well suited to be part of a multidisciplinary team effort to provide care to affected patients.

Professional ethical standards do not tolerate acts of discrimination directed towards the patient. The Health Professions Council states that all "Health-care practitioners should be aware of the rights and laws concerning unfair discrimination in the management of patients or their families on the basis of race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability such as contained in health rights legislation." A patient suffering from an eating disorder may be unduly emotional and difficult to manage. The dental practitioner meets his/her ethical responsibility by persevering with the treatment approach outlined above.

References

1. Szabo CP, Allwood CW. A cross-cultural study of eating attitudes in adolescent South African females. World Psychiatry. 2004; 3(1): 41–4.
2. Morgan CT, King RA, Weisz JR. Introduction to Psychology. 7th ed. New York: McGraw-Hill; 1986.
3. Revelas A. Eating disorders are real treatable medical illnesses. S Afr Fam Pract. 2012; 55(3): 252-5.
4. Moore DC. Body image and eating behavior in adolescents. J Am Coll Nutr. 1993; 12:505–10.
5. Steiger H. Anorexia nervosa: is it the syndrome or the theorist that is culture- and gender- bound? Transcult Psychiatr Res Rev. 1993;30:347–58.
6. Nasser M. Eating disorders: the cultural dimension. Soc Psychiatry Psychiatr Epidemiol. 1988; 23:184–7.
7. Freedman RJ. Reflections on beauty as it relates to health in adolescent females. Women and Health. 1984; 9:29–45.
8. Frydrych AM, Davies GR, McDermott BM. Eating disorders and oral health: A review of the literature. Aust Dent J. 2005; 50(1): 6-15.
9. Anderson L, Shaw J, McCargar L. Physiological effects of bulimia nervosa on the gastrointestinal tract. Can J Gastroenterol. 1997; 1:451-9.
10. Brown S, Bonifazi DZ. An overview of anorexia and bulimia nervosa, and the impact of eating disorders on the oral cavity. Compendium. 1993; 140:1594-1608.
11. Brownridge E. Eating disorders and oral health. How the dentist can help. Ont Dent. 1994; 71:15-8.
12. Johansson A-K, Norring C, Unell L, Johansson A. Eating disorders and oral health: A matched case-control study. Eur J Oral Sci. 2012; 120: 61-8.
13. Becker AE, Grinspoon SK, Klibanski A, Herzog DB. Eating disorders. N Engl J Med. 1999; 340: 1092-8.