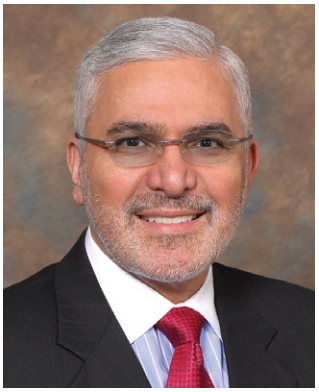
# Anathemas of psychiatric practice



**Henry A. Nasrallah, MD**
Editor-in-Chief

**The quarterly report of the State Medical Board can be a sobering read. In addition to the usual updates about new regulations or requirements for licensed physicians, there is always the disciplinary actions "blacklist" of dozens of medical practitioners in all specialties whose licenses were revoked or suspended due to a shocking array of serious violations.**

Those infractions range from Medicare billing fraud to prescribing narcotics to fictitious patients to engaging in sex with a patient to walking into the operating room drunk. It is truly disheartening to see dozens of physicians destroy their careers by committing a panoply of odious, repugnant, or illegal actions.

The term "anathema" comes to mind when I read about those miscreants. This Greek term is occasionally used in scholarly or religious publications, but rarely in everyday conversations or articles. Anathema refers to something detested, shunned, or denounced. When used by the clergy, it connotes something to condemn, such as a sinful or evil act.

Like all other medical specialists, we psychiatrists have a noble mission of treating and relieving the suffering of those afflicted with brain disorders that manifest as mood, thought, perceptual, behavioral, or cognitive abnormalities. Our main goal is to restore health, wellness, and quality of life to the millions of individuals who buckle under the weight of genetic redispersion, adverse environmental events, or both. So psychiatrists do a lot of "good," which benefits all those who live with mental illness. However, psychiatric practice may have some pitfalls that occasionally lead to anathemas, no matter how diligently a practitioner tries to avoid them. The code of psychiatric ethics is a shield that can preempt anathemas from contaminating clinical practice, but human error will occur when the ethical compass fails.

Here are some examples of anathemas that may rear their ugly heads if a practitioner is not constantly on the alert. It is likely you, the readers of Current Psychiatry, may think of additional anathemas not listed below. If so, I encourage you to send them to me at henry.nasrallah@currentpsychiatry.com in the form of a brief Letter to the Editor, which may be considered for publication.

- **Sexual contact with a patient**. This major anathema must not occur under any circumstance. It will have grave professional consequences for the practitioner and serious emotional repercussions for the patient.
- **Breach of confidentiality**. This is a sacred rule in psychiatric practice that must not be broken under any circumstance. Breaching confidentiality

**The code of psychiatric ethics can preempt anathemas, but human error will occur when the ethical compass fails**

**To comment on this editorial or other topics of interest:**
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will rupture the therapeutic bond and trust that a patient has with a psychiatrist (or psychiatric nurse practitioner).

• **Causing physical or emotional harm**. This anathema can have serious legal implications in addition to being an unacceptable professional violation.

• **Failure to assess patients for suicidal or homicidal risk**. The life of the patient, and others, may be at stake if this critical component is missing in the evaluation of psychiatric patients, even if they appear "stable."

• **Irrational and hazardous polypharmacy**. This type of harm must never occur during medical management of psychiatric patients, and may have legal consequences.

• **Not seeking collateral information**. This may seem like a "minor" anathema, but it can have major repercussions if a gap of clinically important data about the patient leads to erroneous diagnosis or inappropriate treatment. Regrettably, informants are sometimes unavailable.

• **Assessing patients from the neck up only**. Psychiatrists are, first and foremost, physicians who must evaluate the entire medical status of the patient, not just his/her mind. There are numerous bidirectional effects between the body and the brain that can influence diagnosis, holistic treatment, medical outcomes, and prognosis.

• **Treating patients with medication only, without any concomitant psychotherapy**. Such a suboptimal practice is an anathema that is not excusable due to a "lack of time." Every psychiatric patient deserves a biopsychosocial treatment approach.

• **Not inquiring about adherence at every visit**. It is impossible to assess the effectiveness of treatment if adherence is partial or poor. Patients must be constantly reminded that while their psychiatrists are committed to their care, full adherence is a vital responsibility for them to fulfill to ensure optimal outcome.

• **Ignoring the patient's cues, both verbal and nonverbal**. Being rushed by a large workload, a full schedule, or the demands of electronic medical records that distract a psychiatrist from fully attending to what the patient's words, facial expressions, or body language convey can lead to a failure to meet the patient's needs. Even worse, it may lead to missing a serious message a patient is consciously or unconsciously trying to relay.

• **Lowering expectations**. Nothing is more devastating for patients than to feel that the psychiatrist does not believe he/she will ever achieve wellness, or that they are beyond help and will never improve, recover, or overcome disabling psychiatric illness. This will generate profound hopelessness in vulnerable patients, who crave having a normal life free from illness or disability.

• **Using the same medication for all patients**. This is an anathema because one size does not fit all, and patients deserve to have their psychiatrists customize their pharmacotherapy to match their medical status and tolerability. For example, the 11 FDA-approved second-generation antipsychotics are not all the same, and a psychiatrist must select the member of that class that is most likely to be a good match for each patient based on that patient's medical history and the safety/tolerability profile of each antipsychotic.

• **Not continuously upgrading one's practice** to incorporate new evidence-based findings of more effective therapeutic strategies. It is an anathema to continue practicing what was learned in residency 25 to 30 years ago when there's new knowledge and many advances permeating psychiatric practice today.

• **Using alcohol or recreational drugs** during a shift in the clinic or the hospital. No explanation is needed for this anathema!

• **Prescribing for patients without a full evaluation**. That's poor clinical practice, and also is illegal.

• **Billing for patients who were never examined**. That's fraudulent, and stupid!

In an editorial I wrote last year intended for graduates of psychiatry residency training programs about the "DNA of psychiatric practice," I described what comprises good psychiatric practice.[1] Anathemas can be regarded as "mutations" within the DNA of psychiatric practice. It is always my hope that none of the freshly minted psychiatrists going into practice will ever commit an anathema, and end up on the "list of shame" in their State Medical Board's quarterly report….

**Henry A. Nasrallah, MD**
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**Reference**

1. Nasrallah HA. The DNA of psychiatric practice: a covenant with our patients. Current Psychiatry. 2018;17(5):20,22.