May 2018

Principles for freshly minted psychiatrists

I just finished reading Dr. Nasrallah's editorial "The DNA of psychiatric practice: A covenant with our patients" (From the Editor, Current Psychiatry. May 2018, p. 20, 22). It offered very good messages. I can add a few more: "Make a commitment to life-long professional education. Understand how to critique research findings and their clinical applicability. Distinguish fad from science."

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Unfortunately, there is no way a physician who uses an electronic medical record can "Maintain total and unimpeachable confidentiality" as the "The medical record is a clinical, billing, legal, and research document." Since 2003, patients no longer need to give consent for their medical records to be seen by the many staff members who work in treatment, payment, and health care operations, as long as these individuals follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Even de-identified data is no longer safe because re-identification is still possible with all the databases available for cross-referencing (ie, Facebook and hospitals as one instance).

So, when a patient finally tells you about a history of sexual abuse, do you make it clear to him or her that although this information is no longer private, it can be expected to be kept confidential by all the business associates, covered entities, government agencies, etc., who see their records?

Maybe there also would be fewer physician suicides if they could be assured of receiving truly private, off-the-grid psychiatric treatment.

Susan Israel, MD
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I just read your excellent and exhaustive May editorial, which offered advice for new psychiatrists. I was surprised to see that nowhere on the list was "Please remember to practice what you preach and be vigilant about self-care. We have become increasingly aware of the high rates of burnout among physicians. Know your own limitations so that you can appreciate the work that you do."

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Dr. Nasrallah's editorial should have listed something about the terms of payment for the psychiatrist who "provides" his or her clinical services to patients. This is an ethical issue. As you know, usually a corporation, rather than a patient, pays the psychiatrist. This payment may come from a health insurance company, government program, or (increasingly) a large clinic. When an organization pays the psychiatrist, it calls the tune for both the doctor's employment and the patient's access to quality care. Contracts between the hiring organization and psychiatrists are crucial, and therefore, most young doctors must join a hiring organization for financial reasons after completing their psychiatric residency. The young psychiatrists with whom I speak tell me they have no alternative but to be a "corporate dependent" in the world of 2018 psychiatric practice. They are aware of your (and my) noble principles, which should govern their relationships with patients. But the boss often does not agree with such principles.

In my book *Passion for Patients*[1] and as President of the 501(c)3 Minnesota Physician-Patient Alliance think tank (www.physician-patient.org), I argue for empowering patients with the means to direct payments to their physicians. Allowing patients this option is especially important for forming and maintaining strong relationship-based psychiatric and other medical treatments. In 1996, I was fed up with being a psychiatric medical director for 5 years at a large Minnesota Preferred Provider Organization. For me, the saving grace was being able to have an independent, private psychiatric practice. Most of my patients agreed.

continued

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Therefore, I suggest another principle: "Build and maintain an independent psychiatric practice as an escape option no matter what you do should you decide the ethical practice of psychiatry is not possible if you are employed by a given organization."

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Reference

1. Beecher L, Racer D. Passion for patients. St. Paul, MN: Alethos Press; 2017.

I agree with Dr. Nasrallah's guiding principles of psychiatry, which he proposes to govern the relationships of psychiatrists with their patients. However, there is one glaring omission. The first principle should be "to appropriately diagnose the patient's condition," which may or may not be based in psychiatry. Misdiagnoses and inappropriate pharmacologic therapy have ruined the lives of some very good friends of mine, and the need to first do no harm by misdiagnosing the patient, especially in psychiatric emergency rooms and on inpatient units, cannot be overemphasized.

These situations may not rear their head in the everyday practice of psychiatry. However, medical malpractice, especially in the field of psychiatry, is a constant caution that all new physicians need to watch for.

I would like to thank Dr. Nasrallah for his efforts to strengthen the patient–psychiatrist contract.

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Dr. Nasrallah responds

I thank my 5 colleagues for their perspectives on my editorial. You all made cogent points.

I agree with Dr. Israel that our patients' records are now accessible by many entities due to the drastic changes in our health care delivery system. However, while I regard the basic psychiatric signs and symptoms as medical data, like heart disease or cancer, there are personal details that emerge during psychotherapy that should remain confidential and not be included in the written record, and thus are not accessible to billers, health insurance companies, or malpractice lawyers. As for physicians who consider suicide because of fear of the consequences of receiving psychiatric treatment that becomes a matter of record, that is a matter of the unfortunate stigma and ignorance about mental illness and how treatable it can be.

Regarding Dr. Cash's comments, I agree that psychiatrists should be (and are almost always are) introspective about their vulnerabilities and limitations, and should act accordingly, which includes taking care of their needs to stay healthy and avoid burnout.

As Dr. Beecher pointed out, the employment model for psychiatrists does have many implications and constraints for patient care. I concur that having a small direct-care practice, sometimes called a "cash practice," provides patients who can afford it the complete privacy they desire, with no one having access to their medical records except for their psychiatrist. Your book is a useful resource in that regard.

Dr. Kasturi is right about the importance of arriving at an accurate diagnosis before embarking on treatment; otherwise, patients will suffer from "therapeutic misadventures." I have observed this being experienced by some of the patients referred to me because of "treatment resistance."

Thanks again to my colleagues for their comments and suggestions to the newly minted psychiatrists for whom my editorial was intended.

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