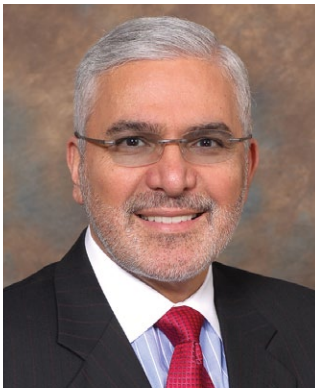
The sins and peccadillos of psychiatric practice



Henry A. Nasrallah, MD
Editor-in-Chief

Psychiatrists and other psychiatric practitioners are prone to an occasional behavioral foible or glitch in judgment—as all humans are.

But as professionals, and by virtue of our rigorous training, we continually reflect on our thoughts and feelings when we care for our patients, and we examine the effect of our behavior and communication patterns on them. Such self-reflection is especially important when it comes to countertransference while treating a person who has been made vulnerable by emotional turmoil and who develops strong transference feelings toward the treating psychiatrist.

Personal integrity is paramount in psychiatric practice; it's an indispensable ingredient when dealing with the intimate thoughts, feelings, and impulses of people who are seeking psychiatric help. In addition, the wisdom to recognize one's limitations as a provider of care is an important attributes of seasoned practitioners. Patients might perceive us as demigods, but we know better than to be carried away with hubris and pretend that we are.

Exercising sound judgment isn't easy

This is especially true when dealing with the varying degrees of ambiguity that shroud complex psychiatric conditions. The overriding principle for good clinical judgment in any medical practice is the patient's welfare, and that must dominate the moral, ethical, medical, and scientific decision-making of all psychiatrists. Those of us in charge of training medical students and residents emphasize this principle every day at the bedside and in the clinic. Upholding those principles, side by side with the knowledge and skills of psychiatric practice, are the hallmarks of good medical training.

But missteps occur. Peccadillos, infractions, and even transgressions happen—accidentally by competent, ethical psychiatrists; deliberately, sometimes, by a few unethical scoundrels. The sins of psychiatric practice come in a range of gravity and consequences. Here are some I've observed among colleagues over the years:

Becoming sexually intimate with one's patient. Violating the sacred boundary of the doctor-patient relationship is unforgivable; it's a sin that scars the patient and can destroy the psychiatrist's reputation and career. We must respect and uphold that boundary—not only during active treatment but even after care is terminated.

Divulging clinical details to others without the patient's consent. Breach of trust is not only an ethical misstep; it is a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with substantial penalties attached.

Patients might perceive us as demigods, but we know better than to pretend that we are

Call to readers
I've listed 2 more troubling "sins" of psychiatric practice in the online version of this Editorial at CurrentPsychiatry.com. Have you observed other sins? Share them with me at henry.nasrallah@currentpsychiatry.com. We'll publish examples in an upcoming issue.

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From the Editor

Treating the mind while ignoring the body and brain. We are physicians first, psychiatrists second. We must fully assess patients who present with psychiatric signs and symptoms to rule out a general medical condition that could be generating behavioral symptoms. Such co-occurring medical conditions might involve various organ systems, such as endocrinopathies, or might emanate from brain lesions, whether traumatic, degenerative, demyelinating, infectious, or neoplastic. Without careful medical evaluation, the wrong diagnosis might be made and inappropriate, even harmful, treatment provided while necessary care is delayed.

Treatment plans can sometimes overlook potential harmful effects of some medications on physical health—whether metabolic, cardiovascular, neurologic, gastrointestinal, hormonal, hematologic, or dermatologic. An optimal treatment plan embarks on healing the mind without ignoring or harming the body.

Failing to obtain additional information from sources who know the patient or who can provide old records. Such information is vital in psychiatry, because the patient's account often is incomplete, even distorted, because of cognitive deficits or psychopathologic factors. Additional information can be corroborative or contradictory, and is sometimes critical—significantly influencing the diagnosis or the treatment plan, or both.

Allowing personal beliefs to influence care. This transgression includes inserting one's views about religion, politics, sexual orientation, ethnic origin, and socioeconomic class into medical care. The same unimpeachable, high caliber of care must be provided to *every* patient, and must not differ in any way from the care that we would recommend to our own family members.

Reducing psychiatry to prescribing a pill. However unacceptable and deficient this reductionist degradation of psychiatric management is, it is sometimes imposed by organizations in which the caseload is huge and the number of providers insufficient. We must resist the temptation to compromise, and must strive to address not only the biological aspects of illness but psychological and social dimensions as well. Patients will not have an optimal outcome if we don't.

Practicing with an outdated knowledge base—one acquired during residency years, often years or even decades, earlier. There is no medical or ethical justification for using 1985, or even 2005, standards of psychiatric care in 2015.

Psychiatry is rapidly evolving, with many ongoing changes and advances. Updating one's practice pattern through lifelong learning is an absolute must for psychiatrists (and for all health care professionals). Utilizing the latest, evidence-based data to guide diagnosis and treatment is an indispensable component of good psychiatric care.

Neglecting to consider treatment options. Consider just a few scenarios: The recurrently relapsing patient with psychosis who is not switched to a long-acting injectable formulation; the persistently psychotic patient who does not receive a trial of clozapine; the treatment-resistant depression patient who is not referred for electroconvulsive therapy or transcranial magnetic stimulation; and the patient receiving an atypical antipsychotic who is monitored inconsistently for metabolic dysregulation.

continued

Treating patients but not vigorously advocating for them—thus allowing a broken, convoluted mental health system to delay or prevent access to care; incarcerate relapsed patients instead of hospitalizing them; permit insurance companies to discriminate against coverage of mental illness; and tie the hands of psychiatrists who want to select medication they judge best for their patients.

None of us is 'without sin'

We all aspire to help our patients in the best way we can, and to avoid errors. However, even a seasoned psychiatrist can stumble unwittingly, and that is understandable and forgivable. It is willful, recurring neglect of the patient's welfare that can be deleterious and that, in my opinion, qualifies as a cardinal sin. Fortunately, such neglect is a low-frequency event in psychiatric practice, but even a single occurrence is one too many.

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