

"Required Ethics Training for Psychiatrists?" By Mark S. Komrad M.D.
Addressing the "Judgement Trance:" Why Ethics CME Should be Required

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You have 20 years of clinical experience under your belt. You feel that you know your strengths, weaknesses, and limits. You've come to believe that the therapeutic relationship is the key "medically active ingredient" in treatment. So, you start to think that it is the most important thing to develop, enhance and preserve in your work with patients. You are treating a new patient who believes that much can be learned from you; not just your knowledge but the way you live your life. You respond. You share stories about your life: your marriage, your struggles parenting your child, your experiences in college. The patient really resonates. This encourages you to start sharing more vulnerable stories--episodes that have much in common with the patient's experience. You find yourself sharing how a professor in college crossed some lines with you, got too close, actually seduced you. The patient feels your pain, because it's similar. Next session, you get a gift from the patient. It's food. The patient invites you to share the food. You need no further reflection, after 20 years, than to check in with your own feelings. It feels right. Develop the relationship, don't allow the patient to feel rejection. You prepare your coffee table to share the repast. The next session, is a beautiful day, you move out to the balcony together and share food again. Feels right. Next session, another gorgeous day, and the park across the street seems like an inviting therapeutic environment. So you move the session out there, it's like having a class outdoors on a beautiful day in college--no harm done. The following session, you get up in the morning, see the weather is fine again, know that it's a hot day, so that morning you dress in something more comfortable and casual for outdoors. It's slightly more revealing, but it feels comfortable, and that's important. Towards the end of that session, after eating, coffee feels right, so you and the patient swing by the cafe for a cup. The therapeutic relationship is deepening, the patient is trusting you more and more. You're getting to material that has never been reached before. You are feeling very effective, the sensation of a senior therapist, at ease in your complex art. You find yourself looking forward to these sessions. In fact, you start to make sure that there is nobody else scheduled immediately after this patient's hour, so you can linger a bit longer over coffee. It helps to move the session to the last one of the day. You are increasingly aware that you are treating a truly remarkable person, and feel fortunate for the serendipity of being matched up by referral and chance. Indeed, you feel that your years of experience permit you to try stretching, taking slight extensions of conventional technique--bending technical rules that are really designed more for beginners, to help structure their introductory years in the ill-defined and elusively broad art of therapy. Like training wheels, you sense there is a point where typical conventions are oversimplified and even unnecessary. This isn't something you can or even need to talk about with any colleague. They probably wouldn't understand. They have to be here, in this particular therapeutic relationship, to really get it. Only you can get it. It took 20 years, but you're really feeling you are starting to get it.

And so it goes: the slow procession of feelings, rationalizations, and instincts which propel you down a self-determined, well meaning, and increasingly self-deluded path. You drift further and further "off-the-reservation," a satisfying journey which, one day, ends in surprise, when you are

being interviewed by the Maryland Board of Physicians about this case. Where did you go wrong? Did you ever know you had?

For the last few years, as Chairman of the Clinical Ethics Committee for Sheppard Pratt Health Systems, I have been called upon widely to give lectures on topics in Medical Ethics, with a specific focus on ethical issues in mental healthcare. The audiences are almost always social workers and psychologists; rarely, if ever, is there a psychiatrist in the audience. Why is this? It turns out that for some years, both of these professions have required not just continuing education credits to renew their licenses to practice, but specifically, 3 credits yearly in ethics. In contrast to our fellow mental health professionals, though we are required to have yearly credits to renew our licenses as physicians, there are no specific requirements for psychiatrists to take courses in any particular area, let alone ethics.

I want to argue that a requirement in ethics training for physicians in general, psychiatrists in particular, should be implemented, in parallel with the already established requirements of social workers and psychologists. Historically, physicians were long resistant to the idea of medical ethics as an important clinical discipline. There was a sense that it belonged as a course in philosophy departments or at special "think tanks" like the Hastings Center for Bioethics in New York, but not in hospitals, on rounds, or in grand rounds. However, that recalcitrance was gradually eroded, partly with the help of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which, over the last decade, has started to require that hospitals have an Ethics Committee, which could be consulted by staff or patients. Even prior to this, the federal government instituted the requirement of an Institutional Review Board (IRB) to review any protocol for human experimentation for ethical soundness.

One need not look past the headlines to observe that we live in times of great ethical confusion and misbehavior in many professions. My own work with ethics consultations in health care systems and on the MPS Peer Review committee has revealed to me that there is indeed considerable ethical confusion and misadventure (both knowingly and unknowingly) among psychiatrists.

Systematic ways of thinking through moral conundrums do exist and have been developed in the formal field of Medical Ethics. These processes are not necessarily merely a matter of following one's intuition. Indeed, I have seen "clinical intuition" lead many a psychiatrist astray in this domain. The ever increasing pressure to make decisions quickly, to spend less time with patients and less time in consultation with colleagues, have all combined to increase the chance of clinical behavior that is not just substandard, but frankly, unethical.

It turns out that considerable thought, writing, and discussion has been taking place in the field of Medical Ethics over the last few decades, which is keeping up with developments. Issues that have challenged ethical thinking are evolving. Such issues as the ethics of relating to managed care organizations, doctor/patient boundaries, and patients refusing treatment are just examples of issues about which thinking has been rapidly evolving in systematic ethical analysis. Critical thinking about these areas is advancing, much as neuroscience and pharmacology are advancing. Yet there is little opportunity to avail oneself of training in these matters. Indeed, the demands of more concrete and procedural knowledge, such as psychopharmacology, can be seductive and

can lead one away from the "softer" topics when considering how to spend precious CME hours.

Moreover, there are not many CME hours out there for ethical training of psychiatrists. I recently had an opportunity to give an hour lecture on a CME closed-circuit TV and webcast program. Though asked for more, it was impossible for the producers to find underwriters for more ethics broadcasts. In contrast, underwriters (read: pharmaceutical companies) were standing in line to sponsor programs on treatments of illnesses with pharmacotherapy.

The fact is that mandating continuing education in ethics for social work and psychology produced a market for such courses, and suddenly, they were commonly available. In my experience, they are eagerly attended, not simply because they are mandated. Attendees seem to find this training of immediate value to common practice conundrums. These seminars actually help to raise basic awareness of when one is actually on ethically controversial ground-- a basic awareness that, though fundamental, is often lacking. It is one thing to know how to skate on thin ice; it is another thing entirely to learn how to recognize that the ice is getting thin.

More than any other kinds of healing professionals, therapists and psychiatrists are often soloists. What we do is, by necessity, very private. Typically, we are utterly alone with our patients. This makes us vulnerable to creating a hermetically sealed zone in which our clinical judgement is deployed, without being readily accessible to feedback from other authoritative colleagues or sources. My work on the MPS Peer Review Committee demonstrates to me the kind of "judgement trance" that can be fostered, in which progressive rationalizations can lead to a subtle, gradual drift away from standard ethical practice. Unfortunately, it is often left to the patient or family member to ring the alarm bell, signaling that the psychiatrist is "off-the-reservation." One need only read the report of sanctions by the Maryland Board of Physicians to see that psychiatrists are overly-represented in that roll call of dishonor.

I submit that this is not surprising, considering the nature of our work. That means that our specialty has a particular need for ethical education to cultivate a more robust and effective ethical self-monitoring.

This is the reason that I think it is time for us to join the good sense of our colleagues, the social workers and psychologists, and require of ourselves mandatory continuing education in one particular area-- ethics. The zeitgeist of our increasingly ethically confused society calls for it, the virtue of humility in the face of a complex clinical art calls for it, and last (and least)-- our malpractice attorneys call for it.

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