The Ethics of Psychiatric Education

John Coverdale, MD, MEd, FRANZCP[a,b,*], Laurence B. McCullough, PhD[b], Laura Weiss Roberts, MD, MA[c,d]

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Ethical issues pervade all of psychiatric clinical practice. These issues range from managing suicidal patients to obtaining assent for care from a young adolescent and from dealing with complicated sexualized issues that may arise in performing psychotherapy to introducing "cutting edge" clinical approaches such as somatic therapies and genetic testing in the care of patients. In addition, the behavior of some psychiatrists causes concern when their interests are promoted over and above those of patients. Such situations can occur when psychiatrists violate social and sexual boundaries with patients, when financial gain becomes an influential consideration in decision-making about the admission of a patient, or when conflicts of interest arise in relationships with pharmaceutical companies or the health care industry. Although these issues pertain to all medical professionals, one early national survey of program training directors in psychiatry asking what topics should be taught in psychiatric ethics found that physician–patient sexual contact and financial considerations in practice were deemed the most important.[1] In a second survey of residents at 10 training programs, the majority of trainees requested that additional curricular attention be given to 19 of 26 ethics topics encompassing issues related to withholding information from patients, informed consent and decisional capacity, responsibilities in terminating with therapy, allocation of health care resources, and colleague impairment.[2]

Psychiatric educators must attend to learners' ability to address constructively the ethical concerns inherent in both routine and challenging clinical problems and to prevent ethical conflicts that arise in everyday practice, particularly when their own

[a] Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, TX, USA
[b] Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston, TX, USA
[c] Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, Milwaukee, WI, USA
[d] Department of Population Health, Medical College of Wisconsin, Milwaukee, WI, USA
* Corresponding author. Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, One Baylor Plaza, BCM 350, Houston, TX 77030.
E-mail address: jhc@bcm.tmc.edu (J. Coverdale).

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interests could supersede those of patients. Ethics, in turn, concerns the clinical judgment, decision-making, and behavior of practitioners (and health care organizations) and both the evidence and arguments that support what these should be.[3] Thus, an ethics of psychiatric education must attend not only to promoting competent clinical judgment and clinical practice but also to promoting ethical behaviors.

This article discusses the central elements of an ethics of psychiatric education. This discussion is framed in light of the work of John Gregory, whose medical ethics helped shape medicine as a profession. References to John Gregory's medical ethics are used here to inform the ethics of psychiatric education in three selected areas of importance to the profession: the management of suicidal patients, managing sexual boundaries between psychiatrists and patients, and avoiding conflicts of interest.

JOHN GREGORY'S ETHICS OF MEDICINE

John Gregory (1724–1773) wrote the first professional medical ethics in the English language that was based on the physician's responsibility to promote and protect the interests of patients. Thus, John Gregory introduced the concept of medicine as a profession and heavily influenced Thomas Percival (1740–1804), who in turn was a major influence on the code of ethics promulgated by the American Medical Association in 1847.[4] John Gregory's contribution was truly revolutionary given the circumstances of practice in Scotland during his lifetime.

In eighteenth century Scotland, medicine was practiced as an entrepreneurial and self-interested business, creating a crisis of intellectual and moral trust among the sick that prompted Gregory to write and lecture on medical ethics. A comprehensive account of this history has been provided by one of the present authors (LBM) elsewhere.[4,5] There was no standard medical curriculum, no licensure, no uniform pathway to becoming a physician, or regulation of practice, and there were a number of different concepts of health and disease. Many of the sick did not trust physicians intellectually, in terms of what they said or how they treated their illnesses. Many of the sick also did not trust physicians morally, in terms of putting the interests of the sick individual first and physicians' financial and other interests second. Some physicians assumed the good manners of a gentleman to pry their way into the houses of the sick and to take advantage of them financially. Some also became sexual predators of the sick. Gregory took the view that this behavior toward the vulnerable ill was unacceptable and was concerned by both a lack of scientific competence and unbridled self-interest.

Gregory responded to this crisis in trust by using the tools of ethics and philosophy of medicine to open medicine to public scouting and accountability. Three key components of his response serve to inform the teaching and practice of medicine today. The first addresses the problem of intellectual trust by calling for medicine to be based on scientific principles and evidence. The second component of his response addressed the problems of moral trust by emphasizing that protecting and promoting the interests of patients should be the physician's primary concern or motivation. The third component was the call to physicians to subordinate the pursuit of their own interests in favor of the needs of patients (**Box 1**).

In addressing the lack of intellectual trust in physicians, Gregory looked to Francis Bacon (1561–1626), who had called for medicine to be based on experience or on the rigorously collected results of natural and designed experiments. The first component then requires that physicians become and remain scientifically and clinically competent. Gregory referred to an openness to conviction that enables a physician to