Developmental Aspects of Ethics, And Their Application to Medical Ethics and Supervisory Relationships

Medicine is one of the three original "learned" professions from Medieval times, along with divinity and law.

ACGME Competencies

Patient Care and Procedural Skills

Medical Knowledge

Interpersonal Communication Skills

Practice Based Learning and Improvement

Systems Based Practice

Professionalism

ACGME Interpersonal and Communication Skills

The physician shall develop and maintain a therapeutic alliance with patients and work collaboratively with professionals and the public. The doctor shall demonstrate the ability to counsel and communicate **professionally** with patients, families, and other medical specialists in the development of a health care management plan.

ACGME Systems Based Practice

The physician shall act as an advocate for patients within the community healthcare system, particularly while accessing care and

support services. In addition the physician shall

be cognizant of the legal aspects of the

healthcare system and their and their impact on

patients and families.

ACGME Practice-Based Learning

The physician shall recognize the need for lifelong learning and analyze current scientific practice-related literature in order to improve current patient care practices. The physician shall undertake a caseload evaluation and implement best practices in order to foster excellence in treatment

ACGME Professionalism

The physician shall demonstrate ethical principles, a commitment to the medical profession, and respect for patients and colleagues while actively involved in professional educational endeavors at the local and national level

Erik Erikson – Eight Stages of Man
Generativity vs. Stagnation

Giving to the next generation -

“A person does best at this time to put aside thoughts of death and balance its certainty with the only happiness that is lasting: to increase, by whatever is yours to give, the goodwill and higher order in your sector of the world” (Erikson, 1974).

Developmental Theories of Ethical Competency

- **Freud's Theory of Psychosocial Development**

- **Piaget's Theory of Cognitive Development**

  Sensorimotor
  Preoperational
  Concrete Operations
  Abstract Capacity

- **Erikson's Eight Stages of Man**
  Generativity versus Stagnation – a capacity to give
  Giving to the next generation - A person does best at this time to put aside thoughts of death and balance its certainty with the only happiness that is lasting: to increase, by whatever is yours to give, the goodwill and higher order in your sector of the world (Erikson, 1974).

Kohlberg's Stages of Moral Development

Level 1: Pre-Conventional

1. Obedience and punishment orientation: How can I avoid punishment?
2. Self-interest orientation: What's in it for me?

Level 2 Conventional

3. Interpersonal accord and conformity: Social norms, good boy/girl.
4. Authority and social-order maintaining orientation: Law and order morality

Level 3 Post-Conventional

5. Social contract orientation
6. Universal ethical principles: Principled conscience

Conscience, Superego and Ego Ideal

Freud's Structural Model 1923, Superego-Uber-Ich

- Derived from identifications with parental and other loved figures and develops out of the ego.

- Catalyst for construction and consolidation towards autonomy is linked to Oedipal struggles and related identifications to defend against threat or harm or loss. These external threats become internal threats from the newly autonomous super-ego.

- Lacunae, fault lines, and inconsistencies based on threat and defense emerge. The patency of the floorboard varies between individuals. It is "by no means a uniform, coherent, integrated, harmonious structure…but a mass of contradictions" (Jacob Arlow, Problems of the Superego Concept 1982)

- The **Ego Ideal** is a component of the superego

  The ideal view of oneself, also based on identifications.

  How high one sets the bar for oneself, and how rigid or flexible it is.

- "Conscience" as commonly used is but one component of the superego,

  though all components of the superego stem from the same source

  (identifications)

Intellectual ability does not correlate with superego development. Nor does education or professional achievement

- 23 Nuremburg defendants were MDs including several psychiatrists. Psychiatrists were highly involved in and at times led the Nazi T-4. Euthanasia Program, research conducted in concentration camps, and provided psychiatric consultation to the Gestapo. An Austrian psychiatrist was the first commandant of Treblinka.

- Radavon Karadzic, psychiatrist, convicted by the Hague as a War Criminal for atrocities during the Bosnian War including five counts of crimes against humanity. (Article 5 of the Statute – extermination, murder, unlawfully inflicting terror upon civilians, taking hostages persecutions on political, racial and religious grounds, inhumane acts including forcible transfer.

- A number of psychiatrists have been major leaders of modern terrorist movements.

- Surgeon General Shirō Ishii, a Japanese army medical officer and the director of Unit 731, a biological warfare unit.

- Bashar Assad, Syrian dictator, is an opthamologist.

- François “Papa Doc” Duvalier who was accused of multiple crimes against humanity in Haiti was a physician trained in Tropical Medicine.

- Pol Pot was a teacher

Objectives

1. Attendees will gain understanding of how ethical issues pertain to everyday practice.
2. Attendees will gain understanding of the relevance of APA and AACAP Ethical Codes to ethical guidelines for the conduct of psychotherapy.
3. Attendees will gain understanding of how ethical guidelines for the conduct of psychotherapy facilitate the depth of clinical work.
4. Attendees will understand the legal foundation to the ethical guidelines for the conduct of psychotherapy.

Content

1. Ethics as reflected in the Hippocratic Oath and the American Psychiatric Association's "Principles of Medical Ethics."
2. Definition of Ethics.
3. Respecting boundaries.
4. Autonomy of older children, adolescents and adults.
5. Liability for Dangerous Patients, Abandonment, and Other Current Issues
6. Protection of Data
7. Communications with parents and children.

CONTENT

1. Ethics as reflected in the Hippocratic Oath and the American Psychiatric Association's "Principles of Medical Ethics."
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5. Liability for Dangerous Patients, Abandonment, and Other Current Issues
6. Protection of Data
7. Communications with parents and children.
8. Challenges in the small community.
9. Countertransference.
10. Written and verbal communication with parties outside the family.
11. Electronic mail.
12. Hospital psychiatry and the psychotherapeutic relationship.
13. Public encounters.
14. Privacy versus secrecy.
15. Greater than one therapist.
16. Conclusions.

Why Ethics

- Ethics is a static, boring topic- a set of fixed rules. In contrast, it is a complex concept that requires constant consideration and enters into everyday clinical work.
- To understand that medical practice involves the most personal disclosures and hence make the patient vulnerable.
- To understand that intense feelings may get stirred up in the patient and the clinician.
- To understand the responsibility of the clinician in many contexts to respond in a helpful manner and not to do harm.

Hippocratic Oath

"I swear by Apollo, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath…to teach then this art I will prescribe regimens for the good of my patients according to my ability and my judgment and *never do harm to anyone*. (**"primum non nocere"** - **first do no harm** added in the 17th century).

"To please no one will I prescribe a deadly drug nor give advice which may cause his death… but I will preserve the purity of my life and my arts. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art…

"If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."

The Webster Unabridged Dictionary defines ethics as:

1) “a system of moral principles”
2) “the rules of conduct recognized in respect to a particular class of human actions or a particular group….”

‘Ethics is what you do when no one is watching’.

Principles of Medical Ethics AMA Code as Annotated for Psychiatry

1. A physician shall be dedicated to providing competent medical care, with **compassion and respect for human dignity and rights**.
2. A physician shall uphold the **standards of professionalism, be honest in all professional interactions**, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
3. A physician **shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.**
4. A physician **shall respect the rights of patients, colleagues, and other health professionals**, and shall **safeguard patient confidences and privacy** within the constraints of the law**.**
5. A physician **shall continue to study, apply, and advance scientific knowledge**, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, **except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.**
7. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
8. A physician shall, while caring for a patient, regard **responsibility to the patient as paramount**.
9. A physician **shall support access to medical care for all people.**

Key Ethical Principles

Core Constructs in Medicine

- Non-malfeasance – Do no harm, misconduct, or wrong-doing
- Beneficence – Actions are solely for the patient's interest, well being (charity, kindness).
- Autonomy – That the patient always has independence for decision making unless impaired, and then this responsibility goes to power of attorney, **not** the clinician
- Justice – Care is provided equally, free of prejudice, bias
- Confidentiality – full respect for the patient's privacy, including no sharing of information outside the treatment relationship without consent.

Boundaries

Hippocrates: "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men be they free or slaves."

- The role of a clinician can be a lone endeavor. A patient's desires and aggressive impulses can induce us to action based on our own needs and conflicts.
- The concept of **therapeutic neutrality** can be a helpful guide in the doctor-patient relationship.
- We need to constantly monitor our reactions to patients and their family.
- Self knowledge can free us to work more objectively and to keep a treatment relationship, and hence, a treatment process on tract.

“In interpersonal relationships, boundaries are serve to maintain identity, protect personal space, and allow for smooth interactions with others.”

“In a professional relationship, such as between a patient and his/her physician, *boundaries are necessary rules and limits because of the power differential inherently present in the relationship.* Professional boundaries are essential to protect the patient’s comfort level and sense of safety. To ensure the patient’s best interest always remains the overriding concern.

When professional boundaries are violated, patients may experience confusion, shame, self-doubt, anger, sadness, and

“In the [doctor]-patient relationship, a dual role relationship is created when the [physician] engages in another, significantly different relationship with the patient. This second role could be social (e.g. friendship) or financial (e.g. collaborating on investment ventures or business, client-attorney). Professional boundaries are at great risk for being violated in a dual role situation because the boundaries for the second role are usually different from those of the professional role. *Because of the conflicts of interest created by dual roles, violations of the role boundaries can compromise professional judgment by impairing the physician’s objectivity*, and undermine patient welfare by impairing the physician’s objectivity, and undermine patient welfare by increasing the likelihood of exploitation.”

John H. Hung, PhD, LP

Minnesota Medical Association

What is Neutrality In the Doctor Patient Relationship?

Neutrality is not indifference to the patient or a caricature of remoteness. It is a strategic
position to provide maximum freedom to the patient to communicate while also serving to
reinforce boundaries.

Taking a position equidistant from the demands of the patient's wishes, dilemmas, fears with respect to their values especially when different from yours.

An attitude "of professional commitment or helpful, benign
understanding that avoids extremes of detachment and
over involvement"

Moore and Fine

This allows development of trust and communication.

Countertransference

Moore and Fine's Psychoanalytic Terms and Concepts include in their discussion of the term "countertransference"…*feelings and attitudes toward a patient… derived from earlier situations in the [physician's] life that have been displaced onto the patient… Others include all … emotional reactions to the patient, conscious and unconscious, especially those that interfere with … understanding…This broad purview might better be designated "counter-reaction".*

The construct of countertransference is intimately related to neutrality

Self scrutiny is very important to the work of providing care and to watch for possible boundary violations.

Common warning signs for potential breaches of boundaries in the behavior of the physician include recurrent lateness to appointments, unusual extensions of appointment times, unnecessary touching of patients, gifts to a patient, and contact with the patient outside of scheduled sessions, especially outside the office setting (with the exception of planned house calls).

Self Disclosure

Unnecessary or excessive self disclosure is a boundary violation for one of two reasons:

1. Self disclosure as an effort to model, influence, sway a patient departs from neutrality and can breach respect for the individual's inherent right to determine their own values, belief's, and solutions.

2. Self disclosure of personal circumstances and problems is a "role reversal…self disclosure is itself a boundary problem because it is a misuse of the patient to satisfy one's own need for comfort or sympathy".

A patient may also become very reluctant to and/or lose their freedom to address their concerns when they perceive the clinician to be vulnerable and dominated by their own needs and distractions.

Gabbard, G., Nadelson, C.
Professional Boundaries in the Physician-Patient Relationship
JAMA, Vol. 273 No. 18

High Risk Times for Boundary Violations

Any time of personal crisis is a time of personable vulnerability that heightens risks for boundary violations:

Common Examples:

- Death of a loved one
- Divorce or marital discord
- Financial difficulties
- Legal difficulties
- Loneliness secondary to loss, relocation, separation from loved ones
- Periods of depression
- Serious illness, health issues
- Serious illness of a loved one
- Heightened caretaking role in personal life leading to one's own personal/dependency needs not being met

“The purpose of professional boundaries is not to create a relationship that is cold, distant, and calculated. That can occur if one applies boundaries rigidly and blindly, without consideration of the context of the relationship. Some of the key ingredients of a healthy [doctor]-patient relationship include trust, mutual respect, genuine caring, and a large dose of compassion. These are entirely congruent with professional boundaries which serve to protect the comfort level, dignity, and best interests of patients, in a relationship in which they can feel safe from exploitation in any form. **You can be friendly towards a patient without expecting them to be your friend. Physicians can have a “professional” relationship with their patients and at the same time be warm, caring, and compassionate.”**

The Challenge of Boundaries in Small Communities

There are additional challenges to maintaining therapeutic
boundaries including appropriate anonymity with patients and their family
members in small communities where paths are more likely to cross outside
of the office or hospital situation.

“Small communities” are often thought of as rural or small town,
but “small communities” are common in larger metropolitan areas. They exist
in neighborhoods, school districts, ethnic and religious subcultures,
professional groups, work places, and common socioeconomic circles.

Referrals that carry a potential for conflicts of interest or significant
compromise of reasonable anonymity should be referred to a colleague
whenever this is possible.

Safeguarding Professional Boundaries

- Self examination of thoughts, feelings, motivations with effort to heighten awareness. Self monitoring of behavior
- Peer and supervisory consultation
- Seek treatment
- Cultivate an atmosphere of open communication about responses to patients in peer meetings, supervision. The more such feelings have a place outside the treatment relationship the less empowered they are to promote unprofessional behaviors.
- Be alert to patients of a particular risk – those with history of being the object of boundary violations, especially by clinicians.
- Be alert to patients of particular personal risk: appearance, attractiveness, circumstances that resonate with yours, particular behaviors that are not experienced by other staff, either alienating or attractive.
- Be alert to patients that elicit in you unusually strong responses, especially responses that you experience as uncharacteristic of you.

- In the hospital setting avoid situations that enhance risk e.g. being with patients alone when not necessary.
- Know your limits. Create a professional culture that allows you to speak to your preference to not work with a particular patient if you feel particularly at risk with that patient.
- Speak up. If you notice a colleague who seems to be at the boundary of a boundary violation through comments, actions, or behaviors, communicate your concern as a means to check such risk. Involve a supervisor if necessary.
- Be humble. Know that an attitude that says it can’t happen to me enhances risk by diminishing self awareness and self monitoring.

Confidentiality

Hippocrates: All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal. All that may come to my knowledge I will keep secret and never reveal.

It is the clinician's responsibility to protect information about the patient. These principles also serve as a basis for the development of the therapeutic space that allows the child, adolescent, or adult to trust in their freedom to reveal what they think and feel without being judged, retaliated against, or violated by breach of their privacy.

Privilege is the patient's. A patient can share what they want from their treatment with whomever they choose. The clinician has no such privilege except communication protected by HIPAA. Be alert to conversations in public areas in the medical setting, as well as outside of the medical setting.

Exceptions

1. Danger to self or others- Tarasoff
2. Reportable illnesses
3. Child or elder abuse
4. Impaired drivers
5. Gunshot wounds

Transmissible Illness

- Ask patients to inform if can confirm
- If a patient does not want to inform, the physician has an obligation to inform if you know who is being infected.
- The Health Department can also inform if agreed upon.
- When the physician informs, the person who has transmitted the illness is not identified. Only the possibility of exposure or transmission is communicated with the need for evaluation

Medical records versus a Summary Letter

Clarify the purpose of a request. Medical records often provide much more information than is needed, including information about others in the family history.

Consider a succinct letter that provides jst what is needed.

Competency

Who makes the decision of competency?
What does the physician assess?

- Capacity vs. Competency
- Testament- will
- Medical decisions
- Advance directives

Exceptions

There is no obligation to report if an individual is not a minor
or elderly, defined as 65 and older.

Patients between the age of 19 and 65 must be their own reporter.

When abuse occurs between non married partners it is legally
categorized as battery

The role of the physician is to provide a safe space to identify,
counsel, and encourage the individual to file a report themselves and to identify safe shelter and resources

Decision Making Capacity

- The patient understands their condition
- Their decision does not change or fluctuate – it is stable
- The patient is able to communicate their choice
- The patient's decision is not influenced by perceptual distortions (hallucinations, delusions) or cognitive impairment
- In the case of treatment, refusing one option does not should not be taken as refusing all options.

Advance Directives

- Medical power of attorney
- Living will
- Verbal communication of wishes

Advance Directives

Advance directives are legal documents that allows any person to outline and direct their wishes as to end-of-life care ahead of time, as long as that individual has capacity when the directive is signed. This ensures their wishes regarding end of life decisions to family, friends, and health care professionals and to avoid confusion or conflict later.

Living Wills

A living will specifies which treatments you want if you are permanently unconscious, dying, or otherwise incapacitated and not able to communicate your wishes at the time.

Written advance directives and living wills are standard or can be individualized, signed legal documents.

Medical Power of Attorney

- A medical power of attorney for health care is the document that names the individual’s health care proxy; a health care proxy is the individual named who is entrusted to make health decisions for another if that person is unable to do so.

- While usually a spouse, adult child, or close friend it can be any named individual who agrees to this, as long as they have some relationship to the individual.

- Ideally, this document is in an individual’s medical record

- A copy is often maintained with their attorney and may also be held by the individual and/or their proxy

Medical surrogates

When no living will or power of attorney exists or is known, medical decision making falls to surrogates.

Surrogates are:

- a spouse, adult children, parents, siblings, or other relatives of the patient
- other individuals with credible, valid knowledge of the patient when closer relations are not available

Surrogates rely on what the patient has communicated to them verbally.

- When the patient’s wishes have been told to multiple people and these individuals do not have conflicting views about what the patient would have wanted, then surrogates have a clearer role affirming the patient’s wishes.
- When surrogates do not agree, it is obviously more complicated.

The first step when there is disagreement is to try and understand the disagreement and assess if a consensus can be reached without coercion. Answering questions and medical clarification may help a consensus emerge. For example, clarifying to all that there is not a reasonable chance of recovery may facilitate accord.

Written and Verbal Communication with Parties Outside the Family

Privilege is the patient's. A patient can share what they want from their treatment with whomever they choose. The clinician has no such privilege except communication protected by HIPAA. Be alert to conversations in public areas in the medical setting, as well as outside of the medical setting.

Cautions:

- Do not absent clinical judgment about what is appropriate to share just because a signed release is obtained.
- Discuss the request with the patient and relevant family members to be sure you understand what is wanted to be shared and what is not.
- Review all material considered for release and its potential long term fate/security.
- Consider alternative communication, written or verbal.
- Keep it simple for the purpose needed. Less is more.

Communication with Parents, Guardians and Children

- A clinician may find themselves challenged to protect the privacy of a patient from parents, guardians, or others perceived as too intrusive, or they may find themselves appealing for greater involvement with parents, guardians, and others perceived as too remote .
- The clinician must balance the rights of family members or guardians and the clinical indications for some communication with them, against the patient’s right to reasonable privacy and the clinical need for the patient to be able to trust that they have sufficient privacy.

- There is growing recognition by the judicial system of a minor’s ability to contribute to decisions based ontheir level of understanding and objectivity.
- Clinical and ethical indications for children and adolescents to participate in decisions about treatment and to have a process of assent.
- Above all, it is respectful, strengthens the alliance, and is a strong position against the potential experience that treatment is being imposed upon them and that their input is being disregarded.

Liability for Dangerous Patients, Abandonment, and Other Current Issues

- Society’s concerns about dangerousness have been heightened in response to the recent tragic violence at schools, campuses, and the workplace.
- The dilemma between duty to the patient and duty to society was the subject of the Pace Law Review published in 1999-2000.
- Patients who pose danger to self or others can present to non-psychiatric physicians. Although confidentiality and privacy must be considered, erring on the side of safety for the patient, the patient’s family, and the community is advised.

Electronic Mail

- Poses limitations to security and the ramifications for privacy and confidentiality – ”the illusions of security.” Well known and not infrequent breaches.
- The limitations of e-mail communication in exchange for direct communication.

Public Encounters

- Challenges to privacy and confidentiality.
- Anticipate encounter and discuss ahead of time.
- Follow patient’s lead but don’t absent your judgement.
- Avoid “overshare” based on your anxiety.

Privacy versus Secrecy

- Legal Foundations: Jaffee v. Redmond
  518 U.S. 1 (1996)
- Citation in U.S. Supreme Court reassertion of client-attorney privilege
- Help patients and family members understand and maintain understanding of the distinction.

Malpractice

Three conditions must be met:

1. That a fiduciary relationship exists - that a doctor patient relationship has been established.

2. That standards of care have been breached, either by omission or commission.

3. That harm (torte) has occurred.

Informed Consent

Documentation is essential - if it is not written in the medical record, it didn’t occur

Review of side effects and risks of significance is essential

Less serious potential side effects can distract focus on the more serious side effects

Maintain vigilance to language at the level of the patient

Avoid pressured decisions when not necessary and when the patient hesitates.

The actions, risks and alternatives of….were reviewed and understood, including (i.e. heart damage, renal insult, etc…)

In Alabama, a youth 14 years and older can seek treatment independent of their parents.

But, parents can enforce treatment up to the age of 19 years unless the youth is deemed emancipated.

A youth is emancipated by virtue of being married, living alone or independently and is self supporting, or is functioning as a parent to a child.

Supervision

- Supervision encompasses functions of mentorship but involves more ongoing involvement and responsibility in the professional life of the supervisee.

- Supervise: To oversee (a process, work, workers etc.) during execution or performance. Synonyms: manage, direct, control, guide

- Do we manage, direct, control or guide?

  In the ideal, guidance with monitoring of safety and professionalism is the central activity within the established frame of a supervisee-supervisor relationship. We want to create a supervisory space that facilitates honesty, open communication and an culture that allows supervisees to seek help when they do not know. This is what ultimately facilitates reliable growth.

The goal is to enhance the attitudes, knowledge and skills of the

supervisee *at the leading edge of their ability*, facilitating growth

and more independent, reliable functioning in the supervisee.

The long term goal is to cultivate the value of excellence and

participate in the supervisee's achievement of their full

potential.

Interferences in the Supervisory Process

- The supervisor miscalculates the expected level of performance from the supervisee:
- The supervisor aims too low and the supervisee becomes bored or loses the opportunity for growth
- The supervisor aims too high based on deficits of the supervisee or expectations beyond the level of the supervisee
- The supervisee is not interested in supervision and/or does not believe
  they need supervision and overestimates their abilities : Are they "teachable"?
- The supervisor is not motivated to supervise; supervision takes time,
  interest and patience

- The supervisee idealizes the supervisor in ways that actually impede their own growth or

- The supervisor cultivates dependency in ways that limit the growth of the supervisee

- Lack of respect: A supervisor my lose respect for a supervisee and a supervisee may lose respect for a supervisor – or both

- Issues of match – analogous to parent-child fit, there me times when the supervisor-supervisee fit impedes the supervisory task. Certain people just don’t mix well.

- Problems with honesty: The supervisory process can be corrupted when the supervisor is not provided with complete or accurate information.

- By commission – misreporting, affirming something was done when it wasn't or factitious presentations or

- By omission – not communicating complete information

- Boundaries can become blurred, and may range from mild to severe transgressions that distort the supervisory relationship
  - -Business transactions
  - -Social relationships
  - -Familial relationships
  - -Romantic feelings
  - -Inappropriate gifts

- Everyone who is engaged in a supervisory relationship is vulnerable to such forces analogous to the responses we have to patients

- The same principle exists: to understand these experiences and use them to inform our clinical work and supervisory work.

Cautionary Signs for Potential Stumbling Blocks

- Recurrent lateness or avoidance on the part of the supervisee or supervisor
- Recurrent absences on the part of the supervisee or the supervisor
- Absence of content to report
- Recurrent introduction of discussions unrelated to the clinical work

Based on the Hippocratic Oath, the guiding principles of supervision is to minimize the risk of harm to the patient and to the supervisee while promoting the supervisee’s competencies, appropriate confidence, and overall ability to provide quality care independently.

Be aware of the vulnerability to overvalue the progress of the supervisee as a reflection of the supervisor’s abilities while also considering limitations or blind spots of the supervisor that may impede progress.

Course Corrections in the Supervisory Process – The Supervisor's Responsibility

- Self reflection on the supervisor's response to the supervisee and the clinical situation
- Consider displacement of self blame when management of the patient does not go well.
- Maintain friendly and professional relationship with supervisee
- Be aware of alterations of the usual supervisory frame
- Model addressing difficulties that arise in the learning process directly, but tactfully and respectfully
- Provide verbal and written evaluations that are accurate, constructive, and *fair for the supervisee's level of training*. It is this feedback that provides the opportunity for professional growth.

- Be aware of the vulnerability to overvalue the progress of the patient or the supervisee as a reflection of the supervisor’s abilities, while also considering limitations or blind spots of the supervisor that may impede progress.

- If a supervisory pair still seems incompatible after reflection on the difficulties, consider change.

- Should patterns of incompatibility become apparent with either a supervisor or a supervisee, consider consultation with the program director and possibly, personal consultation, especially when a pattern of difficulties in supervisory relationships manifests

Supervisee Pitfalls

- Anticipation of criticism that inhibits communication – stage fright
- Worry about mistakes and a more perfectionistic ideal that inhibits use of the supervision
- Difficulty acknowledging not knowing, which is the basis for learning
- Overconfidence of knowledge and skills that block learning and deprive the supervisee of the pleasure and excitement of learning

Supervisor Pitfalls

- Over-gratification from the power hierarchy that that create a harsh environment and impede the learning environment
- Difficulty acknowledging not knowing – no one is a master of all
- Over or under estimation of the supervisee’s level – missing the leading edge of their ability. Over-estimation leads to repeated feelings of inadequacy and under estimation leads to boredom, frustration, and constriction of the opportunity for learning and growth.
- Excessive gratification from the dependency of the supervisee that limits the growth of independent functioning – being needed, idealization, loneliness

- Reluctance to encourage degrees of autonomy in the supervisee based on reluctance to relinquish control or delegate

- Idealization of the supervisee in ways that can blind the supervisor to the educational needs of the supervisee and limit their ability to objectively gauge the level of responsibility they can manage, and to appraise performance accurately in a way that is constructive for the supervisee.

Conclusion

- The issue of ethical behavior in clinical work can be conceptualized in two categories:
  1) absolute, and
  2) involving more complex situations requiring case by case thoughtful consideration.

- The **absolute** category includes *no sexual or physical contact*, *no financial exploitation of the patient, and, over-arching all, no exploitation of the power differential between clinician and patient.*

- Core principles transcend times, trends and jurisdictions.
- Consider the challenges due to advances in technology, variations in state law, and the evolution of federal law.
- The guiding compass remains the clinician's obligation to protect the integrity of the clinical space, to do no harm, to not act upon exploitative interests, and to always maintain respect for the patient.

Tact, sympathy,, and understanding are expected of the physician, for the patient is no mere collection of symptoms, signs, disordered functions, damaged organs, and disturbed emotions. He is human, fearful, and hopeful, seeking relief, help and reassurance. To the physician, as to the anthropologist, nothing human is strange or repulsive. The misanthrope may become a smart diagnostician of organic disease, but he can scarcely hope to succeed as a physician. The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people.

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Tinsley Harrison, M.D.

Introduction, First Edition Harrison's

Principles of Internal Medicine, 1950

Non Adherence

Try to understand why the patient did not follow recommendations, and consider:

1. Did the patient understand your directions?

2. Does the patient need more information or discussion?

3. Can the regimen be simplified?

4. Are finances, schedule, or transportation factors?

Avoid

Blaming t

Threatening

- Making changes without discussion and understanding what led to of non-adherence

- Non-adherence is not lack of capacity

To write a prescription is easy, but to communicate with people is difficult.

To write a prescription is easy, but to communicate with people is difficult

A Country Doctor

Franz Kafka

1919, Prague

Questions That Get to the Heart of the Matter

What has been the happiest time in your life?

What has been the most painful time in your life?

What brings you joy?

Fr. John O'Brian, M.D.

Tell me what it is like to be you?

trainee

Wisdom

"You should always try and be kind because everyone you meet
is struggling."

A woman from Appalachia

"If we have no peace it is because we forget we belong to each
other."

Mother Theresa

Honoring Teachers

“To consider dear to me, as my parents, him

who taught me this art; to live in common

with him and, if necessary, to share my goods

with him; To look upon his children as my own

brothers…”