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Teaching Ethics in Psychiatry: Time to Reset

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When the first author (SS, years ago) taught ethics clinically in Harvard-affiliated hospitals, he encountered an oddity about how people stored “ethical” information. If he asked doctors, individually or in groups, whether there were any *ethical problems* that they were worried about, the answer was almost universally *no*. But if he asked doctors whether there were any *cases or situations that were bothering them*, the answer would be an immediate and resounding *yes*. For example: Mrs. Jones and her children were demanding medication that she didn’t need and that would likely worsen her condition; Mr. Smith was resisting the care of nurses, developing bed sores, and then complaining that he was being ignored and not receiving adequate care; the chief resident was depressed and finding it difficult to keep up with his responsibilities; the nursing staff was finding it difficult to work with a newly recruited doctor; and one of the senior doctors, renowned for his creative problem solving, had become ungrounded, with the consequence that his interventions were unlikely to work and likely, instead, to present liability issues for the hospital.

All of the above situations raise what are, in effect, ethical issues even though they are not generally identified (or, in practice, analyzed) as such. They’re just “problems.” Importantly, these problems are also not experienced and perceived as technical, medical, or scientific problems; they have human, interpersonal, or institutional components that are not open to technical, determinate solutions. These problems are embedded in the setting and, indeed, in the professionals who work in it. If one tried to separate out these problems

from their institutional context—which is itself defined, in part, by the overarching goals of medicine—the problems themselves would be distorted. Their contours and texture are integrally connected with, embedded in, and subject to interpretation and analysis only in the context of the health care setting itself. This setting includes not only the broader institutional environment but the specific clinical situations in which the problems arise, including the needs of each particular patient, the demands and concerns of the other health professionals involved, and the clinical tasks that doctors need to accomplish as part of their professional roles and responsibilities.^{1,2}

One way of understanding what it is for ethics to be embedded in medicine—and, for our purposes here, in psychiatry—is through the notion of *interpretive community*. Stanley Fish first articulated this idea, which falls at the intersection of literary theory and sociology, in two books: *Is There a Text in This Class?* (1980)³ and *Doing What Comes Naturally* (1989).⁴ What makes this idea useful for us is not that it is the one, only, and best way of understanding the institutions of modern medicine but that the notion of an interpretive community provides an especially grounded, tangible way of understanding what it is to be, and to have become, a psychiatrist (or other type of doctor or professional). For Fish, the members of an interpretive community—such as medicine or, more specifically, psychiatry—share a set of practices and assumptions that represent a way of organizing and understanding experience, including determinations of relevance and irrelevance, ways of dividing up or constructing the world, and models of explanation: each member of a particular interpretive community is what Fish calls an “embedded practitioner whose norms, standards of judgment, and canons of evidence are ‘extensions’ of the community itself.”^{4(p 144)} What this notion of interpretive community captures is that in each academic discipline or professional field, the values, standards, and practices come to be embodied in its members—in who one is and how one works. By the same token, the process of professional training can be understood as a process of becoming members of an interpretive community or, in the case of psychiatry, of two consecutive interpretive communities: first medicine and then psychiatry.

But then, if ethical issues and ethical thinking are, as it were, embedded in, and invisibly intertwined with, the clinical

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framework of medicine and psychiatry (let's just talk about psychiatry by itself from now on), how does one identify ethical issues and then address them? And how does one actually teach ethics?

The response comes in two parts, both of which can be seen in the brief anecdote that opened this column. The first will be discussed under the rubric of "implicit ethics," and the second under the rubric of "discoverable ethics."

IMPLICIT ETHICS

Many, even most, clinical situations that raise what an ethicist might consider ethical questions are identified, understood, and addressed without even using ethical language. Within a clinical setting, problems are typically interpreted and analyzed in instrumental terms related to that particular setting—that is, they are problems relating to particular patients, colleagues, institutional demands, and such matters. With good fortune, all goes well: appropriate care is provided; goals are achieved; and everyone involved—psychiatrists and their patients alike—are happy with a job well done. But if something goes wrong with the care, or if the goals are not achieved, then the questions are "Why has that happened?" and "What went wrong?" It would be no surprise if ethical principles or other abstract concepts were involved at some level—and surely many bioethicists would try to analyze the various dimensions of the situation using rights or principles or other abstract concepts—but that is generally not how psychiatrists and other doctors experience problems or shortcomings in care, and generally not how the problems are interpreted or solved.

So, the first of the two answers to how one identifies ethical issues and how one teaches ethics is that the teaching is implicit in psychiatric training. By learning to be psychiatrists and by learning to solve the clinical problems that arise in patient care and that arise in relation to other colleagues and the setting in which psychiatric care is provided, psychiatry residents are inescapably, and implicitly, learning the ethics of psychiatry and also addressing the ethical problems that arise in their work. The goals of providing good, appropriate, humanly responsive psychiatric care and of becoming a good psychiatrist and effective colleague are overarching ones within which virtually any ethical question can be identified, analyzed, and solved in its own terms, without using ethical language.

A conference recently attended by the second author (KK) will provide an excellent example. Her hospital holds periodic, case-oriented ethics conferences, which have been run this past year by the newly appointed Ethics Officer. In organizing the last such conference and in framing the questions to be addressed, she completely avoided ethical language or terminology of any kind. The discussion at the conference itself turned out to be lively and focused, and—importantly—not a single ethical term was used, and not a single ethical principle was mentioned, during the entire conference. At the end of the conference, the ethicist from the local university was

asked to comment, as she always does in one form or another, to provide some learned, informed ethical analysis. When asked this time, however, she said that she had nothing to add because all the issues had been very well covered.* In the second author's opinion, this particular ethics conference was the best that had ever been held during her many years at the hospital.

As a thought experiment, readers might think about the qualities of their "favorite psychiatrist" and just why that person is considered in that way. We would suggest four things to be very likely true: (1) those qualities have nothing explicitly to do with ethics except in some general way such as "she communicates such deep respect and concern for her patients [or students or colleagues]"; (2) in speaking to residents, colleagues, and patients, she almost never uses explicitly ethical language; (3) she represents the highest ethical standards of psychiatry; and (4) anyone who works with her and is taught or supervised by her implicitly learns the highest ethical standards of the profession.

The same holds, of course, for any good teacher and any good supervisor. In learning from them, the ethics of psychiatry is transmitted implicitly, forcefully, and effectively.

DISCOVERABLE ETHICS

In the anecdote that opened this column, the first author initially asked the wrong question, searching for "ethical problems" rather than simply "problems." The point can be generalized: to discover, bring to mind, or identify ethical problems in a professional environment, one just needs to ask the correct questions. In *Rethinking Health Care Ethics*, we talk about *touchstones for learning*, which we understand to be individual experiences—such as confusion, puzzlement, and surprise—that mark encounters with the unexpected, unacceptable, or insufficiently understood (and in need of further thought or examination).² Text Box 1 sets out a list of sample questions that might help to bring out these experiences.

These questions and many others one can generate are all designed to invite students, residents, and fellows, as well potentially as teachers and supervisors, to encounter their work as whole persons and to try to understand and address whatever problems or sources of discomfort (or surprise) one identifies. Within psychiatry itself, Balint groups and reflective practice, considered as approaches to clinical learning and teaching, are oriented along much the same lines.^{5–8} The important point here is that the touchstones for learning are intended to represent the full range of questions that, in observing oneself and others, one might ask in order to capture one's feelings or those of others at that particular time. The list of touchstones is open-ended, as diverse as human experience.

The touchstones for learning are basically a heuristic device for discovering problems that otherwise would remain

*This example coheres with the many clinical vignettes used in our recently published, open access book, *Rethinking Health Care Ethics*.² Ethical language is absent from the vignettes themselves and from the text commenting on them.

Text Box 1
Touchstones for Learning (Examples)

Asked of oneself or to others:

- Why am I, or why are you, so . . .
- puzzled?
- disappointed?
- concerned?
- angry?
- confused?
- shaken?
- upset?
- challenged?
- surprised?
- delighted?

Asked to a group of students, residents, or fellows (as by a supervisor or attending in a small-group conference):

- Has anything happened recently that has left you feeling . . . [same as above]?
- What patients have left you feeling . . . [same as above]?
- Have you had any encounters with other doctors or nurses (or even family members) that left you feeling . . . [same as above]?

Text Box 2
Something Not Quite Right:
(introduced and discussed on following page)

Sophie was a 12-year-old girl with a six-month history of major depression that had gradually developed following her father's sudden death from a heart attack. Sophie had been admitted to the pediatric ward of her local hospital—a teaching hospital affiliated with a nearby medical school—because of poor oral intake of food and fluids. Treatment included intravenous rehydration, followed by a graded increase in Sophie's daily oral intake and daily physical therapy to increase her physical conditioning.

Following the death of her father, Sophie had withdrawn from family life, stopped eating and drinking, and spent most of her time in bed. She self-harmed “as a punishment to myself—kind of a relief that I was being punished. I felt like I needed to be punished.” After Sophie's admission to the hospital, the psychiatry resident reviewed Sophie's mental state on a daily basis. Wherever possible, the resident joined the pediatric team on their ward rounds.

Early on, while Sophie was still quite ill, the psychiatry resident noticed that a senior nurse asked the attending pediatrician when Sophie was going to be discharged. And over the next week, he noticed that the same nurse was raising the same question again and again. The question puzzled the resident because Sophie remained quite ill and was not even nearly ready to be discharged home. During rounds, when the resident raised this matter with the attending pediatrician, he was brushed off with the explanation that the ward was always short of beds, that the nursing staff were always asking about discharge dates, and that when push came to shove, the relevant decisions were medical and not for the nurses.

In the psychiatry resident's weekly session with his supervisor, the supervisor sensed some unusual reticence on the part of the resident and therefore asked him

whether there was something he had not mentioned. The resident then explained his distinct impression was that the ward nurses were, without any apparent reason and contrary to the actual medical situation, trying to get rid of Sophie. The supervisor agreed that the situation was indeed puzzling and asked the resident what he thought should be done. The resident decided that, as a first step, he would discuss the situation with the pediatric residents on the next ward rounds.

The pediatric residents had not noticed anything but agreed that the matter could be addressed at the next group meeting with the pediatric attending, who responded in roughly the same way as before. But this time, one of the pediatric residents pushed back, saying that there was obviously something going on and likewise reason to suspect that the nurses were somehow distancing themselves from Sophie, with consequent impact on the care and attention she was receiving from the nurses.

After a negotiation with the chief nurse, it was agreed that the nurses involved, along with the chief nurse, would meet with the pediatric residents, psychiatry resident, and attending pediatrician. At the meeting, when the situation was presented to the nurses, they responded that nothing was going on, but the pediatric team refused to accept that as being the full story. And it wasn't.

The nurses then explained that Sophie's mother was intrusive, hostile, impatient, and always dissatisfied with what the nurses were doing; that they simply wanted Sophie and her mother to go home; and, in response to a question from the chief nurse, that they had felt reluctant to raise the matter because they felt it would make them look incapable of coping with a difficult situation.

In the week following the meeting, the chief nurse arranged to have a group meeting on the case in which the main issues were (1) what to do when a close family member is making it difficult for the nursing staff to carry out their normal responsibilities, (2) how to recognize, through their own reactions, that a situation is getting out of control and potentially requires the assistance of senior nurses, (3) the need to recognize that their resistance to answering a question (in this case, from the pediatric residents, about whether something undisclosed was happening) was itself a sign that they needed to think more about the situation itself, and (4) the ongoing importance of their keeping track of their own reactions to their work and colleagues and of voicing their concerns in some appropriate way.

The psychiatry resident, his supervisor, and the pediatric team also had a group meeting in an effort to sort out what they had learned. A particular focus of this meeting was the acuity of the psychiatry resident in discerning, through his own puzzlement, that something was amiss. His persistence in bringing the situation to the attention of others was also applauded. There was some tension, however—handled well by the psychiatry resident's supervisor—concerning the attending pediatrician's initial rejection of the suggestion that something was up with the nurses. The attending acknowledged that he might have been too quick in dismissing the residents' concerns and also that the residents were likely well served by both observing, and attending to, the nurses and *their* concerns. The psychiatry supervisor ended the meeting by noting, with just a tiny bit of irony, “You can learn a lot by listening to yourself.”

unnoticed and unaddressed—ones that, on an institutional level, would likely continue as a form of institutional failure or dysfunction, and that, on a personal level, would continue, albeit not consciously, to bother or even fester. And on both the institutional and personal levels, an opportunity for discovery, knowledge, improvement, and growth would have been lost. The case study in Text Box 2 illustrates how the touchstones can be used to explore difficult situations in daily clinical practice.

The touchstones, though of use in any field of health care, lend themselves especially well to training in psychiatry, where residents learn to ask the same sorts of questions of their patients. The touchstones turn those same questions back on the residents themselves. And by being asked such questions by their teachers and supervisors, by asking such questions regularly of themselves and their fellow residents, and by becoming increasingly aware of when situations are, for example, bothering, surprising, or angering them, psychiatry residents will find themselves learning both more and more about themselves and more and more about the ethics and the broader human environment of psychiatry. Also of note is that the questions that any particular resident will ask, and how the questions will be answered, will vary over time as the resident moves through the years of training. Regular attention to the touchstones for learning can be expected to help each resident cope more effectively with the evolving intellectual and personal challenges of training.

TEACHING FORMATS

During the Residency

Given that so much of psychiatric training takes place within institutional settings such as hospitals and clinics, wide-ranging opportunities for teaching ethics are available. The settings embody the goals, values, and practices of psychiatry, and in such settings the touchstone-for-learning questions are sure to raise important questions about patient care, the doctor-patient relationship, the role of the psychiatrist, and dealing with peers, other doctors, and nurses and other staff. Setting aside an occasional half-hour or so as part of any regularly scheduled clinical meeting with residents can serve to legitimate certain types of conversations that would otherwise be lost. The same can be said of scheduling a small but ongoing proportion of meetings to address ethical issues (e.g., once or twice a month in the case of a clinical meeting that is scheduled daily). Asking the residents themselves to select the case or set of cases for discussion (via the touchstones for learning) will ensure that the case material is relevant to their current experience, and it will also encourage the residents, more generally, to speak among themselves about what is troubling or bothering them. An additional advantage of this approach is that it can help to identify and explore matters that are part of the informal and hidden curricula—especially those matters that are, on the human level, unacceptable, abrasive, or generally thought to be too loaded or sensitive to discuss. See

Text Box 3 for the reflections of a pediatric resident (doing her psychiatry rotation) on the difficulties of confronting such questions and of maintaining a sense of self and self-worth.

Discussions with supervisors also provide a rich opportunity to address what we have presented here as *implicit* and *discoverable* ethical issues. A one-on-one discussion with a trusted senior psychiatrist provides an unparalleled opportunity to reflect on, and learn about, questions related to the touchstones for learning. For this format to work effectively, however, such questions need to be seen as legitimate and important, not as signs of weakness. The questions need to be embraced by supervisors and by the residency program more generally. If they are not, the questions simply will not be asked, and the residents' professional and personal growth will be, to that degree, compromised.[†]

For Medical Students on Psychiatry Rotations

The approach to ethics and to teaching ethics, as described in this column, lends itself remarkably well to teaching medical students who are on their psychiatry rotations. Because of the nature of psychiatry itself, psychiatrists involved in teaching medical students have already developed, and psychiatry residents are in the course of developing, outstanding skills in formulating, and asking, questions of patients. These skills are used extensively, too, in teaching medical students during their psychiatry rotations, where one of the central pedagogical goals is to help the medical students to formulate effective psychiatric/psychological questions to use in their future encounters with their own patients. But senior psychiatrists, as well as psychiatry residents, can use these same skills to teach ethics to medical students on psychiatry rotations. If, at the end of a psychiatry rotation, a medical student can take away the importance, both short and long term, of the touchstones for learning and of identifying and reflecting upon the questions thus raised, the student will have taken away something that will last lifelong and actually change his or her life, both professional and personal.

To bring this same point around to the psychiatry residents themselves, if they can learn to be sensitive to the touchstones for learning, they, too, will have gained something that will stay with them lifelong.

THE BROADER ROLE OF PSYCHIATRISTS IN MEDICAL EDUCATION

Because psychiatrists are inescapably closely attuned to the human side of medicine, they often take on a role in teaching medical students about the physician-patient relationship and also about medical ethics. Our own view is that the conception of medical ethics presented in this column, unlike those that are oriented toward “bioethical” principles and their

[†]In this section we have only touched upon the potential institutional arrangements for teaching clinical ethics. Our *Rethinking Health Care Ethics* includes three full chapters on such matters.²

Text Box 3 A Young Doctor's Reflection

Throughout my pediatric residency I had to manage physical exhaustion, unsafe workloads, and burnout, as well as my distress when listening to patients' stories and when caring for very sick children. Having a mentor to talk to really helps, but those relationships were hard to establish in the medical system where I worked. In our first postgraduate year, rotations last only ten weeks. In subsequent years, rotations generally last three months, sometimes six. Between the workload and the pressure to get things done, especially in a short rotation, it's hard for residents to find enough time to form decent relationships with attending physicians ("attendings").

Over time I learned which attendings were safe to talk to and which were not safe. The unsafe ones were those who viewed the issues that I was struggling with as personal weaknesses. These attendings trained us—by their example—not to feel or show emotion, and if we did, they communicated their disappointment and used guilt as a form of control. One time, when working a 12-hour shift covering *half the hospital* (all surgical and subspecialty medical patients in every ward)—after 2½ hours of sleep—I noted that my sleep deprivation made me unsafe to see patients: in one brief exchange I used the words "not safe at work," "burned out," and "beyond my breaking point." The attending's response was a raised eyebrow and a question: "Is your exam stress affecting your work performance?" I felt demeaned and dismissed. After that, I was always very careful in deciding what to say to attendings.

Safe attendings were those who saw these problems at work as ones we all experienced, as problems embedded in the medical system and in the role of being a doctor, and that all doctors—young and old—had to manage. These attendings saw the issues as having an ongoing, adverse impact on the well-being of doctors, and they did not pass judgment. Instead, they created a culture of debriefing and of "checking in" after difficult clinical encounters to see how I and my fellow residents were doing. These small acts went a long way in enabling me (and others) to speak up. They acknowledged the suffering we encountered every day, the horror of child abuse, our repeated close encounters with the deaths of patients, and the many complicated feelings elicited by such events. It was, I was learning, OK not to be OK. With their questions, the attendings opened up a conversation, allowing me and my fellow trainees to feel the difficult feelings, to accept them, to talk about them when asked. Somehow, the mere asking of the questions made it safer for us. Having a senior doctor acknowledge our humanity was powerful and helped us, the junior doctors, speak out.

I was lucky to find a few mentors and to maintain my relationships with them over time. A good mentor is someone you respect and trust, and who you feel safe talking to about difficult topics. You value their opinion and advice. The hardest conversations are ones where your weaknesses come up. How are you going to be judged? A good mentor somehow takes that worry away. Talking about my wants, needs, and emotional responses—even acknowledging them to myself—was always difficult for me. They made me feel like a failure,

a disappointment. But one mentor, in particular, made me see these personal experiences differently. It was such a relief. She wasn't just pushing me onto the treadmill of achievement, or the expected path, or the one she chose. Rather, she helped me to realize that there are many paths in medicine. She normalized my struggles and then challenged me to do what was actually right for me. A great mentor, like her, sees you and treats you like a whole person.

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application (see, e.g., *Principles of Biomedical Ethics*, by Tom Beauchamp and James Childress⁹), is one that lends itself well to this teaching role. Psychiatrists, like other physicians, have neither the training nor the time to immerse themselves in such principle-based approaches and to learn, or at least become critical consumers of, what is actually a separate academic field. Using the touchstones for learning to teach medical students as part of their general medical education is a readily achievable goal and also one that can be expected to have a lasting impact on medical students, as suggested above. Notably, in undergraduate medical education there is a growing interest in teaching ethics from the "ground up" and in using informal ethical discourse—as is apparent, for example, from a recently published article in the *Journal of Medical Education and Curricular Development*.¹⁰

CONCLUSION

We do not mean to downplay the potential importance of bioethics. In especially difficult or complex cases, consults with bioethicists may prove useful. By the same token, although the "informal ethical discourse" of virtually all medical professionals—barring bioethicists—is plenty good enough for the problems of day-to-day psychiatry (and of medicine, more generally), such informal, familiar discourse may fall short in addressing the major "issues of the day," such as genetic engineering, cloning, and disputes over the possession and disposal of frozen embryos. In such cases, the more general, theoretical perspective of bioethicists may help to advance public discussion and understanding. But our concern here is with *learning* and *teaching*, and in this respect, psychiatry residents are no different from anyone else. The informal ethical discourse that they grew up with and that they use every day is their first, and native, language of ethics. It is important that we retain, and build upon, that foundation.

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