Module 2: Slang 'On Board' – A Moral Analysis of Medical Jargon

McCrary, S. and R.C. Christensen, *Slang 'on board'. A moral analysis of medical jargon.* Archives of family medicine, 1993. **2**(1): p. 101-5. Included in booklet.

1. In what situations do you think use of medical jargon is appropriate? In what situations do you think it is not? If confronted with inappropriate use of medical jargon, how would you react?
2. For the first three types of medical jargon outlined in the article (technical jargon, euphemisms and initiatory jargon), give two examples of each: one appropriate and one pejorative, also providing examples of the context in which they would be used.
3. For the final type of medical jargon discussed in the article, derogatory jargon, the authors of the article acknowledge that these terms, which may have "sometimes helpful psychological attributes for the medical staff," nonetheless "indicate a lack of respect for humans as moral agents, and demonstrate a failure to appreciate the altruistic goals of medicine as a profession." These terms, often used by professionals "burdened by the incessant pressures of contemporary medical practice," are said by the authors to have "a corrosive effect on the character of the healthcare team as a whole… even if no direct harm occurs in a particular case." What do you think are the psychological implications for medical professionals of using derogatory slang for patients?

Grace, G.D. and R.C. Christensen, *Referral for medical evaluation: an ethical obligation?* Psychiatric services, 2010. 61(1): p. 3. Link to view: http://ps.psychiatryonline.org/doi/full/10.1176/ps.2010.61.1.3

1. "Most systems that deliver behavioral health care are separated from primary care services by systemic and ideological chasms." What is a way of bridging this gap?
2. The article claims that referring psychiatric patients with other medical symptoms for a medical evaluation may be an ethical imperative. Why?

Joy M, Clement T, Sisti D. *The Ethics of Behavioral Health Information Technology: Frequent Flyer Icons and Implicit Bias*. JAMA. 2016;316(15):1539-1540. doi:10.1001/jama.2016.12534. Link to view: http://jamanetwork.com/journals/jama/article-abstract/2551660

1. According to this article, "one electronic medical record system provides an airplane icon, which system administrators may elect to configure so that clinicians can identify a patient as a high utilizer." This article postulates that "this icon offers an example of how potentially harmful biases may be built into and reinforced by well-intentioned but ill-conceived information technologies, such as those deployed widely across all sectors of health care, and particularly in psychiatric treatment settings where clinical interactions are often more

interpersonally sensitive." How do you think a psychiatric treatment could be negatively affected by the plane icon?
2. Patients with both psychiatric and medical conditions often suffer worse care due to diagnostic overshadowing. "Their psychiatric conditions overshadow their other conditions, potentially biasing the clinician's judgment." What would be a specific example of diagnostic overshadowing?
3. The article ends with the sentiment that we should begin "designing systems that encourage ethical behavior and respectful interactions between physicians and patients." How?

Module 3: Diagnostic Overshadowing

Shefer, G., Henderson, C., Howard, L. M., Murray, J., & Thornicroft, G. (2014). *Diagnostic Overshadowing and Other Challenges Involved in the Diagnostic Process of Patients with Mental Illness Who Present in Emergency Departments with Physical Symptoms – A Qualitative Study.* PLoS ONE, 9(11), e111682. Link to view: http://doi.org/10.1371/journal.pone.0111682

1. The article names three major problem categories associated with diagnostic overshadowing: "problems in eliciting a history, problems in the ED setting and problems related to labelling and stigma." What would be examples of each of these problems?
2. In this study, "the two most severe cases reported in this context involved the death of patients who refused to be examined and staff failed to conduct any assessment of their mental capacity to refuse treatment." What would an assessment of mental capacity to refuse treatment entail?
3. Within the study, it is clear that patients suffer when there is a "lack of clarity about whose role it is to conduct the capacity assessment." This divide seems to exist between psychiatric teams and emergency teams in the ED. How can this gap be bridged?
4. Though stigmatizing views of staff played a small role in diagnostic overshadowing, the main risks enumerated by this study were related to "the complicated nature of presentation or to difficulties in communication or challenging behavior by some patient." How can these factors be addressed to mitigate diagnostic overshadowing?

Jones, S., Howard, L. and Thornicroft, G. (2008), *'Diagnostic overshadowing': worse physical health care for people with mental illness.* Acta Psychiatrica Scandinavica, 118: 169–171. doi:10.1111/j.1600-0447.2008.01211.x Link to view: http://onlinelibrary.wiley.com/doi/10.1111/j.1600-0447.2008.01211.x/abstract

1. The risk of diagnostic overshadowing is greater in some departments than others, such as emergency departments. How could diagnostic overshadowing occur in a department other than an emergency department? Give an example.
2. Diagnostic overshadowing is an under-researched problem, and the majority of studies that exist regarding this issue are qualitative. This article emphasizes that future research should "consider reasons for its occurrence and possible preventative measures." Design a mock-study that does just that.

3. Diagnostic overshadowing can exist apart from mental illness: this article cites studies that find diagnostic overshadowing that creates health disparities for minority groups. What are some other possible instances where diagnostic overshadowing could occur? Give hypothetical examples.

Weiss Roberts, Laura & K Louie, Alan & P S Guerrero, Anthony & Balon, Richard & Beresin, Eugene & Brenner, Adam & Coverdale, John. (2017), *Premature Mortality Among People with Mental Illness: Advocacy in Academic Psychiatry.* Retrieved from https://link.springer.com/content/pdf/10.1007%2Fs40596-017-0738-9.pdf, November 13, 2017.

1. The authors of the article write that "academic psychiatry can do much to address the tragedy of health disparities among people living with mental illness by studying these issues, by elevating them in the public dialog, and by training medical students, residents, and fellows to provide astute mental health care." What is one concrete way that you could be an advocate right now?
2. The article cites a list of steps psychiatrists could take outside of clinical practice to reduce premature morality among people with mental illness. Which of these steps seem realistic to you? Which steps do you think would be more difficult to implement?

Module 4: Relationships with Pharmaceutical Representatives

Christensen, R.C. and M.J. Tueth, *Pharmaceutical companies and academic departments of psychiatry : a call for ethics education.* Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 1998. 22(2): p. 135-7. Link to purchase: https://link.springer.com/article/10.1007%2FBF03341915

1. This article claims that "obviously, interactions between residents and drug companies should not be universally prohibited. However, we do believe they warrant increased ethical examination and monitoring." What do you think this examination and monitoring should entail?
2. This article advocates department-specific guidelines regarding the interactions of pharmaceutical companies with residents, stating that "the endeavor to develop such guidelines would have to be rooted in departmental-wide ethical analysis on a topic that has received scant formal attention in most academic departments of psychiatry." Do you think such guidelines would be realistic or possible to implement in regard to your department? Why or why not?

Christensen, R.C. and L.K. Garces, *Drug company representatives and psychiatrists*. Psychiatric services, 2004. 55(8): p. 944. Link to view: http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.8.944

1. The main argument of this letter to the editor is that interactions between drug company representatives and psychiatrists cannot be simplified into polarized ethics positions for an interesting debate; they are far more complicated. What are some of the complications?

Module Five: Ethical Concerns Regarding the Underserved

Christensen, R.C., *Discharged to the streets: who cares?* Pharos Alpha Omega Alpha Honor Med Soc, 2007. 70(4): p. 15-6. Included in booklet.

1. This article gives two examples: the stories of Mr. Ruiz and Mr. Lancaster. Both of these individuals were discharged by their doctors and were found suffering on the streets. How did their stories impact you?
2. Dr. Christensen cites a "covenant of care" between doctor and patient, which "implies that our moral commitments and professional instincts are singularly "focused upon individualized and excellent care of the patient." What does the term "covenant of care" mean to you? How do you think you'll apply it in your practice?
3. Homeless persons obviously need more from the physician than the average patient. Dr. Christensen ends the article with a call to "prevent suffering and never abandon a patient." What should have the psychiatrists responsible for Mr. Ruiz and Mr. Lancaster's treatment and discharge experiences done? What would you have done in their situation?

Christensen, R.C., *Diogenes and Marcella. A reflection on homelessness and self-neglect.* Pharos Alpha Omega Alpha Honor Med Soc, 2007. 70(2): p. 52-3. Included in booklet.

1. This article examines one of the most enigmatic causes of homelessness: individuals who appear to be on the street by choice, refusing overtures of shelter. Dr. Christensen describes Marcella, a woman who appears to have Diogenes Syndrome. What did you think of Dr. Christensen's approach to Marcella's choices?
2. Dr. Christensen strives to understand Marcella "outside the narrow and limited boundaries of a medical model." What do you think are the limitations of the medical model when working with underserved or homeless patients?

Christensen, R.C., *The language of care. Taking psychiatry to the streets.* The Pharos of Alpha Omega Alpha-Honor Medical Society. Alpha Omega Alpha, 2009. 72(3): p. 36-9. Included in booklet.

1. The street outreach team Dr. Christensen worked on resulted from a collaboration between the city of Jacksonville, community members and the University of Florida. How can a medical professional uniquely advocate and pursue this sort of service?
2. Dr. Christensen stresses the importance of building relationships rather than measuring success by producing clinical outcomes, saying that "no truly meaningful medical treatment can begin until some semblance of a healing partnership has been established." How is this applicable outside of street psychiatry?
3. Dr. Christensen advocates a "language of care," highlighting "presence rather than analysis, invitation instead of interpretation." What are some ways you could practice a culture of care in a clinical setting? Give examples. What concrete actions and steps could you take in a first encounter, and what would you make a point of saying or asking?

Christensen, R.C. and J.C. Byrd, *Role of an Australian Homeless Health Outreach Team: Commentary.* International journal of therapy and rehabilitation, 2010. 17(7): p. 383. Included in booklet.

1. This commentary argues that street outreach works because "the road that leads from a state of homelessness to rehabilitation and recovery is built upon first cultivating trusting relationships and fostering social reconnection." Do you agree?
2. This article argues that street outreach works because it allows for the forging of human relationships with isolated homeless individuals. The article asserts that this is the "human" dimension of care. How do you think this could be a valuable part of clinical practice with a marginalized group?

Christensen, R.C., *The ethics of treating the "untreatable".* Psychiatric services, 1995. **46**(12): p. 1217. Link to purchase: http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.46.12.1217

1. Dr. Christensen asserts that "the traditional virtues of compassion, humility and fidelity are an often-neglected dimension of ethical responsibility." He mentions this in reference to refusing to treat the "untreatable," such as individuals who rejected substance abuse treatment. His argument is that "clients have a claim on us that endures even when they refuse the treatment we offer," and that closing off other psychiatric services to a client refusing substance abuse treatment is wrong. What would you do or say if a client refused a treatment? How would you enact compassion, humility and fidelity?

Christensen, R.C., *Psychiatrists as gatekeepers: a matter of perspective.* Psychiatric services, 1997. Link to view: http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.48.5.583

1. Dr. Christensen reflects that "as a community-based psychiatrist, I've learned that physicians can be gatekeepers who struggle to usher folks out of the health care system, or they can be gatekeepers who struggle to usher individuals through the healthcare gate." In what ways can a psychiatrist be a positive gatekeeper to the underserved? Brainstorm and give examples.

Christensen, R.C., *The mentally ill poor: rethinking ethics.* Psychiatric services, 2000. 51(11): p. 1452-3. Link to view: http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.51.11.1452-a

1. Dr. Christensen writes that "the ethical principles of beneficence, autonomy, and justice have traditionally centered rather narrowly on the physician-patient relationship to the exclusion of examining organizational values and commitments." How could ethical principles be used to explain organizational values and commitments?
2. Dr. Christensen advocates invoking "humaneness, fairness, and social responsibility" on a institutional level. Dr. Christensen outlines some potential actions associated with these values, but sketch them out further, specific to your institution.

Christensen, R.C., *The ethics of cost shifting in community psychiatry.* Psychiatric services, 2002. 53(8): p. 921. Link to view: http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.53.8.921

1. How do you think the example cited in the article could have been prevented? What would you have done instead as the initial treating psychiatrist?

2. Dr. Christensen argues that "the choice not to participate in the cost-shifting practice of 'turfing' uninsured—but clinically complex and seriously ill—individuals onto primary care providers should be an ethical no-brainer." How could you argue this point in the face of institutional budgetary decisions? What arguments would you employ?

Christensen, R.C., *Adapting Your Practice: General Recommendations for the Care of Homeless Patients (review).* J Health Care Poor Underserved, 2004. 15(4): p. 704-705. Link to reviewed item: http://www.nhchc.org/wp-content/uploads/2011/09/GenRecsHomeless2010.pdf Link to review: https://muse.jhu.edu/article/174817/pdf

1. Dr. Christensen summarizes the basic message of the reviewed item to be that "a patient's state of homelessness should impel the provider to modify his or her clinical approach to diagnosis, evaluation, physical examination, the ordering of relevant diagnostic tests, development of a feasible treatment plan, and the implementation of follow-up strategies." The guide gives practical applications of how to do so. What parts of this process would you find challenging, and how would you address these challenges?

Module Six: Wrap Up

Christensen, R.C., *Caring for the invisible and the forgotten.* The Pharos of Alpha Omega Alpha-Honor Medical Society. Alpha Omega Alpha, 2014. 78(4): p. 48-50. Included in booklet.

1. Dr. Christensen emphasized the phrase "I see you. I hear you. You are not invisible." How do you think this could apply in various clinical settings, with both the underserved and other categories of patient?
2. What place does relationship building have in the clinical setting? How should you go about this process?

Christensen, R.C., *Invol.Psych.Hosp.Risk.Mgmt.Ethical.Considerat.* Jefferson Journal of Psychiatry, 1993: p. 42-47. Included in booklet.

1. This article begins with the three facets of treatment decision making: the clinical, the legal, and the ethical. When hospitalizing a patient against his or her wishes, what questions and factors should be considered with each of these three facets?
2. Dr. Christensen acknowledges that "Concretely, however, there is great disagreement at times over how suicidal, dangerous or helpless a person must be to justify overriding their wishes and hospitalizing them." Where do you think the line should be drawn?
3. What ethical concerns are there with this practice, and when it is ethically permissible to involuntarily hospitalize a patient?
4. To quote from the article, "Robert Veatch has suggested, however, that if physicians are to honestly attempt to assess what is 'in the interest' of the patient, they need to consider what the patient's concept of their personal welfare entails, even if the patient's notion is broader and more expansive than immediate medical concerns alone." This goes against common practice of "the physician calculating medical benefits and harms for the patient." How can a

physician work with a patient to find their definition of personal welfare? What questions should the physician ask, and what actions should the physician take?

5. The case study of D.W. illustrates a situation in which a psychiatrist involuntarily hospitalized a patient based on clinician self-interest to avoid "possible litigation in the event of a suicide." When is it justifiable to involuntarily hospitalize a patient based on legal concerns? Consider the realms of medical appropriateness and ethical soundness, and what the interplay would have to be to justify action based on legal considerations.

Grace, G.D. and R. Christensen, *The Mentally Ill Need Us All.* Clinical Psychiatry News, 2003. 31(10): p. 14. Included in booklet.

1. This article asserts that "the dermatologist and gastroenterologist, for example, should be expected and able to recognize psychological problems in their patients and should refer them for care." How could medical specialists be educated to recognize psychological disorders? What guidelines would have to be implemented?

Christensen, R.C. and S.V. McCrary, *Decisions to refuse treatment by depressed, medically ill patients.* The Journal of clinical ethics, 1993. 4(4): p. 335-7. Article on website.

1. This article poses an ethical dilemma: "Depressed, medically ill patients may lack insight into their own condition—which could prevent them from making a valid, informed decision about treatment—yet not be so disturbed that care providers can regard them as lacking the capacity to consent or refuse." At what point is it permissible to override a patient's wishes?
2. As the article states, "in psychiatry…seriously ill patients have traditionally been assumed not to be competent to make many choices about their care (for example, suicidal patients are assume not to be capable of making decisions about their life and death)." If faced with a patient like R.C., whose psychiatric problems may be contributing to the refusal of medical treatment, how would you, a psychiatrist, work with the rest of the medical team?

Christensen, R.C. and S.V. McCrary, *Treatment refusal by an elderly man suffering intensely from treatment-resistant depression.* Psychiatric services, 1995. 46(2): p. 181-3. to purchase: http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.46.2.181

1. This article identifies three areas of ethical concern in regards to the life-threatening refusal of treatment due a psychiatric condition: "obligations of health care providers," "the rights of mentally ill persons to refuse treatment," and "the relationship between psychiatric illness and assessments of the quality of life among elderly persons." Which of these do you prioritize in situations when all three are in conflict?
2. The article comments that "the presence of mental illness does not automatically mean that a patient is incapable of making decisions about treatment." Give an example of a situation in which a person would be incapable of receiving treatment.
3. In the case of Mr. A, the "psychiatric ethics consultants supported the patient's refusal of artificial nutrition and hydration in the event such treatment should become medically indicated." Do you agree with their decision?

Christensen, R.C., *Ethical issues in community mental health: cases and conflicts*. Community Ment Health J, 1997. 33(1): p. 5-11. Link to purchase: https://link.springer.com/journal/10597

1. What are the unique medical issues faced by community psychiatrists?
2. What is an example of "competent refusal of indicated treatment"?
3. Is psychiatric paternalism ever permissible, and if so, in what situations?
4. Dr. Christensen reflects that "moral quandaries based upon balancing the obligations of beneficence with the mandates of justice occur routinely in community mental health and merit serious ethical reflection at all levels of the particular organization." When reflecting and deciding how to allocate scare resources, what questions are important to ask and what factors should be considered?
5. "The organizational structures of most mental health centers are characterized by a quite complex set of relationships between administrators, providers, other members of the multidisciplinary treatment team, and clients within the system." What's the best way to resolve ethical tensions and address issues in this environment?