Abstracts

Quality and Professionalism in Psychiatry

Given space limitations and varying reprint permission policies, not all of the influential publications the editors considered reprinting in this issue could be included. This section contains abstracts from additional articles the editors deemed well worth reviewing.

The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2009

Kreyenbuhl J, Buchanan RW, Dickerson FB, Dixon LB; Schizophrenia Patient Outcomes Research Team (PORT)

Schizophr Bull. 2010 Jan;36(1):94–103

The Schizophrenia Patient Outcomes Research Team (PORT) project has played a significant role in the development and dissemination of evidence-based practices for schizophrenia. In contrast to other clinical guidelines, the Schizophrenia PORT Treatment Recommendations, initially published in 1998 and first revised in 2003, are based primarily on empirical data. Over the last 5 years, research on psychopharmacologic and psychosocial treatments for schizophrenia has continued to evolve, warranting an update of the PORT recommendations. In consultation with expert advisors, 2 Evidence Review Groups (ERGs) identified 41 treatment areas for review and conducted electronic literature searches to identify all clinical studies published since the last PORT literature review. The ERGs also reviewed studies preceding 2002 in areas not covered by previous PORT reviews, including smoking cessation, substance abuse, and weight loss. The ERGs reviewed over 600 studies and synthesized the research evidence, producing recommendations for those treatments for which the evidence was sufficiently strong to merit recommendation status. For those treatments lacking empirical support, the ERGs produced parallel summary statements. An Expert Panel consisting of 39 schizophrenia researchers, clinicians, and consumers attended a conference in November 2008 in which consensus was reached on the state of the evidence for each of the treatment areas reviewed. The methods and outcomes of the update process are presented here and resulted in recommendations for 16 psychopharmacologic and 8 psychosocial treatments for schizophrenia. Another 13 psychopharmacologic and 4 psychosocial treatments had insufficient evidence to support a recommendation, representing significant unmet needs in important treatment domains.

Errors in Medicine

Leape LL

Clin Chim Acta. 2009 Jun;404(1):2–5

Modern awareness of the problem of medical injury—complications of treatment—can be fairly dated to the publication in 1991 of the results of the Harvard Medical Practice Study, but it was not until the publication of the 2000 Institute of Medicine (IOM) report, To Err is Human that patient safety really came to medical and public attention. Medical injury is a serious problem, affecting, as multiple studies have now shown, approximately 10% of hospitalized patients, and causing hundreds of thousands of preventable deaths each year. The organizing principle is that the cause is not bad people, it is bad systems. This concept is transforming; it replaces the previous exclusive focus on individual error with a focus on defective systems. Although the major focus on patient safety has been on implementing safe practices, it has become increasingly apparent that achieving a high level of safety in our health care organizations requires much more: several streams have emerged. One of these is the recognition of the importance of engaging patients more fully in their care. Another is the need for transparency. In the current health care organizational environment in most hospitals, at least six major changes are required to begin the journey to a culture of safety: 1. We need to move from looking at errors as individual failures to realizing they are caused by system failures; 2. We must move from a punitive environment to a just

culture; 3. We move from secrecy to transparency; 4. Care changes from being provider (doctors) centered to being patient-centered; 5. We move our models of care from reliance on independent, individual performance excellence to interdependent, collaborative, interprofessional teamwork; 6. Accountability is universal and reciprocal, not top-down.

Best Practices: Improving Quality of Care for Patients with First-episode Psychosis
Addington D
Psychiatr Serv. 2009 Sep;60(9):1164–6

The principles of early intervention and evidence-based care have been applied to the task of improving outcome for first-episode schizophrenia. Significant progress has been achieved through clinical innovation, research, advocacy, and policy changes. Canada has seen the implementation of such services in a number of jurisdictions, and there is a need to develop tools and strategies for quality assurance and quality improvement. The use of tools such as clinical practice guidelines, program fidelity scales, and performance measures, standards, and benchmarks is well established for quality assurance and quality improvement. These tools are available for other areas of mental health care and are being developed for application to treatment services for early psychosis. This column illustrates some of the tools available for quality improvement and the challenges in their application. Development and application of such tools are required to move first-episode psychosis treatment from innovation to best practice and standard care.

Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series
Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders
Washington (DC): National Academies Press (US); 2006
The National Academies Collection: Reports funded by National Institutes of Health

Millions of Americans today receive health care for mental or substance-use problems and illnesses. These conditions are the leading cause of combined disability and death among women and the second highest among men. Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences—for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole. A previous Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), put forth a strategy for improving health care overall—a strategy that has attained considerable traction in the United States and other countries. However, health care for mental and substance-use conditions has a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace. These and other differences raised questions about whether the *Quality Chasm* approach is applicable to health care for mental and substance-use conditions and, if so, how it should be applied. This new report examines those differences, finds that the *Quality Chasm* framework can be applied to health care for mental and substance-use conditions, and describes a multifaceted and comprehensive strategy for doing so and thereby ensuring that: Individual patient preferences, needs, and values prevail in the face of residual stigma, discrimination, and coercion into treatment; The necessary infrastructure exists to produce scientific evidence more quickly and promote its application in patient care; Multiple providers' care of the same patient is coordinated; Emerging information technology related to health care benefits people with mental or substance-use problems and illnesses; The health care workforce has the education, training, and capacity to deliver high-quality care for mental and substance-use conditions; Government programs, employers, and other group purchasers of health care for mental and substance-use conditions use their dollars in ways that support the delivery of high-quality care; Research funds are used to support studies that have direct clinical and policy relevance and that are focused on discovering and testing therapeutic advances. The strategy addresses issues pertaining to health care for both mental and substance-use conditions and the essential role of health care for both conditions in improving over-

all health and health care. In so doing, it details the actions required to achieve those ends—actions required of clinicians; health care organizations; health plans; purchasers; state, local, and federal governments; and all parties involved in health care for mental and substance-use conditions.

Professionalism and Ethics Education on Relationships and Boundaries: Psychiatric Residents' Training Preferences
Lapid M, Moutier C, Dunn L, Hammond KG, Roberts LW
Acad Psychiatry. 2009 Nov-Dec;33(6):461–9

Objective: Awareness of the privileges and limits of one's role as physician, as well as recognition and respect for the patient as a human being, are central to ethical medical practice. The authors were particularly interested in examining the attitudes and perceived needs of psychiatric residents toward education on professional boundaries and relationships given the heightened current focus on professionalism and ethics. **Methods:** Residents from six psychiatric residencies provided views on professionalism and ethics education on a survey encompassing 10 domains of professionalism. The authors focus on residents' perceived need for education on boundaries in the psychiatrist-patient relationship and in peer-peer and supervisor-trainee interactions. **Results:** Respondents (N = 134) felt that nine relationship and boundary issues arising during training should receive more education: being asked to work with inadequate supervision, resolving conflicts between attendings and trainees, resident health care, adequately caring for patients while adhering to work-hour guidelines, performing work beyond one's competence, mistreatment of residents, sexual/romantic relationships between faculty and trainees, mistreatment of medical students, and sexual/romantic relationships between residents and medical students ($p<0.05$ in all cases). In addition, 15 relationship and boundary issues arising during clinical practice were felt to warrant more education: responding to impaired colleagues, coping with mistakes in clinical care, reporting mistakes, balancing personal and professional life, resolving conflicts, writing prescriptions for friends or family, allocation of health care resources, providing medical advice to friends and family, physicians' social responsibilities, interacting with families, medicine as a profession, gender bias, being asked to falsify clinical information, accepting gifts from patients, and personal relationships with patients ($p<0.05$ in all cases). **Conclusion:** The authors found a perceived need for more education for psychiatric residents for the majority of topics pertaining to boundaries and relationships. Residents who reported encountering ethical dilemmas more frequently wanted more education on these topics.

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