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THE 'GOOD PSYCHIATRIST' STANDARD ACCORDING TO ANTONI KĘPIŃSKI. EXAMPLES FROM THE DECISIONS OF MEDICAL DISCIPLINARY BOARDS

WZORZEC DOBREGO PSYCHIATRY WEDŁUG ANTONIEGO KĘPIŃSKIEGO. PRZYKŁADY Z ORZECZNICTWA SĄDÓW LEKARSKICH

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Abstract

Purpose: To present the physician's work ethic of Professor Antoni Kępiński, who, throughout his professional life, emphasized the importance of a sincere, accepting and non-judgemental approach to the patient. This was the only relationship capable, in Professor Kępiński's opinion, of enabling the practitioner to know the patient and provide successful therapy. Do modern psychiatrists follow this concept? In practice a question arises about the current shape of the psychiatrist-patient relationship and what the relationship should look like.

Views: In his numerous publications Antoni Kępiński lists errors made by psychiatrists while diagnosing and treating patients with mental disorders. Such errors can be divided into three groups: the 'object' error (the doctor is not treating the patient as a subject but rather as an object, their relationship is not partner-like), the 'mask' error (the adoption of an artificial pose that is at odds with the physician's current actual psychic experience), and the 'judge' error (the doctor is judging the patient).

Conclusions: Analysis of sample decisions from Regional Medical Disciplinary Boards (*okręgowy sąd lekarski* — OSL — 'regional medical court'), and the Supreme Medical Disciplinary Board (*Naczelny Sąd Lekarski* — NSL — 'Supreme Medical Court') involving psychiatrists shows behaviours inconsistent with Professor Kępiński's high ideals. Errors result mainly from a lack of ability to take a holistic view of the patient and establish appropriate contact with them as a human being. Hence, there is a need to develop the skill of doctor-patient conversation early on, in specialization training, and later throughout the psychiatrist's entire professional life.

Key words: psychiatrist, medical court, doctor-patient relationship.

PSYCHIATRY: A SCIENCE OR AN ART?

The purpose of treatment is to restore the patient's health or improve the quality of the patient's life. Medical luminaries have for long debated whether therapy is an art or a trade [1]. On the one hand, the therapeutic process requires the doctor to rely on academic research and make sure their research is up to date; on the other hand, specialized knowledge allows doctors their intellectual freedom and creativity [2]. In its dictionary or everyday understanding the word 'art' means proficiency, skill, virtuosity or mastery [3]. Certainly, though, not everything a doctor does requires special skill (e.g. examination of visual acuity), hence some writers express contrary views [4]. There are, however, numerous medical activities that do require suitable proficiency acquired in professional practice (complicated surgeries, psychiatric therapy). References to medical 'art' give rise to no objections in this regard [5].

Antoni Kępiński held a similar view and warned psychiatrists that psychiatry was a field closer to art than science. According to that view psychiatry is a branch of medicine that does not meet the criteria of science: verifiability, repeatability, measurability and objectivity. In psychiatry every patient requires a different individual and holistic approach. There is no room for patterns, schemes or fixed rules for diagnosis and therapy. In this aspect psychiatry is closer to art, as the doctor deals with an individual and not with a general model [6]. In psychiatry one of the characteristics of the doctor-patient relationship is the specificity of intimacy. One of the parties to the relationship wants to reveal as much as possible and the second party is listening eagerly. In somatic medicine this refers to the body, and in psychiatry to the mind [7]. A good psychiatrist can relieve the patient's anxiety [8].

At times psychiatrists feel intense frustration and helplessness when comparing themselves to other doctors, who base their diagnosis and therapy on, among other things, bio-chemical processes, statistics and theory [9]. Other specialists only come into limited emotional contact with the patient, and their schemes, theoretical models, ready aetiological concepts, and terminology create a scientific air [6]. A psychiatrist does not have the same sense of identity as a scientist other specialists do. The characteristic feature that distinguishes psychiatrists from other specialists is clinical training in the relevant aspects of neuroscience and a focus on assisting patients with thought, mood or conduct disorders rather than somatic ailments [10]. According to Antoni Kępiński, psychiatrists envy other specialists somewhat the tangible results of their actions; for example the surgeon will stitch something back together or cut it out, and the patient will either return to health or die. The surgeon experiences satisfaction with his or her work. That is not a type of joy the psychiatrist knows [7]. In somatic medicine the goal is clearly set – the patient has to return to health (…). It is significantly more difficult to determine psychic health, if indeed such a thing exists' [8]. The psychiatrist cannot adequately record his or her observations, as the occurrences being described are not measurable, given that in the psychiatric, i.e. holistic, approach a human being is unique and inimitable [7]. This holistic approach is the most readily apparent in psychiatry and sets it apart from other fields. Professor Kępiński noted: "A doctor always treats the patient, not an ailing organ" [9]. Psychiatry is a medical field that deals with the whole human being [7]. Polish psychiatrists consider psychiatry to be an underestimated and discriminated-against field of medicine, while expressing great satisfaction with the choice of this medical specialty [11].

THE ERROR OF "SCIENTIFIC OBJECTIVITY"

On numerous occasions Antoni Kępiński reminded his readers that psychiatry required unique freedom from scientific objectivization and therewith also freedom from the pseudo-scientific objectification of the patient [7]. He saw the patient as a person. Professor Kępiński noted that one should never, and certainly not in medicine, regard the other as a means to achieving one's own goals, in the sense that we might objectify the other (which also means stripping away the other's freedom), whereas the doctor-patient relationship should be a meeting of two free subjects [7]. The doctor-patient dialogue should be horizontal, i.e. based on equal rights; a shift to a diagonal perspective, i.e. one based on the doctor's power and authority, would be unacceptable. In making this particular error, the psychiatrist positions him- or herself as an "impartial observer" relative to the object of his or her actions, i.e. the patient [12]. In the psychiatrist-patient configuration the doctor takes on the role of an experienced guide who is the only person with whom the patient can establish an understanding and emotional contact [13]. One must not forget that the patient has to return to a life in society. In psychiatry the doctor must combine two goals – the patient's individual goal and the environment's social goal [7]. Not infrequently there occurs a conflict between the two. In Antoni Kępiński's opinion the psychiatrist facing that conflict has two ways out. One is to form a united front with the patient, where the doctor, in principle, identifies with the patient. That could lead to a situation in which the patient feels well only in the psychiatrist's company. The other model of conduct consists in identifying with the patient's environment. In practice that means taking a condemning and aggressive stance toward the patient. The patient, in turn, takes the same stance toward the doctor as toward the patient's own environment, making diagnosis and treatment so much more difficult [7].

Sometimes the doctor sees no way to reconcile the two conflicting relationships. These difficult relationships between the doctor and the patient and between the doctor and the patient's environment are also the factual background of proceedings before medical disciplinary boards – Polish "medical courts". One must not forget that, as far as professional responsibility in the Polish system is concerned, the medical practitioner needs to comply with two normative systems: the ethical (Code of Medical Ethics) and the legal. Proceedings in the area of professional responsibility of physicians are initiated by the disciplinary ombudsman (*Rzecznik Odpowiedzialności Zawodowej* – ROZ – Professional Responsibility Ombudsman), who proceeds either on the patient's or the patient's family's motion, or *ex officio*. If there is evidence of professional misconduct by the practitioner, the disciplinary ombudsman files a request for a penalty (*wniosek*

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o ukaranie) with the disciplinary board. This involves Regional Medical Disciplinary Boards (*okręgowy sąd lekarski* – OSL – regional medical court), and the appellate in this instance is the Supreme Medical Disciplinary Board (*Naczelny Sąd Lekarski* – NSL – Supreme Medical Court). There is currently also the option of filing an extraordinary appeal against the NSL's ruling – an appeal-in-cassation to the Supreme Court (*Sąd Najwyższy* – SN), staffed by professional judges.

One of the cases the ombudsman's office received was the complaint of the father of a five-year-old boy. The complaint alleged that during examination at an inpatient clinic the psychiatrist diagnosed the child with a mental disorder in the form of adaptation disorder with anxiety symptoms, and ordered observation for post-traumatic stress disorder. The patient's parents were in the process of divorcing at the time, and there was acute conflict between them. The Regional Medical Disciplinary Board [14] found that the patient's mother noticed changes in the boy's behaviour from the time an altercation that took place at the pre-school between her and the boy's father. The boy slept uneasily, had nightmares, and nocturnal enuresis (bedwetting) appeared. The boy was also aggressive at the pre-school and withdrawn at home. Things being so, she approached the Neuropsychiatric Centre's Inpatient Clinic, where – after examination and diagnosis – the psychiatrist prescribed fluvoxamine at 25 mg to be taken in the evening. The doctor informed the mother of the drug's use beyond registration along with possible undesirable effects. The mother gave the her written consent to the therapy. In the opinion of the expert appointed in the case the need had been first of all to take action to provide a sense of security for the child and his mother through psychological and legal assistance. On the other hand there is not enough clear scientific evidence to determine whether the administration of the aforementioned drug in a child below 8 years of age showing anxiety symptoms posed a danger to the child's life or health. Experts recommend caution in the use of this drug in the paediatric population. Thirdly, the child's father had the right to be fully informed about the outcome of the psychiatric consultation received by his child and the recommendations given. For a better understanding of the steps taken by the doctor, the father should have approached the psychiatrist directly [15].

In a different situation the Regional Medical Disciplinary Board [16] heard the case of a psychiatrist whose conduct, in the disciplinary ombudsman's opinion, had reflected adversely on the dignity of the profession. The doctor, without medical indications and without the patient's consent, began therapy and treatment without respecting the patient's right to take on a conscious role in the decision-making process. Firstly, he failed to inform her that the actions he was taking – a conversation in evening hours – amounted in fact to an examination. Secondly, without informing the patient of the diagnosis he had made, he issued a prescription and gave it to a family member. Thirdly, at the family's request and in violation of doctor-patient privilege, he issued a written psychiatric opinion of the patient's health, diagnosing her with, among other things, a chronic mental illness. The doctor also failed to keep medical records for the patient. In the ombudsman's opinion the doctor failed to provide any sources of information to support the diagnosis, and the interview was based on information received from family members ill-disposed towards her. The ombudsman wondered at the fact that during the proceedings the victim provided opinions from three experienced psychiatrists and four clinical psychologists who did not find her to be mentally ill. The patient, therefore, based on the psychiatric indications, did not require pharmacological therapy, nor any other form of psychiatric treatment. In the ombudsman's opinion a situation in which the doctor is not an objective diagnostician but instead favours any of the parties involved is unacceptable. Moreover, the manner of the examination of the patient and control of her treatment without informing her of the effects of the drugs prescribed failed to meet the standards of psychiatric care [17].

THE MASK

Antoni Kępiński noted that the conversation with the patient was not sincere when the psychiatrist was taking on an affected pose – a "mask" at odds with the doctor's current frame of mind [12]. "That humility pays off, for the patient, as trust continues to grow, will spontaneously answer questions we had been afraid to ask" [18]. In Kępiński's opinion the psychiatrist ought not to be "artificial" with the patient. Insofar as it is possible the doctor ought to be himself or herself, as authenticity is required for dialogue with the patient [7, 19]. It is beyond any doubt, therefore, that the doctor's authenticity translates into the patient's trust. The doctor-patient relationship has to be based on trust. The patient's trust in the doctor provides them with the confidence that they are not being left alone with their health problems. There is also a feedback loop. The patient's trust must not become the cause of certain improper practices. In one case the ombudsman charged the psychiatrist with a violation of Articles 6 and 10(1) of the Medical Ethical Code, as during the patient's stay and treatment at a rehabilitation facility the doctor had provided drugs (metylphenidate, among others) without the staff's knowledge. Article 10(1) MEC states that in providing medical care the doctor must not exceed his or her professional competence. On the other hand, and in line with Article 6 MEC, a doctor who is at liberty to choose the method of treatment ought to restrict his or her medical activities only to those that are in fact required by the patient, consistent with current

knowledge [20] and known to be the most effective. In this case the OSL [21] found that the defending doctor, driven by compassion for the patient and asked by his mother, provided metylphenidate. The doctor did not consult that move with the facility's staff responsible for the patient. The doctor explained that he had previously treated the patient at his private office and known them well, and that the patient trusted the doctor. The patient was convinced that the use of this drug was part of the therapy at the centre. The real reason for the administration of the drug was that the patient was bored during therapy and made his continued stay at the facility conditional on receiving from the doctor the desired drug according to information provided by the patient's mother. There is no way of regarding the defendant doctor's actions as consistent with Article 6 MEC. There had been no medical grounds for the introduction of an additional drug to the patient's therapy. The doctor had not been the patient's physician in charge and consequently had no access to the medical files and no way of knowing whether metylphenidate would or would not interfere with the treatment or pose a danger to the patient's life or health. At the main hearing the psychiatrist explained that the drug was used in the treatment of ADHD and administered to children below 6 years of age. He had seen no danger to the patient, especially considering that she, trusting the doctor, applied the drug consistently with his recommendations. One had to consider, however, the disciplinary board found, that one of the contraindications of the drug was the patient's dependence on medical drugs or alcohol. It is beyond doubt that the patient exhibited that sort of dependence. In the opinion of specialists, ADHD and drug or alcohol addiction are quite common, there are scientific studies that indicate the need for the use of metylphenidate in certain groups of patients groups [22]. Nevertheless, the patient was no longer under the care of the accused doctor. Other doctors from the center provided the therapy. It is difficult to state unequivocally whether the use of metylphenidate would benefit this patient. However the doctor, guided by compassion for the patient and his mother, prescribed him this drug. The doctor did not behave authentically with the patient. The board emphasized that his conduct failed to show any deference to the most important ethical tenet of the medical profession: *salus aegroti suprema lex*.

THE JUDGE

A psychiatrist has no right to take on the attitude of a judge. Professor Kępiński believed that no one should be judged *a priori*, as passing value judgements on people affects our relationships with them [12]. "In passing an *a priori* value judgement we determine our emotional attitude to the person (…). That attitude is sometimes harmful and makes mutual contacts difficult" [7]. The social perception of a patient with somatic disorders (e.g. renal failure, hypertension) is different from that of a mental patient. Surveys show that the lack of acceptance of persons with mental disorders in society is the result of a number of mistaken and harmful stereotypes. Such negative attitudes involve a fear of the mentally ill [23]. In such a situation the patient feels accused, afraid of society and afraid of the doctor. A patient feeling judged by his or her doctor activates defence mechanisms. The patient defends himself or herself by showing various symptoms intended to justify him or her. Thus he or she takes a hostile and negative attitude to the psychiatrist-judge. That attitude makes therapy more difficult and sometimes impossible [7]. Professor Kępiński believed that "Everyone happens to make decisions about another's fate. Those are not easy decisions to make. And so in such situations various types of norms are of great assistance (…). Such norms are for the judge the provisions of the law, for the physician diagnostic and prognostic knowledge, and for the teacher the examination curriculum" [18]. Thus the psychiatrist, in making decisions about another's treatment, must not omit examination. To Antoni Kępiński, diagnosis and treatment constituted tightly interlinked components of the diagnostic and therapeutic process [12]. Medical examination for the purpose of offering or verifying a diagnosis is broken down into three elements: *anamnesis* (interview), physical examination, and additional examinations (e.g. laboratory tests, ultrasound). The goal of interview is to determine subjective symptoms, whereas the physical and the additional examinations provide objective data [24]. Failure to examine the patient is a manifest error. The need for patient examination in determining the patient's condition is recognized by Article 42 of the Act on the Professions of Physician and Dentist and Article 11(1) of the Act on the Protection of Mental Health, which mandates that any finding made about the condition of a person who has or may have a mental disorder must be preceded by the practitioner's personal examination of the person. The literature emphasizes that the obligation under Article 11(1) of the Act on the Protection of Mental Health exists before any professional activities even start [25].

Decisions of the medical disciplinary board, on the other hand, show that these provisions are not always observed. Moreover, in addition to breaches of legal standards boards find ethical violations such as of Article 1(3) MEC: reflecting adversely on the dignity of the person, or Article 40 MEC: issuing certificates without a current examination. The Regional Disciplinary Board [26] heard the case of a doctor who, at the family's request, had issued a referral to a psychiatric hospital without having seen the patient. The referral, therefore, was based on such medical history as had been made available, and third-party information. Thus, the doctor issued a medical document attesting to the patient's mental condition

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without having the patient and hence without being in a position to make a conscientious assessment of the patient's condition. To lend the improperly issued document more authority, the doctor abused his position by affixing his stamp as a forensic medical examiner.

In a different matter the NSL heard an appeal in the case of a psychiatrist who, while being on duty in a hospital with increased psychiatric supervision, failed in due diligence by giving medical recommendations without having examined a patient, in violation of Article 8 MEC and Article 4 of the Act of on the Professions of Physician and Dentist. In the main hearing before the NSL the Head Disciplinary Ombudsman emphasized that, despite information received from medical staff concerning the lack of effect of the drugs administered at the time, medical decisions were made without examining the patient. At the same time the location from which the doctor gave the recommendation was approximately one minute away from where the patient was staying. In the ombudsman's view the defending doctor's conduct amounted to a gross violation of duty. The NSL found it impossible to agree with the OSL's opinion that omitting the examination had only been an administrative violation [27]. The OSL's decision [28] was reversed and the case remanded for reconsideration. This case was again considered by court. There is currently no final court decision.

CONCLUSIONS

Decisions of medical disciplinary boards in the area of psychiatry, which differs markedly from other medical fields, show that in this sphere too there exists a danger of dehumanizing the doctor-patient relationship. The modern psychiatrist ought to bear in mind that he or she is first of all a physician, rather than feeling like a neutral observer or judge or affecting poses before the patient. In Professor Kępiński's opinion nothing that affects a human being is either good or evil, beautiful or unseemly, wise or unwise, but only human [7]. This exceptional psychiatrist-patient relationship is grounded in the humanist foundations of medicine. The human image of the patient is not to be lost. It is therefore necessary to perceive the patient as a subject rather than an object, view health and illness in a holistic light and not only satisfy the patient's biological needs but also their spiritual ones [29]. Contact with the patient is something the psychiatrist forever continues to learn. This art should begin to be acquired early, during medical studies (psychiatric subjects), then during post-diploma training and ultimately developed throughout the psychiatrist's entire professional life.

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References/Piśmiennictwo

1. Tokarczyk R. Medycyna a normy [Medicine and rules of conduct]. Warsaw: Wolters Kluwer Polska; 2011, p. 12.
2. Zielińska E. Odpowiedzialność zawodowa lekarza i jej stosunek do odpowiedzialności karnej [The physician's professional responsibility and its relationship to criminal liability]. Warsaw: Liber; 2001, p. 29.
3. Słownik języka polskiego [Dictionary of the Polish language]. Vol. III. Warsaw: PWN; 1983, p. 428.
4. Boratyńska M, Konieczniak P. Prawa pacjenta [The patient's rights]. Warsaw: Difin; 2001, p. 128-139.
5. Liszewska A. Odpowiedzialność karna za błąd w sztuce lekarskiej [Criminal liability for medical malpractice]. Cracow: Zakamycze; 1998, p. 24-25.
6. Jakubik A, Masłowski J. Antoni Kępiński – człowiek i dzieło [Antoni Kępiński – the man and the work]. Warsaw: PZWL; 1981, p. 314.
7. Kępiński A. Poznanie chorego [Knowing the patient]. Warsaw: PZWL; 1989, p. 127-128, 40-44, 47, 50-51.
8. Kępiński A. Lęk [Anxiety]. Warsaw: PZWL; 1977, p. 15.
9. Kępiński A. Psychopatologia nerwic [Psychopathology of neuroses]. Warsaw: PZWL; 1986, p. 268.
10. Craddock N, Kerr M, Thapar A. What is the core expertise of a psychiatrist? Psychiatrist 2010; 34: 457-460.
11. Kochański A, Cechnicki A. Opinions of Polish psychiatrists on psychiatry and their own professional role. Adv Psychiatry Neurol 2018; 27: 31-48.
12. Kokoszka A. Jak pomagał i leczył profesor Antoni Kępiński [How Professor Kępiński helped and healed]. Cracow: Medycyna Praktyczna; 1999, p. 21-22, 25.
13. Kępiński A. Schizofrenia. Cracow: Wydawnictwo Literackie; 2001, p. 283.

14. Main hearing before the OSL in Warsaw of 2 July 2017, case OSL 630.21/16.
15. Opinion of the Voivodeship (i.e. provincial) Consultant for psychiatry in children and young patients of 17 January 2016.
16. Main hearing before the Regional Medical Disciplinary Board in Warsaw, 21 January 2018, case 630.44/2018.
17. Professional Responsibility Ombudsman – request for penalty.
18. Kępiński A. Rytm życia [The rhythm of life]. Warsaw: Sagittarius; 1992, p. 249, 263.
19. Chojnacka M. Poznanie chorego w kontekście egzystencjalnych rozważań Martina Heideggera i Karla Jaspersa [Knowing the patient in the content of the existential deliberations of Martin Heidegger and Karl Jaspers]. VIII Otwarte Seminarium Filozoficzno-Psychiatryczne: Antoni Kępiński [8th Open Seminar on Philosophy and Psychiatry: Antoni Kępiński], 16 November 2018, University of Warsaw.
20. Kałuża M. Etyczne aspekty leczenia [Ethical aspects of treatment]. In: Materiały z konferencji „Etyka lekarska", Opole, 14 listopada 1992 r. [Materials of 'Medical Ethics' Conference in Opole, 14 November 1992]; 33.
21. Decision of the Regional Medical Disciplinary Board in Wrocław, 15 May 2015, case Wu 63/14, unpublished.
22. Crunelle CL, van den Brink W, Moggi F, et al. International consensus statement on screening, diagnosis and treatment of substance use disorder patients with comorbid attention deficit/hyperactivity disorder. Eur Addict Res 2018; 24: 43-51.
23. Gzocha P, Kurpas D. Chorzy psychicznie w odbiorze społecznym – wyniki badania pilotażowego [Mental patients in societal perception – results of a pilot study]. Fam Med Primary Care Rev 2011; 2: 147-150.
24. Tatoń J, Czech A. Ogólna diagnostyka internistyczna [General diagnosis in internal medicine]. Warsaw: PZWL; 1991, p. 14.
25. Hajdukiewicz D. Osobiste badanie pacjenta to podstawowy obowiązek lekarza [Personal examination of the patient is the doctor's duty]. Available at: https://prawo.mp.pl/publikacje/orzecznictwo/58055,osobiste-badanie-pacjenta-to-podstawowy-obowiazek-lekarza (Accessed: 15.12.2018)].
26. Decision of the Regional Medical Disciplinary Board in Wrocław, 28 November 2014, case Wu 42/14, unpublished.
27. Main hearing before the NSL, 27 January 2017, case Rep 211/OWU/16.
28. Decision of the Regional Medical Disciplinary Board in Opole, 13 September 2016, case Wu/0003/2016.
29. Bilikiewicz A. Jak zapobiegać dalszej dehumanizacji medycyny u progu XXI wieku [Preventing further dehumanization of medicine at the onset of 21st century]. In: Imieliński K (ed.). Medycyna u progu XXI wieku. Filozofia i technika leczenia [Medicine at the onset of 21st century. Treatment philosophy and technique]. Warsaw: Centre for Postgraduate Medical Education; 1994, p. 51.

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