Commentary: Core Competencies and the Training of Psychiatric Residents in Therapeutic Risk Management

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The treatment of patients who, due to their clinical presentation, pose potential liability risks to the psychiatrist is one of the more stressful aspects of modern psychiatric practice. The need to educate psychiatric residents about the principles of risk management that guide the safe provision of good patient care in such patients is paramount in the current malpractice environment. In this commentary, we discuss the teaching of therapeutic risk management, as described by authors Simon and Shuman, in general psychiatry residency, particularly as it can be integrated within the existing core competencies established by the Accreditation Council on Graduate Medical Education (ACGME). A model outline of this integration for suicide risk management within each of the existing core competencies is presented.

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The successful training of psychiatric residents has become a daunting task, especially with the continual development of new and successful treatment modalities for mental illness. The understanding of the biological underpinnings of psychiatric pathology has increased at an unprecedented rate and has led to the development of novel psychopharmacological agents, each with its own mechanisms of action and unique side-effect profiles and each with its own potential for increasing prescriber liability. The development of new medications for the treatment of schizophrenia shows no signs of slowing.[1] Electroconvulsive therapy (ECT), with its inherent risks (e.g., anesthesia, memory loss), remains the most efficacious intervention for treatment-resistant depression and continues to have a therapeutic role in modern psychiatric practice.[2] Research in newer treatment modalities, including repetitive transcranial magnetic stimulation (rTMS) may eventually lead to additional required educational training and experiences for psychiatric residents.[3] In addition to the need to teach these treatment modalities and the appropriate risk management associated with their use, additional constraints have made residency training more challenging. Residents' duty hours have been limited to decrease their stress and increase the patients' safety.[4] Requirements of scholarly activity and evidence-based practice are monitored and documented. In addition to all of these, training directors must also document that residents have attained the ability to practice independently and to demonstrate attainment of the core competencies set forth by the Accreditation Council for Graduate Medical Education (ACGME).

The ACGME has established six general core competencies based on The Outcome Project, a long-term initiative aimed at increasing emphasis on educational outcomes in the accreditation of residency education programs (Table 1).[5] The project incorporates these competencies, to organize curricula and to support the identification and development of methods for assessing the attainment of these competencies. The six core competencies were chosen and endorsed by ACGME in February 1999, based on existing research of physician competencies and input from various constituents of graduate medical education. Since July 2002, all training programs for every medical discipline have been respon-

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Table 1 The ACGME General Core Competencies

Patient Care
Medical Knowledge
Practice-Based Learning
Interpersonal and Communication Skills
Professionalism
Systems-Based Practice

sible for training requirements related to these core competencies.

Because residency training is not immune from stress attributed to the current malpractice climate, addressing therapeutic risk management in residency makes sense. In difficult clinical situations where there is risk for liability, we agree with the approach in the paper by Simon and Shuman.[6] Understanding how to maintain focus on the patient, avoid defensive practice, and carefully document clinical decision-making should be a required fundamental for future psychiatrists. How to teach it is debatable. Rather than create an additional core competency, we believe that the principles outlined by Simon and Shuman can be successfully integrated within the existing competencies.

Of all of the undesired clinical outcomes inherent in psychiatric practice, the suicide of a patient is perhaps the most stressful. Psychiatric residents, with their limited clinical experience and potential for self doubt, are particularly vulnerable to this stress and may be more prone to development of significant morbidity after the patient's suicide.[7] Therapeutic risk management, as described by Simon and Shuman,[6] constitutes an approach to difficult clinical situations in which the potential for an unwanted outcome (suicide, violence, severe drug reaction) creates stress in the treatment provider. In utilizing therapeutic risk management rather than engaging in defensive practice techniques, the provider focuses on the best clinical treatment for the patient and, with knowledge of the laws that govern the regulation of psychiatric practice, documents his decision-making process. Such an approach has the benefit of reducing the stress associated with managing difficult clinical situations, and teaching this approach to psychiatrists-in-training can provide them a skill that will benefit them for the lifetime of their practice. In the example of suicide risk assessment, a model of therapeutic risk management could be integrated into each of the six ACGME core competencies (Table 1). One example would be as follows:

Patient Care

The resident asks all new patients about suicidal ideation and history of past suicide attempts.

When exploring patient suicidality, the resident displays compassion and seeks to strengthen the therapeutic alliance.

The resident develops a systemized treatment plan geared toward the patient's clinical needs and avoids defensive practice.

Medical Knowledge

The resident is familiar with the static and dynamic risk factors for suicide.

In psychiatric illnesses associated with suicidal behavior, the resident understands appropriate treatment modalities.

The resident is familiar with the emergency detention and civil commitment statutes in his or her practice jurisdiction.

Practice-Based Learning

In the treatment of patients identified with increased suicide risk, the resident actively consults with a supervisor.

The resident is familiar with the medical literature on the phenomenology of all suicidal behavior and integrates this information into effective case management.

In cases of completed suicide or serious suicide attempts, the resident participates in quality care review boards (QCRBs).

Interpersonal and Communication Skills

The resident is attuned to the attitudes about suicidal behavior within the patient's culture and explores these with the patient.

In a clinical situation that requires involuntary hospitalization, the resident presents the decision to the patient as a concern for the patient's safety and communicates it in a manner that minimizes erosion of the therapeutic alliance.

The resident communicates to the supervisor all clinical developments in patients at increased risk of suicide.

Professionalism

The resident seeks patient's permission before involving family members in treatment and discharge planning.

In difficult clinical/legal situations, the resident maintains focus on treating the patient and avoids decision-making based on self-interest in avoiding liability.

The resident avoids bias in the provision of testimony to courts charged with conducting civil commitment hearings.

Systems-Based Practice

In clinical decision-making regarding suicidal patients, the resident documents a comprehensive risk assessment containing the case-specific factors considered in the decision.

The resident is aware of the placement options and is able to navigate the procedures required for emergency hospitalization in his or her jurisdiction.

The resident collaborates with nurses, social workers, and other disciplines in formulating the treatment plan for suicidal patients.

Therapeutic risk management in patients threatening violence or other difficult clinical scenarios can be incorporated in the existing core competencies. While the model we have outlined represents a platform for the teaching of therapeutic risk management in suicidal patients, it does not constitute a comprehensive list of what may be needed within each individual competency. However, incorporating therapeutic risk management into each of the existing ACGME core competencies will provide residents-in-training with more than a working knowledge of how psychiatry and the law interact. It will provide future psychiatrists with the competence to deliver quality patient care in our litigious society.

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