Ethics, Empathy, and Leadership... As you know, business people are busy. Often, our job is to write messages that are highly readable and accessible, so that our readers can understand our messages as quickly and easily as possible. In this exercise, you will work to edit a piece of writing to make it easier for fast reading. Your challenge: Reduce this message by at least 50% while still conveying the meaning. Then copy and paste your version into a discussion forum post. Reduce this message: 50% Editing Activity.docx Download 50% Editing Activity.docx It will help to: Vary sentence length Keep paragraphs short (125 words or fewer) Focus on one concept per paragraph Place key ideas at the beginning Use lists, headings and subheadings for fast reading. Eliminate redundant words and phrases The Article is: Ethics, Empathy, and Leadership Ethics, Empathy, and Leadership I was recently meeting with some fourth-year residents as part of their course on community psychiatry. Since this was an introductory session, we were focusing on the role of the community psychiatrist. We thought about this within both the constraints that many psychiatrists practicing in the community find themselves, and the ideal characteristics and defining features of community psychiatry. Even as trainees, these folks could see how the scope of what they were being asked to do was shaped by financial imperatives and was often limited to biologic perspectives on illness management. They clearly felt discouraged by the limitations on their abilities to practice and learn the more dynamic and humanistic aspects of psychiatry, and wondered whether there was any way around this. Their perceptions and experiences were closely aligned with the discussions generated at our winter meeting in March. (The draft report from that meeting can be viewed on our website, or specifically here.) And it was not surprising to discover that their exposure to the transformation initiatives that are currently underway and recovery-focused practice were quite limited, even as they prepared for life after residency. This made for an interesting discussion, in any case, that was rather thought provoking. How does one try to convey the essence of community psychiatry in thirty or forty minutes, which was all that remained of the session after the preliminary part of our discussion? In response to one of the resident’s questions, I began to think about what makes community psychiatry community psychiatry. He talked about his clinical rotation, in which he saw public-sector clients in a community mental health center. He was scheduled to see patients every 15 – 20 minutes (as a resident!), and he focused on their medications. He wondered whether this was community psychiatry. I told him that to me this sounded like a cheap imitation. We talked about the fact that it was not just the population, the location, or the duration of contact that defined community psychiatry. “So what is it then?” he asked. After looking vacant and scratching my head a while, three words lingered. The first and perhaps most compelling was ethics. Community psychiatry embodies a particular ethos regarding the community and the people that we are involved with. Although there may be a great deal of variability within our ranks with regard to strategies we endorse for achieving our goals, I think what draws all of us to this work is a belief in social justice—that by improving the lives of those less fortunate in our society, we will improve the social environment for everyone. So it is not so much an altruistic impulse that attracts us to the populations we serve, but rather a sense that we can build a better community by becoming part of it. It is difficult to think of a single aspect of our work that is not informed by this ethical perspective, or of a single value defining community psychiatry that is not shaped by it. It gives us a distinct vision. When we engage in our clinical work, we see something other than an individual with an illness, we see someone who functions within a social context, and we understand that our obligation is to assist that person in his or her quest to be effective in it. Those who have been true community psychiatrists don’t need to transform their practice, because they already practice in a manner that promotes recovery. Respect for the beliefs and aspirations of others, tolerance for and appreciation of differences, promotion of autonomy and affiliation: these all flow from ethical underpinnings establishing the value of individuals and their social environments. That everyone in society deserves quality care is not something that requires debate. The second word that stayed in my mind was empathy. What sets community psychiatry apart is a different vision of the culture of the therapeutic interaction. So much of what we are exposed to in training and in thinking of the “doctor-patient” relationship are those things that separate us. We are led to believe that they are sick and we are well; they share their lives with us and we are aloof; they are passive, we are directive, etc. In reality, this we/they dichotomy is artificial, and we have much more in common than we have separating us. We all struggle with our fears, the uncertainty of what lies ahead and our ability to meet the challenges that will confront us, although the magnitude of the challenges we face may be distinct. Understanding our similarity and shared experience is the basis for respect and empathy, and enables us to join with our clients as partners in a common struggle. Coming to this realization may be a long and difficult process, but arriving there is what makes the “relationship” a healing tool more powerful than most of the medications that we prescribe. The third word is leadership. Armed with ethics and empathy, it is nearly impossible to avoid leadership roles; it is an obligation. The kind of leadership that I am thinking about here is obviously much broader than traditional concepts of leadership in hierarchical organizations. It is not necessarily a leadership that carries any authority or exerts any control, and in most cases it is most effective when it does neither. It is a leadership that is compelling because it is driven by vision and principle. It may be exerted on a number of levels, and in a variety of contexts. We can provide leadership in our relationship with individuals who engage our services by helping them to construct a vision for themselves: with our fellow clinicians through the examples we set, in administering our systems of care through a commitment to quality and an understanding of their dynamics, and for our profession by incorporating the ideals and values of community psychiatry into our practices I don’t know whether our discussion of these characteristics of community psychiatry won any converts that day, but it sure made me wish that I could be a community psychiatrist when I grew up.