

SELECT

Opinions of the

Ethics Committee

on

The Principles of Medical Ethics

OF PARTICULAR RELEVANCE TO TRAINEES AND EARLY CAREER PSYCHIATRISTS



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A Note About This Document

This document contains select Opinions of the APA Ethics Committee, which have been identified by the APA/APAF Fellows serving on the Ethics Committee during 2020 and 2021. The Opinions have been selected based on their perceived relevance to trainees and early career psychiatrists for whom this document is intended to provide ethical guidance.

All of the Opinions within this document are those of the APA Ethics Committee only. They do not represent official positions of the American Psychiatric Association. The complete *Opinions of the Ethics Committee on the Principles of Medical Ethics* and the *APA Commentary on Ethics in Practice* (2015) are both freely available on the webpage of the APA Ethics Committee (psychiatry.org/ethics). The *Commentary* is offered by APA as a tool to aid in understanding the complexity of psychiatric ethics and how they apply in different situations. *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (2013 edition), also available on the webpage, has been officially adopted by the American Psychiatric Association and is binding upon all members.

The Opinions within this document have been presented with their original letter and number identification as they appear within the complete *Opinions of the Ethics Committee on the Principles of Medical Ethics*; as a result, neither the individual opinions nor the chapters of this document appear in a consistent chronological or alphabetical order.

APA members who have a question on which they would like an opinion from APA's Ethics Committee on an ethical problem they are trying to solve may contact the Committee via email to apaethics@psych.org.

Principles of Medical Ethics of the American Medical Association

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1

A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

Section 2

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

Section 3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

Section 4

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

Section 5

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

Section 6

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

Section 7

A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Section 8

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9

A physician shall support access to medical care for all people.

Select Opinions of the APA Ethics Committee of Particular Relevance to Trainees and Early Career Psychiatrists

A. BOUNDARY AND DUAL RELATIONSHIP ISSUES

A.5

Question: May a psychiatrist hire a current or former patient?

Answer: It is not ethical to switch a doctor–patient relationship to an employer–employee one. For an ex-patient, the issue is exploitation of the former doctor–patient relationship, and, in most cases, such an arrangement would be unethical. (Section 2) (1990)

A.7

Question: Can I ethically solicit the support of my patients to advocate for political or societal issues that affect their health care?

Answer: Implicit in your question is the recognition of the conflict between Section 2, Annotation 2 (APA), concerning protection of the unique relationship psychiatrists have with their patients from influence outside of the treatment goals, and Section 7 (APA), dealing with our responsibility to strive to improve our communities by interpreting social forces that affect mental illness treatment. It is laudable for physicians to lobby for important political and social causes, especially for those affecting the health care of our patients. However, when we seek to engage our patients in these efforts, we must exercise utmost sensitivity to the susceptibility of patients to our influence, and their desire for privacy. Conversations about political matters may be appropriate in the clinical setting with patients and their families, but vigilance must be exercised to avoid abusing the doctor–patient relationship. Blanket solicitations of support, waiting-room materials, or generalized mailings about social or political issues are usually insensitive to the unique circumstances of each patient. Optional referrals to lobbying or advocacy groups (such as NAMI) might be an effective means to avoid potential inappropriate use of the doctor–patient relationship and allow for the strengthening of the patient’s freedom to choose how best to act. Finally, it is important for the ethical psychiatrist to ensure that his or her own personal needs or biases are not influencing the request made of the patient. Indeed, our own passions about a particular cause are best directed through our own advocacy work, rather than enlisting a patient’s assistance. See *Opinion 9.012, AMA Council Opinions, 2000–2001*. (Section 2) (2000)

A.10

Question: Is it ethical for a staff member in a psychiatric treatment facility to continue treating a patient that the staff member has brought criminal charges against? Similarly, is it ethical for a staff member to continue treating a patient when the staff member is or will be aiding in the criminal investigation and/or prosecution of that patient?

Answer: Either of these dual role situations would be fatal to the establishment or continuation of a mental health professional–patient relationship. The treatment relationship factors necessary – like trust, beneficence, empathy, and confidentiality – cannot genuinely exist in these two examples. It would be necessary to assign other staff members to work therapeutically with this patient preferably assigning the

patient to a separate unit with no contact with the staff member pressing criminal charges. While the need for a legal response to some patients' acts is at times necessary, the facility still has an ethical duty to provide reasonable and appropriate care for the patient. (Section 1) (2006)

A.11

Question: A clinic is partially supported by philanthropic donations. The psychiatrists would like to show videotaped testimonials of clinic patients to board members of their non-profit arm. Can psychiatrists approach specific patients to appear in this videotape, whether it is presented as a request or an opportunity? What about more widespread marketing of the clinic with such testimonials (using actual names and/or photographs)? Would it make any difference if someone other than the treating psychiatrist solicited the patient for this purpose?

Answer: The vignette presents a scenario that evokes problems of confidentiality, respect for a patient's autonomy, potential exploitation, and conflict of interest. Section 2.2 suggests that a treating psychiatrist should not ask a patient to participate in being videotaped if that activity is not related to treatment. The use of names and photographs of patients in marketing has the potential for exploitation and therefore requires careful attention. Institutions that want to solicit donations from patients should first create a clear policy about how to separate the fundraising activity from the clinical work. Clinicians should not be involved in requesting donations from their patients because that inserts the clinician's institution's needs into the patient-provider relationship, violating the fiduciary nature of that relationship. See *Commentary Topic 3.2.7*. (Section 2) (2009; Rev. 2017)

A.17

Question: Is it ethical for psychiatrists to see members of the same family as individual patients?

Answer: Because of the complexity of factors to be considered, there is not a hard and fast rule; each case should be weighed separately. Seeing multiple members from the same family may blur boundaries of the doctor-patient relationship. Depending on the dynamics in the family, there is the possibility of causing complicated feelings of guilt, resentment, or shame if one family member responds well to treatment but the other does not.

Even if a psychiatrist avoids the accidental disclosure of information heard from one patient to another patient from the same family, a patient may have doubts about the confidentiality of their treatment if they know the psychiatrist sees a relative. These doubts may interfere with the doctor-patient relationship and could lead a patient to withhold important information.

On the other hand, there may be a number of considerations that mitigate the above concerns. For example, psychiatrists practicing in rural areas, those treating underserved populations, and those with specialized expertise required by more than one member of the same family may reasonably treat members of the same family. In these instances, the psychiatrist should explicitly discuss concerns about boundaries and confidentiality at the beginning of treatment, and should remain vigilant about all of the potential ethical complications throughout the treatments. (Section 1) (2013; Rev. 2017)

A.20

Question: Is it ethical to perform an internet search on your patient?

Answer: Performing targeted internet searches on a patient is not, in and of itself, unethical. First and foremost, such searching of a patient should only be done in the interests of promoting patient care and well-being and

never to satisfy the curiosity or other needs of the psychiatrist. Also important to consider is how such information will influence treatment, and how the clinician will ultimately use this information. The psychiatrist should ask him or herself these questions before resorting to targeted internet searches.

Transparency in treatment relationships is an ethical virtue. Therefore, psychiatrists should make clear to the patient when information is obtained about them from the internet, and the specific source of that information. This also gives the patient an opportunity to potentially refute information obtained in this fashion. (Section 1) (2017)

A.22

Question: I perform court-appointed forensic evaluations in addition to operating a private psychiatrist practice. What can I, as an ethical psychiatrist, do in response to online reviews or ratings that are posted by someone whom I examined in a court-appointed forensic capacity if the review contains false information that gives the impression the person was treated as a patient by me and does not reveal the forensic nature of the examination. Is there anything I can do vis a vis (i) the rating site (e.g. yelp), which may require revealing details about the examination to request that a particular view be taken down as false in accordance with the site's terms of use, (ii) myself posting a response on the rating site, or (iii) taking any action against the person whose posted the false review?

Answer:

The Ethics Committee has published guidance on this topic in the context of a treatment relationship in its *Resource Document on Responding to Negative Online Reviews* (2019), and the content of that guidance is relevant. Given the forensic context of your involvement with the reviewer, you could request the rating site remove a false post by making a request that gives only a limited amount of personal information. For example, note to the rating site that the statements made in the review are false and there is a public record that proves so. It is not advisable for you to make a public response to a specific individual's review. But you could respond publicly online generally with a posting that does not respond to the claims made in any particular review, but provides information about your practice and the forensic context generally, such as:

"Out of respect for the legal and ethical obligations of physicians to maintain patient privacy, I will not respond publicly to any individual review. I take seriously the concerns of my patients with whom I have a treatment relationship and I encourage anyone who has had a negative experience as a patient with my practice to contact me directly at any time. But please be aware that in addition to treating patients, I also perform forensic psychiatric work where I am appointed by a court to examine an individual with whom I do not (and will not) have a treatment relationship. It is not uncommon for individuals for whom a court has ordered an evaluation to disagree with the conclusions of those evaluations." (Section 2) (2020)

A.23

Question: Is it ethical for a psychiatrist to do an internet search (including using databases such as Westlaw) about a prospective patient, before their initial appointment with the patient, and to then decide whether or not to accept them as a patient in part based on the search results? (For example, if the psychiatrist learns of something he/she/they finds objectionable or "scary" about the individual, the psychiatrist would cancel any appointment and not accept the person as a patient)?

Answer: The challenge for the ethical psychiatrist is how to properly balance the psychiatrist's own right to a safe workspace against our obligation to welcome diverse patients without bias. To that end, it becomes really important for the psychiatrist to form his/her/their own opinion after doing assessment of the prospective

patient. If after your first meeting with the patient, you decide you do not have the resources to safely care for them, it would be OK to work with the patient to refer them to a more appropriate setting. Making the decision to not see the patient based on info discovered through an online search without having a chance to see the patient to form your own objective judgement is problematic.

It would not be ethical to conduct an internet search of a prospective patient if the information obtained is going to be used for the purposes of deciding whether or not to accept the individual as a patient. It is not clear whether the information obtained via an internet search is necessarily valid and there is no opportunity for the patient to refute the information identified in the search if they are refused for care based on that information. APA's guidance on intern searches of patients advises that it is best to obtain the patient's informed consent before performing such a search, but obtaining the patient's informed consent is not possible if the psychiatrist has never met with the patient. In addition the APA guidance states that a search is unethical if not done to further the patient's best interests, but if the information is being used to screen out patients from treatment, this does not seem to comport with using the search for the patient's best interest. Pre-emptive searches used for this purpose can only prevent the formation of a clinician-patient relationship, not further it, and clearly could compromise treatment by preventing that it ever begins.

In addition, arbitrary decisions to exclude a person seeking mental health treatment based on information obtained through dubious means, which may or may not be correct, further stigmatizes and discriminates against psychiatric patients, penalizes such patients for behaviors that could be the result of mental illness and significantly decreases access to care. This is in direct contravention of Section 9 of the *Principles* which enjoins physicians/psychiatrists to "...support access to medical care for all people." Likewise, Section 1 states: "A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights". (Sections 1, 2 and 9) (2020)

A.24

Question: I am writing anonymously to request your recommendations about an ongoing concern I have about the emphasis my organization places on "patient satisfaction scores." At a large medical center, patients are sent member satisfaction scores after our outpatient visits. As psychiatrists we then receive these scores quarterly and there is even a "honor role" email sent out for those who score greater than 95% in patient satisfaction.

Is it appropriate for psychiatrists to be critiqued in this manner and also whether it's even ethical to aim for 90-95 plus percentage of patient satisfaction in psychiatry? Physicians have even been held back from partnership status as result of these scores. Also when thinking about the process of psychiatric and psychotherapy evaluations, my understanding is that often there is an element of tension created in the session and through that perhaps greater change and treatment can result i.e. it seems that very high patient satisfaction may not be a goal we should strive for. In particular I'm also wondering about cases when psychiatrists care for patients with personality disorders and addiction issues where setting limits and boundaries (of course in a compassionate manner) is necessary and that by not setting limits one would be perhaps essentially worsening the splitting of a personality disorder patient etc. So is it ethical for this large HMO to be pushing physicians to strive for very high patient satisfaction scores when this is connected with worse medical outcomes?

Answer: Within the field of medicine, patient satisfaction surveys have become increasingly common and are here to stay. Such surveys are not per se unethical, but there are considerations the ethical psychiatrists should remain mindful of.

To the extent patient satisfaction surveys are intended to measure whether psychiatric patients felt they were treated with dignity and respect, were seen on time and not kept waiting for too long, felt understood (and

listened to), whether the psychiatrist explained treatment interventions and alternatives to their satisfaction or whether the psychiatrist was knowledgeable, they offer a valuable tool for self-reflection and self-awareness on the part of the treating psychiatrist.

With respect to psychiatric treatment, a treating psychiatrist should be mindful of the possibility that transference issues could influence a patient's scores of a psychiatrist, positively or negatively. For that reason a single survey response may not be a reliable indicator of the desirability of a treating psychiatrist's overall approach. However, if a majority of patients score a psychiatrist negatively overall or on some of the measures being evaluated, a deeper evaluation or exploration of the psychiatrist's practice and approach is warranted.

In addition, ethical problems would arise if a psychiatrist were to always try to please the patient by pursuing treatment or a course of action contrary to the psychiatrist's better judgement, such as prescribing what the patient wants when not indicated in order to obtain great scores from the patient, or prescribing a medicine that may be harmful to the patient in an attempt to satisfy the patient. It would be unethical for the psychiatrist to put his/her/their interests ahead of the patient's best interests.

Further, psychotherapeutic best practice could be threatened if the psychiatrist were to focus more on the patient being pleased or happy than on pursuing the appropriate treatment goals on which psychiatrist and patient have agreed. This would also be the case if the psychiatrist routinely avoids respectful and gentle confrontation of the patient when needed so as to remain in the patient's good graces.

With respect to an organizational policy implementing and relying upon patient satisfaction surveys, an ethical issue arises for the treating psychiatrist when the psychiatrist is provided an incentive to do something which the psychiatrist believes may not be in the patient's best interest. The treating psychiatrist is obligated to put the patient's good ahead of the psychiatrist's own benefit, whether that benefit be status, advancement, earnings, etc. If asked or incentivized to do things more for their own or the organization's interests than those of their patients, psychiatrists should advocate within the organization by making the best arguments they can for organizational policy change (including arguments based on scientific data as well as on professional ethics). And, of course, there could be circumstances egregious enough that the ethical psychiatrist might need to consider leaving such an organization. (Section 1) (2020)

A.25

Question: I am a psychiatrist, I work in an Intensive outpatient/Partial Hospitalization program. I became romantically involved with a woman. Subsequent to our starting our relationship, she became aware of where I worked, and said her son had been a patient there. I did not recall her son's name. I looked at the record and found that I had seen her son once, 6 months ago, in coverage for a colleague. I made no changes in medication, and I did not speak to the patient's parents. We became aware of this after we had become involved romantically. What are my ethical obligations here? May I continue the romantic relationship?

Answer: While the ethical prohibition against romantic entanglements with patients is absolute and prohibits even the possibility of future romantic relationships with patients, the purpose of the ethical requirement is to prevent potential exploitation of a patient. Knowingly becoming romantically involved with a prior patient or significant third party (e.g. a relative or caretaker) would be unethical. Here, however, there does not appear to have been a risk of exploitation of the patient. The Ethics Committee panel recommends that the psychiatrist recuse himself from all discussions regarding the patient or his treatment now that he has become aware of the connection. If the psychiatrist takes that step his actions should not be in violation of the rule against relationships with former or current patients. (Section 2) (2020)

B. BUSINESS PRACTICES AND ANCILLARY PROFESSIONAL ACTIVITIES

B.1

Question: Is it ethical to market and offer a telephone referral and assessment service for adults who may be suffering from a mental disorder?

Answer: Yes, with the following cautions and provisos: (1) The use of such services calls into question the effectiveness of such modalities as a substitute for the clinical interview in a face-to-face setting. Research is incomplete in this area, and the ethical physician is obligated to support such interventions-by-telephone with clear scientific evidence of its clinical efficacy and limitations. (2) The confidentiality requirement must be met and the patient must be clearly informed of the efficacy and limitations of such telephone referral and assessment. (3) In addition, the billing for such services must be carefully approached to maintain the clearest contractual understanding with the patient. (Section 1; See also Section 2, Annotation 6, APA.) (1993)

B.3

Question: I have a question about psychiatrists treating patients who are established patients in the care of another psychiatrist, or another healthcare professional. For example, Patient X, who is in treatment with Psychiatrist Y, becomes suicidal, does not inform his/her doctor but instead overdoses and is admitted to the hospital. During that inpatient stay, hospital staff does not communicate with Psychiatrist Y. Moreover, the hospital psychiatrist tells the patient that the patient should stop working with Psychiatrist Y, and instead see a psychiatrist on staff of the hospital. The hospital staff does not encourage the patient to discuss this recommendation with the current doctor, and an appointment is set up with a hospital psychiatrist immediately following the patient's discharge. Has any wrongdoing occurred?

Answer: When a community psychiatrist refers a patient for psychiatric hospitalization, even when the outpatient psychiatrist does not initiate the patient's admission, it is customary and good practice for the outpatient psychiatrist to be informed of the patient's hospitalization by the inpatient team. Such notification respects interprofessional relationships and often yields useful clinical information for inpatient treatment planning.

It is also customary that the patient is redirected to the outpatient psychiatrist for follow up care after discharge. It should be noted, however, that the preference of the patient is relevant. A patient who has been admitted under the care of an inpatient psychiatrist may choose not to consent to the release of medical information to his/her outpatient psychiatrist, and also may choose not to return to this psychiatrist's care. When making such a choice, the patient is entitled to confidentiality. (Section 2) (2005; Rev. 2017)

B.5

Question: I am opening a new practice and want to put on my website my fees and that I will not be accepting insurances. I will print out claims forms for those people who want to submit claims themselves. Is it ethical to list the fees on the website -- in order to be straight-forward and clear?

Answer: Clearly stating one's fee and position regarding insurance assignment is consistent with Section 2, Paragraph 5, which advises the explicit establishment of the provisions of the contractual arrangement between patients and psychiatrist. In addition to posting this information on a website, it should also be a part of the contact with each patient. (Section 2) (2012)

C. CHILD AND ADOLESCENT PSYCHIATRY (Including Child Custody and School Issues)

C.1

Question: A couple I am seeing eventually divorces, and a bitter child custody dispute ensues. What do I do if one spouse asks me to testify and the other asks me not to? What do I do if I am subpoenaed?

Answer: For the first question, you cannot testify without consent from both parties because you are obligated to protect the confidences of both equally. If ordered to testify, you should raise the issue of confidentiality and explain why it would not be in the parties' best interest to testify; however, you may have no choice but to respond to proper legal compulsion. (Section 4) (1986, rev 2017)

C.4

Question: Is it ethical for a psychiatrist to treat one of his or her own children with psychotropic medication?

Answer: Section 6, Annotation 1 (APA) covers such situations. It states that "preservation of optimal conditions for development of a sound working relationship between a doctor and his/her patient should take precedence over all other considerations." Treating one's own child does not preserve the optimal conditions for a sound working relationship, and some states prohibit prescribing for one's family members. Exceptions would have to be compelling to overrule the general rule. (Section 6) (1993, Rev. 2017)

C.8

Question: I work in a hospital in an area with a sparse population of psychiatrists. In cases of emergency, I may treat adolescents on occasion. Despite the fact that I am not a child and adolescent psychiatrist, my employer has asked that that I begin to treat patients as young as 4 years old. I am concerned that it is unethical for me to provide this treatment because I lack training and experience with this patient population. However, although my employer has advertised for a child and adolescent psychiatrist, the facility has not been able to hire one.

Answer: Given that you do not have the education or training to practice with children below the age of 12-14, it would be unethical for you to do so on a regular basis. APA Ethics Principle 2.3 expressly states that a physician who regularly practices outside of his area of competence is unethical. Competence is determined by peer review boards or other appropriate bodies. The *APA Commentary on Ethics in Practice* Section 3.1.2 recognizes that professional competence means practicing within accepted standards of care, remaining current, and sometimes working with supervision and/or consultation. Professional competence includes recognizing the limits of one's skills and referring patients when possible or seeking consultation from a more experienced clinician on issues where the psychiatrist's competence is not clear. Section 3.4.5. notes that in small or underserved communities it may be ethical for a psychiatrist to practice outside of the usual scope of practice *if her training is closely related, there is urgency, and the psychiatrist possesses the most readily available relevant expertise*, but that in such a case the psychiatrist should have appropriate supervision and access to competent consultation.

Two ethical conclusions emerge from this. If you do not believe you are competent to handle certain ages of children even with ready access to consultation, it would be unethical to do it. If you do believe you can competently handle particular age groups, you should have ready access to consultation from a board certified child and adolescent psychiatrist (e.g. Skype, telepsychiatry, etc.) to be able to consult as needed to ensure the patient gets competent care. If there are cases where you are still not comfortable treating the patient, you need to refer them to a board-certified child and adolescent psychiatrist.

Given that you are not board certified in child and adolescent, it would not be ethical for you to assume this role unrestricted (e.g. without supervision or consultation) or to assume it at all if you are not comfortable that you can do it competently with expert consultation. If you do assume this position, it should only be temporary until a board-certified child and adolescent psychiatrist for the hospital can be found.

You should inform the hospital administration of your concerns regarding the request, as the hospital may need to reconsider what ages it can safely and ethically treat given that they do not have a board certified child and adolescent psychiatrist no matter how underserved the area is. The hospital could seek locum tenens child psychiatry coverage, or as a more immediate alternative seek a child psychiatrist via telepsychiatry. (Sections 1, 5) (2019)

D. CONFIDENTIALITY AND INFORMED CONSENT

D.3

Question: Does a psychiatrist have to inform a patient that the therapy session is being taped, or may the psychiatrist surreptitiously tape a session without the patient's knowledge and/or consent?

Answer: The psychiatrist, ethically, should inform the patient and allow the patient to refuse to have the session taped. Reference is made to Section 2 (AMA) which states, in part, "a physician shall deal honestly with patients and colleagues..." In addition, it may be illegal in some states to tape a session without the patient's knowledge and/or consent. One additional point is that the psychiatrist should give very careful consideration to how the tapes are stored and protected. (Section 2) (1981, Rev. 2017)

D.7

Question: May I use a videotape segment of a therapy session at a workshop for professionals?

Answer: Yes, under the following conditions:

1. The patient gives fully informed, uncoerced consent that is not obtained by an exploitation related to the treatment.
2. The proposed uses and potential audience are known to the patient.
3. No identifying information about the patient or others mentioned will be included.
4. The audience is advised of the editing that makes this less than a complete portrayal of the therapeutic encounter.
5. The patient must also be told that the confidentiality will be permanently altered. (Section 4) (1990; Rev. 2017)

D.13

Question: I work in a small college mental health clinic setting. On occasion we see patients who have had a recent relationship breakup with a partner that we also see or have seen in psychotherapy. Often the patient tells his/her story and forms a treatment relationship with the psychiatrist before the connection to the clinician's other patient is revealed. By revealing the conflict of interest to the new patient and referring him/her to a colleague, we risk breaching the first patient's confidentiality. We have generally proceeded with the new treatment relationship unless:

1. We find we cannot provide reasonably impartial or effective care, or
2. One of the two in therapy reveals that they know the other is/was also in treatment, in which case we are able to more openly address the conflict and make an appropriate referral if indicated.

What are your recommendations?

Answer: Working in a small college setting is like working in a small town, or an underserved area where there are a limited number of mental health clinicians available to serve the population. In such settings, conflicts of this nature are inevitable. The solutions you describe seem reasonable as they acknowledge the need to make

decisions on a case by case basis. In some cases, where the treatment is limited to psychopharmacology it may not present a conflict to treat both patients.

As you suggest, sometimes it is impossible to find a plan that will satisfy every ethical value. You are not required to do the impossible. Rather, your responsibility is to weigh the risks and benefits of the various treatment options, keeping the competing values in mind. Then, using clinical judgment, you make whatever reasonable recommendations you can to your patients. (Section 1) (2005)

D.14

Question: The psychiatrist has a patient who is an attorney. This patient has told him that she is a daily marijuana smoker, but has asked him not to note this fact in the medical records. Does this physician have an ethical obligation to record information that is medically/psychiatrically significant even when the patient requests otherwise?

Answer: The ethical tension in this case, and others in which patients request that information not be put in the record, is between obligations of truthfulness and competence on the one hand and beneficence, autonomy, and harm reduction on the other. In this situation, if the psychiatrist documents the substance use, there is a risk that the therapeutic alliance will be damaged and that the patient will not receive treatment. A psychiatrist may address this tension in this case by noting that the patient has requested privacy regarding questions about substance use, while continuing to work with the patient towards treatment goals. The psychiatrist should not place false information in the chart. In the case of clinically relevant information, the information should not be omitted without comment.

That being said, excessive details may not be helpful to patients generally, and specifically in this case. In situations in which not including the information in the record would pose a serious risk of harm or omitting information significant to present condition and current treatment that could compromise the patient's safety or effective treatment, the psychiatrist should inform the patient that he or she cannot continue treatment without documentation due to safety concerns. (Section 2) (2017)

D.17

Question: I am a psychiatrist interested in working with unaccompanied minors at the border. I've heard that the government may use records that I keep as evidence against my patients in deportation, asylum, and other related hearings. Is it ethical for me to provide treatment to minors under these circumstances?

Answer:

Trust between a psychiatrist and a patient is a cornerstone of the patient-doctor relationship. This trust derives from the psychiatrist's responsibility to keep the patient's treatment private so the patient can be truthful and forthcoming about deeply private symptoms and events affecting their care. In this context of trust and care, the psychiatrist's primary obligation is to the patient so that the psychiatrist and the patient collaborate towards the therapeutic goal of the mental health treatment. This therapeutic frame derives from principles of beneficence, nonmaleficence and respect for persons.

Psychiatrists are trained specifically to elicit information from their patients in support of diagnosis and treatment. This information is gathered by the psychiatrist in the patient's clinical interest. Nonetheless, limited exceptions to confidentiality do exist. For example, if a patient shares information concerning risk of harm to the patient or a third party, the psychiatrist may have a duty to disclose information to another clinician or appropriate authority to prevent a future harm. The patient's past acts of harmful or criminal conduct are confidential in the physician-patient relationship unless directly relevant to a present or future known risk or, in some jurisdictions, the investigation of a crime. Even when legal and ethical permission is granted for sharing otherwise confidential information, both law and ethics support sharing the minimum amount of information necessary to prevent harm. If the psychiatrist is treating the patient in a clinical setting, then, the psychiatrist may not share the confidences of the patient unless during the encounter the psychiatrist learns that the patient may be a danger to his or herself or others, or present a safety risk to the detention center. See *Annotations*, Section 4 #8. This limit on confidentiality does not permit the psychiatrist to act as an agent of the government in sharing information adverse to the patient's immigration interest; such activity would be a political misuse of psychiatry to assemble information to enforce immigration and asylum law. See *Position Statement on Abuse and Misuse of Psychiatry*, American Psychiatric Association (2019) ("Abuse and misuse of psychiatry occur when psychiatric knowledge, assessment, or practice is used to further organizational, social, personal, or political objectives without regard to individuals' needs and outcomes"). The *APA Commentary on Ethics in Practice* (CEP) makes this point clear: "Psychiatrists should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of detainees on behalf of military or civilian agencies or law enforcement authorities." CEP at Topic 3.4.10.

When considering the ethical considerations that apply to evaluating and treating minors in detention, it is important to note that the 1997 settlement in *Flores v. Reno* mandated that unaccompanied minors in immigration detention receive an initial assessment to determine whether they have special needs, including mental health needs, and that they receive at least one individual counseling session per week to review their progress, establish short-term objectives, and address both their developmental and crisis-related needs. Programs are charged with preserving and safeguarding confidentiality of individual client records. Stipulated Settlement Agreement, *Flores v. Reno* (1997) at 5 & Exhibit 1 at 2-3. The *Flores* settlement contemplates the establishment of a confidential treatment relationship to address the mental health needs of the minor.

The *Washington Post* has reported that the Office of Refugee Resettlement (ORR) has been implementing an agreement between it and the U.S. Immigration and Customs Enforcement (ICE) by providing notes or reports of clinical therapy sessions with unaccompanied minors to ICE, which then, in turn, has used the information gained in therapy against the unaccompanied minors in deportation hearings and related proceedings.

It is not ethical to provide clinical treatment of minors in immigration detention centers without preserving the confidentiality of that treatment and ensuring the patient's understanding of any limits of confidentiality as described above. Treatment confidentiality is compromised if clinical information is used for any reason other than the clinical or safety interest of the minor patient. A deportation or similar proceeding, by contrast, may well be contrary to the patient's interests. An interagency agreement to share information does not change the ethics of a physician's duty to maintain the confidentiality of a patient's information.

Some may argue that the unique legal setting of an immigration detention facility transforms the psychiatrist's role into a forensic one. A forensic evaluation is different from the clinical evaluation required by *Flores*, however. A forensic assessment is not made for the benefit of the patient, but rather at the request of and for the benefit of the court or identified third party. It is conducted either with informed consent or under explicit legal

authorization. In such assessments, there is no expectation of treatment or of forming a patient-psychiatrist relationship in the interest of treatment. Indeed, in forensic evaluations the individual being evaluated is not referred to as a patient, but rather as an evaluatee in explicit acknowledgement of the non-clinical nature of the encounter. Further, prior to any forensic evaluation, the psychiatrist is ethically required to describe to the evaluatee the purpose of the evaluation, indicating that information divulged during the evaluation is not confidential and is intended for use in a legal proceeding.

Moreover, because the subjects addressed in this question are children, an additional ethical consideration is whether traumatized minors are even capable of providing informed consent, especially for a high-stakes interview. In the case of a psychiatrist's intervention for treatment of an unaccompanied minor, relying upon the minor's agreement to intervention is less problematic due to the primary beneficence and nonmaleficence ethical considerations, especially in the absence of a parent or other adult advocate. However, under the facts presented, in requiring disclosure of a patient's therapy notes, ICE is not acting in *parens patriae* because its use of treatment records to the youth's detriment is not in the best interest of the child. Accordingly, there is doubt that an unaccompanied minor in an immigration detention setting, could provide informed consent to disclose information adverse to their own case.

In summary, if you would be required to share your clinical treatment notes, it would be better that you not participate in evaluating minors in immigration detention. A psychiatrist should not become an agent of the state to the detriment of a patient. It eradicates the trust that patients must have in their psychiatrists. Participating in the evaluation of minors in immigration detention under these circumstances undermines the cardinal principles of beneficence, nonmaleficence and respect for patients, and would be unethical. (Sections 2 & 4) (2020)

F. ETHICS PROCEDURES

F.5

Question: I have personal knowledge that a colleague has behaved unethically with one or more patients. The patients are unwilling to bring an ethics complaint. Is it possible for me or any other psychiatrist who has such knowledge to bring an ethics complaint?

Answer: Yes. Indeed, The Principles of Medical Ethics include the admonition that an ethical psychiatrist's obligation is to recognize and address the unethical behavior of colleagues. As mentioned in the answer to question E2c, the psychiatrist must do something. Options for addressing the behavior include but are not limited to seeking supervision, discussing conduct with the individual and/or reporting to appropriate authorities, including DB ethics committees. An ethics complaint clearly is an option and may well be warranted. The purpose behind this admonition is to lessen subsequent unethical behavior. Further, if there is extrinsic evidence such as a report of a malpractice suit that includes unethical behavior, a district branch ethics committee as a whole may bring an ethics complaint. (Section 2) (1993; Rev. 2017)

G. FORENSIC ISSUES

G.1

Question: Is it ethical for an employed psychiatrist to perform an evaluation to determine the competency of a patient to assist his hospital employer in collecting charges made to the patient?

Answer: No. This is clearly a situation involving a conflict of interest. Any such evaluation should be performed by a psychiatrist who has no financial relationship to the hospital. An evaluation intended to be used against the patient by a doctor at the same hospital where the patient was treated too easily would lead to confusion about the role of the doctor by the patient. (Section 4) (1973; Rev. 2017)

G.13

Question: Can a psychiatrist evaluate a prisoner (i.e., patient) for the state and then determine that the prisoner requires involuntary hospitalization?

Answer: Yes. In this determination, the psychiatrist must do a proper psychiatric examination to ensure that the person meets the clinical criteria for involuntary hospitalization. It is important at the outset for the psychiatrist to make clear to the person to be examined the nature, purpose, and lack of confidentiality of the exam. The established criteria for involuntary hospitalization should be cited in the report to the court. (Section 4) (1994; Rev. 2017)

J. MILITARY AND OTHER GOVERNMENT AGENCIES

J.3

Question: A patient gave a signed release for me to respond to a government intelligence agency in the process of seeking a security upgrade. I refused as I believed this was an improper invasion of the treatment, and I do not believe the patient is a security risk. Was my action ethical?

Answer: If the patient knowingly and without coercion gave his or her consent, the privilege of maintaining or not maintaining his or her confidences is the patient's, not yours. There may be coercion here (no release, no security upgrade), but that is the patient's choice since presumably the upgrade is to his or her advantage. Your last point raises another issue: are you, or psychiatrists in general, knowledgeable and skilled in determining security risks? Clearly, any deception on your part, or the offering of an incompetent opinion, could be a violation of Section 2 (AMA). (Section 4) (1986)

K. PAYMENT, FEE AND FEE SPLITTING ISSUES

K.1

Question: A new psychiatrist in town who works for a local clinic needs a part-time office where he can start up his private practice. To help him, I told him he could use my office in the evenings and pay me a small percentage of his billings. Is this ethical?

Answer: The proper arrangements are to negotiate a reasonable charge for the use of space, secretarial coverage, and other expenses. Greater use, or lesser, would require renegotiation of what constitutes reasonable charges. Though the agreed-upon amount might be similar to what would have resulted from a percentage arrangement, the appearance of fee splitting—the office owner benefiting from referring patients to the new psychiatrist—would be avoided. (See Opinions 6.02 and 6.03, *AMA Council Opinions*, 2000–2001.) (Section 2) (1975; 1976; 1978; 1984)

K.3

Question: Is it ethical for psychiatrists to charge for telephone calls from their patients?

Answer: Psychiatrists can ethically charge for phone calls. Factors for psychiatrists to consider in determining the ethical appropriateness of these charges include whether the charges are reasonable for the services provided, whether they are explicitly established, and whether such charges would create an undue burden for patients seeking appropriate and timely care. (Section 2) (1976; Rev. 2018)

L. PHARMACEUTICALS

L.3

Question: If the FDA has provided a package insert saying that the drug is contraindicated in patients with particular presentation of their illness, would it be ethical to provide the patient with that drug if it is the only drug that has been effective on one of the patient's multiple diagnosis in the past. Does the answer differ if the patient has never been on the drug before? What are the ethical issues that the prescribing physician needs to be aware of?

Answer: The ethical question is not whether a drug should ever be used in a patient without full FDA approval; instead it is whether the psychiatrist has conducted a thorough patient evaluation and history in addition to researching the particular medication in light of that evaluation and history and discussed the potential effects with a patient who has given consent.

Many of the medications psychiatrists prescribe (e.g., anticonvulsants for bipolar disorder) are not FDA approved. We give medications with black box warnings, that are "off-label," or that pose a risk of potential serious harm (e.g., clozapine, lamotrigene) in carefully evaluated clinical situations. "Contraindication" is a relative term, and there is a gradient ranging from "use with caution" to "absolutely contraindicated."

Sometimes, when there are few alternatives, the patient may be willing to assume high risks, especially in the face of no other alternatives, particularly if there is high risk without treatment, or large potential benefits. Obviously, the risk/benefit analysis would be aided by knowing that a patient has responded to the medication in the past.

The psychiatrist should conduct a thorough exam; examine the family history and the patient's history concerning that specific medication; and discuss the case with a colleague or supervisor, after having referenced current literature concerning off-label use of that specific medication. If such an evaluation indicates that off-label use of a drug would be the patient's best option, then competent patients should be fully engaged in a discussion of the risks and benefits of a medication as well as your thinking regarding the analysis of those factors. The patient should be educated about why a drug might have a contraindication, what are the potential adverse consequences of using it, what are the risks and benefits compared with alternatives or no treatment, and how past experience with the medication (when that exists) might figure into the calculus.

Thus, the ethical issue is not in WHETHER to prescribe a medication in some circumstances, but HOW the prescribing of that medication is decided upon by the psychiatrist and presented within the clinical encounter, and the self-determined willingness of a competent patient (or his/her proxy) to assume that risk.

It would be wise for legal reasons for the psychiatrist to document the research conducted and the patient discussions, and even to have all the considerations written out and then have the patient give informed consent in writing in particularly risky situations when working with an FDA-listed "contraindication." (Section 5) (2016)

N. PRACTICE ISSUES

N.4

Question: Is it ethical for a psychiatrist to admit and treat staff members or their families in the hospital where the staff member works?

Answer: It is ethical if the patient wishes to be treated in this hospital and there are limited options in the community. Ideally, separating the treatment role from the co-worker role is a good idea in order to maintain boundaries that allow for more effective treatment and better protect the patient and his or her family's confidentiality. The options should be discussed with the patient, to achieve informed consent. (Section 6) (1985; Rev. 2018)

N.5

Question: What are my obligations as a treating psychiatrist if I disagree with the recommendations of the psychiatric unit director?

Answer: By virtue of their activities and roles, psychiatrists may have competing obligations that affect their interactions with patients when they also have responsibilities to other entities, including the institutions by whom they are employed. The treating psychiatrist has a primary, but not absolute, obligation to the patient. Psychiatrists should remain committed to prioritizing patient interests as treating physicians, expecting that they will find themselves in the position of having to reconcile these interests against other competing commitments and obligations. In the setting of an inpatient unit, the psychiatrist must provide competent treatment to the patient in accordance with the standard of care. In a circumstance in which care is denied by a supervisor, the psychiatrist must advocate for the patient's care and best interest, understanding that competing institutional and systemic considerations may limit available treatment options that extend beyond established standards. In situations in which the treating psychiatrist opines that such limits would pose a danger to the patient or fall short of competent care, the psychiatrist should appeal supervisory decisions in accordance with institutional policy, such as to a director of clinical services or chief. Where no appeal is available, the psychiatrist still maintains an obligation to the patient that may be fulfilled by informing the patient of treatment recommendations and/or alternatives and seeking appropriate referral. *See APA Commentary on Ethics in Practice, Topic 3.1.3.* (Section 2) (1986; Rev. 2019)

N.7

Question: I recently terminated therapy with a very troublesome patient after providing proper notice and choices of alternate treatment. The patient continues to harass me with endless vituperative phone calls. For the telephone company to intervene, I will have to provide the patient's name. Can I ethically do this?

Answer: Confidentiality does not prohibit the psychiatrist from reaching out to the patient via an attorney to request that the patient stop the harassing actions, and to inform the patient about possible reporting to authorities within the law. It would be lawful and ethical for the physician to inform the telephone company of the harassing phone calls, without disclosing that the harassing individual was a patient; this could be done in a way that does not reveal any significant aspects of their therapeutic relationship other than the patient's name. A patient's rights of confidentiality do not preclude the rights of the physician to be free from harassment or other illegal, threatening behaviors. The treating psychiatrist should also consider other potential issues related to his or her personal safety. (Section 4) (1988; Rev. 2019)

N.8

Question: Is it ethical for a supervising psychiatrist to sign a diagnosis on an insurance form for services provided by another professional that he or she is supervising and when the supervising psychiatrist has not examined the patient?

Answer: Section 5, Annotation 3 (APA) clearly states that the supervising psychiatrist must expend sufficient time to assure that proper care is given and not allow the role to be that of a figurehead. What is required differs among public payers such as Medicare and Medicaid, and among private insurers. The ethical psychiatrist must not engage in abuse, deception, or waste of public resources. (Section 5) (1988; Rev. 2018)

N.13

Question: My public hospital requires me to assume more clinical responsibility than my salaried time allows me to manage competently. Is my attempt to do this unethical?

Answer: Your first effort should be directed at getting the hospital to remedy the situation. That failing, you might feel compelled to resign. If you remain and do your best, you are behaving ethically. For us to declare otherwise might place an even greater burden upon our underfunded public institutions. (Section 1) (1990)

N.32

Question:

What are the ethical considerations in the use of mobile mental health apps in the care of patients?

Answer:

Technology is continuously and rapidly advancing. This includes both the hardware and software available and the ways individuals might use them. The surge of innovative models has raised promise for increasing access to healthcare. One of these innovations is the use of mobile health apps. Many mental health professionals are having conversations with their patients and colleagues regarding the usefulness of mobile health applications in the delivery of care to patients or have already begun using such applications. Per Henson et al, there are “over 325,000 [apps] to choose from across all health domains.” But within this booming industry, many questions are raised regarding how to determine the appropriate applications to use, the ethical concerns surrounding mobile health app use, and how to effectively use these apps in treatment, especially in providing mental health care.

Clinicians should always consider ethical principles when providing clinical care to the patients they serve. With regard to the use of mobile health technology in their everyday practice, mental health providers should judiciously review the pros and cons of any device or applications, especially paying attention to potential legal and ethical risks, such as HIPAA or HITECH violations.

If clinicians choose to consider the use of any mental health app to aid in the care that they provide, how would they find the best one? The American Psychiatric Association (APA) has developed a model for app evaluation, which psychiatrists and other clinicians can use with their patients to evaluate apps that the clinician and patient may consider. This model is set up as a hierarchical rating system that provides some guidance questions to think about and discuss with your patient when choosing an app. Such questions center around major themes like Privacy/Security, Ease of Use, and Evidence. For more information and examples of how to use the model, please view the “App Advisor: An American Psychiatric Association Initiative” at <https://www.psychiatry.org/psychiatrists/practice/mental-health-apps>.

In considering the use of mental health apps, here are a few of the key matters related to ethical principles that psychiatrists and other mental health professionals should consider and discuss with their patients.

Confidentiality remains a key principle for psychiatric care. Consider the privacy and security of the app. What data will be collected? What safeguards are in place to protect the information stored by the app? Patients should be confident that personal health information and other personal information will be secure. Torous et al (2019) have recommended that standards be developed and agreed upon regarding data safety and privacy, that apps have transparency of their data storage, use, and sharing practices, and that patients have an option to opt out of data storage and uses that they find objectionable.

Beneficence and non-maleficence: Psychiatrists have ethical obligations to strive to benefit their patients and to prevent harm. In evaluating apps, psychiatrists and their patients should consider: What benefits could be expected from using this app? What is the evidence that has been gathered for the benefits and possible harms of use? A recent literature review (Gould et al, 2019) addressing mental health apps created by the Department of Veterans Affairs or the Department of Defense found support for the feasibility and acceptability of the apps, but scarce research support for efficacy and effectiveness, with a few exceptions. Clinicians were advised to not overstate the potential for benefits. However, there is substantial ongoing research on the benefits of using mental health apps, and the evidence for these benefits can be expected to grow.

Autonomy, truthfulness, and the doctor-patient relationship: What would be the patient's and the psychiatrist's goals in using an app? How do these goals conform or not conform to each other? What are the psychiatrist and patient committing or promising to do?

This last matter is especially important. Patients may hope, for example, that their entering data into the app will convey important information to the psychiatrist on an immediate or short time-frame basis, and that the psychiatrist would see and respond to anything of importance. Psychiatrists should be clear about what will actually occur. For example, they should clarify that they will not be continually monitoring or regularly reviewing input from the patient. Rather, they might review data and questions at their regularly scheduled contacts. Psychiatrists may wish to specifically direct that with urgent or emergency concerns, the patient should contact the psychiatrist according to the psychiatrist's standard methods and not depend on the app for such communications.

Even with the new avenues of receiving some care with technology, one must understand the possible limitations it may place on the psychiatrist-patient relationship. A traditional relationship between a physician and patient relies on trust, discernment, availability, and confidentiality (except in certain circumstances such as patient safety). Current research studies indicate several pitfalls with the use of apps, including accessibility and adherence by the patient and physician. There will be challenges in finding apps that are useful and practical for both the patient and clinician. Any clinician willing to use mental health applications should carefully consider how they will be used and have a thoughtful conversation with their patients regarding their use.

Before they embark on innovative technology usage in practice, we advise that clinicians consider the potential liability connected with such usage and engage in an *informed consent* process with the patient, including disclosure of any financial interest the psychiatrist may have in the app. The app is an aid to the overall care delivery for the patient and not a replacement of the interactions with the provider. There is also some potential for boundary crossings or violations when the therapeutic relationship steps outside the confinements of a traditional setting.

Some psychiatrists or other clinicians may experience pressure or even mandates from employers or insurers to use particular apps with patients in their practice. How should the professional respond to such pressures? The psychiatrist should still evaluate the app in a similar way that they would if they or the patient were proposing use. If in their review they found issues with the app that made use ethically questionable, they might have some obligation to resist pressures or mandates to use the app. For example, the psychiatrist might ask for or insist on discussing the ethical issues among the parties involved. Arguably the patient should know about the treating clinician's concerns and provide informed consent to the use of the app with knowledge of these concerns.

Experts advise that the APA, the AMA, the British National Health Service, and other international organizations should develop consensus standards for mental health apps addressing such issues as data safety and privacy, efficacy and effectiveness, user experience and adherence, and data integration in health records. Much of this work is already underway. In addition, there is the potential for user participation in the development and oversight of apps, and for physician and other clinician cooperation and alliance in this development and oversight. Such collaboration can increase the likelihood of achieving the promise of mental health apps and other technology to increase access to effective mental health care.

Given the rapidly evolving nature of this topic, here are some additional references that psychiatrists may find useful: (1) American Psychiatric Association. App Evaluation Model. Accessed February 26, 2020. <https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model>; (2) Gould, C. E., Kok, B. C., Ma, V. K., Zapata, A. M. L., Owen, J. E., & Kuhn, E. (2019). Veterans Affairs and the Department of Defense mental health apps: A systematic literature review. *Psychological Services, 16*(2), 196–207. <https://doi.org/10.1037/ser0000289>; (3) Henson P, David G, Albright K, and Torous J. Deriving a practical framework for the evaluation of health apps. *The Lancet*. 2019;1: e54; (4) Lustgarten SD, Elhai JD. Technology use in mental health practice and research: Legal and ethical risks. *Clin Psychol Sci Pract*. 2018;25: e12234; (5) Mohr DC, Weingardt KR, Reddy M, Schueller SM. Three Problems With Current Digital Mental Health Research . . . and Three Things We Can Do About Them. *Psychiatric Serv*. 2017;68(5):427-429. doi:10.1176/appi.ps.201600541; (6) Torous J, Andersson G, Bertagnoli A, et al. Towards a consensus around standards for smartphone apps and digital mental health. *World Psychiatry*. 2019;18(1):97-98. doi:10.1002/wps.20592. (Section 5) (2020)

O. PROFESSIONAL LISTINGS, ANNOUNCEMENTS

O.2

Question: Can an ethical psychiatrist list himself in a professional directory?

Answer: While the answer to this question is generally yes, one is advised to seek guidance from the local medical society on all matters related to what can be broadly called advertising. Certainly it would be unethical for the psychiatrist to misrepresent himself or to make fraudulent claims. Deception of the public by misleading, inflated, and self-laudatory claims is to be avoided. (See Opinion 5.02, *AMA Council Opinions*, 2000–2001.) (Section 2) (1978)

O.3

Question: I plan to purchase a solo psychiatric practice and request information on the ethical aspect of this situation. What sort of notices can be sent to other physicians and how can I indicate that I am taking over a practice?

Answer: It is ethical for you to send an announcement to other physicians and agencies from whom you expect referrals that you are taking over another doctor's practice. If you have questions about the format, your local medical society should be consulted. For additional guidance see Opinions 7.03 and 7.04, *AMA Council Opinions*, 2000–2001. (Section 2) (1980)

O.4

Question: May I send out notices to doctors and lawyers in my neighborhood stating I would appreciate referrals?

Answer: Yes, as long as the notices are not deceptive, misleading, or false. Claims of unusual or special competence would be improper. (Section 2) (1990)

P. REFERRAL PRACTICES

P.1

Question: Is it ethical for a psychiatrist to refer a patient to a qualified mental health professional who happens to be his wife?

Answer: Yes. However, the psychiatrist has the same ethical responsibilities in making that referral as he would have if the person were not his wife. He cannot refer cases requiring medical care to her, nor can he give her only token supervision. He should also make clear to the patient that the referral is to the spouse. (Section 5) (1976)

P.3

Question: Is it ethical for a psychiatrist to continue to see a patient in his or her private practice whom the psychiatrist began seeing as an employee of a public clinic? Can other professional members of the clinic refer patients to the psychiatrist?

Answer: The issue is what is best for the patient, rather than for the physician or the clinic. Patients must have the right of free choice of their physician. See Opinion 9.06, *AMA Council Opinions*, 2000–2001:

Free choice of physicians is the right of every individual. One may select and change at will one's physicians, or one may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care.

It is important to ensure that the patient's choice is an informed and voluntary choice. It is the responsibility of the treating psychiatrist to inform the patient of the potential disadvantages – as well as any advantages – of transferring care to a private clinic, including coordination of care, other services provided, and availability of urgent care services, for example. The psychiatrist should avoid any actions that could be construed as initiating or encouraging such a transfer of care. (Section 6) (1979; 1981; 2019)

Q. RESEARCH AND SCHOLARLY ACTIVITIES

Q.4

Question: Would it be ethically appropriate to write a paper on the crucial nature of leadership, including political, without naming names, to address an important issue (such as the growing threat of global warming)?

Answer: Yes, it could be ethically appropriate to write a paper on the crucial nature of leadership, including to address the growing threat of climate change. Commenting in general terms about leadership qualities that would be desirable to make a difference in a policy area would be legitimate and appropriate, *provided that* the comments about the individual are not based on medical knowledge or training.

The Goldwater Rule applies to professional opinions related to individuals one has neither the clinical basis nor the permission to discuss publicly. Talking about what one wishes to see in a leader and what it would take to make a real difference in climate change or any other policy area is perfectly legitimate - provided it does not make any statements about individuals which would require the speaker to call upon his/her medical knowledge or training.

Identifying an individual as having particular behavior traits that suggests the utilization of psychiatric expertise to support an opinion of the identified leader or casting the author's comments in psychiatric terms that would suggest a professional evaluation of issues and personalities involved would not be appropriate. (Section 7) (2018)

Q.5

Question: Before I write about case material in the scientific and professional literature, what ethical considerations should I take into account?

Answer: When publishing case material, the guiding ethical principles to be balanced are respect for persons and scientific integrity and advancement. Historically, ethical publication consisted of adequate disguise of details to preserve the anonymity of individuals involved. Section 4, Annotation 3 (APA) states: "Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved." However, the problem of disguising is not always easily resolved, and close friends, family members, or the patients themselves might still recognize details of the case. Best ethical practice has evolved to include obtaining consent from any patient who is written about in the professional literature. Part of the informed consent process may include sharing the manuscript with the patient prior to publication. There may be rare times when it is not feasible or possible to obtain consent (such as an unbefriended patient for whom there is no known contact) but scientific integrity and advancement nonetheless strongly support publication. The psychiatrist must always consider alternative means to respect persons when making decisions about publication. (Section 4) (1976, 2020)

R. RESIDENT, STUDENT AND OTHER TRAINEE ISSUES

R.3

Question: In a training program in psychotherapy, do trainees need to obtain informed consent from patients in order to present the patient's therapy in class discussions and in supervision groups?

Answer: No, provided that the patient's confidentiality and identity are preserved and patients are aware of the supervisory processes. In addition, the confidentiality of the material presented, even if deidentified, should be a condition of the supervision. (Section 4) (1993; 2019)

R.6

Question: As a resident, it can be daunting to provide care to a patient who is reporting suicidal or homicidal ideation with accessibility to firearms. Given the recent political climate around firearms and mental health, how do we navigate discussing firearm safety while balancing patient risk?

Answer: As mental health professionals, psychiatrists have an ethical and clinical responsibility to discuss firearm safety with their patients. This has become increasingly relevant as gun violence that includes both homicide and suicide has reached new heights during the COVID-19 pandemic.

The burden of gun violence in the US not only outpaces all other developed nations, but is a matter of social equity because it disproportionately affects young adults from minoritized groups.² Among non-Hispanic Black persons between ages of 15-24, for example, guns are the leading cause of death.³ Firearm use in both suicide and homicide costs the US roughly \$280 billion annually.⁴ Recent data published by the CDC reveals that 54% of gun related deaths were suicides, while 43% were homicides.⁵ To be clear, the vast majority of individuals with mental illness are not violent, and studies repeatedly show that mental illness contributes to only approximately 4% of all violence. This is important, as it contradicts public perception that gun violence and all other forms of violence are caused by mentally ill individuals, which further stigmatizes our patients. Nevertheless, since gun violence is a public health issue, psychiatrists must participate in its prevention by addressing it with their patients, especially suicidal patients in whom access to guns increases the risk of completing suicide.⁶ Moreover, psychiatrists can address prevention through legislative advocacy. Legislative efforts like the 2022 Safe Communities Act underscore the importance of the issue of gun safety in communities and neighborhoods.⁷

Consequently, discussions of firearm safety must have a place in patient-physician collaborations. This is not only because firearms pose a risk to household and family members as well as patients, but because public health solutions like legislation, safety locks, and gun safes are available.

Given the importance and prevalence of gun ownership, psychiatrists can remain empathetic about the cultural norms and values of gun-owning patients and communities. A caring and non-judgmental psychiatrist is both collaborative and culturally sensitive, using therapeutic rapport to keep patients safe. Psychiatrists should familiarize themselves with the literature that identifies persons with a history of intimate partner violence, substance use disorders, or homicidal or suicidal ideation as particularly worthy of attention when discussing firearm safety.⁸

Ethical principles including beneficence, fidelity, and nonmaleficence support decisions affecting patient safety. Offering counseling and information in a respectful manner results in informed decision-making. The duty to initiate safety discussions overcomes any sensitivity practitioners and patients may have in addressing such a personal issue. Patients with a risk of violence may consequently require practitioners to consider access to weapons alongside the usual Tarasoff obligations. Addressing access to guns should consequently be part of a psychiatrist's risk assessment.⁹

When discussing firearm safety with patients, psychiatrists can therefore keep in mind a number of professional commitments to patients and their families. These may include discussing the risks associated with

firearm ownership and strategies for reducing those risks, as well as consideration of the patient's cultural and personal values. (Section 1; Section 5; Section 7; Section 8) (2023)

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