

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (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

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*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

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 issues 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)

**Recent Opinions of the APA Ethics Committee on  
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**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)

**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

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

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

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

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)

#### **H.10**

##### **Question:**

am a longstanding APA member and have a question that has arisen within my professional practice circles, and I wonder if you have input. The issue has been raised that, given concerns about police brutality/racism, perhaps police transport of patients from our clinic to local hospitals, if they are in need of inpatient psychiatric hospitalization, is insensitive and inappropriate. Typically our protocol has been use of police transport, and it has gone well (no handcuffs, generally our police are kind, etc). However, I've heard some interest from colleagues about looking at other options for transport. I imagine many pros and cons to this. Dereliction of standards of care, medicolegal risks if something goes wrong, risks with use of transport services that might be less equipped/experienced in transporting patients with psychiatric needs, non-police perhaps not being authorized to use restraint if necessary for safekeeping, etc all are concerns that come to mind. Does the APA Ethics Committee have thoughts on this? We wish to have sensitive protocols in place but also provide high quality treatment in line with standards of care.

##### **Answer:**

The transport of patients in crisis is part of the continuum of psychiatric care. As such, the focus of any transportation decision must focus on the clinical needs of the patient, taking into account safety as essential to care. While in general, transport of patients with mental illness and/or patients in crisis by police has the potential to be stigmatizing, demeaning, fear-inducing and/or traumatic for the individual patient, it may be necessary as the only available and feasible alternative to ensure safe transport. However whenever possible, alternative means of transport (including, for example, voluntary patients being taken by chair car, and involuntary civil patients being taken by ambulance with an involuntary commitment form and/or emergency certificate authorizing the use of a hold during transport) are preferable alternatives. As a rule of thumb, using the police as adjunctive support to clinically-trained personnel is preferable to using police as the sole provider of patient transport to the next site of care.

Options for transport of potentially violent patients may include having providers and supports to encourage the patient to cooperate with ambulance transportation, or giving medication to aggressive patients to decrease agitation and then proceeding with transport by ambulance. If neither of those possibilities is available for a particular situation, police may need to be involved in transport of an aggressive patient, preferably in conjunction with clinically trained personnel and only as a last resort the sole provider of transport.

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

In the ideal world, where police departments are called to transport agitated psychiatric patients, they should respond with a mental health professional or at a minimum emergency medical personnel. In the absence of that, Crisis Intervention Team (CIT) training for police officers should be implemented. If possible, involvement of police officers should be the last resort, utilizing a risk management approach as referenced above. (Sections 1, 2, 3, 7 and 8) (2020)

**K.22**

**Question:**

I would like clarification about what would be considered fee splitting. Specifically, how does it apply to arrangements where a psychiatrist is hired by a group to do evaluations and the group bills their client, for example a law firm or an insurance company, a fee from which they pay the doctor and from which they deduct a portion for themselves for the administrative and billing services they provide? Would the doctor be fee splitting?

**Answer:**

When it comes to questions about fee-splitting, the answer will often be “It depends upon the details.” The core understanding of fee-splitting, which is regarded as unethical by the APA, the AMA, and many specialty organizations, is a payment for a referral, from a physician to another physician, or from physician to institution or vice versa.

AMA Opinion 11.3.4 states “Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.”

In APA Annotations, Section 2:

*7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)*

With regard to the question posed: It isn’t unusual or unethical for a psychiatrist to be employed by a group or contracted as an independent contractor. Groups are entitled to cover their overhead and expenses. When a psychiatrist contracts to perform a service for a group which bills the client, it should be for an agreed upon set fee or salary that will be seen as a fair market fee. The fee should be renegotiated if circumstances change. Percentages should be avoided. And, of course, the psychiatrist should not then bill the client or patient. Finally, it’s important to remember that fee-splitting has been linked with kickbacks and other fraud and abuse in legislation, both at the federal and state level. Some states have broader interpretations of the kinds of arrangements that are considered improper. It is wise to consider legal advice about the terms of one’s arrangements in the jurisdiction of one’s practice. (Section 5) (2020)

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

**N.30**

**Question:**

Psychiatrist has been treating patient for 6 years. Patient has major depressive disorder and Psychiatrist considers her to be at very high risk. She hasn't been hospitalized, but has been very close to hospitalization on a number of occasions because she has become close to catatonic. For the past year, patient has done fairly well with treatment and Psychiatrist has prescribed a number of medications, but Psychiatrist remains concerned that patient needs close supervision during treatment. Patient recently moved out of state; initially was meant to be temporary but has become more prolonged. Psychiatrist cannot provide treatment remotely for the long-term. Psychiatrist has told patient that she needs to find a treatment provider where she is located and has even researched and sent information about 3 potential psychiatrists there who participate in Patient's insurance. Psychiatrist has provided medication refills to CVS pharmacy and provided some telepsychiatry appointments. Most recently, Patient told Psychiatrist she was upset that the Psychiatrist has told her to find a new doctor in her location and as a result she does not want to do any more session with the Psychiatrist. What, if any, actions should the Psychiatrist take at this point?

**Answer:**

It is ethical for the psychiatrist to terminate treatment under these circumstances if she does not feel she can safely care for the patient due to a variety of factors, including geographic distance, the severity of the patient's symptoms, and the psychiatrist's own circumstances. As long as she has provided the patient with ample notice and appropriate referrals or other opportunities for the patient to transition her/his care, she has fulfilled her ethical responsibilities to the patient relating to the principles of non-abandonment and the ethical obligation to provide opportunities for transfer of care. It appears that the psychiatrist has approached the situation with this patient in a thoughtful and ethical manner. She has considered both the needs of the patient and her ability to provide adequate treatment to the patient given the circumstances. The psychiatrist should make sure she has adequate documentation of the following:

1. She informed the patient at the time the patient moved away that she would not be able to continue to provide treatment at a distance on a long-term basis.
2. She has given the patient three alternative treatment providers in the patient's new state of residence who are in-plan with patient's insurance.
3. She has considered the reasons why remote treatment would not adequately serve the patient's treatment needs including that if hospitalization were needed, it would be difficult for the psychiatrist to arrange in a distant jurisdiction, especially if the patient does not agree to a higher level of care.
4. She has considered her own ability to be available to a high-risk patient given her own circumstances and determined that she will not be able to provide adequate care beginning at a certain date.

**Additionally:**

1. The psychiatrist should make sure that there is evidence that the patient has received her recommendations and intent to terminate by certified letter if possible, or an email with an acknowledgement of receipt if a letter is not possible.
2. The psychiatrist should contact her malpractice carrier to ascertain if there are any other specific legal considerations pertaining to state law in the relevant jurisdictions.
3. The psychiatrist may want to review the new ethics opinions related to COVID-19 since they also address telemedicine and personal risk issues.

(Section 6) (2020)

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

**N.31**

**Question:**

I am trying to get a sense of the current guidance on this from the American Psychiatric Association. Specifically is a collaborating psychiatrist required to meet with the nurse practitioner and/or the patients? Or is acceptable for the collaborating psychiatrist to merely sign off on the nurse practitioners work?

**Answer:**

It is ethical for a psychiatrist to play a supervisory role with other mental health professionals, including in circumstances where the psychiatrist does not actually see a particular patient themselves. This happens both in institutions and in private practices. When a psychiatrist assumes a supervisory role for other team members there must be clear, established responsibilities and the psychiatrist must have performed adequate vetting to determine the competence of the supervisee such that there will be sufficient exchange of information, confidence in clinical competence and honesty about who is performing the services. When playing such a supervisory role, the ethical psychiatrist must engage in sufficient activities to ensure they can provide appropriate and safe supervision to the professional they are supervising. This would require the psychiatrist to have an adequate understanding of the knowledge, skills, strengths and vulnerabilities of the professional they are supervising and to understand basic details about the patient(s) to whom they are providing care. The depth of the information the psychiatrist needs to provide appropriate supervision and the manner in which they gather this information will depend on the nature and duration of the supervisory relationship. If the psychiatrist is new to working with the professional they are supervising, this might entail closer contact including in person/video/phone communication with the professional and/or observation of the professional's interaction with patients. In established relationships where the psychiatrist is very familiar with the capabilities of the professional, less direct supervision may be needed. The important factor is not the way in which supervision is provided, but that the psychiatrist has sufficient information to assure that in her/his opinion the professional they supervise is providing patients safe and appropriate care. The ethical psychiatrist should not sign off in a pro forma way without any actual knowledge of the patient or the skill set of the supervisee. (Section 5) (2020)

**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.



**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

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

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

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)

**Q.6**

**Question:**

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

**Answer:**

**Recent Opinions of the APA Ethics Committee on  
*The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2020)***

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).

**Q.7**

**Question:**

I am a retired psychiatrist and writing a memoir that includes disguised stories about former patients, some of whom committed suicide. I am focusing the memoir on the themes of depression, suicide, and hope, and it is intended for both a professional and lay audience. While I have obtained written permission from many former patients, I have not received responses for permission from survivors of several deceased patients. Can you provide some ethical guidance about the publication of my memoir?

**Answer:**

As summarized in the above question regarding publication in professional and scientific literature, disguising of patient identity to preserve anonymity of current and former patients in case study publications may not be adequate, therefore, obtaining consent is an additional protection that shows respect for persons. Clearly, writing about patients involves a continuum from case studies to memoirs to fictional stories inspired by patients. In all three forms of publication, protection of patient privacy and respect for current and former patients are central ethical principles that should guide this activity. Educational benefits for the public and the profession that emerge from publication and teaching about patients are scientific and artistic values that warrant preservation and support. While permission or consent is an ideal that should always be pursued, there will be situations where obtaining permission is not possible, and in some situations, may not be necessary (i.e., in writing fiction).

In cases where permission cannot be obtained or is not required, careful and thoughtful processes that disguise and maintain patient anonymity are required. Consent remains a worthy practice even in memoirs, and certainly demonstrating due diligence in attempting to obtain consent supports the value of respect for persons. Keep in mind that the risk of someone taking offense is always possible in spite of best efforts to disguise an identity. The decision to incorporate a patient experience into professional writing of any kind should be evaluated on a case by case basis keeping in mind any potential harm to the individual. In the event a patient, former patient, or a surviving member of the family denies permission, this should be respected. (Section 4) (2020)