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Q: 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?

A: 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."

Q: Is it ethical for a psychiatrist to serve on the same non-profit board with his patient?

A: The Ethics Committee recognizes that certain interactions between doctors and patients in a social context are not necessarily harmful to the therapeutic relationship. Because of the diverse array of treatments and treatment settings, it is impossible to create unambiguous rules of conduct for all areas of clinical practice. However, psychiatrists must maintain awareness that their behavior should be

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directed toward the patient's therapeutic benefit, and behavior that is likely to conflict with that goal should be avoided. The burden is on the psychiatrist to be respectful, reticent and cautious about any verbal exchange that may compromise confidentiality.

- Q:** Psychiatrist had been prescribing psychotropic antidepressants for a patient who is now leaving town and "wants nothing to do with the doctor." The patient's prescription already ran out and the doctor believes he needs an immediate refill due to his severe depression. Clearly this is more of a legal issue since the doctor cannot prescribe medication after the patient chose to end the relationship. Do you have any advice on what recourse the doctor has to try and ensure the patient remains on medication?
- A:** You should first consider the legal and risk management ramifications of your inquiry. We recommend that you contact your malpractice insurance carrier to determine how to ensure the doctor-patient relationship is really terminated.
From an ethical perspective, the patient can terminate the relationship. It is ethically sound for the psychiatrist to want to do something to assist with ongoing care (beneficence) while also respecting the patient's self-determination (autonomy). You could contact the patient, in writing, stating your opinion that the patient is at risk and should seek follow-up care, and that you are available to provide referrals for ongoing care and/or provide bridge care, pending new treatment if the patient so chooses. If the patient has imminent risk of harm or meets involuntary evaluation or treatment criteria, you would be well-advised to seek that treatment for the patient. Although you had expressed that you do not believe the patient to be suicidal, we must stress that you should assess imminent risk to the best of your ability. You might find it helpful to consult a risk person and a clinician on the matter.
- Q:** Dr. X practices in Sacramento with his wife, who is also a psychiatrist but not an APA member. Their incorporated practice is in an office building, which they own. They wish to sell the building and have been working with a real estate agent. The agent informed them that a potential buyer is interested and it turns out the buyer is the father of Dr. X's wife's current adult patient. Dr. X and his wife have not yet had direct contact with the patient or his father regarding this matter. How should they proceed?
- A:** The APA Ethics Committee had issued an opinion addressing property sales between psychiatrists and their current or former patients. It states, "Psychiatrists have responsibility to be mindful of boundaries with both current and former patients. Buying or selling property is not necessarily precluded. For instance, in small town where patient is the only real estate developer, it might be fine." Although the potential buyer in your situation is your wife's patient's father, the opinion is still applicable. It allows you to proceed, with thought and care. For instance, it might be wise to let your real estate agent and lawyer handle interactions with the buyer and his agents and lawyers. Dr. Ezra Griffith, Chair of the Ethics Committee, has kindly offered to speak with you directly should you need further guidance. He is copied on this email. Please understand that while he will help you explore issues to consider, you should not interpret the discussion as prescriptive advice.
- Q:** I found out that someone is forging my name to get controlled medications. Multiple names are being used, but all with the same last name. This last name is the same as a former patient's, who I learned a couple of years ago had forged at least one prescription using my name in another town. This former patient is at the same address as all the supposed people who are getting the medication with the forged prescriptions. Can I breach confidentiality and use the former patient's name when I report the forgeries?

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- A:** You should report a stolen prescription pad but not volunteer speculation about who could have stolen it.
- Q:** A member called about a 12-year-old patient who said things like “I wish I were dead,” “If I never woke up again, that would be fine,” and “I wish I were not here.” The child denies having a plan to kill herself or the intent to do it. The member is wondering what the ethical balance is regarding whether to tell the parents. He is consulting his malpractice carrier on the legal part.
- A:** I am a child psychiatrist and am not aware that children of age 12-13 can be treated without parental/guardian consent. Statements alluding to self-harm as those described must always be taken seriously, and parents should be informed and involved in the treatment accordingly. This question appears to be one of clinical judgement rather than ethics. (Dr. Brooks with agreement from others)
- Q:** Member has a number of patients who work (or may work) for the federal government. The patients give authorization for Member to be contacted and he is sometimes asked to complete security clearance forms regarding those patients which ask him, for example, if the patient is capable of handling high security matters. He doesn't feel comfortable answering such questions. Can he decline to complete the forms?
- A:** Referred to Resource Document: Psychiatrists' Response to Requests for Psychiatric Information in Federal Personnel Investigations
- Q:** Dr. X is the only doctor who does ECT at a large hospital. It's a very active ECT practice; he does 12 or 15 ECT treatments in a morning. He is planning on retiring and is wondering if he can essentially sell this lucrative practice. Right now, he deals directly with the insurance company for the service but uses the hospital's facilities. Both he and the hospital bill the insurance company as he is a contractor to the hospital. He gets his referrals from the hospital. Is it ethical for him to sell this practice?
- A:** Although it's not typically a practice in psychiatry, physicians and dentists sell their practices all the time, and there is nothing unethical about it. Today, many physicians' practices are actually bought by hospitals. However, this particular inquiry takes a little bit of a different twist. It's not clear what is Dr. X's current relationship with the hospital, is he a totally independent practitioner who is a private attending physician at the hospital, or does the contractual arrangement that the doctor currently has with the hospital mean that the patients who are referred to him for ECT really belong to the hospital, and not to the doctor. In that case, there is no assurance that the hospital will continue to refer to the "buyer" physician, so Dr. X may not have anything to sell, or at very least, ethically, this nuance needs to be made known to the buyer, and written into the "bill of sale".
- Q:** I recently had an adult married women patient tell me that she is having sexual relations with her male therapist with whom she just started treatment maybe a month ago. She has a back ground of being sexually abused. She understands that the therapist has committed a serious professional boundary violation and there is a good possibility it is not the first time. She refuses to turn him in or to stop seeing him. I do not know the identity of the therapist and I do not think she ever told me who she would be seeing when I asked her to get therapy a few visits back. I told her that I am duty bound to report this kind of infractions.

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She was referred because she had sex with a total stranger after they had a few drinks and smoked cannabis. They met on an airliner while she was returning home from a business trip. She felt guilty about the incident since she wants to keep her relationship with her husband intact.

I told her that I would probably not be able to continue with her care under these circumstances and scheduled her back for follow-up in two weeks to determine the best course of action.

A: The woman is an adult of sound mind (i.e., has capacity, as presumed from her going on business trips). She knows what the therapist is doing is wrong but refuses to stop therapy (and sexual relations) with him. She does not want to report the therapist despite knowing she could. The writer has no way of identifying the therapist. If the woman were incompetent or cognitively impaired, that would stimulate a different understanding/response from me.

On another note, how does the writer know the therapist is a psychiatrist? Could be some other professional; for example, I do not know the ethics guiding the practice of Licensed Practical Counselors (LPCs) or Licensed Marriage and Family Therapists (LMFTs.) Regardless, the best the writer can do is discuss with the patient, the inappropriateness of her sexual relations with her therapist and the negative impact on her treatment, especially given her history of sexual abuse. Her pattern of indiscriminate sexual intercourse was the initial impetus for the writer's referral of the patient for therapy.

I do not believe the writer should abandon this vulnerable patient at this critical time; she needs an ethical and trusted professional to help guide her treatment through the complicated state of affairs she is currently engaged in. I do not understand why the writer is making treatment contingent on the patient reporting her therapist, or what the writer is really worried about that is yet unspoken. It would be enough for the therapist to document discussions had with the patient regarding this issue and the professional advice rendered, including a discussion (and the patient's understanding) of the options available to her. To stop treating her at this time on account of this issue would be problematic, in my opinion. (Charles Dike with agreement from Ezra Griffith)

Q: Invariably, the patients feel totally justified in their request for a therapy dog letter and see the doctor as being uncaring and lacking empathy for refusing to write it. When I've tried to say no, it clearly damages the doctor-patient relationship. Which of my patients is it inappropriate to write a letter for? Again, every patient feels that their request is justified and appropriate.

A: This question raises three compelling issues:

1. **Integrity:** The psychiatrist must not write anything in a letter that he doesn't believe is true. We receive requests to bend the rules (eg: to write a prescription for a larger amount of a medication to save on patient copays), and it is up to us to protect our integrity by refusing to do anything fraudulent. If the psychiatrist doesn't believe the companion animal is truly necessary for the patient's mental health, then he shouldn't write the letter. Alternatively, if he agrees that a companion animal would be helpful in the patient's housing, but that the patient doesn't need the animal in order to fly on a plane or eat in a restaurant, the letter can specify that.
2. **Protecting the doctor-patient relationship:** While denying a patient's request may feel like it harms the alliance in the moment, allowing the patient to manipulate the psychiatrist into a false position also is harmful to the relationship. If the patient knows the doctor doesn't really believe what he's putting in the letter, the doctor's credibility is eroded. The patient may start to wonder what else the doctor says but doesn't fully believe.
3. **Federal and state regulations:** The ADA is quite clear that emotional support animals are not service animals, so they don't enjoy the same latitude of exemptions from restrictions. For example, an

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emotional support dog is not allowed in medical/clinical settings, but a service animal is. I believe some states have specific laws concerning emotional support animals, so this psychiatrist may want to check Florida statutes to determine what criteria exist, if any, to guide his determinations. (Zilber, with contribution from Griffith, Bernstein and Brooks)

Q: I have been in a discussion with a colleague regarding integrated care. He believes that integrated care programs are unethical based on the wording of the Goldwater ruling, as the Psychiatrist is rendering an opinion without seeing the patient directly. I tend to disagree based on a number of factors. I'm not sure whether this has been entertained and would appreciate any comment.

A: The Goldwater Rule has no impact in a collaborative care setting for many reasons. The rule addresses public statements based upon publicly available information (e.g. in the media) about a public figure when there is no physician patient relationship. In a collaborative care setting, the psychiatrist is part of the care team with access to the patient's private medical records and history. In most states, there will be a physician/patient relationship between the consulting psychiatrist and the patient who has consented to the psychiatrist being part of the team. In the collaborative care setting, if a psychiatrist were to make public statements about a patient's condition, he or she would be violating basic principles of patient confidentiality and entirely different ethics principles (and state and federal laws) would govern. (Drafted by Colleen, with approval from Griffith and Brendel.)

Q: [In response to Trump's tweet to ban transgender people from military service]
I greatly appreciate the APA statement: <https://www.psychiatry.org/newsroom/news-releases/apa-opposes-banning-transgender-service-members-from-serving-in-military>

But, I still do not think this addresses military psychiatrists involvement. Specifically, it is not the policy, per se, which I think that is most unethical (though I might personally disagree with Transgender ban as a policy), rather it is the question of how medical information is being used to harm, which seems most unethical.

As you know, with President Trump's announcement on 26JUL2017 on Twitter, stating "... be advised that the United States government will not accept or allow transgender individuals to serve in any capacity in the U.S. Military," military psychiatrists are in an urgent ethical dilemma.

I acknowledge that this is still to be sorted out administratively, but regardless of the source/mechanism, statements from the Commander-in-Chief are perceived as military orders. Service members are trained to expect that orders of the President will be followed.

Over the past year, psychiatrists assessed Military Members who identify as transgender, and, when appropriate, diagnosed them with Gender Dysphoria, per DSM5. Now, this same diagnosis and medical information, consistent with the President's statement, is being used to do harm, with potential punitive separation from the military. Additionally, there is significant psychological distress, for many, associated with this shift in policy and associated ostracism. Thus, the psychological impact of the order is immediate, regardless of it being implemented.

Unlike other matters related to identity, psychiatrists were necessarily involved, due military instructions to first render DSM5 Diagnosis, Gender Dysphoria.

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I seek ethical guidance from APA, since my diagnoses, as a military psychiatrist, are being used for harm rather than to alleviate suffering.

Moreover, I ask APA to continue to advocate for protections for these patients, whom I diagnosed as having Gender Dysphoria. This could mean, for example, return to the previous policy, or not permitting any prior Gender Dysphoria records (or treatment thereof) to be used punitively.

I also for protections for me, as a military psychiatrist, from complaints of unethical practice, given these policy changes were unforeseen.

A: Your dilemma regarding how to ethically manage changes in the military's response to trans service members touches on several elements from the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. Your previous evaluations of trans patients that resulted in a diagnosis of Gender Dysphoria are in the medical record, but are not a public record. One would expect that military medical records would be held to the same standard of confidentiality as civilian records. Psychiatrists practicing in the military should be aware of exceptions to confidentiality in situations where there is risk of harm to the patient or others. Section 4, article 1 of the *Principles* states,

Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care... Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

If a patient chooses to disclose their Gender Dysphoria diagnosis to commanders or other authorities in their process of making a gender transition, even if that disclosure subsequently causes harm to the patient because of policy changes in the institution, the psychiatrist has not done anything unethical by having made the diagnosis in good faith.

We have identified three questions implicit in your query.

1. What are my ethical obligations to existing patients? Your ethical duty to patients for whom the diagnosis has already been made and documented in the medical record includes continued vigilance about confidentiality. Section 4, article 2 asserts,

A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies.

If the military seeks information from the psychiatrist about patients who may have been given a Gender Dysphoria diagnosis, the psychiatrist should only release that information after obtaining proper authorization from the patient, which should include an informed consent discussion about the potential consequences of release of the information.

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If the military is seeking information from the psychiatrist about patients who may have been given a Gender Dysphoria diagnosis and the patient is unwilling to sign a release, then the psychiatrist should only release information as allowed as per HIPAA and DoDI 6490.08. The psychiatrist may discuss the request with their assigned Medicolegal Consultant prior to making such a release to ensure that only the minimum amount of information necessary, if any, is released. If the military has concerns regarding a trans Service Member that may impact the member's fitness for duty, the psychiatrist should adhere to guidance in DoDI 6490.04

Hormonal therapy is a possible prohibition for deployment, so if an individual wants to deploy they may wish to review with their provider the implications of beginning this therapy.

2. What are my ethical obligations to patients still in the military who are concerned about the impact this will have on them? Any distress experienced by trans patients because of a change in policy that threatens their employment or service status should be treated with compassion in accordance with usual standards of care. The ethical obligation of the psychiatrist is to remain supportive of the patient.
3. What are my ethical obligations to new patients who are transgender with respect to diagnosing them in their record? If a new patient comes to the psychiatrist and introduces the subject of transitioning for the first time, which normally requires a revelation to one's commander and obtaining the support of the commander for the process, a psychiatrist must now weigh the patient's clinical needs and the potential implications for their ongoing service. Going forward, it is ethical to have an informed consent discussion with a new trans patient, to help them consider whether it is in their interest to move forward with the transition at this time while things are uncertain. As with any sensitive topic, documentation in the medical record should be circumspect, including only the information necessary to justify a diagnosis and treatment plan, while still accurately reflecting the clinical encounter.

In addition to these guidelines, the ethical psychiatrist employed by the military may also want to consider Section 1, article 2: "A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation." This principle may need to be considered along with 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." Military psychiatrists may want to consider the extent to which they can advocate for the wellbeing of their patients without threatening their ability to continue to serve their patients.

Q: Dr. X is the attending psychiatrist at an adolescent residential community treatment facility. There is a 16 year old transgender male patient (originally female) at the facility. Patient has two living family members—a grandmother and a great aunt—who both refuse to allow him to return home and live with them unless he reverts to identifying as female. Dr. X and his wife are interested in either fostering or adopting the patient and have not yet spoken to him nor his family about the idea. What ethical implications should they consider?

A: You have asked for an answer to the one question that you put to the Committee, namely, is it inherently unethical for you (and your wife) to seek the placement of your teenage child patient in your home with you as foster or adoptive parents. The answer to your question is that yes, it is inherently unethical. Let us go on to explain further why that is so.

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The ethical principle that applies is one of dual agency, that is, the tension that arises whenever physicians seek to involve themselves in the solution to a problem without seeing how they have also inserted themselves into the treatment plan. Ethically you cannot have a doctor/patient (or even a former patient) relationship and a parent/child relationship with the same individual.

Section 1, Paragraph 1 of the *Principles of Medical Ethics Applicable to Psychiatry* states that “a psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist should be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor/patient relationship, and thus upon the well-being of the patient.” While the Committee has no doubt that your intention is well-meaning, and that you are acting out of beneficence, nevertheless there is no way to establish that your action is not also in some way an exploitation of your patient.

You also add that you would not expect the Committee to make a determination of what is in the best interest of the child, and we will not. We will say, however, that nothing precludes you and the treatment team from doing everything else to assist your patient, other than your personally adopting him. This would include continued efforts at family therapy, still an appeal to local social service agencies despite your reticence, or perhaps even involvement of your state’s appropriate legal resource.