Opinions of the Ethics Committee

on

The Principles of Medical Ethics

With Annotations Especially Applicable to Psychiatry

2017 Edition

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ASSOCIATION

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Opinions of the APA Ethics Committee

(To facilitate ease of use of this document, the Ethics Committee has categorized their opinions by topics (see below). The topics are identified by a capital letter, followed by a number which refers to one of the nine Principles of Medical Ethics. Small letters are used to identify the order in which the opinion was issued. For example, opinion "A.1.a" falls under the topic of Boundary and Dual Relationship Issues, refers to Section 1 of the Principles of Medical Ethics and is the first opinion to be issued on this topic under Section 1.)

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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. Further, the insurance form must indicate the role of both supervisor and the person supervised. If these provisions are met, the answer is yes. (1988)

N.5.b

Question: If the family of an adult patient requests a second opinion, what are the obligations of the consultant? Can he or she disagree with the treating psychiatrist?

Answer: We are assuming the patient is competent, in which case, the second opinion is his or her request. If the patient is not competent, it is the family's request. The treating psychiatrist should agree to the request. With proper consent, the treating psychiatrist may discuss the case with the consultant. Also, with proper consent, the consultant may discuss his or her opinion with the treating psychiatrist; however, the consultant is not obligated to do so since he or she was employed by the patient or family to give them advice, and the choice to include the treating psychiatrist is theirs alone. Of course, the consultant can disagree with the course of treatment based on his or her professional judgment, or there would be no purpose in obtaining a second opinion. (1989)

<u>Section 6</u>

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.

N.6.a

Question: Because of ill health, it has become necessary for me to retire. I have sent a written announcement to that effect to all my patients 90 days in advance. Full-fee patients have been accepted by other psychiatrists, but I am having great difficulty placing my Medicaid patients. The local public clinics have long waiting lists. Will I be abandoning my patients?

Answer: No. Ninety days written announcement is quite adequate. It is unfortunate you are having such difficulty placing your Medicaid patients, but you have done all you can be expected to do. Your colleagues might wish to consider their roles as ethical practitioners in assisting you and your patients in your time of need. (1978)

N.6.b

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: This does not appear to be an ethical question, but rather a question of what is best for the patient, primarily, and the feeling of hospital staff, secondarily. Ideally, the patient should be admitted to another hospital. However, availability of needed special services or continuity of care may take

precedence (e.g., the admitting psychiatrist was treating the patient before admission and this is the psychiatrist's only hospital). (1985)

N.6.c

Question: In our underserved area, the doctors at a local mental health center do not have or want privileges at a local hospital and do not feel they have responsibility if a patient of theirs needs to be hospitalized. Is this ethical?

Answer: The decision does not appear to be ethical and may constitute patient abandonment. A solution could be provided by a contract between the mental health center and the hospital and its medical staff to provide services when needed that are not provided by the mental health center and its psychiatrists. (1988)

N.6.d

Question: Is it ethical for a psychiatrist practicing in a small community to treat an adult member of another psychiatrist's family when there is much family acrimony? The psychiatrists do not work together and have infrequent contact.

Answer: The treating psychiatrist must assure confidentiality, of course, and provide a treatment environment in which the patient feels secure. Further, any relationship with the parent psychiatrist must not preclude a sense of trust on the part of those involved. Another consideration is whether there is another psychiatrist within reasonable distance. With proper consideration of those concerns, it would not be unethical. (1989)

O. PROFESSIONAL LISTINGS, ANNOUNCEMENTS

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.

O.2.a

Question: A member lists himself in the telephone Yellow Pages as a "certified psychoanalyst." His colleagues know he is not a psychoanalyst. Is he unethical?

Answer: Section 2, Annotation 3 (APA) states:

> A psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

It is not ethical to claim a competence not possessed. The ethics committee would want to know what the psychiatrist's actual training and experience were. The title "psychoanalyst" is not owned exclusively by any organization. Thus, a person might not be unethical in using that title, even though he or she was not a graduate of an accredited training center, if training from other sources reasonably related to the task of being a psychoanalyst had been received. (1978)

O.2.b

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.) (1978)

O.2.c

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. (1980)

O.2.d

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. (1990)

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.

O.7.a

Question: Is it ethical for a psychiatrist to offer his or her professional services to a public figure based on data from the media?

Answer: No. Section 7, Annotation 3 (APA) cautions against drawing clinical conclusions based on information gleaned outside the clinical setting. Furthermore, it would seem unwise for a physician to solicit patients by such means. (1994)

P. REFERRAL PRACTICES

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.

P.2.a

Question: A colleague and I wish to own and manage a day hospital. Will it be a conflict of interest if I refer my patients there?

Answer: Not if it is clinically appropriate to do so and your patients are informed in advance of your financial interest. This also requires that you make other arrangements for them if they object. (1991)

P.2.b

Question: Our state hospital has an arrangement with a public clinic to have the clinic's psychiatrists treat their patients in our hospital and refer patients back to the clinic at discharge. Any problems?

Answer: No, assuming the psychiatrist taking the discharge referral is the clinically proper person. This is the standard practice in the private sector attending model. (1991)

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.

P.5.a

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. (1976)

P.5.b

Question: Is it proper for a public clinic to establish a referral list that excludes some psychiatrists? All psychologists?

Answer: Only if the exclusions are based on reasonable grounds. For example, the clinic might limit the list to psychiatrists willing to take emergencies, or to reduce their fees, or be available to provide hospital care, and so forth. The clinic certainly has a right, in fact an obligation, not to refer to a psychiatrist it has good reason to believe is not ethical or competent. The clinic would not be obligated to refer a child to a general psychiatrist if a child psychiatrist were available. Excluding psychologists is another matter if this is a blanket exclusion. Since laws governing the practice of psychology are so different, this would have to be determined by local laws. It would not be appropriate to refer a patient who needs the special skills of a psychiatrist to a psychologist. Section 5, Annotation 4 (APA) states:

In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment. (1978)

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.

P.6.a

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. (1979; 1981)

P.6.b

Question: A patient had been seeing a particular psychiatrist. The patient now is covered by a PPO of which the psychiatrist is not a participant. An emergency occurs, and the primary care physician refers the patient to a mental health clinic that contracts with the PPO; the clinic states the patient will go on its waiting list for services. Who is responsible?

Answer: If the mental health clinic's contractual responsibilities do not include emergency care, the primary care physician must make another appropriate referral out of plan, ideally to the original psychiatrist. The PPO would be obligated to cover that service unless the insurance benefit excludes such care. If the mental health clinic is contracted to cover such services, it must do so and cannot use a waiting list for an emergency. (1989)

Q. RESEARCH AND SCHOLARLY ACTIVITIES

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.

Q.4.a

Question: Are there ethical problems in writing a psychoanalytic casebook?

Answer: 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.

The problem of disguising is not always easily resolved. Close friends, family members, or the patients themselves might see through the disguise. This could lead to legal liability as well as a charge of unethical conduct. Thus, the psychiatrist-writer must give special attention to this matter and may have to sacrifice some scientific accuracy for the sake of preserving privacy. On occasion, the psychiatrist-writer has shown the material in advance to his or her patients and received their informed consent for its publication. (1976)

Q.4.b

Question: A convict has sued me for a number of reasons including violation of his confidentiality, and he seeks to prevent my publication of any case based on his history. He has made my manuscript part of the court record. I believe the court will rule in my favor, but what about the ethical issue? Section 4, Annotation 3 (APA) requires adequate disguisement, but Annotation 10 (APA) requires fully informed consent as does Annotation 11 (APA).

Answer: Taken in total, presenting case material requires that patient identity be hidden; if this is not possible (for example, the patient or a video is presented), then fully informed consent is required. In this situation, however, since the patient has made known that the manuscript applies to him, it is not possible to hide his identity so that informed consent is necessary. A court decision may settle the legal issues but not the ethical issues. (1989)

Q.4.c

Question: What are the obligations and responsibilities of the executors of the estate of a deceased psychiatrist with respect to the records of former patients? May they be used for scientific or research purposes?

Answer: The ethical issue is one of confidentiality. Any disclosure of any record must have the consent of the individual patient. Medical records, although generally the property of the doctor, must be used only for the benefit of patients and their medical care. The use of such records even for such lofty

purposes as science and research puts one on thin ice indeed. For these records to be seen, examined, analyzed, or otherwise used by researchers or scientists would require highly informed consent. (1993)

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.

Q.5.a

Question: Elderly patients often cannot give consent to be research subjects, but there is a great need for more knowledge about the aging process. What is the ethical position in this dilemma?

Answer: Obviously, if there is no ethical way to do research on our most disabled patients, we will be seriously hindered in developing preventive and therapeutic approaches for those most in need of help. The federal government has adopted regulations relating to this problem when the research is federally funded. Those regulations should be checked as guidelines. In addition, we suggest the following:

a. The preparation of a “living will” at the time the person was competent, which would indicate the desire to be a subject for research that is not dangerous and extend authority to some person to give approval. Such a living will would be very desirable, though obviously not always available, because individual may not have considered these issues during the time of his or her competency.
b. A determination of competency with the appointment of a conservator or guardian to be sure that the individual is not, in fact, now able to agree or refuse to be a subject. This conservator or guardian would have a responsibility not only to give approval, but also to provide continuous monitoring of the welfare of the conservatee.
c. It goes without challenge that there needs to be careful peer review of this research, heightened by the use of subjects who are not able to make this determination for themselves. It is very necessary that the peer review mechanism consider the welfare and best interests of the subjects.
d. Even though incompetent, the individual should retain the right to withdraw at any time as a subject from the project. See Opinion 2.07, AMA Council Opinions, 2000–2001. (1977)

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.

Q.7.a

Question: Does the ethical prohibition embodied in Section 7, Paragraph 3 of the Annotations apply to psychologically informed leadership studies based on careful research that do not specify a clinical diagnosis and are designed to enhance public and governmental understanding?

Answer: The psychological profiling of historical figures designed to enhance public and governmental understanding of these individuals does not conflict with the ethical principles outlined in Section 7, Paragraph 3, as long as the psychological profiling does not include a clinical diagnosis and is the product of scholarly research that has been subject to peer review and academic scrutiny, and is based on relevant standards of scholarship. (2008)

Expanded Opinion (2017):

Question: May a psychiatrist give an opinion about an individual in the public eye when the psychiatrist, in good faith, believes that the individual poses a threat to the country or national security?

Answer: Section 7.3 of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (sometimes called "The Goldwater Rule") explicitly states that psychiatrists may share expertise about psychiatric issues in general but that it is unethical for a psychiatrist to offer a professional opinion about an individual based on publicly available information without conducting an examination. Making a diagnosis, for example, would be rendering a professional opinion. However, a diagnosis is not required for an opinion to be professional. Instead, when a psychiatrist renders an opinion about the affect, behavior, speech, or other presentation of an individual that draws on the skills, training, expertise, and/or knowledge inherent in the practice of psychiatry, the opinion is a professional one. Thus, saying that a person does not have an illness is also a professional opinion. The rationale for this position is as follows:

1. When a psychiatrist comments about the behavior, symptoms, diagnosis, etc., of a public figure without consent, the psychiatrist violates the fundamental principle that psychiatric evaluation occurs with consent or other authorization. The relationship between a psychiatrist and a patient is one of mutual consent. In some circumstances, such as forensic evaluations, psychiatrists may evaluate individuals based on other legal authorization such as a court order. Psychiatrists are ethically prohibited from evaluating individuals without permission or other authorization (such as a court order).

2. Psychiatric diagnosis occurs in the context of an evaluation, based on thorough history taking, examination, and, where applicable, collateral information. It is a departure from the methods of the profession to render an opinion without an examination and without conducting an evaluation in accordance with the standards of psychiatric practice. Such behavior compromises both the integrity of the psychiatrist and of the profession itself.

3. When psychiatrists offer medical opinions about an individual they have never examined, this behavior has the potential to stigmatize those with mental illness. Patients who see a psychiatrist, especially their own psychiatrist, offering opinions about individuals whom the psychiatrist has not examined may lose confidence in their psychiatrist and/or the profession and may additionally experience stigma related to their own diagnoses. Specifically, patients may wonder about the rigor and integrity of their own clinical care and diagnoses and confidentiality of their own psychiatric treatment.

Psychiatrists, and others, have argued against this position. We address five main arguments against this position:

a) Some psychiatrists have argued that the “Goldwater Rule” impinges on an individual’s freedom of speech as it pertains to personal duty and civic responsibility to act in the interest of the national well-being. This argument confuses the personal and professional roles of the psychiatrist. The psychiatrist, as a citizen, may speak as any other citizen. He or she may observe the behavior and work of a public figure and support, oppose, and/or critique that public action. But the psychiatrist may not assume a professional role in voicing that critique in the form of a professional opinion for the reasons discussed above, those being, lack of consent or other authorization and failure to conduct an evaluation.

b) Psychiatrists have also argued that the “Goldwater Rule” is not sound because psychiatrists are sometimes asked to render opinions without conducting an examination of an individual. Examples occur, in particular, in certain forensic cases and consultative roles. This objection attempts to subsume the rule with its exceptions. What this objection misses, however, is that the rendering of expertise and/or an opinion in these contexts is permissible because there is a court authorization for the examination (or an opinion without examination), and this work is conducted within an evaluative framework including parameters for how and where the information may be used or disseminated. In addition, any evaluation conducted or opinion rendered based on methodology that departs from the established practice of an in-person evaluation must clearly identify the methods used and the limitations of those methods, such as the absence of an in-person examination.

c) Psychiatrists have further argued that they should be permitted to render professional expertise in matters of national security and that the “Goldwater Rule” prohibits this important function. While psychiatrists may be asked to evaluate public figures in order to inform decision makers on national security issues, these evaluations, like any other, should occur with proper authority and methods within the confidentiality confines of the circumstances. Basing professional opinions on a subset of behavior exhibited in the public sphere, even in the digital age where information may be abundant, is insufficient to render professional opinions and is a misapplication of psychiatric practice.

d) Some psychiatrists have argued that they have a responsibility to render an opinion regarding public figures based on Tarasoff duties to warn and/or protect third parties. This position is a misapplication of the Tarasoff doctrine. Actions to warn and/or protect a third party occur in situations in which a psychiatrist is providing treatment to or an evaluation of an individual who poses a risk to others and Tarasoff serves as a rationale for a limited sharing of otherwise confidential or privileged information. However, for information in the public domain, law enforcement agencies that have the same, and perhaps even greater, access to information about the individual are charged with protecting the public.

e) Finally, some psychiatrists have argued that rendering an opinion based on information in the public domain without conducting an examination should be permissible because psychiatrists are often involved in psychological profiling. However, psychological profiling differs markedly from self-initiated public comments as described in this opinion. Psychological profiling occurs when a law enforcement or other authorized agency or

authorized party engages a mental health professional to provide information about the characteristics of an individual who might have perpetrated a crime; the behavior of a suspect or other figure; other characteristics of an individual; or a prediction of future risk. The authorization for this work derives from the requester and is not initiated by the psychiatrist. It is also meant to be shared with the requester, and not the general public. Finally, as this work often lacks examination of the individual and relevant data from appropriate collaterals, the psychiatrist must explicitly address the limitations of the methods used in rendering a profile, should not opine about a diagnosis, should not include a diagnostic opinion, and must clearly state the inherent limitations in making predictions about future behavior.

Nothing in this opinion precludes the psychological profiling of historical figures aimed at enhancing public and governmental understanding of these individuals. As Opinion Q.7.a states, this profiling should not include a diagnosis and should be based in peer-reviewed scholarship that meets relevant standards of academic scholarship. Such scholarship should clearly identify the methods used, materials relied upon, and methodologic limitations, including the absence of formal evaluation of the subject of inquiry

R. RESIDENT, STUDENT AND OTHER TRAINEE ISSUES

Section 1

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

R.1.a

Question: I run a process group for psychiatric residents at a training hospital, and I have learned that some of the residents refuse to admit patients from certain hospitals or with certain diagnoses. Are the residents' actions unethical? What are my ethical responsibilities as the process group leader, given the constraints of confidentiality for this group?

Answer: Your question raises a number of issues for consideration.. We assume the residents were informed of the limitations to confidentiality at the beginning of the process group? Either way, it would be incumbent upon the leader to reveal confidential information as necessary if the practice under discussion could endanger patients. (See Section IV, Para 8 of the Principles of Medical Ethics with Annotations Applicable to Psychiatry).

Refusing admission of patients can occur for a variety of reasons, some ethical and some not. An exploration of the reasons residents refused patient admissions would need to occur to understand the ethical implications. Additionally, the residents' actions could potentially be illegal, and possibly unethical as well, if they violated the Emergency Medical Treatment and Active Labor Act (EMTALA) passed by Congress in 1986. Hospitals are obligated to provide treatment to patients who are medically unstable. The question does not address whether these patients were stable or not at the time their admission was refused. (2006)

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.

R.2.a

Question: One of our young male residents on one occasion asked the wife of a man he saw in consultation for a date and on another accepted a ride from a woman patient of his with an eroticized transference toward him. Has he behaved unethically and should he be sanctioned?

Answer: Although we have not received a complaint about which we can make a judgment, your query suggests to us the resident has shown poor judgment at best and evidence of failure to understand the limits of the doctor–patient relationship. We would recommend special education and supervision for him to avoid any such behavior in the future. (1987)

R.2.b

Question: A resident had acted unethically and then transferred residency programs. The first program did not inform the new residency training director about the resident's improper behavior. Can a residency training director initiate an ethics complaint?

Answer: Yes. The APA has developed "A Basic Model Ethics Curriculum for Psychiatric Residents" as a guide for residency training directors. In addition, faculty members are expected to act as role models for their students and are bound to conduct themselves in a professional and ethical manner. A psychiatrist should expose physicians deficient in character or competence.
The physician writing the letter may support the transfer but fail to communicate immoral or incompetent behavior. A complaint may be filed against a resident who is a member of the APA; it can be based on extrinsic evidence, such as university or licensing board rulings or actions. (1997)

R.2.c

Question: Several years ago as a psychiatric resident I was involved in the psychopharmacological treatment of an adolescent patient. She has since moved out of her mother's home. Recently I encountered the patient's mother in a Divorce Recovery Course. We subsequently met for coffee. Is it ethical for this to become a dating relationship?

Answer: A doctor-patient relationship is established when a psychiatrist provides treatment to a patient; this includes provision of "split treatment. Parents are typically an integral part of the treatment of children or adolescents. For example, parents must provide informed consent when psychotropics are prescribed to a minor in most instances, thereby assuring their active participation. Romantic involvement either during or subsequent to treatment with key family members may be construed as exploitation of the patient and family; it could be a method by which a psychiatrist meets his or her own needs. Furthermore, this romantic involvement may discourage the original patient and other family members from seeking subsequent treatment with the trusted psychiatrist. Romantic involvement with key family members is also unethical. (2003)

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.

R.4.a

Question: As a student health service psychiatrist, I treat some students psychotherapeutically and see others for administrative reasons. Do I have a potential ethical conflict?

Answer: You certainly do if you do not define your roles clearly and in advance to the student. You cannot give an administrative opinion if the student has made a psychotherapeutic contract with you. This is a classic example of "double-agency." If the college demands that you confuse your roles, you should refuse to participate and must ethically withdraw from the arena if the college will not relent. Even a student's consent for you to make an administrative report after a period of psychotherapy does

not resolve your conflict since the consent may not be freely given but coerced. The college should be advised to seek an administrative opinion from a psychiatrist not involved in a treatment relationship with the student. (1977)

R.4.b

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. (1993)