Recent Opinions of the APA Ethics Committee on
***The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (2020-2022)**

A.23

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

Answer: The challenge for the ethical psychiatrist is how to properly balance the psychiatrist's own right to a safe workspace against our obligation to welcome diverse patients without bias. To that end, it becomes really important for the psychiatrist to form his/her/their own opinion after doing assessment of the prospective patient. If after your first meeting with the patient, you decide you do not have the resources to safely care for them, it would be OK to work with the patient to refer them to a more appropriate setting. Making the decision to not see the patient based on info discovered through an online search without having a chance to see the patient to form your own objective judgement is problematic.

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

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

A.24

Question:

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

Is it appropriate for psychiatrists to be critiqued in this manner and also whether it's even ethical to aim for 90-95 plus percentage of patient satisfaction in psychiatry? Physicians have even been held back from partnership status as result of these scores. Also when thinking about the process of psychiatric and psychotherapy

evaluations, my understanding is that often there is an element of tension created in the session and through that perhaps greater change and treatment can result i.e. it seems that very high patient satisfaction may not be a goal we should strive for. In particular I'm also wondering about cases when psychiatrists care for patients with personality disorders and addiction issues where setting limits and boundaries (of course in a compassionate manner) is necessary and that by not setting limits one would be perhaps essentially worsening the splitting of a personality disorder patient etc. So is it ethical for this large HMO to be pushing physicians to strive for very high patient satisfaction scores when this is connected with worse medical outcomes?

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

To the extent patient satisfaction surveys are intended to measure whether psychiatric patients felt they were treated with dignity and respect, were seen on time and not kept waiting for too long, felt understood (and listened to), whether the psychiatrist explained treatment interventions and alternatives to their satisfaction or whether the psychiatrist was knowledgeable, they offer a valuable tool for self-reflection and self-awareness on the part of the treating psychiatrist.

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

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

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

With respect to an organizational policy implementing and relying upon patient satisfaction surveys, an ethical 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)

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)

A.26
Question:
A former patient who has had long-term psychotherapeutic treatment in an institution has moved on in life and become a licensed mental health clinician. It's now been more than a decade since the treatment relationship ended with the institution and the individual has now applied for a job as a clinician at the institution. Members of the hiring team and the staff with whom the patient would work had direct clinical roles with the patient and are concerned about the ethics of the situation, given that there are boundary/ ethics concerns and guidance that caution against hiring former patients across multiple clinical disciplines represented on the team. At the same time, they are aware of the ADA law and the institution's mission to not stigmatize or fail to hire someone because of a history of (now treated) mental illness. What ethical considerations are relevant to decisions about hiring former patients in this context and how should these decisions be made? If the institution were to develop a policy on hiring former patients, what ethical elements and considerations should inform the policy?

Answer:
Traditional standards and the existing APA Ethics Opinion (A.5, which opines that "*It is not ethical to switch a doctor-patient relationship to an employer-employee one*") are based on the idea of a single doctor, working alone, and a patient joining to help in that solo practice. To hire a patient in these circumstances remains problematic, because there is a specific and likely intense doctor-patient relationship formed, and this relationship might well influence the current working relationship on both sides. Will the doctor feel comfortable instructing the new employee, or even terminating their work for cause if needed?

However, the situation with a former patient, who is now a mental health professional, returning to an institution as a professional is different in several important ways. Having a strict boundary rule without incorporating views of mental illness that recognizes that it is people who suffer these conditions, who are more than "our patients," could lead to the narrow conclusion that psychiatrists cannot manage the nuance and

complexity of relationships required when boundary challenges occur. Instead, what is most important in boundary dilemmas like this is avoiding coercion and respecting privacy.

Indeed, it is not just the letter of the ADA that matters, but the spirit of it that makes a difference. Psychiatrists rightly focus more now on stigma and bias against those with mental illness than we did in the past, and yet psychiatrists ourselves are not free of stigma and bias. It is crucial to support the concept that treatment matters, and that people can recover and live full lives by addressing the challenges of mental illness. Psychiatrists should model that seeking treatment is a healthful and positive behavior and not a stigmatized act that will forever preclude a person, once a patient, from joining a team of respected mental health professionals. A history of mental health treatment should not be used to ban employment; a history of appropriate qualifications and pursuit of necessary medical treatment should be positive indicators for employment.

We can learn from the model of those in the recovery movement and pioneers like Marsha Linehan, who have been forthcoming about their own struggles and have used that wisdom to help others. The institution may be able to draw on the recovery model and peer therapy approaches to recognize that this person has special and unique skills and experiences to bring to the treatment team. Hopefully the institution will consider how to include this new colleague, assuming the applicant is otherwise well qualified, by considering appropriate boundaries, means to discuss challenges that arise, and other modes of supporting success all around. The institution may negotiate a boundary issue such as this, including by talking to the applicant and getting their input as to how they would like ethical concerns managed if they did come to work at the clinic. Ideally a mental health institution could be structured not as an "us" and a "them," but as a "we," a healing community that supports inclusion, flourishing, and the possibility of hope for all its members.

As to the ethical principles at stake here, the institution should reflect on all its policies, whether for hiring or treatment, to assure that they minimize bias and support the opportunity for recovery and inclusion for those with mental illness. It would be hypocritical for the institution to stand against bias but practice it within its own walls.

As for policies, the institution might address how mental health issues and treatment should be supported for any member of the staff, whether at the leadership or new staffer level. Many large corporations are now working to enhance mental health treatment options, knowing that they are a major cause of absenteeism and can undermine an employee's level of function and success. In short, good mental health care is essential for the success of any institution, and surely this is true for mental health institutions as well. There should be appropriate insurance coverage for those who need ongoing mental health support, and ways to pursue ongoing treatment with sufficient privacy and quality. Likewise, when a former patient is hired, the institution should consider addressing at the time of hiring where and with whom the former patient who becomes an employee would receive treatment were the person to have a relapse or recurrence of illness. It would be problematic for the former patient to be treated by his/her now professional colleagues. Instead, it should be agreed that the former patient who has become an employee would seek treatment at another facility if mental illness recurred or at the same institution only if the institution were large enough to preclude interaction with work colleagues in a treatment context. (Section 2) (2022)

A.27

Question: I have been in practice in a small midwestern city for over 40 years. Many of my patients have been seen regularly during that time. I have begun the process of transitioning patient care, but a number of my

patients are concerned about my availability after I close the practice. I expect there may be texts, emails and calls from them and requests to have a cup of coffee on occasion. I have been careful to maintain appropriate boundaries, but the depth of the longstanding relationships will make an abrupt termination difficult. They know I will eventually retired. Once I retire, my attorney has indicated that I should have no contact with former patients. However, I cannot just stop talking to people I have known for so long, without them feeling that my concerns and the relationship was not genuine. I would appreciate any ideas you might have.

Answer: Based on the question presented, it sounds like the member psychiatrist has reduced their practice, not closed it, and has limited the services they are providing. These actions are not in themselves inappropriate, provided that the treating psychiatrist has evaluated and documented their assessment of each patients' needs, and reasonably judges that the circumstances of the reduced or limited practice meet those needs. The "tapering" of care can help to ease the termination or eventual transition. If, however, any patient needs services that the psychiatrist is no longer providing, then the psychiatrist must make a referral to an alternative treatment provided and plan the patient's transition.

Once the psychiatrist retires from clinical practice, it is advisable that they cease all planned interactions with the former patients. The psychiatrist should use the clinical termination process to address any concerns a patient may raise about how they will cope with ending of the treatment relationship (and not attempt to address such concerns outside of a treatment session). Continued planned interaction or allowing ongoing contact and communication after termination of treatment may imply that the doctor-patient relationship is continuing, which would be fraught with potential problems for the psychiatrist and potential harm for their patients. As the Ethics Committee has previously observed, "social relationships [with patients] may negatively affect the therapeutic relationship." *APA Commentary on Ethics in Practice,* Topic 3.2.6. And it "advises caution regarding the establishment of a platonic friendship between a former patient and a psychiatrist." Opinion A.9 in the *Opinions of the Ethics Committee on the Principles of Medical Ethics* (see also Opinion A.15).

Of course, in a small town chance public encounters may occur; and it may be helpful for the psychiatrist to consult *APA Commentary on Ethics in Practice* Topic 3.2.6 (Therapeutic boundary keeping) and Topic 3.4.5 (Ethical issues in small communities), which note, among other things, that the "rules guiding professional behavior are context sensitive." Chance public encounters are distinct from planned continued interactions.

The panel notes that, to the extent the psychiatrist's concerns may originate from their own interests, they should consider that psychiatrists must avoid patient interactions that are aimed at gratifying the psychiatrist's own needs. *APA Commentary on Ethics in Practice* Topic 3.2.6. So long as the patients have been properly assessed and referred appropriately for their ongoing treatment needs, the long-time treating psychiatrist should not need fear the impact of ceasing contact with them. (Section 2) (2022)

B.6

Question: I am a part time practicing psychiatrist and am planning to start a separate private business as a life coach working 1:1, in small groups, and with an online community in a completely non-medical capacity. The content of my coaching will focus on teaching time management systems, organization, communication skills and creative problem solving with the general public and working parents. Am I beholden to therapeutic practices when doing these non-medical business activities? I will not be advertising under any of my active medical licenses although I will have my credentials (i.e. MD, psychiatrist) listed on my website.

Answer: The Committee applauds the psychiatrist for wishing to maintain the ethics of the profession and believes that psychiatric physicians should strive to adhere to the ethical standards of their profession even when they branch out into endeavors such as coaching, which do not require their licensure. The Committee does not see any of these coaching activities as unethical in and of themselves. It recommends that the psychiatrist include an explicit statement on their website and/or other public interface noting that coaching does not include psychiatric assessment or treatment. The psychiatrist must be quite careful to stay on the correct side of that line — if a coaching client seems to exhibit psychiatric symptoms, the Committee recommends referring to a different doctor, to keep lines clear. The psychiatrist should not offer both psychiatric and coaching services to the same person, and probably not offer both to the same group if serving as a consultant. But given that coaching is quite popular and lacks specific credentials, it seems reasonable that a thoughtful psychiatrist may branch out in this way.

The Committee wishes to note that physicians are held to a high standard of training and our medical licenses may not so easily allow us to compartmentalize the professional activities we define as "non-medical" or in this case "non-psychiatric" from our professional scope of practice. For example, a physician convicted of a crime having nothing to do with the practice of medicine (embezzlement, for example) could still lose their license in many states. Further, the psychiatrist should keep in mind that it is entirely possible for a disgruntled client – whose coaching sessions did not produce desired results – to claim the status of a patient seeking redress by filing complaints with licensing boards, ethics committees and even initiating civil lawsuits. The psychiatrist might consult with their malpractice insurer and/or attorney about the potential risks of interpretation that may arise, both so that the psychiatrist continues to maintain professionalism and an ethical stance, and so that the psychiatrist is not surprised or caught unaware by a client seeing things differently. (Section 2) (2022)

D.17

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

Answer:

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

Psychiatrists are trained specifically to elicit information from their patients in support of diagnosis and treatment. This information is gathered by the psychiatrist in the patient's clinical interest. Nonetheless, limited exceptions to confidentiality do exist. For example, if a patient shares information concerning risk of harm to the patient or a third party, the psychiatrist may have a duty to disclose information to another clinician or appropriate authority to prevent a future harm. The patient's past acts of harmful or criminal conduct are confidential in the physician-patient relationship unless directly relevant to a present or future known risk or, in some jurisdictions, the investigation of a crime. Even when legal and ethical permission is granted for sharing otherwise confidential information, both law and ethics support sharing the minimum amount of information necessary to prevent harm.

If the psychiatrist is treating the patient in a clinical setting, then, the psychiatrist may not share the confidences of the patient unless during the encounter the psychiatrist learns that the patient may be a danger to his or herself or others, or present a safety risk to the detention center. *See Annotations*, Section 4 #8. This limit on confidentiality does not permit the psychiatrist to act as an agent of the government in sharing information adverse to the patient's immigration interest; such activity would be a political misuse of psychiatry to assemble information to enforce immigration and asylum law. *See Position Statement on Abuse and Misuse of Psychiatry*, American Psychiatric Association (2019) ("Abuse and misuse of psychiatry occur when psychiatric knowledge, assessment, or practice is used to further organizational, social, personal, or political objectives without regard to individuals' needs and outcomes"). The *APA Commentary on Ethics in Practice* (CEP) makes this point clear: "Psychiatrists should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of detainees on behalf of military or civilian agencies or law enforcement authorities." CEP at Topic 3.4.10.

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

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

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

Some may argue that the unique legal setting of an immigration detention facility transforms the psychiatrist's role into a forensic one. A forensic evaluation is different from the clinical evaluation required by *Flores*, however. A forensic assessment is not made for the benefit of the patient, but rather at the request of and for the benefit of the court or identified third party. It is conducted either with informed consent or under explicit legal authorization. In such assessments, there is no expectation of treatment or of forming a patient-psychiatrist relationship in the interest of treatment. Indeed, in forensic evaluations the individual being evaluated is not referred to as a patient, but rather as an evaluee 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 evaluee the purpose of the evaluation, indicating that information divulged during the evaluation is not confidential and is intended for use in a legal proceeding.

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

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

E.4

Question: Is it ethical for a psychiatrist to make public statements via news media or social media or other means recommending treatments for disease that are of unproven efficacy or known to be not effective?

Answer: Disseminating inaccurate or misleading information about the prevention or treatment of disease is unethical. A physician must "uphold the standards of professionalism [and] be honest in all professional interactions." *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry,* Section 2. Psychiatrists should offer opinions and recommendations honestly and in context with full disclosure of facts so as not to mislead. Offering opinions based on some of the facts without the context of all of the facts can also be construed as misleading particularly if the speaker is a physician, a person with authority or special knowledge.

Psychiatrists, like other physicians, have a responsibility to serve the public good and community at large, including during a public health crisis like the COVID-19 pandemic, which includes a responsibility to offer recommendation and opinions honestly with full context and disclosure of facts so as not to mislead. *See, e.g.*, *Principles*, 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"). Doing so requires that physicians maintain competence and responsibly promote factual, evidence-based practices and information, and an acknowledgment of the limits of certainty in a rapidly evolving situation. This is even more critical in a rapidly evolving novel medical or public health crisis when knowledge of the nature of the disease, including recommended interventions to prevent harm, may also evolve as more is learned about the disease. In such instances, ethical psychiatrists will base their public opinions about the disease on information and recommendations provided by experts engaged in the specific area of study that pertains to the disease. Disseminating falsehoods about a pandemic disease such as COVID-19, including misleading information about scientifically supported public health protocols or vaccines, is unethical.

Likewise, using one's position as a physician to publicly promote disinformation about practices that are not scientifically grounded or generally accepted within the medical community for treatment of the disease would be unethical, if the information presented is not supported by fact and presented honestly, responsibly and with full context. Providing misleading information about prophylaxis and unproven treatments would also be

unethical, as this could foreseeably cause harm by contributing to behaviors that place individuals and the public at risk for infection with potentially serious morbidity or mortality. Section 1 of the *Principles* states that a "physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights." Competence encompasses the ability to provide expertise in a responsible and informed manner, recognize the limits of one's expertise, apply clinical knowledge within the accepted standards of medicine, and obtain and maintain knowledge sufficient for competent professional practice. *See APA Commentary on Ethics in Practice,* Section 3.1.2. As the *Principles* mandate 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." *Principles*, Section 5.

Statements questioning recommended or accepted practices and scientifically proven treatments, if not appropriately supported, explained and qualified, can mislead and cause harm. On the other hand, statements of opinion and questions raised in the course of professional debate, even if they question current practice, and even if raised in a public forum are not unethical if they are made responsibly, honestly, and are supported by fact or competent interpretation of evidence. The ethical physician must take extra care in making such statements to be sure they are accurate, made in context, and fully disclose the basis for such a position and the potential weaknesses of the position.

On matters relating to medicine, physicians have an especially powerful platform. For that reason, "Psychiatrists need to sustain and nurture the ethical integrity of the profession when in the public eye." *APA Commentary on Ethics in Practice,* Topic 3.4.7. When speaking publicly about a pandemic, therefore, it is particularly incumbent upon psychiatrists to honestly and responsibly share factual information. (Sections 1, 2,5 & 7) (2021).

E.5

Question: Is it ethical for a psychiatrist to make public statements via news media or social media or other means recommending specific forms of treatment for non-psychiatric diseases or disorders that are not encountered within the standard medical training of psychiatrists, e.g., newly described disorders or diseases, and for which the psychiatrist has no accredited clinical training regarding treatment?

Answer: As stated above, the psychiatrist has an ethical duty to exercise competence and provide accurate information when making public statements about diseases or disorders. Professional competence includes recognizing the limits of one's knowledge and skills and practicing within those limits. *See, e.g., APA Commentary on Ethics in Practice* Section 3.1.2. For additional discussion about the ethical implications that result from practicing outside one's area of competence, see the Opinion C.8. (Sections 1 & 5) (2021).

E.6

Question: I work for a nonprofit mental health clinic. We have many state documentation requirements. To meet these requirements my director proposes to bring in all of my patients who are "Med only" (they only see me and not a therapist) and have a member of the clinical staff do their medical self report, consents, treatment plan, safety plan, crisis plan and discharge plan and have them come in every 6 months to update these documents. I have no objection to this but the agency proposes to bill this as "Individual Psychotherapy" services. In addition, most of my patients are Medicaid and some Medicare, so there are legal considerations in ensuring we are not stretching definitions or rules in our billing. Am I right to object for billing since the patient has no other

relationship with the clinical staff and only the medical report/treatment, safety, crisis, discharge plans are remotely related to clinical care? I have been informed that my boss plans to go ahead and bill for these services no matter what. Again, I do not dispute that some patients might benefit from a crisis plan and a safety plan, etc. However blanket billing for all patients including those who are entirely stable or who are nonverbal (autistic/IDD) seems wrong to me. My question is, if the billing goes through and I have a reasonable concern that the bills are not proper, do I have an obligation to "whistle blow" to protect myself from any actions by Medicare, Medicaid, or private insurance companies?

Answer: Psychiatrists have an obligation to uphold the ethical duties of honesty and integrity, and to avoid fraudulent actions. (*See, Principles, 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"); *see also APA Commentary on Ethics in Practice,* Topic. 3.2.3). Billing and documentation represent the contractual, truthful expectations of a patient encounter, so that any expansion of documentation outside those expectations slides into fraud and exploitation. There must be a direct connection between the purpose of a visit and how it is billed (*see, e.g.* Opinion K.18), including where treatment and safety plans are included in clinical encounters. If the provider can rationally include any of these in a "med encounter" then so be it. But if they cannot, there is at least an obligation to raise the question to the internal billing office and the director. Those individuals will be familiar with the Medicare/Medicaid regulations and the State's specific allowances. The psychiatrist may also consider informing their malpractice carrier of the employer's intended billing plan and ensuring the employer receives that malpractice carrier's input. (Section 2) (2022).

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.

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)

H.12

Question:

A. Is it ever ethical to use the news media to make allegations of professional misconduct against a colleague, rather than going through formal channels that may afford safeguards against error, bad faith, or a rush to judgment?

B. How does the ethical psychiatrist define his or her scope of practice for giving opinions in public, keeping in mind our time-honored adherence to the Goldberg Rule?

C. When is it unethical for a psychiatrist to make, or encourage, a complaint to a disciplinary agency?

D. Is it ever ethical to make, or encourage, a complaint against a colleague to a disciplinary board without knowledge of his or her actual clinical practice?

E. How does the ethical psychiatrist make the distinction between a bona fide clinical or scientific controversy, versus a deviation from generally accepted standards of care?

F. Is it ever ethical to use the threat of sanction by a medical board or other disciplinary body to suppress regular scientific methods or regular clinical practice?

Answer:

A. A psychiatrist should be concerned about the potential legal ramifications (such as slander or libel) of making allegations of professional misconduct in the media. If there is evidence suggesting professional misconduct by a psychiatrist, it is more appropriate to report this through the APA Ethics process, to the state licensing authority, or to the formal established structures of an involved institution. Judgements regarding violations of established norms of ethical or professional conduct should be made not by individuals but by bodies authorized to take evidence and make informed decisions.

B. Section 7.3 of *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*(sometimes called "The Goldwater Rule") states that psychiatrists may share expertise about psychiatric issues in general but that it is unethical for a psychiatrist to offer a professional information about an individual based on publicly available information without conducting an evaluation. For further guidance on The Goldwater Rule, please see Opinion Q3.

C. It would be unethical to make or encourage a complaint that one knows to be false.

D. The answer to this question is an extension of answer C. Section 2 of the Principles of Medical Ethics states that "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." However, APA's ethics rules require that such reports be based on at least some first-hand knowledge. If a patient or a colleague with firsthand knowledge of the problematic clinical/ethical issue informs you about it, you could encourage them to report it since they have knowledge of the behavior. In addition, an APA affiliated ethics committee can take on a case when there is extrinsic evidence of the event, e.g. a prior judgment or consent decree, without the members having direct knowledge of the issues. Since the media is somewhat less than reliable, we have been requiring extrinsic evidence to be more substantive like sworn testimony or prior judgments, rather than news articles.

E. It is difficult to discern what is being asked in this question. Psychiatrists deviating from generally accepted standards of care expose themselves to potential ethical or legal jeopardy. The standards of care, of course, evolve with evidence from research and observations of practice. Among the expected supports for innovative practice are scientific testing, peer-reviewed publication, replication, and broad or widespread acceptance within a relevant scientific or professional community.

F. We don't understand this question. It seems that a threat of sanction for standard practice would be an empty threat. (Sections 2, 4, 5, 7) (2021)

J.6

Question: I am a psychiatrist who works for the Veteran's Administration (VA). The VA has employed psychiatrists like me who have a case load, often taking cases who are discharged from the hospital and "HUB" psychiatrists in a region. HUB psychiatrists are all virtual (performing telemedicine only) and work full or part time but do not see high risk patients and do not do new workups or see patients discharged from the hospital. Frequently, my (outpatient) patients are transferred from my care to a HUB psychiatrists without my knowledge and without any hand off where I can fill the HUB psychiatrist in on how the patient has been handled. This assignment and reassignment of patients is done by the administration. The HUB psychiatrists provide telemedicine and are in different states and likely have never met me, the original treating psychiatrists. The only handoff is the patient's electronic record. The patient is not given advanced notice or a choice in the matter. I also receive patients from the hospital without a hand off with the treating physician, but only notes, generally of a nurse practitioner that are more likely than not incomplete.
The performance measure in the VA called continuity of care means seen by a provider but not necessarily by the same provider. A doc's panel may be 1500 patients but patients are transferred to providers as they become more stable, back to primary care providers, not just specialty providers. Similarly, when a psychiatrist leaves a job, the administrators will assign the patients and the electronic record is the only handoff. Individual stations (local Vas) determine their own procedures and there is significant variability across Vas regarding assignment of patients.

1. Is the VA's practice of transferring my patients to a HUB psychiatrist without my knowledge or the patient's knowledge and consent and without a hand off to transition the patient an ethical practice? What are my ethical responsibilities in this situation?

2. Is the VA's practice of transferring patients out of the hospital to outpatient care without a handoff of someone to speak with about the patient's hospitalization and care an ethical practice? What are my ethical responsibilities in this situation? What if the information I have from the record is not complete or sufficient for me to follow up?

Answer: A practice of transferring an outpatient patient to a HUB psychiatrist without informing the psychiatrist or patient is not an ethical practice. At the very least the patient should be informed of this change prior to the transfer in care occurring.

Within the private practice setting, patients have the right to freely choose their physicians. *See, e.g.* Opinion 9.06, *AMA Council Opinions*, 2000-2001 ("Free choice of physicians is the right of every individual… The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care…It is important to ensure that the patient's choice is an informed and voluntary choice. It is the responsibility of the treating psychiatrist to inform the patient of potential disadvantages- as well as advantages - of transferring care..."). And within public institutions, an attempt should be made to place patients with physicians of their choice when feasible although clinical, administrative and risk management decisions may ultimately dictate a different outcome. Nonetheless, patients in all practice settings deserve to be informed of a transfer of care from one treating physician to another.

The treating psychiatrist, when they have learned of any potential transfer of care, should provide counsel to the patient about the transfer including to "assist the patient in identifying relevant options that promote an informed treatment decision, including those that are not available from the psychiatrist or from the organization with which the psychiatrist is affiliated." *Annotation*s, Section 8.4. In addition, the treating psychiatrist should be mindful that if they believe they are being asked to do things more for the organization's interests than those of their patients, they should advocate within the organization for organization policy change by making the best arguments available to them (including arguments based on professional ethics).

Regarding a transfer from inpatient hospital care to outpatient care, the best practice for patient care is to have a verbal handoff in care. However, it is much more common and remains ethical for the transfer of care to take place based on written documentation. It would be an unethical practice for no written documentation to be created regarding inpatient care.

The treating psychiatrist should consider contacting the inpatient psychiatrist or other treating provider to obtain any necessary information if they determine that the records available are incomplete or not adequate for them to provide care to a patient they receive. It is customary and good practice for the outpatient psychiatrist to be informed of their patient's hospitalization by the inpatient team, including because such notifications often yield useful clinical information for treatment planning. But if that notification is not done, the outpatient treating psychiatrist can take the initiative to contact the inpatient treatment team to obtain relevant information for outpatient treatment planning. (Section 3) (2021).

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)

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)

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.

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

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

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

Beneficence and non-maleficence: Psychiatrists have ethical obligations to strive to benefit their patients and to prevent harm. In evaluating apps, psychiatrists and their patients should consider: What benefits could be

expected from using this app? What is the evidence that has been gathered for the benefits and possible harms of use? A recent literature review (Gould et al, 2019) addressing mental health apps created by the Department of Veterans Affairs or the Department of Defense found support for the feasibility and acceptability of the apps, but scarce research support for efficacy and effectiveness, with a few exceptions. Clinicians were advised to not overstate the potential for benefits. However, there is substantial ongoing research on the benefits of using mental health apps, and the evidence for these benefits can be expected to grow.

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

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

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

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

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

Experts advise that the APA, the AMA, the British National Health Service, and other international organizations should develop consensus standards for mental health apps addressing such issues as data safety and privacy, efficacy and effectiveness, user experience and adherence, and data integration in health records. Much of this work is already underway. In addition, there is the potential for user participation in the development and

oversight of apps, and for physician and other clinician cooperation and alliance in this development and oversight. Such collaboration can increase the likelihood of achieving the promise of mental health apps and other technology to increase access to effective mental health care.

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

N. 33

Question: I've heard a lot of talk lately about racism, structural racism, and social determinants of health. What duties do I, as an ethical psychiatrist in private practice, have when it comes to these topics?

Answer: To provide competent care, a psychiatrist should cultivate an awareness of the adverse effects on mental health that result from racism and ethnoracial discrimination. Ethnoracial discrimination affects the mental health of individual patients and contributes to mental health disparities across society. A treating psychiatrist should be mindful of the impact that racism and ethnoracial and other kinds of discrimination may have in the lives of patients and their families, in clinical encounters, and in the development of mental health services. In a spirit of curiosity and humility, psychiatrists should engage in education or other relevant activities that will adequately equip them to be aware of their own perspectives and biases and to explore the impact of the construct of race and racism on patients' lives. The psychiatrist should strive to foster a safe and welcoming environment for patients and their families, which includes recognition of the role that societal factors, including racism, have played on the patient's current situation and mental health.

A psychiatrist may choose to go beyond individual education and competent clinical practice to educate themselves further about the history of racism and its impact today. Doing so may lead the psychiatrist to engage in advocacy for policies and laws that combat racism and promote increased access for underrepresented groups to healthcare and other resources. Engaging in such activities would be consistent with the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, which dictates that a "physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health" and "support access to medical care for all people." (Sections 7 & 9) (2021).

N. 34

Question: As a psychiatrist, what should I consider when deciding whether to terminate treatment with a patient due to difficulties in the physician-patient relationship? Additionally, what steps should I take if I do decide to terminate the treatment relationship or discharge a patient under various circumstances?

Answer: Psychiatrists must balance the ethical principles of patient autonomy and fidelity to the therapeutic relationship with their professional obligation to provide effective – or at least non-harmful – care. Though the physician-patient relationship is a collaborative endeavor established for the benefit of the patient, there may be times when the physician-patient relationship is difficult. If the therapeutic alliance begins to erode, the psychiatrist should try to find ways to improve the relationship by working with the patient to establish parameters that allow treatment to continue; sometimes a consultant can be helpful. However, there may come a time when there is an impasse between a treater and a patient such that the treater concludes that for various legitimate reasons, the therapeutic alliance has ruptured. For an adult, it is between the patient and the doctor, but for a minor or an adult with a conservator of person/guardian, the therapeutic alliance expands to the parent(s) in the case of minors, and sometimes to the conservator/guardian in the case of an impaired adult. If the relationship cannot be repaired, or the parties cannot abide by the conditions they had agreed upon, the physician may transfer the patient's care to another clinician, or the patient may terminate treatment with the psychiatrist (AMA Principles of Medical Ethics, Section 6).

It is ethical for a psychiatrist to terminate treatment if they do not feel they can safely care for the patient due to a variety of factors, including the psychiatrist's own circumstances, but it would be unethical to terminate the relationship until an adequate alternative plan of care has been established. The decision to end a treatment relationship must be carried out in a way that minimizes risk to the patient. From an ethical perspective, if the psychiatrist decides to terminate the treatment relationship, it is important to inform the patient properly, offer alternatives, and document the effort in the medical record. The psychiatrist should make sure that the patient has received their recommendations and the intent to terminate by certified letter if possible, or an email with an acknowledgement of receipt if a letter is not possible. The termination letter should include a list of at least three alternative treatment providers, as well as crisis centers, and other reasonable opportunities for the patient to transition their care. When feasible, it is best practice for the psychiatrist or their staff to contact the alternative treatment providers to confirm that they can accept the patient and meet any other necessary criteria to administer treatment (e.g., in-network with patient's insurance company, are located close to the patient's residence, and can competently treat the patient's condition). The current psychiatrist should remain available to provide bridge care if the patient chooses. The patient should receive ample notice of the termination (i.e., long enough in advance to permit the patient to secure another physician and to ensure appropriate transfer of medication management (AMA Code of Medical Ethics, Opinion 1.1.5). The psychiatrist should cooperate with the patient's request to release files and/or share information with contemporaneous and subsequent treating physicians.

The usual methods for initiating emergency medical treatment, including involuntary emergency evaluation and possible commitment, may need to be employed if the patient exhibits imminent risk of harm or meets involuntary evaluation or treatment criteria. Furthermore, if the psychiatrist has concerns about formally terminating the doctor-patient relationship or is unsure of how to do so, they may wish to contact their attorney and/or malpractice insurance carrier to inquire about any specific legal considerations pertaining to the relevant jurisdiction and/or any financial or coverage considerations for the patient.

With respect to patient transfers, when a community psychiatrist refers a patient for psychiatric hospitalization, even when the outpatient psychiatrist does not initiate the patient's admission, it is customary and best practice for the outpatient psychiatrist to be informed of the patient's hospitalization by the inpatient team. Such notification respects interprofessional relationships and often yields useful clinical information for inpatient treatment. It is also customary that the patient is redirected to the outpatient psychiatrist for follow-up care after discharge if the patient and psychiatrist both consent. If the outpatient psychiatrist is no longer willing or able to

continue care, the onus is on the outpatient psychiatrist, who has a treatment relationship with the patient, to recommend an alternative plan of care to the patient as previously described. Precipitous termination of the treatment relationship by the outpatient psychiatrist while the patient is hospitalized without providing an alternative plan is problematic. Regarding a transfer from inpatient hospital care to outpatient care, the best practice is a verbal handoff. However, it is much more common and remains ethical for the transfer of care to take place in written documentation. It would be an unethical practice for no written documentation to be created regarding inpatient care. Nonetheless, patients in all practice settings deserve to be informed of a transfer of care from one treating physician to another. Additionally, physicians are obligated to develop discharge plans that are safe for their patients and specific to their needs. To facilitate a safe discharge of a patient from an inpatient unit, the psychiatrist must make the determination that the patient is medically stable and ready for discharge from the treating facility and collaborate with those health care professionals and others who can facilitate a patient discharge. The plan must consider the patient's particular needs and preferences (AMA Code of Medical Ethics, Opinion 1.1.8) (Section 6) (2022)

N. 35

Question: I am an attending psychiatrist working essentially as the sole psychiatrist covering an inpatient unit and outpatient clinic. My contract is ending and my last day of work is in about ten days. Thus far, I have been unable to agree with the administration on terms under which I would to continue to provide coverage on a locum basis. With no inpatient coverage slated for ten days from now, I am hesitant to accept new patients into the unit for inpatient admission. Is it ethical to accept patients for inpatient psychiatric admission when I know coverage of the unit come ten or so days from now is in doubt?

Answer: A psychiatrist should not be placed in a position to provide improper care for things outside of their control (see Ethics Opinion H.2: *"a lay board cannot set a policy that requires a psychiatrist to give improper care"*). It is not the ethical obligation of professionals to accept unjust terms or unsafe conditions in order to make up for the institution's shortcomings. Although psychiatrists have obligations to their patients' future and present care, they may be limited in what they can do to influence resource decisions, particularly after their employment contract ends. And individual professionals are not responsible for future systemic decisions.

Yet, psychiatrists have ethical obligations to advocate within their institutions for appropriate care, coverage, and fair compensation. In so doing, they can be clear about their dates of employment and the standards they expect while employed, but they need not participate in systems whose foresight and staffing do not meet their standards.

Given the legal and ethical challenges presented in this situation, the psychiatrist may consider proposing negotiations with the institution, likely with the assistance of an attorney skilled in mediation, to request more transparency about the proposed duration of the per diem work and the available steps to remedy staffing shortages, and a possible negotiation on fees. During that process, given the need for the institution to secure adequate supervision of the unit, the psychiatrist could ethically point out that reaching a mutually satisfactory arrangement would be beneficial to the institution, given that the alternative would be the psychiatrist's departure. Ultimately, the psychiatrist may ethically leave the institution, assuming that reasonable notice was offered.

Ethically, psychiatrists must also take appropriate steps to inform incoming patients of relevant changes or gaps in care at the institution (see Ethics Opinion N.5). Given the current shortage of psychiatric beds and care, some

capable patients and their families may still choose to enter this facility, even given full information about future staffing shortages. (Sections 2 and 6) (2022)

N. 36

Question: For the last seven years I worked in a large managed care outpatient psychiatric clinic setting, and I became increasingly aware of the number of patients either coming to me already on stimulants for "ADHD" or demanding the ADHD diagnosis and medications. Often these patients were higher functioning people who did not have a clear history of attention impairment in childhood. It's very complicated because these people can easily recite off the DSM V for ADHD, and then there are also many people who say they had impairment in functioning in childhood, but it doesn't necessarily all add up because of their current functioning. Many of us psychiatrists in the outpatient clinic started to feel very trapped by this and almost felt forced to prescribe the stimulants. When I would try to obtain collateral of who previously diagnosed the patient with ADHD, I would often find an evaluation that was very brief and didn't go through the necessary elements of thorough evaluation to arrive at the diagnosis of ADHD. Even when one does go through the clinical assessment though for ADHD or even the Adult Self Report or other scales, it's still very subjective and in a sense if the patient is advocating for this diagnosis, they can easily obtain it and the scripts for stimulants.

I feel that ethics play a big role in this ADHD interest, perhaps social media is fueling this or the need for performance enhancement and I find it disheartening that if you look at many articles, the MDs who seem to be most interested in ADHD are also heavily funded by biopharma, so it feels wrong in many ways. I am not saying that ADHD doesn't exist in adults but I'm saying that we need to be more strategic about diagnosis and more objective testing scales etc. Otherwise, before we know it even more people will be on stimulants who don't need to be.

1) What is the best way to handle these cases of patients saying they have ADHD and essentially lying or over representing their perceived symptoms of attention issues? Should we refer most cases for complete more objective neuropsych testing?

My main question is this: 2) I've made the decision that I just don't feel I can continue to assess patients for ADHD even though obviously by training I can, but I'm just not interested anymore in considering this my specialty of practice. There will be many patients though coming into the clinic with these requests and I'm wondering is it okay for a board-certified adult psychiatrist to tell a patient "I am sorry, but I don't specialize in evaluation and/or treatment of ADHD" and to recommend that they seek evaluation by a ADHD specialist in the community? Is this discriminatory to do this or is it alright?

Is it okay ethically to tell a patient I don't evaluate for/specialize in adult attention deficit hyperactivity disorder? Or is it better to just say a blanket statement that because of an all telepsychiatric practice I don't prescribe ANY controlled medications and therefore I don't assess for ADHD given that I'm unable to prescribe a stimulant which is standard of care for treatment of ADHD.

But as I said above, the real issue for me isn't the controlled medications in general, it's that I am questioning the existence/prevalence of this massive amount of people who say they have ADHD and demand treatment, and they don't have it. I just feel I need to take a break from ADHD evaluations but is it okay for me to do this? If I suspect possible ADHD in my evaluation but I don't want to fully commit to it, couldn't I say something like rule out ADHD?

Answer: This question raises some important points about an issue that many psychiatrists find challenging, especially if they are unfamiliar with evidence-based guidelines for evaluating and treating adult attention deficit disorder. Fortunately, some guidelines are available, and others are in development.

First, we draw attention to some general issues raised.

Considerable discretion has always been given to physicians regarding which patients to serve, and what treatments to offer. Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 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."* This choice is also affected by the requirement for staying within the boundaries of one's competence and allowing that psychiatrists may decline to provide care for those who do not have a mental disorder amenable to psychiatric treatment. APA Commentary on Ethics in Practice Topic 3.1.2: *"Psychiatrists should practice within the bounds of their competence as reflected in their training, education, and professional experience, all of which is kept current through continuous education and practice."* Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, Section 6.2: *"An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment."* However, in asserting these choices, psychiatrists should strive to avoid bias or discrimination towards individual patients. They must also be honest. APA Commentary on Ethics in Practice Topic 3.2.2: *"Patients seeking psychiatric care have the fundamental expectation of honesty from their psychiatrists. Honesty includes both ensuring that information provided is truthful and that information is not withheld from the patient."* For example, it would be unethical to tell a patient that the psychiatrist (or their group) do not treat certain disorders or provide certain treatments, when in fact they do. Also, it would be problematic to avoid the issue by using a "rule out" diagnosis without specifying what would be needed to make or rule out the diagnosis. There are also suggestions that the psychiatrist may be perceiving some unfairness in the division of work within a group, or perhaps disagreement with the other psychiatrists in the practice and picking and choosing which patients to see. This may not be an ethical issue, but it appears that this may be part of this psychiatrist's conflict. It would be important to work this out openly and not allow it to affect the care of individual patients. Some individuals or practice groups may encounter such requests more frequently, for example, university health practices or practices within large academic communities.

To address the issues related to this specific diagnosis and treatment:
Evaluation and treatment of adult attention deficit disorder occur within a context:

- Physicians may be unfamiliar with available evidence-based guidance or seek more dependable guideline sources.
- Stimulants have a reputation (whether merited or not) for performance enhancement and may be sought for this purpose.
- At present (late 2022) there is a recognized shortage of stimulant medications, whether due to increased diagnosis and prescription or supply-side issues, or both.

To avoid the clinical (and perhaps moral) hazard of diagnosing a condition that the patient doesn't have and prescribing a potentially harmful medication that is not medically needed, it may be wise for individual psychiatrists, and groups by agreement, to develop a protocol regarding these requests which they can fairly and honestly apply to all new patients. They should base this protocol on the best information at hand and believe it to be defensible clinically and ethically.

On the one hand, among more unacceptable criteria would be making this diagnosis and prescribing stimulants to anyone who asked, or without a competent evaluation, or based on bias or subjective reactions to individual patients.

More acceptable protocols might include, for example:

- A competent and thorough evaluation.
- Use of validated rating scales.
- Psychological or Neuropsychological testing.
- Other health records.
- Childhood history supportive of the diagnosis, confirmed if feasible.
- A check of the controlled substances prescription database.
- Objective evidence of functional impairment.

The specifics of what to include in such a protocol would be dependent on the evidence available, and up to the judgment of an individual or a group. A protocol would at least diminish the likelihood of bias.

In response to the psychiatrist's "main question": "Is it okay ethically to tell a patient I don't evaluate for/specialize in adult attention deficit hyperactivity disorder?"
It would certainly not be ethically proper if the statement were not honest. Moreover, rather than adopting such a position, there are professionally and ethically more defensible approaches to take, as described above.

Q.5
Question: Before I write about case material in the scientific and professional literature, what ethical considerations should I take into account?

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

Q.6
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)

Q.7
Question: Does the Goldwater Rule muzzle psychiatrists such that they cannot engage in wider political discussion about despots, dictators, and totalitarianism (such as the situation in Ukraine in March 2022)? How can a psychiatrist engage in political discourse, including commenting on traits exhibited and clearly observable in world leaders, without running afoul of the rule against providing "clinical diagnosis" of individuals that haven't been examined, given that silence about propaganda and psychological manipulation used by such leaders comes across to the public as tacit approval? What are some specific examples of what psychiatrists can discuss while abiding by the Goldwater Rule, including about disinformation campaigns on social media?

Answer: In no way is the Goldwater Rule (Section 7.3 in *Principles*) intended to muzzle or stifle psychiatrists in their professional and personal responsibility to participate in activities that improve the community and society. Section 7 specifically defines such a responsibility. The Goldwater Rule is not intended to eliminate participation in controversial public discussion involving public figures, but to offer guidance in the proper dissemination of professional knowledge and experience in the public domain. Just as a general physician would not offer a diagnosis and treatment recommendations for a public figure discussing symptoms of dizziness or headache on a radio show, so should the psychiatrist refrain from diagnoses and professional conclusions based on information that has not included a direct examination and patient-physician relationship.

In 2017, the APA Ethics committee clarified aspects of the Goldwater Rule in Opinion Q.3. Here, members of the Ethics committee provided specific guidance about the care that should be taken in commenting publicly on public figures. Specifically, the committee explained the reasoning that offering professional opinions of public figures even short of diagnosis, (e.g., opinions about affect, behavior or speech), in the absence of an examination and lack of authorization or permission draws on professional knowledge and is unethical.

Yet, nothing in the clarification prohibits psychiatrists from exercising their rights to speak as private citizens or to comment in general about the implications of certain publicly observed behaviors and the potential psychiatric implications of such behaviors. It is the difference between professional and personal opinions that matters here, as well as the specificity of the response.

For example, psychiatrists are, of course, encouraged to express their political views and whether they do or do not support a particular political leader or policy. Their professional input is also useful to helping the public understand traumatic events and the types of triggers that might set such events in motion in general, but such input should not be about a particular individual. For instance, in the aftermath of school shootings, a psychiatrist may be asked to offer commentary to the media. It would be reasonable to educate the public about what is known and not known about the psychology of this type of mass violence and those who historically have perpetrated it, so long as the psychiatrist refrains from offering a professional opinion about the specific shooter in the incident under scrutiny. Psychiatrists should not draw any professional conclusions about the specific individual based upon what they have learned or observed outside of a physician-patient relationship, unless one of the exceptions noted in Opinion Q.3 applies. The Goldwater Rule was not intended to discourage psychiatrists from their responsibilities to educate the public and utilize professional knowledge in improving society.
(Section 7) (2022)