



## **APA Commentary on Ethics in Practice**

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## **Section 1. Introduction**

Ethical conduct by psychiatrists requires more than mere knowledge of ethics principles. It also requires that psychiatrists consistently apply that knowledge in their day-to-day professional activities. This assures that ethically sound judgment is exercised and the actions that follow fall within accepted ethical bounds. Important to the ethical practice of psychiatry are the abilities: 1) to recognize ethical aspects of a professional situation; 2) to reflect on one's role, motives, potential "blind spots", biases, and competing or conflicting interests; 3) to seek out, critically appraise, and make use of additional knowledge and valuable resources, e.g., clinical, ethical, cultural, or legal information; 4) to systematically evaluate the ethical aspects of a professional situation and identify possible courses of action; and 5) to create appropriate safeguards in an ethically complex situation. Moreover, obtaining additional data, seeking appropriate consultation or supervision, maintaining clear professional boundaries, and separating roles that may pose conflicts are all actions that can help ensure ethical decision-making and minimize the likelihood of ethical breaches. Regardless of their role, all psychiatrists retain the obligation to avoid bias and discrimination.

This document is intended to assist psychiatrists in understanding and applying the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry to their practice.

### ***Uses of this document***

This document is written for psychiatrists who serve in many roles. It may be of particular value to individual psychiatric practitioners in their clinical activities. It may also be helpful to teachers and academic psychiatrists as they convey expectations regarding ethical conduct to the next generation of physicians.

This document is intended to aid in understanding the complexity of psychiatric ethics and how they apply in different situations. It is not a "rule book" but rather a tool. It is not intended to cover all ethically important situations and novel ethical questions that psychiatrists may encounter in the course of their careers. It is not intended for the resolution of courtroom disputes, which apply legal rather than clinical standards and values, nor is it intended to undermine ethical practitioners serving in communities where scarce mental health resources call for flexibility. Furthermore, it cannot fully capture all of the circumstances that alter the ethical nature of a particular decision or action.

This document emphasizes the importance of ethical skills as well as knowledge of ethical principles and their application to psychiatric practice; however, it is only as good as the integrity and judgment of those who use it.

## **Section 2. Ethical principles in the professional practices of psychiatrists**

By focusing on:

- The ethical basis of the physician-patient relationship;
- Ethically important practices in psychiatric care;
- The ethical basis of relationships with colleagues; and
- Other ethically important topics in psychiatric practice,

this document highlights ethical principles that find expression in the professional practice of psychiatrists in their various roles and activities. Knowledge of ethical principles will allow psychiatrists to respond to complex and novel situations with an understanding of their ethical implications and to make ethically-sound decisions.

### **Section 3.      Practice Domains**

#### ***3.1: The ethical and professional basis of the physician-patient relationship***

##### ***Topic 3.1.1      The physician-patient relationship***

The physician-patient relationship is the cornerstone of psychiatric practice, and its goal is to promote patient health and well-being, embodying the key ethical considerations of respect for persons, fairness or equity, and beneficence. Patients often lack medical expertise and sometimes struggle with symptoms that adversely affect their autonomous decision-making. The psychiatrist is responsible for rendering medical care in the patient's best interest while respecting the patient's goals and autonomy.

The physician-patient relationship is a collaborative endeavor between two autonomous individuals who establish the professional relationship for the benefit of the patient. Every effort should be made to have the relationship begin by mutual consent. Psychiatrists should be cautious in interactions with persons who are not (or not yet) patients to avoid rendering input, advice, or other suggestions that might lead to the assumption or expectation that a treatment relationship has begun. These early conversations can occur over the phone or through other media. Especially as new consultative roles are emerging for psychiatrists, psychiatrists should ensure clarity of role for themselves, colleagues, and patients in a given system or treatment of a patient to ensure the highest standard of care. The relationship may include a child's parent or guardian, next of kin, an adult's legally recognized substitute decision-maker, or anyone a competent patient invites to participate. For patients lacking competency, psychiatrists should still consider requests to include persons important to the patient in the treatment in consultation with the patient's substitute decision maker. The relationship may continue for as long as an illness persists or until a patient either transfers care to another clinician or chooses to end treatment. Because psychiatric patients share sensitive and intimate details of their lives with the psychiatrist, psychiatric patients may be especially vulnerable to undue influences, including persistent societal influences, and the psychiatrist should be sensitive and careful that the psychiatrist's conduct does not physically, sexually, psychologically, spiritually or financially exploit or harm the patient.

There may be times when the physician-patient relationship is difficult and when the therapeutic alliance erodes. The psychiatrist should try to find ways to improve the relationship by working with the patient jointly to establish parameters that would enable treatment to continue; sometimes a consultant can be helpful. If the relationship cannot be repaired, or the parties cannot abide by the conditions agreed upon, the physician may transfer the patient's care to another clinician, or the patient may terminate the psychiatrist. In either case, the psychiatrist should cooperate with the patient's request to release files and/or share information with contemporaneous and subsequent treating physicians.

##### ***Topic 3.1.2      Professionally competent care***

Professional competence is the ability to apply clinical knowledge and to provide care within the accepted standards of clinical practice, which includes providing appropriate expertise as well as adequate time and attention to meet each patient's needs responsibly. Professionally competent care at times may involve the consideration and use of innovative treatments, consulting with other physicians, and practicing only within one's field of expertise.

In a rapidly evolving and diverse field such as psychiatry, competent practice is influenced by advances in a variety of disciplines, including the behavioral, social, and biological sciences, and by religion, and the complex social and economic contexts of practice.

Given the detrimental effects of all forms of discrimination, competent practice requires that a psychiatrist be aware and mindful of the existence and potential impacts of racism, ethnoracial, and other forms of discrimination in the lives of patients and their families. Obtaining and maintaining knowledge and skills sufficient for competent professional practice requires attention throughout a psychiatrist's career.

Psychiatrists should maintain professional competence through continuing education, supervision, and/or consultation. 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. Psychiatrists should make referrals or delegate care only to persons who, based on their training and experience, are in the psychiatrist's reasoned judgment, competent to deliver the necessary treatment.

### *Topic 3.1.3 Dual agency and overlapping roles*

By virtue of their activities and roles, psychiatrists may have competing obligations that affect their interactions with patients. The terms "dual agency," "dual roles," "overlapping roles," and "double agency" refer to these competing obligations. Psychiatrists may have competing duties to an institution (e.g., employers, the judicial system, or the military) and to an individual patient, or to two patients or two institutions.

The treating psychiatrist has a primary, but not absolute, obligation to the patient. Wherever possible, however, the treating psychiatrist should strive to eliminate potentially compromising dual roles by attending to the separation of their work as clinicians from their role as mandated reporters, institutional or administrative representatives. However, as the medical system becomes increasingly complex, it is critical for psychiatrists to recognize that not all competing obligations may be resolved. Psychiatrists should remain committed to prioritizing patient interests as treating physicians, expecting that they will find themselves in the position of having to reconcile these interests against other competing commitments and obligations. For example, unsafe discharge of a patient in need of care when a third-party payer refuses to cover expenses could be problematic as the decision to discharge does not prioritize the patient's interests.

Psychiatrists should inform patients about the potential for competing obligations within the treatment or other non-clinical evaluation, such as a forensic evaluation. At a minimum, the psychiatrist should inform the person being treated as a patient or evaluated for another purpose of the purpose of the clinical encounter or evaluation, the limits on confidentiality of the treatment/examination, and the parameters of the relationship between the physician and the patient or evaluatee, (e.g., who requested the examination/evaluation, whether an ongoing relationship will occur, and, if so, the parameters/expectations of that relationship).

Treating psychiatrists should carefully reflect on the situation when asked to serve as a forensic expert or witness on behalf of a patient under their care. There are many considerations, including the loss of confidentiality between doctor and patient, the potential for the psychiatrist to provide testimony that is adverse to the patient upon cross examination, and the ability of the treatment relationship to continue after the psychiatrist has testified, perhaps having said some things that, while honest, were not to the patient's liking. The central principle in the psychiatrist's decision about whether to testify and/or serve as an expert for the patient is the patient's overall interest and wellbeing. At a minimum, psychiatrists should carefully address with patients that there is a balance that must include weighing the risks and benefits of testifying and not testifying. For example, if a psychiatrist does not testify, a patient may have no realistic chance of securing deserved disability benefits. Psychiatrists should be sure to include a candid discussion of the potential risks of unintended outcomes, the lack of scientific precision in the legal process, and the potential for an adverse decision.



### **3.2: Central ethical and professional practices in psychiatric care**

#### **Topic 3.2.1 Confidentiality**

Medical confidentiality is the physician's obligation to their patient not to reveal the patient's personal or health information without that patient's explicit, informed permission. This obligation is an ethical duty distinct from the legal duty to protect patient privacy.

Patients should be informed of the limits on confidentiality at the beginning of the physician-patient relationship and again as necessary and/or relevant. Disclosures, even with informed consent, should be limited to the requirements of the situation, particularly when legal privacy rules provide a lower standard of protection than ethics require. Progress notes should record only the information necessary for good continuity of patient care.

There are legally imposed limits on confidentiality. For example, most states impose some obligation to warn or protect intended victims or report threats to authorities when there is a reasonable probability that patients may carry out the threat to harm themselves or another person. All states impose a duty to report child abuse and most require reporting of elder abuse. In addition, a rapidly growing number of states require physicians to check prescription monitoring databases to promote patient safety and to avoid duplicate prescriptions and polypharmacy by multiple providers. Because the specific requirements of each state's law vary, psychiatrists should know the legal limits on confidentiality in the jurisdiction(s) in which they practice.

The advent and expansion of the use of electronic medical records and the increasing use of care coordinators and integration of medical care present challenges to traditional notions of patient confidentiality. The need to share information and coordinate care to benefit the patient must be weighed against the patient's need for confidentiality. Where electronic records are concerned, many hospitals inform patients of how the records will be used upon admission or upon use of the hospital system and patients sign a notice that they have been informed.

The psychiatrist should exercise caution in notes that may be available to others to include only the information that would be necessary for evaluation and treatment of the patient's condition. In addition, as part of their routine practice, psychiatrists may inform patients about the types of information that are included in the record, how the information in the record could be shared with others (with and without consent), and/or patient options for amending the record.

#### **Topic 3.2.2 Honesty and integrity**

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. Psychiatrists should strive to provide complete information to patients about their health and all aspects of their care, unless there are strong contravening cultural factors or overriding therapeutic factors such as risk of harm to the patient or others that would make full disclosure medically harmful. Limiting the sharing of information with the patient should be the exception rather than the rule in respect for the value of honesty in the therapeutic relationship. Decisions not to share information with a patient should be thoughtfully considered and justified after a careful process of analysis. Psychiatrists may consider the value of deliberation with treatment teams, supervisors, and/or colleagues in coming to decisions to withhold clinical information from patients in recognition that decisions not to share information may fundamentally affect the patient's dignity.



In general, omission (intentional failure to disclose) and evasion (avoidance of telling the truth) will undermine a trusting and constructive relationship between the psychiatrist and the patient and should be avoided. Sharing information with any patient, including children, should occur in clinically and developmentally appropriate terms and settings.

During the course of patient care, psychiatrists are often asked to communicate with other individuals and agencies. Psychiatrists should not provide third parties with more information than is needed under the circumstances and they should stick to the facts. Releasing inaccurate or misleading clinical information to insurers, employers, or other third-party entities is a specific example of dishonesty and may constitute fraud.

### *Topic 3.2.3 Non-participation in fraud*

As stated in the above section, psychiatrists should uphold their ethical duty to honesty and integrity. Fraud is an action that is intended to deceive, and ordinarily arises in the context of behavior that seeks to secure unfair or unlawful gain. Psychiatrists should be aware that fraudulent actions, in addition to being unethical, may also trigger legal sanctions. Moreover, because honest dealings with patients are fundamental to the physician-patient relationship, any act of deception or misrepresentation with a patient has the potential to compromise the psychiatrist's ability to provide competent care.

Psychiatrists communicate with numerous agencies and individuals during patient treatment. They are responsible for the usual physician contact with funding and reimbursement agencies, families, employers, and other third parties. However, because of their expertise in human behavior, psychiatrists are often asked, formally and informally, for information justifying or excusing patient actions. These requests offer numerous opportunities for ethical missteps. While each unique situation may have particular circumstances affecting the ethical analysis of a psychiatrist's conduct, psychiatrists should be particularly aware of their ethical responsibilities to honesty and integrity even in situations that occur for the benefit of the patient. Specific examples of fraud in psychiatric practice include making false or intentionally misleading statements to patients, falsifying medical records, research, or reports, submitting false bills or claims for service, lying about credentials or qualifications, supporting inappropriate exemptions from work or school, providing unnecessary treatment, taking credit for another's work, and writing a prescription for a patient in a family member's name. These are some examples of actions that are not ethically acceptable in the practice of psychiatry. Some may also be legally actionable.

### *Topic 3.2.4 Informed Consent*

Psychiatrists should recognize the importance of informed consent for assessment or treatment as an essential means to provide recognition of and respect for the patient's autonomy and personhood. Informed consent is an ongoing process that involves disclosing information important to the patient and/or decision-maker, ensuring the patient/decision-maker has the capacity to make treatment decisions, and avoiding coercive influences. Typical elements of disclosure include an accurate description of the diagnosis and the proposed treatment, its potential risks and benefits, any relevant alternatives, including no treatment at all, and the relative risks and benefits of each option. Psychiatrists should honor the specific and enduring personal, social, and cultural values of their patients and, in general, not condition a patient's ongoing treatment on a patient's acceptance of specific treatment recommendations. It is the exception rather than the rule that a psychiatrist

would terminate a treatment relationship due to a patient's refusal of a specific recommendation, and generally limited to compelling circumstances in which such refusal involves actual, threatened, or heightened risk of harm to the patient or others. Psychiatrists must prioritize the ethical principles of respect for patient autonomy and dignity of the person, while recognizing their professional obligations of providing effective – or at least non-harmful – care. Therefore, psychiatrists may ethically refuse to provide or insist on withholding certain treatments to or from a patient when those treatments would be harmful to the patient or contrary to an established and rational therapeutic plan, even if the patient demands those interventions.

#### *Topic 3.2.5 Involuntary psychiatric treatment*

Involuntary psychiatric treatment is on occasion needed to ensure the safety of the patient or the safety of the community. The legal doctrines of police power and of *parens patriae* (i.e., the state as parent) have provided the customary rationale for involuntary treatment. Involuntary treatment may involve interventions such as psychiatric hospitalization, court-ordered outpatient treatment, and/or treatment with psychiatric medications.

Enforced treatment contains an inherent ethical tension among several values: respecting the individual's autonomy, providing care for that individual, and protecting the community. To exercise this coercion while balancing these competing values calls for great sensitivity on the part of the psychiatrist. When involuntary treatment is imposed, it should ensure the least restrictive clinically appropriate alternative and, to the extent possible, respect the informed consent process and the patient's decision-making capacity. With any involuntary treatment special attention should be paid to avoiding bias and discrimination.

#### *Topic 3.2.6 Therapeutic boundary keeping*

Therapeutic boundaries are the professional limits on the conduct of the relationship between psychiatrists and their patients. They are required to ensure that the psychiatrist does not take advantage of a patient and to ensure that there is no appearance of impropriety in the psychiatrist-patient relationship. Psychiatrists must never exploit or otherwise take advantage of their patients, must avoid patient interactions that are aimed at gratifying the psychiatrist's needs and impulses, and must not use their position to influence the patient in a manner that may undermine or threaten treatment goals. The concept of "beneficence" holds that all interaction with a patient should be for the benefit of the patient and the concept of "non-maleficence" holds that interactions that could potentially cause harm or misunderstanding should be avoided. However, the psychiatrist should show compassion towards, interest in, and kindness to patients.

Sexual behavior with patients is unethical. Further, even the possibility of future sexual or romantic relationship may contaminate current clinical treatment. Therefore, sexual activity not only with current, but also with former patients is unethical. Likewise, any occasion in which the physician interacts with a current or former patient in a way that may be a prelude to a more intimate relationship should be avoided.

While sexual contact is the most obvious form of unethical behavior, other non-sexual behaviors may also undermine the therapeutic relationship and cause harm to the patient. For example, psychiatrists should be aware that business transactions and relationships with patients as well as non-sexual social relationships may negatively affect the therapeutic relationship. Because of

the diverse array of treatments and treatment settings, it is impossible to create unambiguous rules of conduct for all areas of clinical practice. However, psychiatrists must maintain awareness that their behavior should be directed toward the patient's therapeutic benefit, and behavior that is likely to conflict with that goal should be avoided.

Finally, rules guiding professional behavior are context sensitive. Because of this contextual element, it is important to distinguish boundary violations from boundary crossings. Boundary violations are transgressions that are immediately harmful, are likely to cause future harm or are exploitive of the patient, and as such, are always unethical. Boundary crossings are deviations from customary behavior that do not harm the patient and that on occasion may facilitate the therapeutic process. However, because of their potential to erode the therapeutic relationship, especially in the context of long-term psychotherapy, boundary crossings should be undertaken in treatment only in an intentional manner and when the benefits clearly outweigh the risks. For instance, the appropriateness of accepting a small gift from a patient should be evaluated in light of the cultural and community context and the therapeutic impact. Likewise, a hug may be appropriate in certain circumstances as a sign of respect for the culture of the patient or of compassion and support. Psychiatrists must evaluate the situation and ensure that their conduct is not misconstrued and is in the best interest of the patient. Psychiatrists are encouraged to seek peer or other consultation in these matters, especially when they are in doubt about what action to take.

#### *Topic 3.2.7 Ethical philanthropy and political advocacy in psychiatry*

Across all fields of medicine, organizational fundraising must be conducted with sensitivity so as not to exploit the relationship of trust that the physician has with the patient. Psychiatrists should consider whether the therapeutic relationship would encourage the patient to donate when he or she otherwise would not. The inherent conflict of interest must also take into account patients' competent decisions and their right to act as citizens. To be ethically acceptable, fundraising in psychiatry must be based in trust and honesty and in the fulfillment of goals of shared importance to the organization and the donor. Most importantly, philanthropic activities must be non-exploitative. Individual psychiatrists must not approach their patients for funds or initiate identification of specific patients for their institutions to solicit, as this may adversely affect the therapeutic relationship and cannot sufficiently safeguard the patient from exploitation.

While psychiatrists are expected to participate in activities contributing to the improvement of the community and public health, care should be exercised when the psychiatrist enters political discussions with the patient. In that context, there is potential for invading and exploiting the treatment relationship, especially when patients are asked to support political causes. Psychiatrists should refrain from attempting to influence the patient's political views, although they may promote the patient's civic engagement. Psychiatrists should exercise thoughtfulness in their interactions with patients regarding political issues, including the materials they provide or make available.

### **3.3: The ethical and professional basis of the relationship with colleagues**

#### *Topic 3.3.1 Seeking professional consultation*

Psychiatrists treat challenging illnesses, and psychiatric illnesses are influenced by complex social and cultural contexts, co-morbid conditions, and discrimination including ethnoracial discrimination. Because of this complexity, psychiatrists should carefully consider the need to further educate themselves and for consultation with colleagues and/or supervisors, especially

when patients are not doing well. Professional competence entails recognizing the limits of one's own perspective and clinical skills. Consultation in the analysis of ethical dilemmas is also sound practice.

If psychiatrists receive referrals for conditions that are outside their area of particular expertise and more specialized psychiatrists are available, they should consider making a referral to the more experienced clinician. Consideration of such a referral may include consultation with the specialist. Psychiatrists should exercise care in working on teams with and delegating responsibility to non-physicians to assure patients receive sound care.

Psychiatrists should agree to patient requests for consultation (or to the requests of family/guardian for minor or incompetent patients) and are free to accept or reject the consultant's opinions, while including a discussion with the patient about their decision to accept or not. Psychiatrists may suggest, but should not dictate, a choice among consultants. If psychiatrists disapprove of the professional qualifications of the consultant, or have a difference of opinion with the findings that cannot be resolved with the patient, they may withdraw from the case after suitable attention to the patient's ability to find needed care from another provider.

#### *Topic 3.3.2 Relations with non-psychiatrists on multidisciplinary teams*

The treatment of patients often occurs on multidisciplinary teams. Psychiatrists are regularly asked to assume a collaborative role with other mental health clinicians on such a team, and such collaboration can produce an ethical tension regarding the extent of responsibility of the psychiatrist for treatment decisions. When collaboration occurs between independent practitioners (as in split psychotherapy/psychopharmacology treatment), psychiatrists should coordinate care with their colleagues and should be aware that they are assuming shared responsibility for the overall treatment but are still solely responsible for the medical aspects of treatment. The psychiatrist and the collaborating clinician must communicate to their common patient the unique roles of each.

Given that there are times where the number of psychiatrists available is insufficient to meet the needs of the population, the psychiatrist should be willing to consult with, and for, non-medical or medical non-psychiatric providers when necessary.

#### *Topic 3.3.3 Responsibilities in teaching and in supervising psychiatrists-in-training*

As teachers and supervisors, psychiatrists must model not only clinical expertise but also a high standard of professional ethics. They must foster a positive, respectful learning environment, mindful of the asymmetry in power between themselves and their trainees, with a resulting responsibility on teachers (for example, avoidance of sexual involvement with trainees).

#### *Topic 3.3.4 Responding to the unethical conduct of colleagues*

All psychiatrists have an obligation to recognize and address the unethical behavior of colleagues, including a variety of behaviors that violate professional standards, (such as exploitation of a patient, dishonesty or fraudulent professional activities, or behavior that discriminates against patients or others for any reason, including on the basis of race, gender, gender identity, religion, sexual orientation or other protected status) including behaviors that intentionally demean or humiliate patients or colleagues/supervisees. In some instances reporting is also mandated by law. Options for addressing behavior may include seeking advice from supervisors, engaging in consultation with the individual, or reporting behavior to the appropriate authorities (including Ethics Committees of District Branches of the American Psychiatric Association).

#### *Topic 3.3.5    Responding to impaired colleagues*

Impairment among psychiatrists may arise from physical, mental, or substance use-related disorders. Such impairment may compromise professional competence and pose a serious threat to patient welfare. Impaired psychiatrists who do not seek help and correct the problem fail the community of psychiatrists, its standards, and their patients. Patients may not recognize an impairment or, if they do, be reluctant to report it.

A psychiatrist who is concerned about an impaired colleague's ability to care for patients safely may attempt to counsel or encourage the impaired colleague to seek treatment and to refrain from patient care. However, if the impaired psychiatrist does not respond to a collegial approach, the psychiatrist has an obligation to address the problem through appropriate channels such as the chief of the service, the hospital medical staff procedures, the state's impaired physician program, the state medical board, or another available route (e.g., a District Branch wellness committee).

### **3.4: Other ethically important topics in psychiatric practice**

#### *Topic 3.4.1    Working within organized systems of care*

While psychiatrists enjoy professional autonomy in their practice, an increasing number of psychiatrists work within at least one system of care, such as a hospital, group practice, multispecialty group practice, accountable care organization, government system, military system, or work for third-party payors. These systems have increased in complexity but can create opportunities for improved patient care through innovation, clinical research, integration of health care, collegiality and peer relationships. However, they also create potential for conflict between the primacy of the individual patient and the legal, business and political interests of the care system about which the psychiatrist should be aware and monitor.

In increasingly complex systems of care, treating psychiatrists will encounter situations in which the primacy of individual patient care competes with other compelling interests and obligations. Psychiatrists in any system of care, whether or not they are providing clinical care to individual patients, maintain responsibility to patient interests and commitment to promoting organizational ethics supportive of individual patient care and care of patients more generally. Care systems may employ a variety of cost containing measures, including prospectively, concurrently, or retrospectively reviewing treatment, emphasizing preventive or primary care services, requiring specific approvals for specialty procedures or referral, promoting the use of treatment guidelines, or creating economies of scale to streamline care within large systems. In these systems, other values often compete with the interests of the individual patient. The fundamental tension of psychiatrists working in organized settings, then, is that the terms of employment relate to the needs of the venture, but as physicians, psychiatrists working in organized systems of care cannot ignore the needs of patients. Physician-executives or administrators retain obligations to patients even when they are not directly involved in patient care. For example, physician executives or administrators practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system (especially among those traditionally marginalized), and help identify alternatives available outside of the system when the patient's psychiatric or medical well-being requires it.

#### *Topic 3.4.2 Clinically innovative practices*

Clinical decision-making without established research evidence to guide practice requires informed clinical judgments drawing on the best available research, adherence to the ethical principles of beneficence and non-maleficence, and sound theoretical reasoning. When usual treatments have failed, psychiatrists may offer non-standard or novel interventions using a shared decision-making approach grounded in the patient's informed consent and a thorough discussion of risks, benefits, and alternatives to the innovative treatment. Since innovative practice sometimes leads to important scientific advances, it should not be categorically discouraged; however, because it may prove ineffective or even harmful, psychiatrists should proceed with caution in their use of clinical innovation. When considering use of clinical innovation, psychiatrists should consider first consulting colleagues and exploring other resources to ensure that careful thought has been given to possible alternatives as well as to the safest and most effective use of innovative interventions.

#### *Topic 3.4.3 Psychiatric issues in end-of-life care.*

Psychiatrists can have a critical role to play in end-of-life discussions because of their experience in dealing with sensitive and difficult discussions with patients. Psychiatrists can also identify and treat common psychiatric and neuropsychiatric symptoms at the end of life. Finally, psychiatrists may be well-positioned to address the psychological suffering that accompanies the potential stigmatization and marginalization of those nearing the end of life.

Appropriate approaches to end-of-life care often combine treatment-specific information with values histories. Such approaches allow physicians to balance information regarding end-of-life care with accurate knowledge of patient preferences. Patients must be provided sufficient information for making decisions and their wishes documented and reassessed over time. Ongoing discussions with caregivers can be an invaluable source of information. Use of the full range of tools for improving end-of-life care — including advance directives, treatment vignettes, and values histories — can begin to overcome the barriers to treatment faced by persons requiring end-of-life care.

Where there is doubt regarding the authenticity or stability of decisions, psychiatrists may contribute specialized expertise in focused capacity assessments. In addition, specific assurances that patients will not be abandoned can mitigate feelings of hopelessness. Information on the likely course of an illness and means for managing symptoms can also bring hope. Improved communication is critical for addressing common feelings of dread and despair, identifying and treating depression, addressing medication side effects or related neuropsychiatric symptoms, and supporting families in dealing with psychosocial stressors. Psychiatrists, like all physicians, should be truthful with patients about their diagnoses and prognosis and must have the requisite compassion and skill to thoughtfully and sensitively foster dialogue with patients who are seriously ill and suffering from a terminal illness.

#### *Topic 3.4.4 Relations with the Pharmaceutical and Other Industries*

New psychopharmacologic medications, medical devices, and innovations in genetics and biotechnology are increasingly important elements of modern psychiatric practice. Psychiatrists may interact with industry in many ways, including presenting at industry sponsored lectures and appearing in industry sponsored publications and advertisements, accepting and distributing sample products, recommending patients for industry sponsored clinical trials, and accepting personal or office gifts or corporate donations from industry.

Psychiatrists should recognize that industry has obligations beyond patient welfare, including primary obligations to shareholders that psychiatrists do not share.

All psychiatrists should be aware of the potential conflicts that interactions with industry pose between business objectives and the psychiatrist's clinical or research responsibilities. Although the mere appearance or existence of a conflict of interest does not by itself imply wrongdoing, the failure to recognize and actively address such conflicts does compromise professional integrity and threatens the independence of the psychiatrist's judgment. For example, receiving gifts from industry may cause the psychiatrist to favor one medication over another.

At a minimum, psychiatrists should disclose their affiliations, relationships, and financial involvement with Industry to their patients in clinical settings and to audiences in professional presentations, even if they believe they are inconsequential.

Addressing conflicts of interest should be guided by three principles: the primacy of patient welfare, the independence of the psychiatrist's judgment, and disclosure. The guiding principle should be that the patient's interest rises above that of the psychiatrist or Industry. In each clinical decision the psychiatrist makes, he must be able to justify why that decision was in the best interest of the patient.

#### *Topic 3.4.5 Ethical issues in small communities*

Patients in small or underserved communities may encounter greater barriers to care because of limited health care resources, including the absence of specialty and subspecialty expertise and fewer health services. In small and/or remote communities, psychiatrists may effectively function as generalists across a broad range of clinical areas in psychiatry rather than specialists in a particular area of psychiatry. In an underserved context, if a patient care situation falls outside a psychiatrist's usual scope of practice, he or she may justifiably provide care if the psychiatrist has closely-related training and experience, if the psychiatrist possesses the most readily available relevant expertise, and if the patient's clinical needs warrant evaluation and intervention (e.g., because of severity and/or urgency). Where professional boundaries may be crossed by treating a neighbor or community acquaintance, the crossing should be in the patient's interest. Psychiatrists who choose to extend the scope of their practice in such a manner incur an obligation to expand their expertise in appropriate ways by supervision, consultation, formal courses, or other means of education.

#### *Topic 3.4.6 Professional Use of the Internet and Communication Technology*

Innovations in internet and communications technology over the past several decades have the potential to improve access to, delivery of, and quality of psychiatric care. However, these advances may also pose potential challenges to sound and ethical practice. While each type of technology and situation requires a case-by-case analysis, psychiatrists should be aware of potential ethical challenges in its use before using the technology in providing patient care. Psychiatrists are responsible for obtaining sufficient knowledge about the technologies they employ to respect patient confidentiality and deliver competent care. Psychiatrists must be aware of their responsibility to maintain professional boundaries in their internet activities – both in respecting their patients and in establishing separation between personal and professional internet and social media presence. Before using electronic communications or other technologies in the care of patients, psychiatrists should inform patients of the parameters of this technology use, including privacy, appropriate use (e.g., administrative vs. clinical), expectations, and emergency contact procedures.

#### *Topic 3.4.7 Public Statements*

For some in our profession, psychiatry can extend beyond the physician-patient relationship into the broader domain of public attention: in administration, politics, the courtroom, the media, and the internet. Psychiatrists need to sustain and nurture the ethical integrity of the profession when in the public eye. A psychiatrist may render a professional opinion about an individual after an appropriate clinical examination and accompanying waiver of confidentiality and should not do so unless the examination and waiver have occurred. When a personal examination has not been performed and when a psychiatrist is asked for a professional opinion about a person in light of public attention, a general discussion of relevant psychiatric topics — rather than offering opinions about that specific person — is the best means of facilitating public education. In some circumstances, such as academic scholarship about figures of historical importance, exploration of psychiatric issues (not diagnostic conclusions) may be reasonable provided that it has a sufficient evidence base and is subject to peer review and academic scrutiny based on relevant standards of scholarship. When, without any personal examination, the psychiatrist renders a clinical opinion about a historical figure, these limitations must be clearly acknowledged. Moreover, labeling public figures cavalierly with psychiatric conditions, based on limited or indirect clinical knowledge is not consistent with this approach and undermines public trust in the profession of psychiatry. Psychiatrists should also exercise caution when asked to provide the profile of or otherwise comment on the kind of person who might have committed a crime by clearly and publicly identifying the inherent uncertainty in profiling and the necessity of considering additional information as it becomes available.

#### *Topic 3.4.8 Civil disobedience*

Civil disobedience is the nonviolent and principled refusal to obey the dictates of government. It may occur when a psychiatrist's ethical obligation to a patient conflicts with the law, for example when the state's request for patient information seems to the psychiatrist to jeopardize the patient's well-being. Psychiatrists should clearly state their ethical obligation in such cases, pursuing options within the law until they have been exhausted. Psychiatrists may subsequently agree to comply with the mandate or not. While physicians have an ethical responsibility to respect the law, it is conceivable that a practitioner could violate the law without violating professional ethics. If psychiatrists refuse to comply with the law, however, they should be aware of the legal consequences of their action and consider obtaining legal counsel.

#### *Topic 3.4.9 Execution*

Psychiatrists should not participate in a legally authorized execution and may not assume roles that lead them to facilitate, implement, develop or monitor any techniques involved in execution. When a condemned prisoner has been declared incompetent to be executed, psychiatrists should not treat the prisoner for the *sole* purpose of restoring competence unless a commutation order is issued before treatment begins. However, the psychiatrist may treat the incompetent prisoner, as any other patient, to relieve suffering.

#### *Topic 3.4.10 Psychiatrist participation in interrogations*

Psychiatrists providing medical care to individual detainees in military, criminal, or civilian settings may face conflict between their primary obligation to their patients and obligations to the institution (e.g., ensuring safety). Treating psychiatrists who become aware that detainees may pose a significant threat of harm to themselves or to others are not precluded



from ascertaining the nature and the seriousness of the threat or from notifying appropriate authorities of that threat, consistent with the obligations applicable to any psychiatrist relationship. As in any other setting, psychiatrists should safeguard the confidentiality of patient information, understanding that there may be legal or ethical requirements to disclose information. In these settings, the record may be the property of the institution and psychiatrists should be aware that non-clinical entities may have access. Psychiatrists should inform patients in these settings that information disclosed in treatment may not be confidential and of the specific limits on confidentiality.

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.









