

**Opinions of the
Ethics Committee
on
The Principles of Medical Ethics**

*With Annotations Especially
Applicable to Psychiatry*

2025 Edition



Published by the American Psychiatric Association
Washington, DC

Copyright© 2025 American Psychiatric Association
ALL RIGHTS RESERVED

04 03 02 01 4 3 2 1

Manufactured in the United States of America
2025 Edition

(Previous editions 1979, 1983, 1985, 1989, 1992, 1993, 1995, 2001, 2009, 2014, 2015,
2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024)

American Psychiatric Association

800 Maine Ave SW, Suite 900

Washington, DC 20024

www.psychiatry.org

TABLE OF CONTENTS

FOREWORD	1
PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION	3
OPINIONS OF THE APA ETHICS COMMITTEE	4
A. BOUNDARY AND DUAL RELATIONSHIP ISSUES	4
B. BUSINESS PRACTICES AND ANCILLARY PROFESSIONAL ACTIVITIES	21
C. CHILD AND ADOLESCENT PSYCHIATRY (Including Child Custody and School Issues)	27
D. CONFIDENTIALITY AND INFORMED CONSENT	31
E. DUTY TO REPORT AND PROFESSIONAL COMPETENCY ISSUES	42
F. ETHICS PROCEDURES	47
G. FORENSIC ISSUES	49
H. INTERACTION WITH OTHER PROFESSIONALS	54
I. MANAGED CARE	60
J. MILITARY AND OTHER GOVERNMENT AGENCIES	62
K. PAYMENT, FEE AND FEE SPLITTING ISSUES	69
L. PHARMACEUTICALS	78
M. PHILANTHROPY, GIFTS AND WILLS	80
N. PRACTICE ISSUES	83
O. PROFESSIONAL LISTINGS, ANNOUNCEMENTS	110
P. REFERRAL PRACTICES	112
Q. RESEARCH AND SCHOLARLY ACTIVITIES	115
R. RESIDENT, STUDENT AND OTHER TRAINEE ISSUES	121

Foreword

The Ethics Committee of the American Psychiatric Association receives requests for opinions, generally regarding the ethicality of conduct in professional and other settings. Answers to these questions are drafted by “teams” composed of members and/or consultants of the APA Ethics Committee.

The Opinions that follow in this document date back to 1973 and each offers a perspective from the particular moment in time at which it was given. Opinions in certain areas have evolved over time due to various factors, such as the increasingly complex medical landscape in which psychiatry is practiced and cultural evolutions which have taken place within society. Some, but not all, historical answers have been reviewed and revised; when changes are made a revision date has been noted after the original date of the Opinion.

In the rapidly advancing and diverse field of psychiatry, ethical practice requires abiding by the core ethical principles in the face of ongoing societal and cultural evolution. This includes practicing with cultural sensitivity and adopting practices which will promote the dignity and well-being of each individual patient. A small example would be to ask a patient their preferred name and/or pronouns if the psychiatrist is unsure of the patient’s preference. Psychiatrists should be cognizant of relevant contextual information relating to a patient’s background, which may include but not be limited to culture, race, ethnicity, gender, sexual orientation, religion, socioeconomic status, and geographical background and be alert to how these may contribute to bias, implicit or explicit. Psychiatrists must maintain respect for their patients’ identities, values, beliefs, worldviews and experiences throughout the course of treatment. Specific considerations related to such factors may be referenced in certain Opinions within this document. Whether or not referenced within a particular Opinion, the need for cultural sensitivity in providing professionally competent patient-centered care should be considered to overlay the guidance provided in every Opinion.

The material is presented as responses to questions related to the seven *Principles of Medical Ethics of the American Medical Association* (section citations are followed by “AMA”). References are made to *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* by the American Psychiatric Association (section citations are followed by “APA”) and the American Medical Association’s *Current Opinions with Annotations of the Council on Ethical and Judicial Affairs* (2000–2001), herein referred to as “AMA Council Opinions.”

The published Opinions in this booklet are offered to assist APA’s members and district branches in understanding the *Principles*. Only those questions and answers that address specific issues with heuristic value have been included. Questions of a routine nature or those not clearly related to a *Principle* have been excluded. No actual ethical complaints received by APA regarding identified psychiatrists have been used so that this volume does not comprise a casebook of unethical conduct. Of note, these opinions are those of the APA Ethics Committee only. They do not represent official positions of the American Psychiatric Association. In addition to these Opinions, the *APA Commentary on Ethics in Practice* (2015) is offered by APA as a tool to aid in understanding the complexity of psychiatric ethics and how they apply in different situations. That document is freely available on the webpage of the APA Ethics Committee.

The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013 edition) has been officially adopted by the American Psychiatric Association and is binding upon all members.

Principles of Medical Ethics of the American Medical Association

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1

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

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.

Section 3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

Section 4

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

Section 5

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

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.

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.

Section 8

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9

A physician shall support access to medical care for all people.

Opinions of the APA Ethics Committee

A. BOUNDARY AND DUAL RELATIONSHIP ISSUES

A.1

Question: Is it proper for a psychiatrist to advise a patient to make an investment from which the psychiatrist receives a finder's fee?

Answer: Clearly, no. Section 2, Annotation 2 (APA) states:

The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

(Section 2) (1978; Rev. 2017)

A.2

Question: A patient of mine is a social worker. Is it ethical for me to also supervise her therapeutic work while a patient? Or after termination of her therapy?

Answer: To the first question, no; it would constitute a potential exploitation as well as confusion of the therapeutic relationship. To the second, probably not. (Section 2) (1988; Rev. 2017)

A.3

Question: Is it ethical for a psychiatrist to buy property from, or sell property to, a patient or ex-patient?

Answer: Psychiatrists have the responsibility to be mindful and protective of boundaries with both current and former patients. Buying or selling property is not necessarily precluded. There are various factors to be considered, such as potential for exploitation of the patient or ex-patient in these kinds of transactions. (Section 2) (1989; Rev. 2017)

A.4

Question: I am publishing a book about a particular psychiatric disorder in hopes of reducing stigmatization. With proper informed consent (Section 4, Annotation 11, APA), I wish to present some of my patients who have benefited from treatment to the media in a book promotion tour. Their expenses will be covered by the publisher, and I will have no contact with the patients other than the public interview while on the tour. I hope to financially benefit from the publication. Any problems?

Answer: Yes, there are multiple problems with this arrangement. This is a clear deviation from the original treatment plan with which the patients were in agreement. Their consent, while "freely" given, is likely to be heavily influenced by their transference feelings, the need to please you. The "reward" in the form of free travel in your near presence is likely to create serious distortions in the relationship. But, most

seriously, the entire project suggests an exploitation of your patients for your personal gain that outweighs the potential benefit of public education. (Section 2) (1989)

A.5

Question: May a psychiatrist hire a current or former patient?

Answer: It is not ethical to switch a doctor–patient relationship to an employer–employee one. For an ex-patient, the issue is exploitation of the former doctor–patient relationship, and, in most cases, such an arrangement would be unethical. (Section 2) (1990)

A.6

Question: This is complicated. I am being sued by a former patient, the relative of a current patient who is unaware of the suit. Can I use information about the former patient provided by the current patient that would support my defense? Can my lawyer depose the current patient?

Answer: No, to both questions. The solution of your legal problem is not germane to your treatment responsibilities to your current patient. (Section 4) (1991)

A.7

Question: Can I ethically solicit the support of my patients to advocate for political or societal issues that affect their health care?

Answer: Implicit in your question is the recognition of the conflict between Section 2, Annotation 2 (APA), concerning protection of the unique relationship psychiatrists have with their patients from influence outside of the treatment goals, and Section 7 (APA), dealing with our responsibility to strive to improve our communities by interpreting social forces that affect mental illness treatment. It is laudable for physicians to lobby for important political and social causes, especially for those affecting the health care of our patients. However, when we seek to engage our patients in these efforts, we must exercise utmost sensitivity to the susceptibility of patients to our influence, and their desire for privacy. Conversations about political matters may be appropriate in the clinical setting with patients and their families, but vigilance must be exercised to avoid abusing the doctor–patient relationship. Blanket solicitations of support, waiting-room materials, or generalized mailings about social or political issues are usually insensitive to the unique circumstances of each patient. Optional referrals to lobbying or advocacy groups (such as NAMI) might be an effective means to avoid potential inappropriate use of the doctor–patient relationship and allow for the strengthening of the patient’s freedom to choose how best to act. Finally, it is important for the ethical psychiatrist to ensure that his or her own personal needs or biases are not influencing the request made of the patient. Indeed, our own passions about a particular cause are best directed through our own advocacy work, rather than enlisting a patient’s assistance. See *Opinion 9.012, AMA Council Opinions*, 2000–2001. (Section 2) (2000)

A.8

Question: I am a divorced child psychiatrist. A couple consulted me as to how to inform and support their children as they had decided to divorce. I successfully counseled them for a handful of sessions. Afterward, the then ex-wife reconsulted me for assistance in improving her relationship with one child in particular that had been polarized by the divorce. I saw her in this context for an additional series of sessions.

Months later, I learned that this former patient was interested in a personal relationship with me. She had been in long-term individual psychotherapy with another professional throughout my treatment of her. I consulted a colleague, and he said the usual prohibitions about dating a former patient would not necessarily apply given I never treated her as an individual. What is ethically appropriate in this situation? Can I date this woman now?

Answer: It would not be ethical for you to have a social relationship with this former patient. You have treated her and her family members. She has placed trust in you and disclosed matters of a highly personal nature. She may also have developed a positive transference toward you, which makes the relationship vulnerable to a psychological power differential. Establishing a dating relationship with her could be exploitative of this therapeutic relationship. A therapeutic relational dynamic persists even after therapy ends, holding open the possibility of return treatment, if necessary. See *Commentary* Topic 3.2.6. (Section 1) (2001; Rev. 2017)

A.9

Question: Is it ethical for a psychiatrist to have a platonic friendship with a sibling or a parent of a former patient?

Answer: The Ethics Committee advises caution regarding the establishment of a platonic friendship between a former patient and a psychiatrist. Both the APA and the AMA hold that significant third parties (e.g., relatives and caretakers) are afforded the same considerations as are patients. Thus the psychiatrist also must guard against boundary violations, third party exploitation, and breaches of patient confidentiality in interactions with third parties. For example, the psychiatrist may seek such a friendship based on information that was acquired in the context of a doctor-patient relationship. Would this ensuing friendship in any way exploit the third party? Another potential pitfall relates to confidentiality as a cornerstone of treatment. Could such a friendship exist without threatening patient confidentiality? In sum, it cannot be determined a priori that a social relationship of this type would be ethical or not. In most cases establishing a friendship of this sort would be ill-advised given these concerns. (Section 2) (2002)

A.10

Question: Is it ethical for a staff member in a psychiatric treatment facility to continue treating a patient that the staff member has brought criminal charges against? Similarly, is it ethical for a staff member to continue treating a patient when the staff member is or will be aiding in the criminal investigation and/or prosecution of that patient?

Answer: Either of these dual role situations would be fatal to the establishment or continuation of a mental health professional-patient relationship. The treatment relationship factors necessary -- like trust, beneficence, empathy, and confidentiality -- cannot genuinely exist in these two examples. It would be necessary to assign other staff members to work therapeutically with this patient preferably

assigning the patient to a separate unit with no contact with the staff member pressing criminal charges. While the need for a legal response to some patients' acts is at times necessary, the facility still has an ethical duty to provide reasonable and appropriate care for the patient. (Section 1) (2006)

A.11

Question: A clinic is partially supported by philanthropic donations. The psychiatrists would like to show videotaped testimonials of clinic patients to board members of their non-profit arm. Can psychiatrists approach specific patients to appear in this videotape, whether it is presented as a request or an opportunity? What about more widespread marketing of the clinic with such testimonials (using actual names and/or photographs)? Would it make any difference if someone other than the treating psychiatrist solicited the patient for this purpose?

Answer: The vignette presents a scenario that evokes problems of confidentiality, respect for a patient's autonomy, potential exploitation, and conflict of interest. Section 2.2 suggests that a treating psychiatrist should not ask a patient to participate in being videotaped if that activity is not related to treatment. The use of names and photographs of patients in marketing has the potential for exploitation and therefore requires careful attention. Institutions that want to solicit donations from patients should first create a clear policy about how to separate the fundraising activity from the clinical work. Clinicians should not be involved in requesting donations from their patients because that inserts the clinician's institution's needs into the patient-provider relationship, violating the fiduciary nature of that relationship. See *Commentary* Topic 3.2.7. (Section 2) (2009; Rev. 2017)

A.12

Question: I just have a question on boundaries and implications with regards to jeopardizing the confidentiality with a current situation. We have a fellow therapist with whom I share clients and she wants to see me as a patient. Also the therapist's case may be discussed (as a patient) in the team meetings we have weekly with other psychiatrists in the group. All other psychiatrists in the group also share patients with her. This is an awkward situation but the therapist wants to see me as a patient. Technically, since she is a postdoctoral student and we are a part of a university we cannot refuse care if the patient wants it. I am looking for APA guidelines in this type of situation.

Answer: The scenario you pose is a dual agency problem. You and the post doc student already have a psychiatrist/co-therapist relationship, it would not be right to add a doctor/patient relationship on top of that. Further, of course, you couldn't discuss her personal treatment in their team meetings with the other psychiatrists, but that would be just the beginning of potential conflicts. You must decline to treat her yourself because a supervisor-student relationship can be inferred within the university setting. What you can, and should do, is to offer to help her find a psychiatrist away from their university setting, someone whose work you respect, and thereby make a genuine effort to get her into the right hands. You shouldn't assume that because she is part of the university you are obliged to take her as a patient. (Section 1) (2010)

A.13

Question: We are a small agency with an adolescent residential treatment program and community mental health outpatient program. We are trying to hire a parent advocate. The only applicant is the father

of an adolescent who was in our residential treatment program three years ago. Part of the psychiatric staff has raised the concern that if the agency hired this individual for that job, it would create the same ethical issues as a psychiatrist hiring a former patient in their office, and that the psychiatric staff should oppose the hire.

Answer: The process for peer advocacy is one that is developing across the country. In this particular case, hiring the father of a former patient would not be unethical. However, it raises confidentiality questions, but that concern should be minimized as peer advocates should not have access to any patient records. (Section 2) (2010)

A.14

Question: Can a psychiatrist use the legal services of a patient, who is an attorney, to assist in a difficult dissolution of the psychiatrist's practice from the psychiatrist's current partner?

Answer: No, to do so would be a boundary violation involving dual agency. A doctor cannot have both a doctor-patient relationship and an attorney-client relationship with the same individual. (Section 2) (2010)

A.15

Question: A former patient is requesting strongly that he continue to see me socially now that our therapy is complete, having transferred him to another provider three years ago. We have had one such meeting at a restaurant to bring "closure" because he said it would be easier for him long-term if he knew I had related to him at least once as something other than a patient. Prior to this, he also researched the location of my new office, traveled there uninvited, and surprised me and my staff by presenting me with a "release" that he had drafted with a lawyer promising to forfeit his right to sue me for malpractice. He previously suffered much emotional turmoil after terminating with his previous psychiatrist. This termination included him filing a Board of Medicine complaint against the previous psychiatrist and only reaching some sense of closure through final contact(s) with his previous therapist.

I am concerned that it may not be helpful to my former patient for us to continue any association, despite his ardent belief in the benefit of such an association; nevertheless, he may in fact decompensate at least somewhat without contact with me. Given his past behavior concerning both me and his previous psychiatrist, I am also concerned about his reaction to my enforcement of a policy of no further contact, and sense that if I can point to this policy as an accepted APA policy or procedure for psychiatrists concerning former patients, that might help him to perceive it as less of a personal blow.

Answer: You describe a very complicated patient with challenging clinical management issues. As Section 6 states, "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." You terminated treatment with this patient three years earlier and have no ethical obligation to resume treatment or maintain contact with him. Your description of this patient brings up concerns of dependency issues, manipulative behavior, threats to the maintenance of clear boundaries, hostility, and perhaps even impaired reality testing. As his former treating psychiatrist, you appear to have exhausted all clinically reasonable options. Compliance with his demand to transition to a friendship is strongly

discouraged. If you are concerned about medico-legal issues, it may be prudent to contact your medical malpractice carrier or personal attorney. Ongoing clinical supervision with a respected colleague for complex clinical situations and/or consultation with the Ethics Committee of your local district branch may prove to be fruitful when dealing with difficult cases such as this one. (Section 6) (2011)

A.16

Question: I am a psychiatrist providing services for seriously mentally ill indigent persons. The doctors have been asked to fill out a Social Security Administration form titled Medical Source Statement of Ability to do Work-Related Activities (mental). My concern is that I am placing myself in an unethical situation of dual agency and that completing this form places me in an evaluative as well as a treating role. Could you advise?

Answer: Psychiatrists commonly find themselves in dual roles. While there is nothing inherently unethical about dual roles, they may lead to outcomes that are not in the patient's interest.

A treating psychiatrist is often in the most informed position to provide an understanding and psychiatric evaluation of a patient for purposes other than treatment. Thus, there is a potential to serve a significant advocacy function for a patient.

When facing such a dilemma the clinician is well advised to think through, and perhaps discuss with a colleague, the pros and cons of conducting the evaluation. In some cases, doing the evaluation may be an act of beneficence. In certain cases, doing the evaluation would be of no service to the patient and could injure the patient's interests. Similarly, not doing the evaluation could reflect the physician's lack of commitment to the patient. But not doing it could also be a reasoned outcome, as the clinician recognized an inability to do the evaluation honestly and objectively. The point is that the decision should be clinically informed and not decided casually. The spirit of the ethics guideline in this context is to protect the patient's interests. (Section 1) (2011; Rev. 2017)

A.17

Question: Is it ethical for psychiatrists to see members of the same family as individual patients?

Answer: Because of the complexity of factors to be considered, there is not a hard and fast rule; each case should be weighed separately. Seeing multiple members from the same family may blur boundaries of the doctor-patient relationship. Depending on the dynamics in the family, there is the possibility of causing complicated feelings of guilt, resentment, or shame if one family member responds well to treatment but the other does not.

Even if a psychiatrist avoids the accidental disclosure of information heard from one patient to another patient from the same family, a patient may have doubts about the confidentiality of their treatment if they know the psychiatrist sees a relative. These doubts may interfere with the doctor-patient relationship and could lead a patient to withhold important information.

On the other hand, there may be a number of considerations that mitigate the above concerns. For example, psychiatrists practicing in rural areas, those treating underserved populations, and those with specialized

expertise required by more than one member of the same family may reasonably treat members of the same family. In these instances, the psychiatrist should explicitly discuss concerns about boundaries and confidentiality at the beginning of treatment, and should remain vigilant about all of the potential ethical complications throughout the treatments. (Section 1) (2013; Rev. 2017)

A.18

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

Answer: The Ethics Committee recognizes that certain interactions between doctors and patients in a social context are not necessarily harmful to the therapeutic relationship. Because of the diverse array of treatments and treatment settings, it is impossible to create unambiguous rules of conduct for all areas of clinical practice. However, psychiatrists must maintain awareness that their behavior should be directed toward the patient's therapeutic benefit, and behavior that is likely to conflict with that goal should be avoided. The burden is on the psychiatrist to be respectful, reticent and cautious about any verbal exchange that may compromise confidentiality. (Section 2) (2016)

A.19

Question: Dr. X practices in Sacramento with his wife, who is also a psychiatrist but not an APA member. Their incorporated practice is in an office building, which they own. They wish to sell the building and have been working with a real estate agent. The agent informed them that a potential buyer is interested and it turns out the buyer is the father of Dr. X's wife's current adult patient. Dr. X and his wife have not yet had direct contact with the patient or his father regarding this matter. How should they proceed?

Answer: The APA Ethics Committee had issued an opinion addressing property sales between psychiatrists and their current or former patients. It states, "Psychiatrists have responsibility to be mindful of boundaries with both current or former patients. Buying or selling property is not necessarily precluded. For instance, in small town where patient is the only real estate developer, it might be fine." Although the potential buyer in your situation is your wife's patient's father, the opinion is still applicable. It allows you to proceed, with thought and care. For instance, it might be wise to let your real estate agent and lawyer of handle interactions with the buyer and his agents and lawyers. (Section 2) (2016)

A.20

Question: Is it ethical to perform an internet search on your patient?

Answer: Performing targeted internet searches on a patient is not, in and of itself, unethical. First and foremost, such searching of a patient should only be done in the interests of promoting patient care and well-being and never to satisfy the curiosity or other needs of the psychiatrist. Also important to consider is how such information will influence treatment, and how the clinician will ultimately use this information. The psychiatrist should ask him or herself these questions before resorting to targeted internet searches.

Transparency in treatment relationships is an ethical virtue. Therefore, psychiatrists should make clear to the patient when information is obtained about them from the internet, and the specific source of that information. This also gives the patient an opportunity to potentially refute information obtained in this fashion. (Section 1) (2017)

A.21

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

Answer:

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

The ethical principle that applies is one of dual agency, that is, the tension that arises whenever physicians seek to involve themselves in the solution to a problem without seeing how they have also inserted themselves into the treatment plan. Ethically you cannot have a doctor/patient (or even a former patient) relationship and a parent/child relationship with the same individual. Section 1, Paragraph 1 of the *Principles of Medical Ethics Applicable to Psychiatry* states that “a psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist should be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor/patient relationship, and thus upon the well-being of the patient.”

While the Committee has no doubt that your intention is well-meaning, and that you are acting out of beneficence, nevertheless there is no way to establish that your action is not also in some way an exploitation of your patient. You also add that you would not expect the Committee to make a determination of what is in the best interest of the child, and we will not. We will say, however, that nothing precludes you and the treatment team from doing everything else to assist your patient, other than your personally adopting him. This would include continued efforts at family therapy, still an appeal to local social service agencies despite your reticence, or perhaps even involvement of your state’s appropriate legal resource. (Section 1) (2018)

A.22

Question: I perform court-appointed forensic evaluations in addition to operating a private psychiatrist practice. What can I, as an ethical psychiatrist, do in response to online reviews or ratings that are posted by someone whom I examined in a court-appointed forensic capacity if the review contains false information that gives the impression the person was treated as a patient by me and does not reveal the

forensic nature of the examination. Is there anything I can do vis a vis (i) the rating site (e.g. yelp), which may require revealing details about the examination to request that a particular view be taken down as false in accordance with the site's terms of use, (ii) myself posting a response on the rating site, or (iii) taking any action against the person whose posted the false review?

Answer:

The Ethics Committee has published guidance on this topic in the context of a treatment relationship in its *Resource Document on Responding to Negative Online Reviews* (2019), and the content of that guidance is relevant. Given the forensic context of your involvement with the reviewer, you could request the rating site remove a false post by making a request that gives only a limited amount of personal information. For example, note to the rating site that the statements made in the review are false and there is a public record that proves so. It is not advisable for you to make a public response to a specific individual's review. But you could respond publicly online generally with a posting that does not respond to the claims made in any particular review, but provides information about your practice and the forensic context generally, such as:

"Out of respect for the legal and ethical obligations of physicians to maintain patient privacy, I will not respond publicly to any individual review. I take seriously the concerns of my patients with whom I have a treatment relationship and I encourage anyone who has had a negative experience as a patient with my practice to contact me directly at any time. But please be aware that in addition to treating patients, I also perform forensic psychiatric work where I am appointed by a court to examine an individual with whom I do not (and will not) have a treatment relationship. It is not uncommon for individuals for whom a court has ordered an evaluation to disagree with the conclusions of those evaluations." (Section 2) (2020)

A.23

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

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

It would not be ethical to conduct an internet search of a prospective patient if the information obtained is going to be used for the purposes of deciding whether or not to accept the individual as a patient. It is not clear whether the information obtained via an internet search is necessarily valid and there is no opportunity for the patient to refute the information identified in the search if they are refused for care based on that information. APA's guidance on intern searches of patients advises that it is best to obtain the patient's informed consent before performing such a search, but obtaining the patient's informed consent is not possible if the psychiatrist has never met with the patient. In addition the APA guidance

states that a search is unethical if not done to further the patient's best interests, but if the information is being used to screen out patients from treatment, this does not seem to comport with using the search for the patient's best interest. Pre-emptive searches used for this purpose can only prevent the formation of a clinician-patient relationship, not further it, and clearly could compromise treatment by preventing that it ever begins.

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

A.24

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

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

A.28

Question: I am Medical Director of a private psychiatric clinic. We also operate a psychiatric, supportive living house. I have questions about two cases involving hiring former patients of clinic staff:

- 1) In the first case, I was about to hire a young man to be one of the support staff at the house, when I saw a message from our answering service that he had requested a medication refill. Looking into this, I found that the individual is a patient that I had seen in the past, and that a Nurse Practitioner at the clinic is still prescribing for this patient. The Nurse Practitioner has no interactions, however, with the psychiatric supportive living house, where this young man applied for a position, although the supportive living staff are clinic employees.
- 2) The second case is that a former patient, who I had seen some 8 years ago, has gotten sober and has been working in addiction facilities. He has applied for a position in the psychiatric supportive living house.

Would we be ethically prohibited from hiring either of these individuals? Would there be a recognized waiting period before we could hire them, if they were to start to receive care elsewhere? What are the ethical considerations of hiring?

Answer: Psychiatrists must be mindful of boundary challenges involving their patients, both former and current, and an important factor to consider is the potential for exploitation of the patient. For this reason, the Opinions of the APA Ethics Committee have long included, in Opinion A.5, the guidance that it “is not ethical to switch a doctor-patient relationship to an employer-employee one. For an ex-patient, the

issue is exploitation of the former doctor-patient relationship, and, in most cases, such an arrangement would be unethical.” More recently, the Opinions included recognition of the complex and varied circumstances in which employment of an individual with a patient relationship might arise. For example, Opinion A.13 provides that given the specific circumstances of a certain fact pattern, hiring as a peer advocate *“the father of a former patient would not be unethical.”* Similarly, Opinion A.26, acknowledges that the dictate of a total prohibition against hiring a patient was based on the idea of a solo practitioner who would engage the individual to work directly with them, in which case the doctor-patient relationship would significantly influence the working one. In those more recent Opinions, the Ethics Committee noted that attention to the details of a particular situation is needed to manage the nuance and intricacies required when boundary challenges arise from relationships with patients.

In both of the cases presented here, the individuals in question are described as former patients of the Medical Director. The Medical Director, as a high-level administrator in the clinic, is likely to have some direct supervisory role over the former patients even if they are employed in the supportive living house rather than the clinic itself. Those former patients could feel pressured or otherwise influenced as employees by the knowledge that the Medical Director possesses confidential information about them, a situation which could present dual roles that may be challenging to manage. Moreover, it would be difficult for the medical director’s view of the employee to not be influenced by the director’s knowledge of them gained through their former treatment relationship. Should conflicts arise during their employment, there is a risk that the employee would feel targeted on the basis of their status as a former patient. This could lead to fraught workplace dynamics that are avoidable if the dual roles are avoided from the start.

Under the question presented it is unclear whether the psychiatrist has a compelling need to hire these particular individuals (e.g., for lack of other applicants or an urgent staffing need) that should be taken into consideration. If the psychiatrist believes that hiring these individuals would be compromising to the patient(s) and/or ethically problematic for them or other members of the clinical staff, avoiding these conflicts should take precedence over a more general wish to avoid stigma or bias against individuals with mental illness.

In the first case described, the former patient of the Medical Director is currently receiving care from a Nurse Practitioner of the clinic. It is unclear whether the ongoing treatment activity (clinic) and employment activity (supportive living house) would take place at the same physical location or separate venues. If they would be distinct physical locations, this would provide some protection against an problematic overlap of roles. Except in very rare circumstances (e.g., emergencies in small towns), it would almost always be unethical for an individual to have to receive treatment directly from colleagues with whom they interact professionally. It is not inherently unethical for a treating psychiatrist to be employed by the same entity as a patient, so long as the institution is large enough and there is consideration given to ensuring that an overlap of the dual roles can be avoided. A patient may be hired if the institution doing the hiring is large enough to preclude interaction with work colleagues in the treatment context. There must be enough separation and clear boundaries between the employment and treatment to ensure that the rights of the patient will not be infringed by the employment. Academic centers, for example, might regularly employ both the treating psychiatrist and their patients within the same umbrella entity, but are large enough to avoid such individuals having any overlap between their treatment and employment interactions.

While in the first case, there may be enough separation between the Nurse Practitioner and supportive living staff to mitigate concerns of dual roles of the Nurse Practitioner, given that the potential employee is a former patient of the Medical Director, it is still unclear that the arrangement between the clinic and the supportive living staff is such that adequate privacy and boundaries are in place to mitigate the potential for dual roles.

Ultimately, in both cases described in the present question, as the previous treatment provider would potentially have a supervisory role over the hired former patients in his role as Medical Director, there is a tension that cannot clearly be mitigated. (Section 2) (2024)

A.29

Question: I have an older patient who has started TMS treatment. During her first treatment, with our TMS tech and two trainees, she said that she wanted help writing a book and asked if I knew anyone. I said I don't think so and mentioned that the only person that I know who could do that kind of work is my daughter. Unexpectedly, she asked me to introduce her so that they could have a conversation about it. I am reaching out to you to glean your thoughts on this issue. I have made it clear that if I made the introduction, they would need to decide between themselves what they wanted to do, if anything, and that I wouldn't be part of it. I also told her that I wanted to do a bit of research to make sure that I am not violating boundaries. I certainly can appreciate how this could be problematic in certain cases. Given that this is not going to be an intensive psychotherapeutic relationship with me - and given that she will be treated by an NP and therapist in the office, my gut tells me that it is not going to be an issue. However, I think it is best for me to reach out and get your thoughts on this issue.

Answer: Therapeutic boundaries are required to ensure that the psychiatrist does not take advantage of the patient and to ensure there is no exploitation in the psychiatrist-patient relationship. A boundary crossing should be undertaken in an intentional manner only when the benefits for the patient clearly outweigh the risks. Even more flexible models of patient-professional boundaries that apply cultural perspectives consider the risk of harm to patients. This situation presents clear risks, the presence of dual roles, and a likely boundary violation from the start.

Because the treater's introduction identifies the treater's family member as an expert and a consultant in a potential collaborative business venture (a book), there is cause for concern. The psychiatrist's daughter potentially benefits by elevating her reputation, expanding her opportunities, and conferring reciprocal (albeit indirect) benefits to the psychiatrist. He has made an introduction that could benefit a family member and expanded his role to a likely business matter in the community. It is impossible to separate the psychiatrist from the collaboration. Further, if things go poorly, conflicts from a failed collaboration could impact the psychiatrist-patient relationship and the treatment itself.

Ultimately, it is not clear that the benefits of such a boundary crossing would outweigh the risks. Indeed, even offering the daughter at the start is problematic, as the treater takes on a non-therapeutic, but likely business referral role that could benefit a family member. The ethical tension of such a dual role cannot clearly be mitigated.

As an alternative to connecting his daughter and the patient directly, the psychiatrist could ask his daughter for a list of names of experts for the patient to contact if so desired. If the psychiatrist chooses to do so, neither he nor his daughter should be involved in initiating communications between the patient and any

other contacts to avoid continued involvement. In this situation, the psychiatrist can assist the patient with the original request in a manner that avoids the ethical concerns presented above. (Section 4) (2024)

B. BUSINESS PRACTICES AND ANCILLARY PROFESSIONAL ACTIVITIES

B.1

Question: Is it ethical to market and offer a telephone referral and assessment service for adults who may be suffering from a mental disorder?

Answer: Yes, with the following cautions and provisos: (1) The psychiatrist must be mindful of any limits on the effectiveness of such modalities as a substitute for the clinical interview in a face-to-face setting. Research remains incomplete in this area, and the ethical physician is obligated to support such interventions-by-telephone with clear scientific evidence of its clinical efficacy and limitations. (2) The confidentiality requirement must be met and the patient must be clearly informed of the efficacy and limitations of such telephone referral and assessment. (3) In addition, the billing for such services must be carefully approached to maintain the clearest contractual understanding with the patient.

In recent years, the availability of telehealth technologies has allowed psychiatrists and patients to continue treatment while physically apart. While using these technologies, psychiatrists have an ongoing ethical responsibility to maintain patient confidentiality and proper therapeutic boundaries. Psychiatrists should also inform patients of potential limits to confidentiality given the risks inherent to the use of the internet that would not necessarily exist for an in-person session and clearly establish expectations for any change in the treatment relationship by ensuring patients are aware that telehealth sessions are treatment sessions in the course of care and will be billed as such. (Section 1; See also Section 2, Annotation 6, APA.) (1993; Rev. 2023)

B.2

Question: My patient has been asked to repay overpayment of VA funds which has led directly to the patient's vague threats of suicide. The VA agency is asking me if it is ok to proceed with asking for repayment. What is my ethical/legal responsibility?

Answer: The first issue is one of confidentiality. The VA cannot receive any information regarding your patient without the direct consent of the patient. In this instance, the patient would need to be informed about why the VA was requesting information, i.e., in order to have you weigh in on whether or not the patient could withstand a request for the return of funds.

The second issue is one of dual relationships. In this instance, your most important role is that of a treating psychiatrist to your patient. However, it appears that the VA wishes for you to offer a consultation regarding an administrative decision, while you are simultaneously providing clinical care. It would seem in the patient's best interest that the administrative request be satisfied through an independent assessment, made by an independent clinician, and not by you. (Section 4) (2002)

B.3

Question: I have a question about psychiatrists treating patients who are established patients in the care of another psychiatrist, or another healthcare professional. For example, Patient X, who is in treatment with Psychiatrist Y, becomes suicidal, does not inform his/her doctor but instead overdoses and is admitted to the hospital. During that inpatient stay, hospital staff does not communicate with Psychiatrist Y.

Moreover, the hospital psychiatrist tells the patient that the patient should stop working with Psychiatrist Y, and instead see a psychiatrist on staff of the hospital. The hospital staff does not encourage the patient to discuss this recommendation with the current doctor, and an appointment is set up with a hospital psychiatrist immediately following the patient's discharge. Has any wrongdoing occurred?

Answer: 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 good 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 planning.

It is also customary that the patient is redirected to the outpatient psychiatrist for follow up care after discharge. It should be noted, however, that the preference of the patient is relevant. A patient who has been admitted under the care of an inpatient psychiatrist may choose not to consent to the release of medical information to his/her outpatient psychiatrist, and also may choose not to return to this psychiatrist's care. When making such a choice, the patient is entitled to confidentiality. (Section 2) (2005; Rev. 2017)

B.4

Question: I am the treasurer of my district branch and am trying to think of some ways to increase our revenue. My idea is to sell a monthly advertising program to research groups. The DB staff would send out information describing clinical studies for which participants are needed and psychiatrists would put the brochures in their waiting rooms. If patients are interested, they can contact the research company directly. The psychiatrist would merely provide a venue for advertising in his or her office. Do you see any ethical issues with this plan?

Answer: We commend you in asking for an opinion prior to embarking on this enterprise. For a psychiatrist to place material in the waiting room advertising the needs of a research group, even though it would seem to be an entirely voluntary participation on the part of the patient, may be interpreted as a recommendation to the patient to participate in research, and may imply an endorsement on the part of the psychiatrist. Displaying material in the waiting room which has been placed there to raise money for the DB (an issue of self-interest) goes against the ethical principle of not influencing the patient in any way not directly relevant to the treatment goals, and your DB would be ill-advised to undertake such a scheme. (Section 1) (2012)

B.5

Question: I am opening a new practice and want to put on my website my fees and that I will not be accepting insurances. I will print out claims forms for those people who want to submit claims themselves. Is it ethical to list the fees on the website -- in order to be straight-forward and clear?

Answer: Clearly stating one's fee and position regarding insurance assignment is consistent with Section 2, Paragraph 5, which advises the explicit establishment of the provisions of the contractual arrangement between patients and psychiatrist. In addition to posting this information on a website, it should also be a part of the contact with each patient. (Section 2) (2012)

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)

B.7

Question: I am a psychiatrist working with a national telehealth company. I would be the PC Owner (physician who oversees the PC operation, hiring, quality control, etc.) and receive reasonable reimbursement for that role. I'm relatively new to understanding this all, but essentially it gives me the opportunity to have a national presence as a psychiatrist building a clinic that serves a large number of students, set the protocols, establish best practices, etc. without having to manage the business/marketing side. I am overseeing NP's as part of the position (I have designed the compliance and quality protocols, as well as do all of the NP hiring myself, I also assisted in designing the clinical pieces of their training). I would love any guidance that the APA can provide on the ethics of these arrangements and pitfalls to consider from an ethical or practice perspective.

Answer: The Committee applauds the psychiatrist for raising these questions and recognizing the potential for ethical pitfalls that may arise from such an arrangement. The structures through which psychiatric care is provided in America are evolving rapidly, and the Committee notes that some aspects of this territory are novel both for Committee members and for the psychiatrists working within these structures. This opinion cannot provide a perfect path for navigating these complex circumstances but is instead offered as a note of caution to assist the psychiatrist in identifying some considerations to which they must be attuned.

In the undertaking as described, there is an inescapable dual agency and overlapping role for the psychiatrist, who will have competing duties as a fiduciary owner of the business and to patients as a psychiatrist (both as a direct treater and supervisor of patient care). As the *Commentary on Ethics in Practice* advises, in such positions, “[p]sychiatrists 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.” Topic 3.1.3. The proposed structure is not inherently unethical, but it is essential that the psychiatrist ensure it is established in such a way that ensures medical providers will have autonomy in making treatment decisions that are in the best interests of patients.

A key consideration for the physician is that the arrangement should be constructed to give precedence to patients’ best interests and to allow the clinical providers to exercise independent medical judgment. The “physician shall, while caring for a patient, regard responsibility to the patient as paramount.” *Principles*, Section 8. The Committee strongly recommends that a psychiatrist considering an arrangement of the nature described employ capable legal counsel to assist them in navigating the different state requirements that apply to such activities. The psychiatrist should also ensure that the contractual business relationship is set up such that there is not a likelihood of business interests undermining the quality of care provided to patients. The following non-exhaustive list of potentially problematic scenarios is offered for illustrative purposes of issues the physician must guard against:

- a reimbursement structure which would compensate volume of care over quality of care by forcing care providers to see an unreasonable volume of patients in a particular time period;
- a restriction upon the maximum number of treatment sessions allowed, without regard to the needs of particular patients;
- hiring of inadequately trained or experienced providers based on cost considerations;
- restrictions on the ability to treat patients based on screening or indicators that might flag them as being “troublesome” and at higher risk of needing elevated levels of care; and

- protocols or practices that prevent treatment of patients with particular diagnoses or would prohibit necessary treatment options as a cost-saving practice.

The physician must also give careful consideration to the processes established under the arrangement for ensuring the quality of care provided to patients. These should include, for example, procedures for evaluating the quality of care provided to ensure it meets appropriate standards, planning for continuing education, regular supervision of treatment providers, ensuring that the supervision ratio is appropriate, and processes for escalation of challenging cases by non-physician providers on the treatment team. Recognizing that rules for NP practice and supervision differ depending on the state, the psychiatrist should respond accordingly. However, ethics guidelines regarding supervision of colleagues in a collaborative care model should be emphasized, including shared responsibility for the overall treatment of patients (Topic 3.3.2).

In addition, the psychiatrist must be mindful to ensure the procedures established appropriately account for the telehealth environment. This includes, but is not limited to:

- Planning for how a provider would act to prevent a patient from harming themselves or others when not providing in person treatment - will there be a requirement, for instance, that patients participate in treatment only from a registered location?
- Ensuring that cross-state licensure and controlled substances prescribing laws are adhered to in the instance of a national company (see [*Opinions of the Ethics Committee on The Principles of Medical Ethics*](#), Opinion N.21).
- Attending to digital equity considerations, including recognizing the modality, privacy and security, accessibility, and appropriateness of digital care.
- Maintaining the capability to refer patients to in-person care when clinically indicated and maintaining emergency management protocols.
- Developing processes to verify the patient's identity and location (e.g., self-report).
- Adhering to the highest standards of electronic data privacy and security.

Further, as stated in the Resource Document on Best Practices in Synchronous Videoconferencing-Based Telemental Health, the psychiatrist “is responsible for maintaining the same level of professional and ethical discipline and clinical practice principles and guidelines as in-person care in the delivery of care in (telemental health), as well as additional (telemental health)-related concerns such as consent processes, patient autonomy, and privacy.”

The psychiatrist must further ensure that the business relationship is structured in such a way that if disclosed to the patient in full transparency would not be likely to negatively affect the physician-patient relationship. Ethical practice requires that the psychiatrist be honest in all professional interactions, including with patients, meaning that the reimbursement practices should be known or knowable to patients in complete transparency (*Principles*, Section 2). The possibility for such disclosure to patients should be a condition of the contractual business relationship. An ownership or reimbursement structure that would be likely to undermine the patient-physician relationship if disclosed to the patient would be inherently problematic. If there are any limitations based on the cost of treatment, these are to be clearly identified, and the patient should be counseled on appropriate options. As *Principle 8.4* states, “[i]n informing a patient of treatment options, the psychiatrist should 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.”

The psychiatrist owner must also ensure that the contractual ownership relationship ensures there is an option for them to exit if they determine that the structure is not in accordance with their professional and ethical duties. If the practices forced or encouraged by the business entity end up being incompatible with their professional ethical obligations, the physician must have a viable opportunity to extricate themselves from the arrangement and must ensure that they do so in a manner that does not lead to abandonment of a patients. This includes being cognizant of ensuring that any contractual non-compete clauses not be so unreasonable that they would likely deter a physician from leaving an arrangement if they find it to be incompatible with good patient care. Physicians should be able to extricate themselves from a problematic arrangement without unreasonable difficulty, e.g., having to move to another state or similar unreasonable sacrifices. (Sections 2 and 8) (2024)

C. CHILD AND ADOLESCENT PSYCHIATRY (Including Child Custody and School Issues)

C.1

Question: A couple I am seeing eventually divorces, and a bitter child custody dispute ensues. What do I do if one spouse asks me to testify and the other asks me not to? What do I do if I am subpoenaed?

Answer: For the first question, you cannot testify without consent from both parties because you are obligated to protect the confidences of both equally. If ordered to testify, you should raise the issue of confidentiality and explain why it would not be in the parties' best interest to testify; however, you may have no choice but to respond to proper legal compulsion. (Section 4) (1986, rev 2017)

C.2

Question: I am leaving a hospital where I am the only child psychiatrist. Is it ethical for me to turn over my child patients to psychiatrists whose competency is not known to me?

Answer: You owe it to your patients that they be transferred to competent replacements. If you believe they are not, to avoid possible abandonment, the hospital should be advised to seek competent replacements. (Section 6) (1990)

C.3

Question: Is it proper for a school to refer children to a psychiatrist who is also the school's paid consultant, especially when there may be an adversarial issue between the school and the family?

Answer: As a general rule, paid consultants to a system should not receive referrals from that system because the potential conflicts of interest are legion. There may be rare exceptions, such as an underserved area with shortage of child psychiatrists. (Section 2) (1991; Rev. 2017)

C.4

Question: Is it ethical for a psychiatrist to treat one of his or her own children with psychotropic medication?

Answer: Section 6, Annotation 1 (APA) covers such situations. It states that "preservation of optimal conditions for development of a sound working relationship between a doctor and his/her patient should take precedence over all other considerations." Treating one's own child does not preserve the optimal conditions for a sound working relationship, and some states prohibit prescribing for one's family members. Exceptions would have to be compelling to overrule the general rule. (Section 6) (1993, Rev. 2017)

C.5

Question: In a child custody case, a report was submitted to the court based solely on review of the hospital records of a child, and an interview with the ex-husband, regarding the mother's mental status

and continuing custody. I am wondering if it was appropriate to render an opinion without having examined the child or the mother.

Answer No; the standard of practice in doing child custody evaluations is for all parties to be examined. In situations where all parties cannot be examined after reasonable efforts are made, a psychiatrist may render an opinion, but must clearly identify limitations in the sources of information, and should refrain from making an opinion if the available sources of information are inadequate to form an opinion. (Section 1) (2003; Rev. 2017)

C.6

Question: A member called about a 12-year-old patient who said things like “I wish I were dead,” “If I never woke up again, that would be fine,” and “I wish I were not here.” The child denies having a plan to kill herself or the intent to do it. The member is wondering what the ethical balance is regarding whether to tell the parents. He is consulting his malpractice carrier on the legal part.

Answer: I am a child psychiatrist and am not aware that children of age 12-13 can be treated without parental/guardian consent. Statements alluding to self-harm as those described must always be taken seriously, and parents should be informed and involved in the treatment accordingly. This question appears to be one of clinical judgement rather than ethics. (Section 4) (2017)

C.7

Question: First scenario: teenage patient reveals drug usage to the psychiatrist and tells psychiatrist not to tell his mother. Mother is also a patient of the psychiatrist. The father who is not a patient, does know about the drug use and while the parents are separated they are both guardians. What is the ethical thing for the psychiatrist to do? And second scenario: Patient under the age of 18 reveals drug usage to psychiatrist and does not want parents to know. Can psychiatrist tell patient that he can only treat him if there is transparency on this issue between patient and parents so they can help? Or, is psychiatrist required to keep the information confidential if the patient requests

Answer: The ethical response to both situations is analogous regardless of whether certain family members are also patients of the psychiatrist or the status of the parents’ marriage. The psychiatrist must first assess whether the patient has the capacity and is sufficiently mature to make such decisions independently despite being a legal minor. If the patient does not, then the psychiatrist needs to seek a surrogate decision maker (likely a parent/guardian). Assuming the patient does have sufficient capacity, then the psychiatrist has an ethical obligation to keep the information provided to him/her private and confidential *unless* in the psychiatrist’s estimation the drug use places the patient or others at risk of harm, in which case he/she has an obligation to disclose the information to protect the patient/others. And the psychiatrist needs to explain this to the patient when he/she makes the request for the information to be kept secret from the parent. (See, e.g., APA Annotations to Sections 4, #7 and #8). Whenever a patient prefaces disclosure with the request that it be held in confidence, it is advisable to clarify at that precise point in treatment that the psychiatrist cannot honor such a request if it involves dangerousness to self or others, or if state law compels the psychiatrist to report to authorities or parents/guardians in the case of the minor. Some states may have specific public health laws that touch upon the issue of minors divulging

substance use and under what circumstances the information can be held in confidence for example. (Section 4) (2018)

C.8

Question: I work in a hospital in an area with a sparse population of psychiatrists. In cases of emergency, I may treat adolescents on occasion. Despite the fact that I am not a child and adolescent psychiatrist, my employer has asked that I begin to treat patients as young as 4 years old. I am concerned that it is unethical for me to provide this treatment because I lack training and experience with this patient population. However, although my employer has advertised for a child and adolescent psychiatrist, the facility has not been able to hire one.

Answer: Given that you do not have the education or training to practice with children below the age of 12-14, it would be unethical for you to do so on a regular basis. APA Ethics Principle 2.3 expressly states that a physician who regularly practices outside of his area of competence is unethical. Competence is determined by peer review boards or other appropriate bodies. The *APA Commentary on Ethics in Practice* Section 3.1.2 recognizes that professional competence means practicing within accepted standards of care, remaining current, and sometimes working with supervision and/or consultation. Professional competence includes recognizing the limits of one's skills and referring patients when possible or seeking consultation from a more experienced clinician on issues where the psychiatrist's competence is not clear. Section 3.4.5. notes that in small or underserved communities it may be ethical for a psychiatrist to practice outside of the usual scope of practice *if her training is closely related, there is urgency, and the psychiatrist possesses the most readily available relevant expertise*, but that in such a case the psychiatrist should have appropriate supervision and access to competent consultation.

Two ethical conclusions emerge from this. If you do not believe you are competent to handle certain ages of children even with ready access to consultation, it would be unethical to do it. If you do believe you can competently handle particular age groups, you should have ready access to consultation from a board certified child and adolescent psychiatrist (e.g. Skype, telepsychiatry, etc.) to be able to consult as needed to ensure the patient gets competent care. If there are cases where you are still not comfortable treating the patient, you need to refer them to a board-certified child and adolescent psychiatrist.

Given that you are not board certified in child and adolescent, it would not be ethical for you to assume this role unrestricted (e.g. without supervision or consultation) or to assume it at all if you are not comfortable that you can do it competently with expert consultation. If you do assume this position, it should only be temporary until a board-certified child and adolescent psychiatrist for the hospital can be found.

You should inform the hospital administration of your concerns regarding the request, as the hospital may need to reconsider what ages it can safely and ethically treat given that they do not have a board certified child and adolescent psychiatrist no matter how underserved the area is. The hospital could seek locum

tenens child psychiatry coverage, or as a more immediate alternative seek a child psychiatrist via telepsychiatry. (Sections 1, 5) (2019)

D. CONFIDENTIALITY AND INFORMED CONSENT

D.1

Question: May I release treatment information to an insurance company about an adolescent patient? The father gave written permission.

Answer: It is ethical for a psychiatrist to release treatment information to an insurance company about an adolescent patient. Psychiatrists, in doing so, should provide the minimum necessary information required to justify the claim to the insurance company. When treating adolescents, psychiatrists should assume that the policy holder/ parent will have access to diagnostic information shared with the insurer and, therefore, at the onset of treatment should inform the adolescent patient of his or her practices regarding the limits on confidentiality of the treatment relationship. (Section 4) (1977; Rev. 2016)

D.2

Question: When preparing a training videotape on psychotherapy, must the identity of persons other than the patient who may have private matters revealed be protected?

Answer: Section 4, Annotation 3 (APA) applies to anyone about whom private matters may be revealed. For example, in the taped psychotherapy session, a family member of the patient may be discussed. Information about third parties should not be revealed. (Section 4) (1980; Rev. 2017)

D.3

Question: Does a psychiatrist have to inform a patient that the therapy session is being taped, or may the psychiatrist surreptitiously tape a session without the patient's knowledge and/or consent?

Answer: The psychiatrist, ethically, should inform the patient and allow the patient to refuse to have the session taped. Reference is made to Section 2 (AMA) which states, in part, "a physician shall deal honestly with patients and colleagues..." In addition, it may be illegal in some states to tape a session without the patient's knowledge and/or consent. One additional point is that the psychiatrist should give very careful consideration to how the tapes are stored and protected. (Section 2) (1981, Rev. 2017)

D.4

Question: Can I give confidential information about a recently deceased mother to her grieving daughter?

Answer: No, unless she is a legally authorized representative. Ethically, the mother's confidences survive her death, but this is not a bar to being compassionate and caring, consistent with the values of the profession, without releasing information. (Section 4) (1983; Rev. 2017)

D.5

Question: As a condition of referring patients to our hospital, Employee Assistance Program (EAP) staff requires we keep them informed about treatment progress and even sit in on treatment planning conferences. Is it ethical to agree to such a condition?

Answer: EAPs are very much a part of the current referral process and it is acceptable, in fact advisable, to develop working relationships with them. However, patient confidences cannot be compromised. To avoid this, information provided to an EAP, or attendance at a treatment planning conference, requires informed and uncoerced consent from the patient. (Section 4) (1986; Rev. 2017)

D.6

Question: Do I have an ethical responsibility to complete insurance forms for a former patient for services I rendered? For a current patient I am treating?

Answer: Yes to both questions. See *AMA Council Opinion 6.07*, which states:

The attending physician should complete without charge the appropriate “simplified” insurance claim form as a part of service to the patient to enable the patient to receive his or her benefits. A charge for more complex or multiple forms may be made in conformity with local custom. (Section 4) (1987)

D.7

Question: May I use a videotape segment of a therapy session at a workshop for professionals?

Answer: Yes, under the following conditions:

1. The patient gives fully informed, uncoerced consent that is not obtained by an exploitation related to the treatment.
2. The proposed uses and potential audience are known to the patient.
3. No identifying information about the patient or others mentioned will be included.
4. The audience is advised of the editing that makes this less than a complete portrayal of the therapeutic encounter.
5. The patient must also be told that the confidentiality will be permanently altered. (Section 4) (1990; Rev. 2017)

D.8

Question: The abusing father of a former patient who committed suicide is demanding the medical records of his dead son and claims, as the executor of the son’s estate, the legal right to these records. I am certain the patient would never have entered treatment if he thought his father would get his records. What do I do?

Answer: Your ethical obligation is to withhold the records in order to honor the wishes of your deceased patient. You should maintain the confidentiality of the records if federal and state privacy laws permit you to withhold the records in this type of circumstance. (Section 4) (1990; Rev. 2017)

D.9

Question: What are the obligations and responsibilities of the executors of the estate of a deceased psychiatrist with respect to the records of former patients? Specifically, should the executor notify all persons about whom there is a medical record?

Answer: Executors of a deceased psychiatrist's estate should ensure that patients are informed about the death and resources to establish continuity of care. (Section 4) (1993; Rev. 2017)

D.10

Question: Is it ethical to send a questionnaire to members of managed care plans and healthcare systems who have received psychiatric and/or substance abuse services as part of quality assurance protocols?

Answer: Yes, with the appropriate assurance to patients that the material will be anonymous and confidential, and if the mailing material (envelope) does not contain information identifying the nature of the services provided to the member-patients. (Section 4) (1993; Rev. 2017)

D.11

Question: What are the ethical considerations of my using videotaped excerpts of actual therapy sessions of my patients for workshops for mental health professionals, or sharing these excerpts through social media?

Answer: Informed consent from the patient, including clear descriptions of where and how the material will be used and whether it is for single use or ongoing, is required to share any excerpts of therapy sessions due to the confidential nature of this information. Psychiatrists should be aware that posting this information on social media raises the stakes considerably. (Section 2) (1993, rev. 2017)

D.12

Question: Is it ethical for a physician to have his or her name listed as a creditor on a debtor's report?

Answer: The ethical issue is the enduring loss of confidentiality for a psychiatric patient versus the physician's right to collect his or her fees. We believe that it is best to decline to be listed as the creditor. Federal law does prohibit the physician's name from appearing on the debtor's credit record in cases of treatment for chemical dependency. See Opinion 6.08, *AMA Council Opinions*, 2000–2001. (Section 4) (1994)

D.13

Question: I work in a small college mental health clinic setting. On occasion we see patients who have had a recent relationship breakup with a partner that we also see or have seen in psychotherapy. Often the patient tells his/her story and forms a treatment relationship with the psychiatrist before the connection to the clinician's other patient is revealed. By revealing the conflict of interest to the new patient and referring him/her to a colleague, we risk breaching the first patient's confidentiality. We have generally proceeded with the new treatment relationship unless:

1. We find we cannot provide reasonably impartial or effective care, or
2. One of the two in therapy reveals that they know the other is/was also in treatment, in which case we are able to more openly address the conflict and make an appropriate referral if indicated.

What are your recommendations?

Answer: Working in a small college setting is like working in a small town, or an underserved area where there are a limited number of mental health clinicians available to serve the population. In such settings, conflicts of this nature are inevitable. The solutions you describe seem reasonable as they acknowledge the need to make decisions on a case by case basis. In some cases, where the treatment is limited to psychopharmacology it may not present a conflict to treat both patients.

As you suggest, sometimes it is impossible to find a plan that will satisfy every ethical value. You are not required to do the impossible. Rather, your responsibility is to weigh the risks and benefits of the various treatment options, keeping the competing values in mind. Then, using clinical judgment, you make whatever reasonable recommendations you can to your patients. (Section 1) (2005)

D.14

Question: The psychiatrist has a patient who is an attorney. This patient has told him that she is a daily marijuana smoker, but has asked him not to note this fact in the medical records. Does this physician have an ethical obligation to record information that is medically/psychiatrically significant even when the patient requests otherwise?

Answer: The ethical tension in this case, and others in which patients request that information not be put in the record, is between obligations of truthfulness and competence on the one hand and beneficence, autonomy, and harm reduction on the other. In this situation, if the psychiatrist documents the substance use, there is a risk that the therapeutic alliance will be damaged and that the patient will not receive treatment. A psychiatrist may address this tension in this case by noting that the patient has requested privacy regarding questions about substance use, while continuing to work with the patient towards treatment goals. The psychiatrist should not place false information in the chart. In the case of clinically relevant information, the information should not be omitted without comment.

That being said, excessive details may not be helpful to patients generally, and specifically in this case. In situations in which not including the information in the record would pose a serious risk of harm or omitting information significant to present condition and current treatment that could compromise the patient's safety or effective treatment, the psychiatrist should inform the patient that he or she cannot continue treatment without documentation due to safety concerns. (Section 2) (2017)

D.15

Question: I found out that someone is forging my name to get controlled medications. Multiple names are being used, but all with the same last name. This last name is the same as a former patient's, who I learned a couple of years ago had forged at least one prescription using my name in another town. This former patient is at the same address as all the supposed people who are getting the medication with the forged prescriptions. Can I breach confidentiality and use the former patient's name when I report the forgeries?

Answer: You should report a stolen prescription pad but not volunteer speculation about who could have stolen it. (Section 4) (2016)

D.16

Question: Is it ethical to text information to other members of a treating team about a patient? What if de-identified? If so, would age and diagnosis be acceptable?

Answer: The use of public, unsecured wireless networks to transmit information with or about a patient is not permissible. The potential for patient information to be compromised, and therefore, violate patient confidentiality, is simply too great. The Ethics Committee is aware, however, that certain protective advances do exist, but the Ethics Committee lacks the technical knowledge to make assurances about how or when the medium of transmission would be safe. Further, our understanding is that significant concern continues to exist in medicine that current technology does not yet allow for sufficient security with text messaging.

Regarding "de-identification", one must be careful because providing too little information about the patient may actually cause a misidentification of the patient among members of the treatment team. (Section 4) (2017)

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 evaluatee in explicit acknowledgement of the non-clinical nature of the encounter. Further, prior to any forensic evaluation, the psychiatrist is ethically required to describe to the evaluatee the purpose of the evaluation, indicating that information divulged during the evaluation is not confidential and is intended for use in a legal proceeding.

Moreover, because the subjects addressed in this question are children, an additional ethical consideration is whether traumatized minors are even capable of providing informed consent, especially for a high-stakes interview. In the case of a psychiatrist's intervention for treatment of an unaccompanied minor, relying upon 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)

D.18

Question: What are the ethical considerations of texting with a patient?

Answer: Although physicians may adopt HIPAA-compliant encrypted healthcare portals for communicating with patients, patients may prefer to text their physicians. HHS and CMS have confirmed that all emails and text messages containing protected health information (PHI) must be encrypted. However, there is an exception to this rule of encryption: the HIPPA Privacy Rule gives patients the right

to communicate with their physicians using unencrypted email and texting only if the patient has been informed about the level of risk, and if they prefer unencrypted email or text messaging. (See <https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html>). Such forms of communication can promote patient engagement and can be very useful for routine communications like appointment reminders. Patients like and have the right to use them. So, what does this mean for physicians?

Under HIPAA, physicians remain responsible for safeguarding the PHI of their patients. Entities have the duty to warn patients of the risk of unencrypted communications, and they can only text patients if the patient consents to receive text messages after being warned about the potential risks. Documentation of warning and consent is required and should be documented in the medical record. If a physician texts their patient information for which the patient has not given their consent, the physician will be in violation of HIPAA. When warning their patients about the risks of texting and obtaining consent, physicians should be cognizant of the guidance from the APA Ethics Committee on informed consent:

APA Commentary on Ethics in Practice Topic 3.2.4: “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 values of their patients and, in general, not condition a patient’s ongoing treatment on a patient’s acceptance of specific treatment recommendations.”

Therefore, to safeguard patient PHI and avoid HIPAA violations, psychiatrists should, at a minimum, follow these three steps before texting patients:

1. **Warn** patients that there is some level of risk in sending unencrypted emails or texts.
2. **Let the patient decide** whether or not they want to text and what categories of information may be sent by text. If the patient prefers unencrypted email or text message, the patient has the right to receive them. If the patient decides not to send and receive unencrypted text messages, implement measures to block such text messaging, and notify everyone responsible for sending communications of the patient’s restriction.
3. **Document** the warning and patient’s consent in writing within the medical record. If the patient does not consent to sending or receiving messages, document all actions to block text messaging. It would also be wise for the physician to print communications with patients sent via text messaging or email to add to the patient’s medical record.

Further, physicians must recognize that texting, both in encrypted and unencrypted forms, is never an entirely secure form of communication and should be cognizant of that limitation when sending

information via text. Even if text messages are encrypted, mobile devices can be lost or stolen and are susceptible to hacking. It is the duty of the ethical psychiatrist to understand these risks so that when they warn patients about texting, their patients can feel fully informed to weigh the risks and benefits of using text messaging to communicate with their physicians.

Physicians may be tempted to disallow texting as a form of communication with patients to avoid the possibility of a HIPAA violation. However, the physician's primary obligation is to further the best interests of the patient; if the patient's circumstance is such that texting would be an easy and particularly effective form of communication for them, the psychiatrist should not prevent the patient from using text messaging, provided that the patient has been properly warned about the risks and has given their consent. While psychiatrists may prefer to use healthcare portals that are encrypted and HIPAA-compliant, if a patient prefers texting, the psychiatrist should strive to accommodate the patient's expressed preference. The goal of the psychiatrist should be to offer the best care that they can provide while making sure that their patients are informed about the risks and benefits of the choices that they are making. Patients have autonomy, and in many scenarios this autonomy grants them the right to say that they understand the risks and are comfortable communicating over text.

While texting patients about scheduling may be fairly straightforward, psychiatrists must be cautious about sending clinical guidance and other sensitive information over text. Written communications, especially succinct communications such as text messages, can leave a lot open to misinterpretations and misunderstandings. When deciding whether or not to text patients clinical advice, the obligation of the ethical psychiatrist is to be considerate of the implications of insecure messaging while weighing the risks and benefits of providing clinical guidance over text. One way that psychiatrists can respond to texts from their patients initiating a sensitive discussion or seeking clinical guidance is to call the patient to have a conversation rather than replying via a text communication. When making the decision to text about patient information or clinical guidance, both patients and physicians must weigh the risks of unsecure communication with potential benefits to the patient, such as ease of communication and strengthening of rapport and the therapeutic relationship. Such informed decisions begin with an understanding of the risks. (Sections 2 and 4) (2023)

D.19

Question: A psychiatrist was involved in a case in which the patient was involuntarily hospitalized, largely on the basis of collateral information provided by one of the patient's family members, who indicated grave concern that the patient was acutely suicidal. After providing collateral information, the family member requested that their identity be withheld from the patient in order to avoid conflict over their role in the involuntary hospitalization. The psychiatrist agreed to protect the identity of the collateral information source, but then proceeded to document the family member's identifying information in the electronic medical record. The patient soon discovered the family member's identity because of recent policies which grant patients immediate and live access to the records - in this case, while the patient was still admitted to the hospital. This discovery caused significant conflict between the patient and the family member. Did the psychiatrist act unethically in this situation? What obligations does the psychiatrist have to the source of collateral information? What could have been done in this case to prevent this issue, and what should be done now that this conflict has emerged?

Answer: In cases of crisis or imminent threat to safety/wellbeing, the psychiatrist's foremost ethical and clinical obligation is to the patient's safety. Safety concerns override concerns about conflicts in the patient's relationships and concerns about the confidentiality of sources of collateral information. Collateral information sources are essential to psychiatrists' clinical decision making, and collateral information should always be documented carefully in the medical record. However, if the source of collateral information is adamant about maintaining their confidentiality, the psychiatrist might not always need to include specific identifying information in the record, particularly if the psychiatrist knows that the patient may choose to review their medical record and the contents within at any point. While it is common clinical practice to document the source of collateral information in the EMR, consideration should be made in specific situations when sensitive information is shared.

Psychiatrists have no confidentiality obligations to sources of collateral information, as there is no established patient-doctor relationship between them. Therefore, it would not be an ethical breach, as outlined in *The Principles of Ethics with Annotations Especially Applicable to Psychiatry*, for the psychiatrist to disclose the source of collateral information to the patient. Nevertheless, when a psychiatrist obtains collateral information from a source, they should disclose the potential that the information could be shared with the patient. Rather than guaranteeing confidentiality to collateral sources, the psychiatrist should explain directly during the initial conversation that they may not be able to protect confidentiality, that the psychiatrist has an ethical duty to be honest with their patients, and that the psychiatrist's ultimate obligation is to the patient and the potential for imminent threat to safety/imminent harm. The psychiatrist may wish to explain to sources of collateral information how information they provide will be used and documented, and the psychiatrist should be careful not to make promises to collateral sources or other contacts that may not be possible to keep.

Another layer of this situation is patients' immediate access to medical records, which is an evolving issue that can complicate the psychiatrist's role and relationship with patients. Psychiatrists increasingly need to be thoughtful about documenting sensitive information in the EMR, mindful that the patient will subsequently have access to the records, and that the sensitive information contained therein can lead to conflicts.

Whether collateral information can be documented in a separate location is a question for the hospital legal and EMR teams. Psychiatrists have other options for documenting - for example, they often use private psychotherapy notes that are separate from the official medical record - and the psychiatrist should clarify whether such documents are permitted by the hospital, and how they can be used.

Any time there is a rupture between the clinical team and the patient or the patient's family, there is also an opportunity for repair. An individual's mental health crisis can be related to an accumulation of challenging family dynamics that have reached a tipping point. Treatment teams often become the focus of and outlet for conflict when there is a rupture within a family; this could represent a need to displace an overwhelming conflict between family members onto more distant parties. While acknowledging areas

where the psychiatrist can improve their practices, it is also important to address the underlying family dynamics. The treatment team can most effectively respond in situations like this by first acknowledging that strong feelings of their own are often conjured when there is a conflict between the clinical team, and the patient, and the patient's family, and then creating a space where they can non-defensively listen to both the patient and family's complaints, with a goal for resolution. It is always difficult to establish and maintain rapport and trust during involuntary treatments, but taking time to ask the patient and the family what they need to repair this situation can go a long way in making sure the treatment is useful to the patient. Modeling openness to feedback and a desire to repair can hopefully facilitate a parallel process between the patient and their family. Ideally, this creates a route that is therapeutic for the patient, the patient's family, and the treatment team. (Sections 2 and 4) (2023)

E. DUTY TO REPORT AND PROFESSIONAL COMPETENCY ISSUES

E.1

Question: Have I behaved ethically in not disclosing to state authorities that my patient had sexually abused his children? The state requires that all child abuse be reported to the authorities, and I may be subjected to a malpractice suit. In my defense, the abuse as reported by my patient had not been as extreme as reported by the wife. Furthermore, the patient and I had been therapeutically working on the problem, and I anticipated an early resolution.

Answer: All states have statutes mandating health care and mental health providers report suspected child abuse. (Section 4) (1981; Rev. 2017)

E.2

Question A: An ex-patient calls a psychiatrist's wife to inform her that she and the psychiatrist are having an affair. Can the spouse bring an ethics complaint?

Answer: Yes. (Section 2) (1989)

Question B: Do colleagues who are aware of a psychiatrist having an affair with their patient have an obligation to report this alleged behavior?

Answer: Yes. The commentary topic 3.3.4 states that all psychiatrists have an "obligation to recognize and address the unethical behavior of colleagues." The commentary offers options for addressing the behavior including but not limited to seeking supervision, discussing conduct with the individual, and/or reporting to appropriate authorities, including DB ethics committees. The colleague must do something when they have personal knowledge of such unethical behavior by a colleague. Ethical psychiatrists should be especially alert to guard against implicit bias influencing the course of action they pursue when they suspect or become aware of unethical conduct by a colleague. (Section 2) (1989; Rev. 2017; 2023)

E.3

Question: I recently had an adult married women patient tell me that she is having sexual relations with her male therapist with whom she just started treatment maybe a month ago. She has a background of being sexually abused. She understands that the therapist has committed a serious professional boundary violation and there is a good possibility it is not the first time. She refuses to turn him in or to stop seeing him. I do not know the identity of the therapist and I do not think she ever told me who she would be seeing when I asked her to get therapy a few visits back. I told her that I am duty bound to report this kind of infractions. She was referred because she had sex with a total stranger after they had a few drinks and smoked cannabis. They met on an airliner while she was returning home from a business trip. She felt guilty about the incident since she wants to keep her relationship with her husband intact. I told her that I would probably not be able to continue with her care under these circumstances and scheduled her back for follow-up in two weeks to determine the best course of action.

Answer: The woman is an adult of sound mind (i.e., has capacity, as presumed from her going on business trips). She knows what the therapist is doing is wrong but refuses to stop therapy (and sexual relations)

with him. She does not want to report the therapist despite knowing she could. The writer has no way of identifying the therapist. If the woman were incompetent or cognitively impaired, that would stimulate a different understanding/response from me. On another note, how does the writer know the therapist is a psychiatrist? Could be some other professional; for example, I do not know the ethics guiding the practice of Licensed Practical Counselors (LPCs) or Licensed Marriage and Family Therapists (LMFTs.) Regardless, the best the writer can do is discuss with the patient, the inappropriateness of her sexual relations with her therapist and the negative impact on her treatment, especially given her history of sexual abuse. Her pattern of indiscriminate sexual intercourse was the initial impetus for the writer's referral of the patient for therapy. I do not believe the writer should abandon this vulnerable patient at this critical time; she needs an ethical and trusted professional to help guide her treatment through the complicated state of affairs she is currently engaged in. I do not understand why the writer is making treatment contingent on the patient reporting her therapist, or what the writer is really worried about that is yet unspoken. It would be enough for the therapist to document discussions had with the patient regarding this issue and the professional advice rendered, including a discussion (and the patient's understanding) of the options available to her. To stop treating her at this time on account of this issue would be problematic, in my opinion. (Section 4) (2017)

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 misinformation or 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. Such misinformation may also have a disproportionate harmful impact on particular communities, such as historically mistreated communities and vulnerable populations. 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. When a psychiatrist provides commentary on a practice with historical and/or cultural value for a particular community, it would be appropriate for them to specify the scientific basis for medical use for the practice and separately identify the historical and/or cultural significance it may hold for a particular community.

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. Particular risks may be perceived or exist for those in lower positions of power and/or from minoritized groups who find themselves faced with administrative directions which they believe could lead to fraudulent activity. Given such challenges, psychiatrists in administration leadership should work to ensure that the structure of their organization enables and supports reporting and appropriate resolution of such issues without retaliation against reporting physicians. (Section 2) (2022).

E.7

Question: What obligations does an ethical psychiatrist have to establish a plan for their patients if the psychiatrist becomes unable to provide competent medical care (e.g., due to an impairment in the psychiatrist's functional abilities resulting from a change in physical or mental health)? What are the obligations of an ethical psychiatrist to recognize and address the potential impairment of a colleague's ability to competently practice psychiatry?

Answer: A psychiatrist's incapacity raises many challenges, including in the areas of clinical coverage, administrative responsibilities, and medical records. Such a decline in functional capacity, regardless of etiology, raises additional ethical considerations to ensure that one's patients will continue to receive competent care. The ethical responsibility to provide competent care requires that psychiatrists recognize that competence is fluid, context-dependent, and requires lifelong self-reflection regarding one's present abilities. Thus, psychiatrists have an ethical obligation to continuously monitor their own capacities to practice competently. And if they become aware of concerns they are not able to do so or will be unable to do so in the foreseeable future, to implement steps to ensure competent care is provided to their patients. Similarly, the ethical psychiatrist at risk for any impairment (including temporary) may consider potential contingency plans for how their patients could continue to receive competent care should they become unable to provide it themselves taking into account the relative available resources. The APA Resource Document [Closing a Practice at Short Notice: What Every Psychiatrist and Their Family Should Know](#) provides guidance to assist with planning and risk management at the practice level in the event of an emergency closing, including template worksheets for the psychiatrist to use to provide a plan for implementation in an emergency closing.

The *APA Commentary on Ethics in Practice*, Topic 3.3.5 describes the psychiatrist's ethical duty when a psychiatrist becomes concerned about an impaired colleague's ability to care for patients safely. This guidance is similarly applicable in this question. That *Commentary* states:

“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. An impaired psychiatrist who does not seek help and correct the problem fails the community of psychiatrists, its standards, and his or her 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 evaluation or 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 state's impaired physician program, the state medical board, the chief of the service, the hospital medical staff procedures, or other available route (e.g. a District Branch wellness committee).”

(Sections 1 & 2) (2023)

F. ETHICS PROCEDURES

F.1

Question: A psychiatrist was accused by a former patient of sexual misconduct and she was encouraged by her present psychiatrist to file a lawsuit; the psychiatrist also filed a complaint with the licensing board. The original psychiatrist denies his guilt and wants to be heard by his district branch ethics committee, who did not receive a complaint. Can he request a hearing?

Answer: There is no provision for a potentially accused member to seek a hearing; that action lies with the complainant. Perhaps there should be such a mechanism, though the psychiatrist seeking this hearing could be subject to disciplinary actions; he cannot ask for a hearing with immunity. (Section 2) (1988)

F.2

Question: In the reverse of the usual, a “social relationship” turns into a professional relationship. Is this worthy of an investigation?

Answer: Yes. What is the nature of this “social relationship” and does it continue now that a professional relationship has occurred? Was the psychiatrist treating this person honestly in accepting clinical responsibility under the circumstances? And, what is the nature of the professional relationship? Some advice? Comfort in a crisis? Medications? Formal psychotherapy? Was there a treatment contract including a fee? Who is complaining? Answering these questions through investigation should lead to a decision on whether a possible ethics violation has occurred. (Section 2) (1988)

F.3

Question: Should our ethics committee process a complaint of excessive fees?

Answer: The guiding issue is the nature of the contract between patient and psychiatrist. If the psychiatrist may have billed in excess of the contract, or failed to make the contract explicit, an ethics violation may have occurred and justifies your involvement. (Section 2) (1990)

F.4

Question: Our ethics committee has trouble distinguishing between issues of ethics, law, competency, and impairment. We wonder if we err in reviewing competency issues and fear we will lose APA liability coverage.

Answer: To practice incompetently as a pattern of practice, especially after being so advised by peer review, or to practice in an area of medicine without proper training, is to have behaved unethically. An isolated incident of incompetent care may better be handled by other peer review mechanisms. Your district branch might use a routing mechanism to choose the most appropriate component to receive the complaint. Your ethics committee will be covered by the APA if you follow procedures correctly, since incompetency is clearly an ethical issue. (Section 2) (1990; Rev. 2017)

F.5

Question: I have personal knowledge that a colleague has behaved unethically with one or more patients. The patients are unwilling to bring an ethics complaint. Is it possible for me or any other psychiatrist who has such knowledge to bring an ethics complaint?

Answer: Yes. Indeed, The Principles of Medical Ethics include the admonition that an ethical psychiatrist's obligation is to recognize and address the unethical behavior of colleagues. As mentioned in the answer to question E2c, the psychiatrist must do something. Options for addressing the behavior include but are not limited to seeking supervision, discussing conduct with the individual and/or reporting to appropriate authorities, including DB ethics committees. An ethics complaint clearly is an option and may well be warranted. The purpose behind this admonition is to lessen subsequent unethical behavior. Further, if there is extrinsic evidence such as a report of a malpractice suit that includes unethical behavior, a district branch ethics committee as a whole may bring an ethics complaint. (Section 2) (1993; Rev. 2017)

G. FORENSIC ISSUES

G.1

Question: Is it ethical for an employed psychiatrist to perform an evaluation to determine the competency of a patient to assist his hospital employer in collecting charges made to the patient?

Answer: No. This is clearly a situation involving a conflict of interest. Any such evaluation should be performed by a psychiatrist who has no financial relationship to the hospital. An evaluation intended to be used against the patient by a doctor at the same hospital where the patient was treated too easily would lead to confusion about the role of the doctor by the patient. (Section 4) (1973; Rev. 2017)

G.2

Question: A nearby state institution for “the criminally insane” has been the object of continuing charges of patient mistreatment. Should the ethics committee investigate?

Answer: This is not the kind of issue an ethics committee has the resources to investigate. However, if there are allegations that there are psychiatrists in the institution violating the APA Annotations then those psychiatrists could be investigated regarding such possible violations. (Section 1) (1975; Rev. 2017)

G.3

Question: I am a consultant to a Catholic diocese in the matter of approving or disapproving marriage annulments. I review reports and information gathered about the individuals and give an opinion on whether they are competent to request an annulment. I do not examine them personally. Is this ethical?

Answer: Yes. Consultants to various medical, social, and rehabilitative agencies are presented with data provided by agency personnel and are asked to give an opinion on such issues as rehabilitation potential and competency, or consultants are asked to recommend a treatment regimen. To ask them to perform a personal examination in each case would be impractical and prevent such agencies from benefiting from psychiatric consultation. The psychiatrist must, of course, observe the rules of confidentiality (Section 4, Annotation 4, APA) and of proper relationships with other health professionals (Section 5, Annotations 2, 3, and 4, APA). (Section 7) (1976)

G.4

Question: Can an ethical psychiatrist participate in the legal execution of a prisoner by injecting a lethal dose of a sedative?

Answer: Section 1 (AMA) says: A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

Section 1, Annotation 4 (APA) states: A psychiatrist should not be a participant in a legally authorized execution.

One could argue that death by injection of a sedative is more compassionate and more dignified than some other methods of execution. Nevertheless, the overriding meaning of this Principle is that the physician–psychiatrist is a healer, not a killer, no matter how well purposed the killing may be. See Opinion 2.06, *AMA Council Opinions*, 2000–2001. (Section 1) (1977; Rev. 2017)

G.5

Question: There has been a series of especially gruesome murders in a community. The similarity of the crimes strongly suggests they have been committed by the same individual, who in all likelihood is mentally ill. A forensic psychiatrist has drawn up a speculative psychological profile. Is it proper for the psychiatrist to make this profile public? If a local psychiatrist believes the profile may be that of a patient, should the psychiatrist report this to the police?

Answer: Since this profile is speculative and not representative of anyone known by the forensic psychiatrist, it is ethical to assist the police by providing them advice about the identification of the killer. If a psychiatrist believes the profile is that of one of his patients, the psychiatrist has the following options: (a) if it appears the problem is now history and future attacks will not occur, the psychiatrist should assist the patient with the assistance of the patient’s lawyer in a decision to go to the police; (b) if there is reason to believe the attacks may continue, if the future violence does not seem imminent the psychiatrist should strongly urge the patient, perhaps with the assistance of the patient’s lawyer, to go to the police; (c) if the patient refuses, or if in the psychiatrist’s opinion the danger is too strong to delay, it is ethical for the psychiatrist to notify the police and any potential identifiable victims as well. Section 4, annotation 8 (APA) states: “This is a permissive statement. In some jurisdictions, there is an obligation to report in some of the circumstances described above or risk legal liability.” (Section 4) (1977; Rev. 2017)

G.6

Question: I am asked to render an opinion for insurance purposes to determine if a suicide was a result of illness. Is it ethical for me to offer a diagnosis based on a review of records and without having had an opportunity to examine the patient?

Answer: Yes. The psychiatrist’s report should explicitly identify that the methods did not include an in-person evaluation and are based solely on record review. (Section 4) (1983; Rev. 2017)

G.7

Question: A psychiatrist testifies for the state in a criminal case about the competency of the defendant. The psychiatrist based the testimony on medical records and did not examine the defendant nor have the defendant’s approval to render an opinion. Was this ethical?

Answer: It depends. In criminal cases, a personal examination generally is necessary. However, if reasonable efforts to perform a personal examination of the criminal defendant are made, a personal examination is not performed, an opinion may be given if the limitations of the exam are stated and the ensuing weakness of the conclusion is acknowledged. In regard to the defendant’s approval, in general, a defendant’s consent should be obtained prior to an evaluation. In instances where that is not legally

required such as when the assessment is court ordered, that issue should be worked out between the psychiatrist, the attorneys and the court. (Section 7) (1983; Rev. 2017)

G.8

Question: In my role as a forensic examiner of sexual offenders for a state agency, it is clear there is an expected opinion from me. What is my ethical responsibility?

Answer: Your responsibility is to give the opinion to which your professional judgment leads you. Submitting to pressure to alter your opinion would be unethical. Section 2 (AMA) states: “A physician shall deal honestly with patients and colleagues.” In the context of a forensic evaluation, this ethical guidance requires that you strive to render an objective opinion, identify the entity on behalf of whom or which you are conducting the evaluation, inform the evaluatee of the purpose of your evaluation and any potential conflicting roles (e.g. treater and forensic evaluator), notify the evaluatee of the known or reasonably anticipated limits on confidentiality of the evaluation, and clearly state whether or not the evaluation shall constitute an ongoing treatment relationship. (Section 2) (1986; Rev. 2019)

G.9

Question: I was treating a member of a prominent family when the patient was murdered along with some other family members. Under court order, I testified in the murder trial and in a civil action. Now a TV company wants to make a documentary of this and have me serve as a consultant. May I do so ethically?

Answer: We don’t think it creates a good image of our profession for you, as the treating doctor of one of the victims, to be the named consultant. If you wish to pursue this, we don’t see an inherently unethical issue, but you must reveal nothing new and provide no new insights other than those you made public in the trials. (Section 4) (1987)

G.10

Question: Is it ethical for me to provide a competency examination before the execution of a felon?

Answer: While it is not ethical to participate in an execution (see Opinion G.4), it is ethical to provide a competency examination. The prisoner must be fully informed of the examination’s purpose and lack of confidentiality, have legal representation, and the opinion must be rendered in keeping with accepted standards. The position of the psychiatrist at this point should not be exaggerated to further his or her own opinion of capital punishment and must be supported by the facts. (Section 1) (1990)

G.11

Question: Is it ethical for a psychiatrist to evaluate a family member who is a plaintiff in a civil litigation suit and then testify on the family member’s behalf concerning the issue of mental damage resulting from the family member’s claimed injury and damage?

Answer: To do the evaluation would be highly questionable from an ethical standpoint. There is too great a likelihood that the psychiatrist’s clinical evaluation will be influenced by the relationship with the family

member as well as the likelihood that the patient-relative's presentation of concerns will be influenced also. Any attempt to serve as an expert witness in a legal proceeding would be vulnerable to challenge. Under these circumstances, providing competent medical service would be too difficult when the patient is also a family member. (Section 1) (1993)

G.12

Question: Do the same ethics principles apply in a diagnostic/consultative relationship (e.g., performing evaluations for an insurance company) as in the physician–patient relationship?

Answer: Yes. Ethical physicians must comply with the code of ethics whenever providing professional services. Even when providing administrative or consultation services, physicians must conduct themselves appropriately. (But in such situations, the confidentiality expected in a therapeutic relationship may not exist.) This lack of confidentiality should be explained to the patient. (See also Sections 2 and 4, APA.) Since performing an evaluation for an insurance company is a forensic psychiatric assessment some additional ethics considerations are applicable. In a forensic psychiatric role answering the legal question truthfully has a greater priority than helping the person evaluated in contrast to a treatment relationship. (Section 1) (1993; Rev. 2017)

G.13

Question: Can a psychiatrist evaluate a prisoner (i.e., patient) for the state and then determine that the prisoner requires involuntary hospitalization?

Answer: Yes. In this determination, the psychiatrist must do a proper psychiatric examination to ensure that the person meets the clinical criteria for involuntary hospitalization. It is important at the outset for the psychiatrist to make clear to the person to be examined the nature, purpose, and lack of confidentiality of the exam. The established criteria for involuntary hospitalization should be cited in the report to the court. (Section 4) (1994; Rev. 2017)

G.14

Question: State-licensed psychiatrists are hired as independent contractors through an independent medical services company to provide all medical and mental health services for a state's prisons. At one facility, the inmates are convicted sex offenders sentenced by the courts to a facility with special treatment capabilities for this population. The treatment is administered using a multidisciplinary team, and offenders are told their treatment records are confidential except for cases of dangerousness issues (e.g., threat of self-harm or harm to others).

Psychiatrists are part of the treatment teams and may or may not have much direct contact with inmates, but at a minimum attend every six-month review meetings where they are privy to the inmates' confidential treatment materials.

Near the end of the inmates' incarcerations, an Inmate Release Committee, composed of lay staff administrators, meets to determine which inmates should be screened for possible involuntary civil commitment as sexually violent predators. If the decision is to have them screened, two or three

psychiatrists perform the evaluations. Sometimes these evaluating psychiatrists have been members of the inmates' treatment teams. At times these psychiatrists have allegedly relied upon and revealed confidential treatment material, such as from group therapies, when conducting evaluations and rendering commitment decisions on their own patients. Is it ethical for a former treating psychiatrist to conduct an evaluation?

Answer: Psychiatrists who are members of a treatment team, even if their contact with inmates is limited, have nevertheless established a physician-patient relationship. Therefore, based on the background information provided, the practice of treating psychiatrists later serving as adversarial evaluators for the state governmental jurisdiction on their patients would constitute a violation of Section 4 of The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. At the onset of treatment inmates must be informed of the psychiatrist's dual relationship to them and to the prison system, and that their records can later be used to help determine whether they will be civilly committed as sexually violent predators (SVP). Absent that warning psychiatrists should not engage in SVP evaluations. SVP assessments are especially problematic because while portrayed as a civil procedure the reality often is designed to achieve lengthy confinement with little treatment or likelihood of release. Protections are much more necessary here than in civil commitment in a civil hospital which is primarily designed to help the patient and usually shorter term. (Section 4) (2004; Rev. 2017)

H. INTERACTION WITH OTHER PROFESSIONALS

H.1

Question: Is it ethical to teach counseling principles to the clergy? Is it ethical to give them advice in the management of specific cases?

Answer: It is ethical to teach counseling principles to the clergy. The second question is more complex. Section 5, Annotation 3 (APA) states:

When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he/she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.

Formal supervision of a pastoral counselor would not differ from the supervision of other nonpsychiatrist professionals. It is in informal contacts that problems arise. A cleric might call a psychiatrist for advice or seek a “curbstone opinion.” Perhaps a cleric might bring up a specific case during a seminar with a group of other clergies. Ethical psychiatrists should refrain from giving specific patient management advice, assuming there is not an emergency situation, unless they are very much aware of the capabilities of the receiver of the advice and have sufficient information about the patient to make the advice reliable. Psychiatrists are both ethically and legally responsible for the advice they give. (Section 5) (1975)

H.2

Question: Is it ethical for a psychiatrist to be a party to a clinic whose lay advisory board responsibilities include “shall establish or recommend policies regarding the case intake and termination process, duration of treatment, diagnostic groups to be served, scope of services and program evaluation”?

Answer: Section 1, Annotation 3 (APA) states:

It is ethical for a physician to submit his/her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body.

Clearly, a lay board cannot set a policy that requires a psychiatrist to give improper care. However, public-funded clinics are responsible to the public and its representatives, and a public decision can be made that sets general guidelines and limitations for the clinic staff: for example, age groups and diagnostic categories to be served, outpatient or day care or inpatient services, nondiscriminatory policies, and so forth. The clinic cannot do everything for everybody because of finite funding; it is the governing body’s responsibility to set the limits with professional advice provided by the clinic staff. (Section 6) (1977)

H.3

Question: Is it ethical for a psychiatrist and a psychologist to form a professional corporation as equal partners?

Answer: Usually there are local laws governing professional corporations that prevent this possibility. Where there are no such laws, such a corporation is permissible. Such a corporate arrangement, if agreed

to, should not have features that interfere with the psychiatrist's medical judgment, nor may the psychiatrist delegate to the psychologist any matter that requires medical judgment. This corporation must observe all ethical requirements that an individual physician must meet. The responsibility to see that this occurs falls upon the psychiatrist partner. See Section 5, Annotations 2, 3, and 4 (APA). (Section 5) (1978)

H.4

Question: Is it proper for a psychiatrist to be the "medical director" of a private clinic, the rest of whose staff are nonmedical professionals, when the psychiatrist spends very little time at the clinic?

Answer: It is not ethical for the psychiatrist to lend his or her name to the clinic merely to legitimize it. The psychiatrist must spend sufficient time at the clinic to assure that proper care is given and that nonmedical staff are not assuming responsibilities requiring medical training. See Section 5, Annotations 2, 3, and 4 (APA). (Section 5) (1978)

H.5

Question: Can I market a tape that helps people stop smoking? It will encourage relaxation and instill the idea of being an active nonsmoker rather than quitting smoking and is based on my office experience where I utilize a light hypnotic trance.

Answer: It is ethical to market useful health assistance and information to the public. However, you are subject to the usual ethical constraints to not make exaggerated claims and to provide material that reflects competent medical opinion. (Section 5) (1987)

H.6

Question: A mental health management company wants me to sign a contract with them that says my services would be limited to evaluation and medications (unless otherwise expressly approved), thus serving as a consultant to nonmedical professionals. This doesn't seem proper to me.

Answer: Our Principles and Annotations (Section 5, Annotations 2, 3, and 4, APA) state that you cannot delegate responsibility to those not competent nor serve as a figurehead to cover other practitioners. If you believe this organization demands you do so, don't join. We cannot judge the ethics of the health plan, but we can judge those of any psychiatrists who participate. (Section 5) (1990)

H.7

Question: Our hospital proposes that attending psychiatrists provide medical management and that other hospital-employed professionals provide psychotherapy. We don't have to do this if we think it clinically unwise, but the hospital will preferentially refer patients to those who do. Your opinion, please

Answer: We do not address the ethics of hospitals but those of the psychiatrists practicing there. It is ethical to delegate treatment to other professionals if the psychiatrist is confident they are competent and it will not compromise the patient's welfare. It is not ethical, however, for the psychiatrist to make that

decision if financial inducement (patient referrals) takes precedence over the best interests of the patient. Further, a direct quid pro quo referral arrangement would be an unethical payoff. (Section 5) (1990)

H.8

Question: I work in a group practice, and one of our psychologists is being sued by a former patient for their having had a sexual relationship. The psychologist has admitted to it. We fired him, sent a letter to his patients indicating that he was no longer with the practice, and that we would help arrange for alternative care should they wish to continue treatment with our group. The letter did not indicate that he was fired or why he was no longer without practice.

I share several patients with this psychologist, who is now in solo practice. He sees them for therapy and they see me for medication management. Should I continue to see these ongoing patients, or should I tell them that I am no longer working with this psychologist? If so, how much should I tell them about the reason why I will no longer work with him?

Answer: You could indicate to those patients who continue to see you and the psychologist that (1) you are no longer working with him and (2) you can either refer them to another psychiatrist, or they can ask the psychologist to refer them to another psychiatrist. (Section 2) (2002)

H.9

Question: I work in a group practice and recently learned that a psychologist in the group is giving medication advice to patients, including specific medication directions. I have reported this to the psychologist's supervisor who indicated action will be taken after a review with the department chief. Am I required to report this to the psychology board?

Answer: Reporting this to the supervisor and contacting the Psychology Board to get its input (regarding whether they welcome a report) is wise. The psychologist may have practiced medicine without a license. This is a licensing issue and in some states could rise to a criminal offense. You have been responsibly proactive and have fulfilled an ethical duty to report another professional who may have put a patient in harm's way. (Section 2) (2012)

H.10

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

Answer: The Goldwater Rule has no impact in a collaborative care setting for many reasons. The rule addresses public statements based upon publicly available information (e.g. in the media) about a public figure when there is no physician patient relationship. In a collaborative care setting, the psychiatrist is part of the care team with access to the patient's private medical records and history. In most states, there will be a physician/patient relationship between the consulting psychiatrist and the patient who has consented to the psychiatrist being part of the team. In the collaborative care setting, if a psychiatrist were

to make public statements about a patient's condition, he or she would be violating basic principles of patient confidentiality and entirely different ethics principles (and state and federal laws) would govern. (Section 5) (2017)

H.11

Question: I 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)

I. MANAGED CARE

I.1

Question: Should I answer telephone inquiries from a UR nurse working for a managed care system asking about my patient's need for treatment and progress?

Answer: If the patient has given his or her consent and you are confident of the identity of the caller, you may do so. However, you should provide only that information relevant to the question and not reveal private information not relevant to the question. The right to confidentiality rests with the patient who has made a decision to relinquish it as a condition of insurance coverage. Under HIPAA, consent is not always required to speak with an insurer or other health care provider; however, from an ethical perspective, it is always best to ask a patient's permission to share information. (Section 4) (1987; Rev. 2018)

I.2

Question: A local PPO does things I feel are unethical. They encourage their members to use PPO psychiatrists, unfairly compete with those of us who didn't join, and use draconian utilization control methods, even interviewing the patients themselves or calling them on the telephone. Do you agree they (the PPO's psychiatrist staff) are unethical?

Answer: Psychiatrists who participate in managed care systems are not inherently unethical if:

1. Patients and prospective patients (or their employers) make an informed decision to participate, which includes knowledge of the following:
 - a. their other options;
 - b. benefit limits;
 - c. the pre-authorization and current authorization process;
 - d. their right to appeal a utilization decision;
 - e. the limits as to whom they can see without having to make a greater financial investment; and
 - f. the potential invasion of their privacy by the review process.
2. No exaggerated claims of excellence are made.
3. Care provided is competent and meets patient needs within the contracted benefit limits.
4. The utilization review process is not unduly invasive of the doctor-patient relationship.
5. Reviewers are not financially rewarded for denying care.

Failure to meet these requirements may justify an ethics complaint against a psychiatrist involved. (Section 6) (1990)

I.3

Question: I don't participate in an insurance plan. My patient has requested reimbursement from an insurance company and the insurance company has demanded the patient charts for an audit. May I provide the records to the insurance company? Can you charge the patient?

Answer: For the physician to provide these charts, it is suggested that consent be obtained from any patient whose chart is to be the subject of such an audit. A general consent, obtained at the time one applies for insurance, may be inadequate. As with court-ordered release of records, attention must be paid to the release of confidential information about persons other than the patient. This may require that records be redacted for sensitive material by the treating physician. (Section 4) (1998; Rev. 2018)

I.4

Question: Can a psychiatrist who is serving as a managed care or insurance utilization reviewer (who does not have a direct relationship with the patient) ethically limit access to care in ways known to be in violation of parity? Here it is assumed the issue is not medical necessity, but whether the insurance company or manage-care company chooses to cover the benefit in question. (Examples: a reviewer refuses to authorize residential treatment because it is not a covered benefit--and a court has hypothetically determined that it is inconsistent with the parity law to exclude residential benefits, or a reviewer refuses to support treatment for a personality disorder, despite these being major disorders that carry a significant risk of suicide, complicate the treatment of other comorbid disorders, have a practice guideline, and several recognized evidence based treatments. Please note these examples are offered for clarity, but are not the only instances about which I am inquiring.)

Answer: In our opinion, the questions posed can be distilled into one; does the psychiatrist working as a managed care or utilization reviewer owe primary obligation to the patient or to the plan? To be clear, in this situation, the psychiatrist is a non-treating psychiatrist. The Opinions of the APA ethics code are best interpreted as meaning that for a treating psychiatrist in a managed care setting, patient welfare is primary. Similarly, for forensic psychiatrists in most contexts, patient care is not primary, and their primary duties instead are to promote justice and answer questions honestly.

A managed care or utilization reviewer is not a treating psychiatrist. Managed care is designed to cut costs, reduce premiums, and possibly increase profits. The reviewer is hired by the company to assess whether the care meets the criteria the plan has established. The reviewer cannot authorize benefits that are not covered by the plan. The patient who purchased the insurance should have been supplied the coverage by the plan. In our opinion, the psychiatrist managed care or utilization reviewer owes his primary obligation to the managed care company and a secondary one to the patient. In this context, it is a reasonable expectation that the reviewer will stay within the guidelines established by the company.

With regard to violations of parity laws as described in your question, it is not the ethics responsibility of the reviewing psychiatrist to determine whether the plan is meeting parity law requirements. Presumably, that would be outside his employment and obligations. If the plan is not following parity requirements, then others, including the patient or the treating psychiatrist, may take some action against the plan. The primary duty of the reviewing psychiatrist in this situation is to evaluate whether the requested treatment is warranted and covered by the plan. It would be unethical for the psychiatrist to deny care that was in fact covered by the plan. Nevertheless, some may wish to argue that the reviewer may be seen as obligated to advocate for change in the managed care plan. That is a laudable goal, but not one that can be mandated for those psychiatrists who are reticent about engaging in political advocacy. (Section 1) (2015)

J. MILITARY AND OTHER GOVERNMENT AGENCIES

J.1

Question: As a military psychiatrist, I have a responsibility to examine personnel who have used drugs, to determine if it is medically safe to proceed with the administrative process of rehabilitation and separation. Some of these people are one-time users, do not need rehabilitation, nor deserve separation. I object to such participation and believe it is unethical. Am I correct?

Answer: We do not believe you are correct, although we recognize your dilemma. This dilemma is similar to those encountered by psychiatrists working under any system of care and is a conflict of duty and obligation. The service regulations are the law under which you as a military officer serve. You may advise as to your belief that the law is incorrect. However, your opinion that it is medically safe to proceed with requirements of regulations does not place you in an unethical position. (Section 3) (1985; Rev. 2018)

J.2

Question: In an INS investigation, is it ethical for a psychiatrist to certify that an immigrant has revealed his or her homosexuality to the psychiatrist when that is the sole purpose of the “examination” and certification? This will result in exclusion of the person from the United States.

Answer: Section 1, Annotation 2 (APA) states: A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

If the psychiatrist’s only role is an administrative one that requires a physician’s signature confirming a statement of homosexuality, the action is unethical. The psychiatrist would be a party to a policy that excludes because of sexual orientation. (Section 1) (1986)

J.3

Question: A patient gave a signed release for me to respond to a government intelligence agency in the process of seeking a security upgrade. I refused as I believed this was an improper invasion of the treatment, and I do not believe the patient is a security risk. Was my action ethical?

Answer: If the patient knowingly and without coercion gave his or her consent, the privilege of maintaining or not maintaining his or her confidences is the patient’s, not yours. There may be coercion here (no release, no security upgrade), but that is the patient’s choice since presumably the upgrade is to his or her advantage. Your last point raises another issue: are you, or psychiatrists in general, knowledgeable and skilled in determining security risks? Clearly, any deception on your part, or the offering of an incompetent opinion, could be a violation of Section 2 (AMA). (Section 4) (1986)

J.4

Question: Member has a number of patients who work (or may work) for the federal government. The patients give authorization for Member to be contacted and he is sometimes asked to complete security clearance forms regarding those patients which ask him, for example, if the patient is capable of handling

high security matters. He doesn't feel comfortable answering such questions. Can he decline to complete the forms?

Answer: Referred to *Resource Document: Psychiatrists' Response to Requests for Psychiatric Information in Federal Personnel Investigations*. (Section 8) (2017)

J.5

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

But, I still do not think this addresses military psychiatrists involvement. Specifically, it is not the policy, per se, which I think that is most unethical (though I might personally disagree with Transgender ban as a policy), rather it is the question of how medical information is being used to harm, which seems most unethical. As you know, with President Trump's announcement on 26JUL2017 on Twitter, stating "... be advised that the United States government will not accept or allow transgender individuals to serve in any capacity in the U.S. Military," military psychiatrists are in an urgent ethical dilemma. I acknowledge that this is still to be sorted out administratively, but regardless of the source/mechanism, statements from the Commander-in-Chief are perceived as military orders. Service members are trained to expect that orders of the President will be followed. Over the past year, psychiatrists assessed Military Members who identify as transgender, and, when appropriate, diagnosed them with Gender Dysphoria, per DSM5. Now, this same diagnosis and medical information, consistent with the President's statement, is being used to do harm, with potential punitive separation from the military. Additionally, there is significant psychological distress, for many, associated with this shift in policy and associated ostracism. Thus, the psychological impact of the order is immediate, regardless of it being implemented. Unlike other matters related to identity, psychiatrists were necessarily involved, due military instructions to first render DSM5 Diagnosis, Gender Dysphoria.

I seek ethical guidance from APA, since my diagnoses, as a military psychiatrist, are being used for harm rather than to alleviate suffering. Moreover, I ask APA to continue to advocate for protections for these patients, whom I diagnosed as having Gender Dysphoria. This could mean, for example, return to the previous policy, or not permitting any prior Gender Dysphoria records (or treatment thereof) to be used punitively. I also for protections for me, as a military psychiatrist, from complaints of unethical practice, given these policy changes were unforeseen.

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

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

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

We have identified three questions implicit in your query.

1. What are my ethical obligations to existing patients?

Your ethical duty to patients for whom the diagnosis has already been made and documented in the medical record includes continued vigilance about confidentiality. Section 4, article 2 asserts:

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

If the military seeks information from the psychiatrist about patients who may have been given a Gender Dysphoria diagnosis, the psychiatrist should only release that information after obtaining proper authorization from the patient, which should include an informed consent discussion about the potential consequences of release of the information. If the military is seeking information from the psychiatrist about patients who may have been given a Gender Dysphoria diagnosis and the patient is unwilling to sign a release, then the psychiatrist should only release information as allowed as per HIPAA and DoDI 6490.08. The psychiatrist may discuss the request with their assigned Medicolegal Consultant prior to making such a release to ensure that only the minimum amount of information necessary, if any, is released. If the military has concerns regarding a trans Service Member that may impact the member's fitness for duty, the psychiatrist should adhere to guidance in DoDI 6490.04. Hormonal therapy is a possible prohibition for deployment, so if an individual wants to deploy they may wish to review with their provider the implications of beginning this therapy.

2. What are my ethical obligations to patients still in the military who are concerned about the impact this will have on them?

Any distress experienced by trans patients because of a change in policy that threatens their employment or service status should be treated with compassion in accordance with usual standards of care. The ethical obligation of the psychiatrist is to remain supportive of the patient.

3. What are my ethical obligations to new patients who are transgender with respect to diagnosing them in their record?

If a new patient comes to the psychiatrist and introduces the subject of transitioning for the first time, which normally requires a revelation to one's commander and obtaining the support of the commander for the process, a psychiatrist must now weigh the patient's clinical needs and the potential implications for their ongoing service. Going forward, it is ethical to have an informed consent discussion with a new trans patient, to help them consider whether it is in their interest to move forward with the transition at this time while things are uncertain. As with any sensitive topic, documentation in the medical record should be circumspect, including only the information necessary to justify a diagnosis and treatment plan, while still accurately reflecting the clinical encounter.

In addition to these guidelines, the ethical psychiatrist employed by the military may also want to consider Section 1, article 2: “*A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.*” This principle may need to be considered along with Section 3: “*A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.*” Military psychiatrists may want to consider the extent to which they can advocate for the wellbeing of their patients without threatening their ability to continue to serve their patients. (Section 4) (2018)

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 psychiatrist 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.” *Annotations*, 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).

J.7

Question: What are the ethical considerations for military psychiatrists related to (i) turning over existing records and/or (ii) creating future records documentation, in light of the *Memorandum* with Subject “*Additional Guidance on Prioritizing Military Excellence and Readiness*” issued by the Office of the Under Secretary of Defense on February 26, 2025?

Answer: Military psychiatrists face a traditional tension between their duty to patients and to standards of military readiness. Consequently, the confidentiality of medical information is limited in certain areas like suicidality, hospitalization, and acute conditions that interfere with military duty. Additional circumstances affect high-ranking patients. Discussions, confidentiality limits, and fitness decisions are made case-by-case. See, e.g., *Annotations* Section 4.6.

A relevant APA Ethics Opinion (Opinion J.5) encourages informed consent discussions surrounding diagnoses that may affect the patient's confidentiality and future military service, careful documentation

limited to information justifying a diagnosis and treatment plan, and supporting patients who are caused distress by an assessment and its implications. Clinical judgment plays a significant role in these decisions. Ethics principles in psychiatry also oblige the psychiatrist not to be party to policies that exclude individuals or demean their dignity (*Annotations* Section 1.2), but psychiatrists must still respect the law, seeking change when it is contrary to patient best interests (*Annotations*, Section 3). Psychiatrists will need to consider the extent they can advocate for patients without threatening their own ability to serve patients in the long run.

With the current Department of Defense's focus on gender dysphoria, military psychiatrists have ethical obligations to educate their communities on the lack of research supporting its incompatibility with military service (See, e.g., 2.28.25 [*APA Statement of Gender Dysphoria and Military Readiness*](#)), and a related obligation to underscore the similarity to arguments used historically to exclude Black recruits, women in combat, and gay or lesbian recruits and service members.

It is difficult to be more specific about the updates and cancellations currently advanced by the Department of Defense before they are discussed and crafted, although the traditional Department of Defense Instruction 6490.08 that identifies limits and requirements for reporting medical information to command does not appear to be affected. (Sections 1, 3 and 4) (2025)

J.8

Question: I am a psychiatrist working at a VA that did not request an extension to the federal return to work mandate despite the lack of office space. Leadership at my VA plans on turning our group therapy rooms into cubicle farms from which we will, in masse, provide telepsych to veterans. This seems to be a violation of the privacy of our veterans. Even if we use headsets to avoid broadcasting the veteran's voice, our own voice will be overheard by others. This would require me to censor my questioning to protect patient privacy. The APA ethics policy also guides us to respect the privacy of other staff members. Sometimes very traumatic topics are raised in our video appointments; veteran and nonveteran staff members need to have a private space to decompress after such visits. It is sensitive work that we do. What are the ethical considerations to be considered?

Answer: The most salient ethical considerations for cases that challenge patient privacy include the responsibility to provide competent care and the duty to protect confidentiality, as well as issues arising for psychiatrists functioning within systems of care.

Both the [*APA Commentary on Ethics in Practice*](#) and the [*Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*](#) assert the duty to provide competent care and to maintain confidentiality. In usual circumstances the ethical psychiatrist should provide care in a setting and a manner that accomplishes both. Telepsychiatry presents characteristic challenges to confidentiality. For example, psychiatrists sometimes recognize in virtual sessions that the patient is not alone, that others are in the room or the vicinity. The psychiatrist must then make judgments and tailor their statements and questions to the circumstances. The present question presents the converse situation, in which potential intrusions may occur on the psychiatrist's side of the technology. Psychiatrists with control over their setting should provide appropriate privacy for telepsychiatry sessions. When an institution controls the setting, the institution bears some responsibility for optimizing privacy. However, lapses in institutional

responsibility do not absolve the psychiatrist from the ethical obligation of maintaining confidentiality. Special circumstances, such as unexpected events or resource limitations, may require the individual psychiatrists to deliver their care in settings that are not optimal, or to utilize technology adaptations (such as headphones) to minimize intrusions.

Psychiatrists functioning within systems of care may have an obligation to raise concerns to the system when the system asks or expects them to practice in a manner that may conflict with ethical duties. The *Commentary*, Topic 3.4.1, notes that systems “... 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.” And further, “Psychiatrists practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system, and help identify alternatives available outside of the system when the patient’s psychiatric or medical well-being requires it.” (*Commentary*, Topic 3.4.1). Psychiatrists recognize that each individual’s need is unique and a one-size-fits-all approach may be problematic. Thus, a patient’s clinical presentation, individual preference or other administrative and risk management considerations may indicate an alternative clinical meeting approach than that proposed for general use.

Psychiatrists may recognize legal and political issues affecting their care of patients and acknowledge their responsibility to the community and society. “A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient” (*Principles*, Section 3). However, the psychiatrist must exercise discretion and caution about involving the patient in political discussions or action (See *Commentary*, Topic 3.2.7).

In summary, the ethical psychiatrist will do their best to provide competent care and maintain confidentiality in unusual circumstances, while trying to improve the circumstances imposed by systems of care. The psychiatrist will also inform the patient of the limitations on care and confidentiality in such circumstances, while exercising caution about organizational or political considerations entering the treatment relationship. The psychiatrist will be alert to situations where the proposed environment of care fails a patient and act accordingly to provide care under circumstances most suited to the patient’s needs. (Sections 3, 4, and 8) (2025)

K. PAYMENT, FEE AND FEE SPLITTING ISSUES

K.1

Question: A new psychiatrist in town who works for a local clinic needs a part-time office where he can start up his private practice. To help him, I told him he could use my office in the evenings and pay me a small percentage of his billings. Is this ethical?

Answer: The proper arrangements are to negotiate a reasonable charge for the use of space, secretarial coverage, and other expenses. Greater use, or lesser, would require renegotiation of what constitutes reasonable charges. Though the agreed-upon amount might be similar to what would have resulted from a percentage arrangement, the appearance of fee splitting—the office owner benefiting from referring patients to the new psychiatrist—would be avoided. (See Opinions 6.02 and 6.03, *AMA Council Opinions*, 2000–2001.) (Section 2) (1975; 1976; 1978; 1984)

K.2

Question: A psychiatrist brings a colleague into the office. What is a proper means of paying that colleague for his or her services? Would it be any different if the colleague is not a psychiatrist but a nonmedical mental health professional?

Answer: See Section 2, Annotation 7 (APA):

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.

A physician is licensed by the people of a state to provide medical care. He is not licensed to establish an entrepreneurial business when the care of patients is subordinated to profit. His role as “captain of the ship” does not entitle him to profit from the efforts of nonmedical practitioners nor from psychiatrists dependent upon him for an opportunity to enter the community. He may pay a salary to the new colleague commensurate with his professional work. If the arrangement provides for the colleague(s) to collect fees, he may only charge that colleague(s) what is appropriate for services he provides, such as space, secretarial support, supervision, and consultation. To the extent psychiatrists ignore this ethical requirement, they lose the support of public trust. (Section 2) (1976; 1978; 1990)

K.3

Question: Is it ethical for psychiatrists to charge for telephone calls from their patients?

Answer: Psychiatrists can ethically charge for phone calls. Factors for psychiatrists to consider in determining the ethical appropriateness of these charges include whether the charges are reasonable for the services provided, whether they are explicitly established, and whether such charges would create an undue burden for patients seeking appropriate and timely care. (Section 2) (1976; Rev. 2018)

K.4

Question: Quite often I have patients in my psychiatric practice who let large balances accumulate over and above what their health insurance pays. I've heard that some offices ask the patient in continuing treatment to sign a payment schedule agreement when this happens. Is this ethical?

Answer: Yes. This should be established with the patient's consent as part of the contractual agreement. See Section 2, Annotation 5 (APA). It would also be permissible to add a service charge for the actual administrative costs of rebilling. Care must be taken with the utmost consideration for the patient and their circumstances when revising any billing practice which has the potential to interrupt ongoing treatment. (See Opinion 6.08, *AMA Council Opinions*, 2000–2001.) (Section 2) (1977; 1979; Rev. 2023)

K.5

Question: Is it ethical for a psychiatrist to bill for services provided by a nonmedical professional?

Answer: Yes, as long as the psychiatrist indicates the role was supervisory and what the discipline of the nonmedical professional was. It would not be ethical, in fact it would probably be fraudulent, to bill for the services of another as if performed by the psychiatrist himself or herself. (Section 5) (1977)

K.6

Question: Is it ethical to charge for missed appointments? To raise fees in the middle of treatment?

Answer: Yes to both questions, but with consideration of the following ethical statements:

Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the treating physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established. (Section 2, Annotation 5, APA)

It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of the patient and his/her circumstances. (Section 2, Annotation 6, APA). Clearly, problems exist only when the psychiatrist fails to establish the financial aspects of the treatment relationship with the patient or when billing is introduced which was not anticipated by the patient. (Section 2) (1978; Rev. 2023)

K.7

Question: I have two psychologists in my group practice. They receive case supervision from me on a regular schedule, and I charge them a specific and agreed-upon fee. Is this ethical?

Answer: It certainly is. Section 2, Annotation 7 (APA) states:

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 (APA). (Section 2) (1978)

K.8

Question: A patient with limited resources pays a small fee for psychotherapy, unaware her mother pays the remainder. The patient assumes she is being seen for a reduced rate. Is this unethical?

Answer: A physician shall deal honestly with patients. This arrangement violates honesty. Should the patient find out her mother has been subsidizing her treatment behind her back and the psychiatrist is complicit it could affect the treatment. If, on the other hand, the patient is involved in setting the arrangement and the patient agrees, then it would not be unethical. (Section 2) (1984; Rev. 2018)

K.9

Question: It has been brought to our attention by angry ex-patients that a colleague not only charges for missed appointments canceled more than 24 hours in advance but also charges for future appointments after the patient refuses to continue treatment. If these arrangements were in the original treatment contract, are they ethical?

Answer: There are limits to how much a contract can commit a patient since it can be argued that the contract was not drawn between equal parties. When a patient discontinues treatment, charging for appointments made for the future may be a futile exercise and incomprehensible to most patients and medical colleagues. However, more important than a legalistic view of contracts is Section 1 (AMA):

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

There are occasions when issues of fees have to be given secondary importance if aggressive pursuit of payment is experienced by the patient as an assault upon his or her dignity and integrity. The wise and ethical physician recognizes times when it is best to accept the position of the patient. We believe your colleague's behavior is not ethical. (Section 2) (1985)

K.10

Question: Is the following arrangement ethical? I practice forensic psychiatry, and a group of lawyers will provide my name as an expert to prospective clients for a proportion of my fee.

Answer: No. Opinion 6.02, AMA Council Opinions, 2000–2001, states:

Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical.

In our opinion, it is equally unethical if the fee is split with an attorney. (Section 2) (1985)

K.11

Question A: A group of us cover for each other during vacations and sometimes for convenience, such as providing ECT for each other's patients. Is it proper for the attending psychiatrist to bill for colleagues' services and share the payments with them?

Answer: Yes, with three conditions: the billing indicates who provided the services, the patient is advised and agrees to the arrangement, and there is no fee splitting. (Section 2) (1986)

Question B: If the insurance company requires the covering physician to bill separately rather than the attending, is that ethical?

Answer: Yes, as above, and if the covering charge represents actual services performed. (Section 2) (1986)

K.12

Question: A hospital owned by a psychiatrist plans to pay each admitting doctor \$300 for the admission and completion of an "admission plan." Is this ethical?

Answer: No. It is expressly termed unethical by the AMA (Opinion 4.01, AMA Council Opinions, 2000–2001). It is also illegal in many jurisdictions and nationally for federally funded patients. It is not clear what an "admission plan" is. If it is the initial treatment plan, this is the normal responsibility of the attending physician to complete. (Section 2) (1986)

K.13

Question: I billed my patient's insurance company for his care and when no payment was received, I billed the patient. When the patient did not pay, I utilized a collection agency that eventually collected the full amount but kept one-third as their share. Then the insurance company paid and the patient demanded the money. I want to keep the amount I lost to the collection agency. Is that ethical?

Answer: No. You should refund to the patient the payments received from the insurance company. Fees and their payment are a contractual agreement with the patient. In this situation, there was a presumption the insurance company would pay a portion of the bill, something the patient relied upon. Their failure does not make the patient liable for your collection costs. Collection costs, like other billing expenses, are part of the practice overhead built into your fee schedule. (Section 2) (1986)

K.14

Question: A private referral organization will make referrals to me in return for payment proportional to the number of referrals I receive. Is this unethical fee splitting?

Answer: It would certainly appear to be. Charges could be made on the basis of cost of the business plus a desired profit but not tied to the amount of fee-generating business volume. Additionally, the psychiatrist needs to be assured that he or she is a participant in an operation that is competent and ethical in other regards: no exaggerated claims, referral only to competent professionals, and referrals themselves made in a competent manner based on patient need. (Section 2) (1986)

K.15

Question: Is it ethical to allow the father of a former patient to provide construction services to me to pay off the bill and to pay off his own bill since the father is now my patient?

Answer: It is ethical to receive goods or services in lieu of fees for the son's bill as long as it is at fair market value and does not exploit the patient. However, while not clearly unethical relative to the father's bill, we recommend against such an arrangement with a current patient because of the likelihood of impairing the treatment relationship. (Section 2) (1988)

K.16

Question: Is it proper for me to pay a psychology group a percentage of my fees for office space, secretarial coverage, and billing costs? I am entirely independent of them to avoid any shared liability problems.

Answer: While this is a common practice, unfortunately, it is not ethical and constitutes fee splitting. The costs of these services should be established at market value and paid per your agreement or contract. Whether this is a sufficiently arms-length arrangement to avoid shared liability requires a legal opinion. (Section 2) (1988)

K.17

Question: A local hospital privileges only members of a psychiatric group, not accepting those who are not members. The hospital excluded local child psychiatrists who are not group members, but it claims to provide child psychiatric services. Further, the group charges a percentage of fees for administration from its members. Is the hospital unethical?

Answer: Our function is to keep our members ethical, not hospitals. Hospitals may contract exclusively with a medical group. Deceptive advertising is not proper for a hospital, and this may be occurring. The psychiatric group relationship appears to constitute fee splitting and may not be ethical. While we may not declare a hospital unethical, our members who participate in such questionable activities, or benefit from them, may be called before an ethics committee. (Section 6) (1990)

K.18

Question: I am treating a patient in regular weekly psychotherapy; the patient occasionally is unable to attend and cancels at the last minute due to business demands. The patient wants to pay for these missed appointments. Is it ethical to bill her?

Answer: Psychiatrists should explicitly review with the patient any policy about charges for missed appointments. (See Section 2, Annotations 5 and 6, APA.) If a physician has not charged for missed appointments and is now thinking of a change, consideration of the motives for the change is important. The new policy should apply to all patients. If the patient understands and agrees to the policy, then it is entirely ethical to bill for missed appointments. The bill should explicitly identify the charge as being for a missed appointment. Charging a fee and billing as a medical psychotherapy session is improper, deceptive, and opens the physician to possible allegations of insurance fraud, billing fraud, or both. Billings now include other payers in addition to the patient. Some contracts for services, including federal and state programs, clearly exclude the option of billing for missed appointments. The ethical psychiatrist must honor his or her agreement under the contract's terms. In some states, laws may prohibit billing for missed appointments under any circumstances. Such billing might be construed as representing services that were not provided, thus placing the physician at risk of being unethical. (See Section 3, APA, which states in part: "A physician shall respect the law...")

So the answer is: "It depends." Do review any contractual agreements you may have and the state law. (Section 2) (1998)

K.19

Question: A psychiatrist sees a patient at a reduced fee until the patient obtains insurance, and then bills the insurance company the full amount for subsequent sessions. Is this ethical?

Answer: If the doctor states the usual and customary fee to the patient at the beginning of treatment, but then reduces the fee given the patient's limited resources, it is not unethical to restore to a higher fee when the patient's financial situation improves, that is, the patient now has insurance coverage. (Section 2) (2018)

K.20

Question: My patient died and there is a longstanding balance that has not been paid. Is it ethical to pursue collection of the unpaid balance with the deceased patient's husband?

Answer: It is ethical to pursue payment through the patient's estate. Psychiatrists should be aware that responsibilities for patient's confidentiality persist beyond a patient's death and therefore should limit collection efforts to the executor or another representative of the estate. (Section 2) (2018)

K.21

Question: For clinical work that may be prolonged and collection of fees potentially difficult and protracted, may I insist on prospective payment?

Answer: For any treatment, contemporaneous payment at the time of service or payment on a short-time basis (e.g., each week) for ongoing service is preferable. Prospective payment may be ethically permissible if the terms are fully disclosed and agreed upon prior to beginning treatment. However, the psychiatrist should be aware of the potential for coercion in prospective payment arrangements. (Section 2) (2018)

K.22

Question: Is it ethical for a psychiatrist to terminate a patient because of the patient's nonpayment of bills, if the psychiatrist believes the patient still needs treatment?

Answer: It can be ethical to sever a treatment relationship due to non-payment of bills. The psychiatrist and patient entered into an agreement to exchange treatment for compensation, and it is ethically permissible to end such an agreement when one side or the other fails to live up to it. As in all healthcare fields, the decision to end a treatment relationship must be made so as to minimize risk to the patient. Advance warning is appropriate, so that the patient can seek other treatment or pay overdue bills. In the interest of promoting continuity of care, it would also be helpful for the psychiatrist to recommend ongoing care with alternate providers.

K.23

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)

K.24

Question: I have a question about ethical considerations of sliding scale or other reduced fee arrangements in private practice. I do not have the administrative resources to make a sliding scale available to all patients. I have seen online commentary from some psychologists who make available a handful of slots in their schedule for reduced fee or sliding scale or pro bono appointments. Some allot the slots "first come first served." Some allot the slots based on whether a client inquires about reduced fees. Could or should a psychiatrist offer such slots? Opinion K.19 is helpful, indicating that it can be ethical to reduce your usual and customary fee when a patient experiences financial hardship. My question is whether you can do this "ad hoc" as a particular patient experiences financial hardship? Or must you have a universal reduced fee policy that is available to all patients? I would like to do this, if ethical, when a patient who has been seeing me for ongoing psychotherapy then experiences financial hardship and would otherwise have to stop psychotherapy with me and find another provider. Financially and administratively, I cannot offer a sliding scale to everyone. But I worry that offering a reduced fee to only some patients may raise a potential boundary issue of preferential treatment.

Answer: The psychiatrist is right to worry about the potential for boundary crossings and violations as well as accusations of discrimination if this practice is not employed in a transparent manner. Transparency is key, as well as the avoidance of bias. It will be important for all patients to be aware of the clinic policy regarding the potential for payment of fees on a sliding scale, even if the policy states that the clinic can only do so for up to 2% of patients and on a first-come-first served basis or any other metric the clinic proposes to use for such determination (for example, using paystubs, tax returns, incontrovertible info that suggests financial hardship, etc.). The important issue is for everyone to be aware of the policy, including the limitations of offering it to all, and have equal access to it. A statement such as "Sliding scale eligibility is determined on a case by case basis by the clinic/organization/provider" may suffice.

The clinic may elect to offer such considerations only to existing patients who have suddenly come into financial hardship, or state upfront that priority will be given to existing patients. Again, the information should be available to all patients, including its availability to only a certain percentage of patients who meet eligibility criteria. To avoid the risk of bias, the psychiatrist should list the criteria for eligibility clearly, perhaps in bullet points, in a clinic policy handbook such that anyone else, including the office manager, would arrive at the same decision if presented with the facts of a particular case. (Sections 2 and 6) (2025)

L. PHARMACEUTICALS

L.1

Question: Can a physician buy stock in a company that makes a medication that one prescribes for patients?

Answer: The key consideration is if there is a conflict of interest. For example, is there exploitation of the physician–patient relationship for the physician’s financial gain (i.e., does the physician’s ownership influence the clinical decision)? This seems unlikely if a physician owns shares of stock in a publicly held company and prescribes one of the medications that the company makes. However, if the physician has control of a pharmacy committee of a large organization and can direct that only one brand of a certain class of drugs will be available, then there is more likelihood of some conflict. (Section 2) (1994)

L.2

Question: Is it ethical for a psychiatrist to accept payments from pharmaceutical companies for referring patients to participate in drug studies?

Answer: It is unethical for psychiatrists to accept fees for referring patients for clinical care, research, or any other service. (Section 2) (1997; Rev. 2018)

L.3

Question: If the FDA has provided a package insert saying that the drug is contraindicated in patients with particular presentation of their illness, would it be ethical to provide the patient with that drug if it is the only drug that has been effective on one of the patient’s multiple diagnosis in the past. Does the answer differ if the patient has never been on the drug before? What are the ethical issues that the prescribing physician needs to be aware of?

Answer: The ethical question is not whether a drug should ever be used in a patient without full FDA approval; instead it is whether the psychiatrist has conducted a thorough patient evaluation and history in addition to researching the particular medication in light of that evaluation and history and discussed the potential effects with a patient who has given consent.

Many of the medications psychiatrists prescribe (e.g., anticonvulsants for bipolar disorder) are not FDA approved. We give medications with black box warnings, that are “off-label,” or that pose a risk of potential serious harm (e.g., clozapine, lamotrigene) in carefully evaluated clinical situations. “Contraindication” is a relative term, and there is a gradient ranging from “use with caution” to “absolutely contraindicated.”

Sometimes, when there are few alternatives, the patient may be willing to assume high risks, especially in the face of no other alternatives, particularly if there is high risk without treatment, or large potential benefits. Obviously, the risk/benefit analysis would be aided by knowing that a patient has responded to the medication in the past.

The psychiatrist should conduct a thorough exam; examine the family history and the patient’s history

concerning that specific medication; and discuss the case with a colleague or supervisor, after having referenced current literature concerning off-label use of that specific medication. If such an evaluation indicates that off-label use of a drug would be the patient's best option, then competent patients should be fully engaged in a discussion of the risks and benefits of a medication as well as your thinking regarding the analysis of those factors. The patient should be educated about why a drug might have a contraindication, what are the potential adverse consequences of using it, what are the risks and benefits compared with alternatives or no treatment, and how past experience with the medication (when that exists) might figure into the calculus.

Thus, the ethical issue is not in WHETHER to prescribe a medication in some circumstances, but HOW the prescribing of that medication is decided upon by the psychiatrist and presented within the clinical encounter, and the self-determined willingness of a competent patient (or his/her proxy) to assume that risk.

It would be wise for legal reasons for the psychiatrist to document the research conducted and the patient discussions, and even to have all the considerations written out and then have the patient give informed consent in writing in particularly risky situations when working with an FDA-listed "contraindication." (Section 5) (2016)

M. PHILANTHROPY, GIFTS AND WILLS

M.1

Question: My patient of almost 5 years has a terminal illness. With my assistance she has been able to more effectively deal with her approaching death. She has no family and wishes to bequeath her estate to me. Would it be ethical for me to accept?

Answer: It would not be advisable for you to knowingly permit yourself to be the beneficiary. To do so gives the appearance of impropriety and raises the possibility of exploitation of the therapeutic relationship. We advise you to encourage your patient to make this gift to a trust, foundation, educational institution, or public charity whose purposes are consistent with the patient's wishes. (Section 1) (1983)

M.2

Question: A patient of mine died and, without my prior knowledge, bequeathed a painting to me. Is it ethical for me to accept this bequest?

Answer: Questions to be asked are the relative value of the painting compared with amounts left to the family, their feelings on the matter, and your sureness of no element of coercion on your part. On the face of it, considering you had no chance to advise the patient on this matter before death, it would appear to be ethical to accept this bequest as a token of appreciation. (Section 1) (1986)

M.3

Question: I have been the psychiatrist for a family, seeing various members when necessary for the past 5 years. The father, knowing my concern and knowledge of the family and their trust of me, asks if I will consent to be executor of his estate and possible trustee of the children. Ethically, may I accept such a responsibility, perhaps waiving the usual executor or trustee fees?

Answer: We believe this responsibility would be an unethical and unwise mixture of roles that opens the possibility of information gained in the confidence of treatment to alter your performance as an executor or trustee. This information might result in impairing your necessary objectivity to conduct either or both of these responsibilities. (Section 2) (1989)

M.4

Question: A group of former patients have organized a nonprofit foundation to raise funds to promote a particular form of therapy of mine. None of the money comes directly to me. Is this ethical?

Answer: The issue is whether this is unethical exploitation of former patients by endeavors not directly relevant to the treatment goals. It would appear to be and, thus, is unethical. (Section 1) (1990)

M.5

Question: Our university asks us to solicit donations from former patients to support research. I wonder if this is ethical?

Answer: It would appear not to be ethical as it exploits the therapeutic relationship for purposes not relevant to the treatment goals. This would be even more so if you or other treating psychiatrists personally benefited from the donations. As noted in Topic 3.2.7 of the *APA Commentary on Ethics in Practice*, “organizational fundraising must be conducted with sensitivity so as not to exploit the relationship of trust that the physician has with the patient . . . 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.” (Section 1) (1990; Rev. 2023)

M.6

Question: I am the executive director of an institute where I direct research and produce teaching events, among other things. Is it ethical to solicit present or former patients to contribute to this charitable institute?

Answer: The ethical issue is whether the psychiatrist exploits the special relationship with a patient or a former patient. Receiving the benefits of a fundraising effort, even if this includes contributions from patients, does not in and of itself create an ethical problem as long as there is no exploitation or coercion. For example, if there is a general fundraising effort in which the general public is solicited by your organization, no violation of ethics principles has occurred. On the other hand, if you suggest to a fundraiser that one or more particular persons (current or former patients) might be receptive to a solicitation, then you may have crossed over the ethical line, exploiting the physician–patient relationship, and perhaps breaching the patient’s confidentiality. (Section 1) (1993)

M.7

Question: Is it ethical to accept a large monetary gift from a current patient that was given in appreciation of recommending an attorney at the patient’s request, a recommendation that was financially beneficial to the patient?

Answer: No. Taking such a gift, even if unsolicited, very likely exploits the physician–patient relationship and generally would result in a contamination of the treatment process to the disadvantage of the patient. (Section 2) (1993)

M.8

Question: A psychiatrist has been named in the will of a former patient; the will stipulates that scholarships be given in honor of the psychiatrist. Is this ethical?

Answer: Yes. As long as the psychiatrist does not participate in the selection of the candidates or other uses of funds, there is no possible exploitation or conflict of interest. (Section 2) (1994)

M.9

Question: Is it ethical for a physician to make a memorial contribution to a scholarship fund, established for a patient who recently took her life?

Answer: It is ethical for a physician to respond with a reasonable contribution to the memorial scholarship fund established on behalf of her now deceased patient. As Karl Menninger said, “When in doubt, be human.” Furthermore, physicians are encouraged to participate in activities that will lead to the betterment of the community and public health, and making a contribution to a scholarship fund would be one example of how to advance these ethical goals. (Section 7) (2001)

M.10

Question: A patient has in the past insisted on bringing gifts to the office for me. In the past they have been nominal but recently my patient wanted to give me a fairly expensive gift. I was hesitant to accept the gift and my patient expressed that he would be hurt if I did not do so. Is it ethical to accept the gift under these circumstances?

Answer: In this situation an ethical psychiatrist would politely decline the gift given its material value and remain kindly firm on that position. The psychiatrist may also use this as an opportunity to explore the meaning of gift-giving for the patient and what the patient hopes to achieve by giving the gift to the psychiatrist. It is also an opportunity for therapeutically addressing the therapeutic relationship and potential transference. Maintaining appropriate therapeutic boundaries is the responsibility of the psychiatrist and it is important to keep a therapeutic relationship professional. Although there may be times in which a small gift may not be detrimental to the therapeutic relationship, they are often a source of strain and the gift-giving process carries with it a number of risks. As noted in Topic 3.2.6 of the *APA Commentary on Ethics in Practice*, “rules guiding professional behavior are context sensitive . . . 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.” Large gifts are particularly problematic and are almost never appropriate. (Sections 1 and 2) (2020; Rev. 2023)

N. PRACTICE ISSUES

N.1

Question: Is it ethical for a psychiatrist to direct an acupuncture clinic where he or she supervises Chinese acupuncturists?

Answer: Section 2, Annotation 3 (APA) states: *A psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical.* Because acupuncture is a recognized form of therapeutics in many jurisdictions, if the psychiatrist is providing sufficient supervision to assure that good care is being given, the psychiatrist is behaving ethically. Section 3, Annotation 2 (APA) states: *Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture.* (Section 3) (1973; Rev. 2019)

N.2

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

Answer: No. Ninety days written announcement is quite adequate. It is unfortunate you are having such difficulty placing your Medicaid patients, but you have done all you can be expected to do. (Section 6) (1978; Rev. 2018)

N.3

Question: Is it ethical for a colleague to make a diagnosis of mental illness solely because the individual has joined a “new religion” or “cult”?

Answer: No. See Section 1 (AMA):

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

and Section 1, Annotation 2 (APA):

A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

While a person who joins a “cult” might be mentally ill, that decision must be made based on the accepted diagnostic standards, not “cult” membership per se. (Section 1) (1984)

N.4

Question: Is it ethical for a psychiatrist to admit and treat staff members or their families in the hospital where the staff member works?

Answer: It is ethical if the patient wishes to be treated in this hospital and there are limited options in the community. Ideally, separating the treatment role from the co-worker role is a good idea in order to maintain boundaries that allow for more effective treatment and better protect the patient and his or her family's confidentiality. The options should be discussed with the patient, to achieve informed consent. (Section 6) (1985; Rev. 2018)

N.5

Question: What are my obligations as a treating psychiatrist if I disagree with the recommendations of the psychiatric unit director?

Answer: By virtue of their activities and roles, psychiatrists may have competing obligations that affect their interactions with patients when they also have responsibilities to other entities, including the institutions by whom they are employed. The treating psychiatrist has a primary, but not absolute, obligation to the patient. 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. In the setting of an inpatient unit, the psychiatrist must provide competent treatment to the patient in accordance with the standard of care. In a circumstance in which care is denied by a supervisor, the psychiatrist must advocate for the patient's care and best interest, understanding that competing institutional and systemic considerations may limit available treatment options that extend beyond established standards. In situations in which the treating psychiatrist opines that such limits would pose a danger to the patient or fall short of competent care, the psychiatrist should appeal supervisory decisions in accordance with institutional policy, such as to a director of clinical services or chief. Where no appeal is available, the psychiatrist still maintains an obligation to the patient that may be fulfilled by informing the patient of treatment recommendations and/or alternatives and seeking appropriate referral. *See APA Commentary on Ethics in Practice, Topic 3.1.3.* (Section 2) (1986; Rev. 2019)

N.6

Question: A reviewing psychiatrist for an insurance company has not examined my patient. Is it ethical for the reviewing psychiatrist to tell me how to treat my patient?

Answer: No; but it is ethical for the reviewing psychiatrist to raise questions about the care or offer suggestions. The treating psychiatrist and the patient are decision makers about the treatment. However, the contract between the patient and the insurance company includes the right of review and the right of the insurer, in some circumstances, to terminate the benefits. Generally, there is also a right of appeal by the patient and the treating physician. Outright rejection by the reviewing psychiatrist may result in benefit termination, throwing the financial responsibility upon the patient. Ultimately, patients have a right to participate in the decision to have their care undergo review, understanding that refusal to allow review might jeopardize their insurance coverage. (Section 1) (1987)

N.7

Question: I recently terminated therapy with a very troublesome patient after providing proper notice and choices of alternate treatment. The patient continues to harass me with endless vituperative phone calls. For the telephone company to intervene, I will have to provide the patient's name. Can I ethically do this?

Answer: Confidentiality does not prohibit the psychiatrist from reaching out to the patient via an attorney to request that the patient stop the harassing actions, and to inform the patient about possible reporting to authorities within the law. It would be lawful and ethical for the physician to inform the telephone company of the harassing phone calls, without disclosing that the harassing individual was a patient; this could be done in a way that does not reveal any significant aspects of their therapeutic relationship other than the patient's name. A patient's rights of confidentiality do not preclude the rights of the physician to be free from harassment or other illegal, threatening behaviors. The treating psychiatrist should also consider other potential issues related to his or her personal safety. (Section 4) (1988; Rev. 2019)

N.8

Question: Is it ethical for a supervising psychiatrist to sign a diagnosis on an insurance form for services provided by another professional that he or she is supervising and when the supervising psychiatrist has not examined the patient?

Answer: Section 5, Annotation 3 (APA) clearly states that the supervising psychiatrist must expend sufficient time to assure that proper care is given and not allow the role to be that of a figurehead. What is required differs among public payers such as Medicare and Medicaid, and among private insurers. The ethical psychiatrist must not engage in abuse, deception, or waste of public resources. (Section 5) (1988; Rev. 2018)

N.9

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

Answer: The treating psychiatrist must assure confidentiality, of course, and provide a treatment environment in which the patient feels secure. Further, any relationship between the treating psychiatrist and the family member psychiatrist must not bar the establishment of a therapeutic alliance between the treating psychiatrist and the patient. If there is another psychiatrist within a reasonable distance, use of that provider may be considered. With proper consideration of those concerns, it would not be unethical for a psychiatrist practicing in a small community to treat an adult member of another psychiatrist's family. *See APA Commentary on Ethics in Practice*, Topic 3.4.5, "Ethical issues in small communities." (Section 6) (1989; 2019)

N.10

Question: Family members, as well as patients, occasionally complain that the psychiatrist will not share information with them about diagnosis, treatment recommendations, and treatment alternatives. What are the ethical requirements?

Answer: A patient has the right to be fully informed about these issues to be able to give consent to the treatment plan but with consideration that the information will not be harmful. Family members, however, are very limited in the amount of information they can receive unless the patient gives consent. There are exceptions, of course, such as imminent danger to self or others or incompetence of the patient who needs family protection. States have different laws limiting release of information about patients, and this should be well understood by psychiatrists in each state. At the same time, the psychiatrist should help family members understand the legal and ethical limits of divulgence and provide them with support and understanding within those limits. To not do so makes the psychiatrist appear to be indifferent to family distress. (Section 4) (1989)

N.11

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

Answer: If the patient is competent, a second opinion should be at his or her request. If the patient is incompetent, the request should come from the legally empowered surrogate decision-maker. The treating psychiatrist should agree to the request. With proper consent, the treating psychiatrist may discuss the case with the consultant. Also, with proper consent, the consultant may discuss his or her opinion with the treating psychiatrist; however, the consultant is not obligated to do so since he or she was employed by the patient or surrogate to give them advice, and the choice to include the treating psychiatrist is theirs alone. Of course, the consultant can disagree with the course of treatment based on his or her professional judgment, or there would be no purpose in obtaining a second opinion. (Section 5) (1989; Rev. 2018)

N.12

Question: We have a difficult time getting other physicians to do our hospital physical examinations. Some of our psychiatrists are doing them. Is this ethical?

Answer: Yes, in fact it is the standard of practice in some areas. The psychiatrist as a licensed physician can do this quite appropriately, assuming he or she has the necessary skills and calls in another psychiatrist if he or she believes it could be harmful in a particular situation. (Section 1) (1990)

N.13

Question: My public hospital requires me to assume more clinical responsibility than my salaried time allows me to manage competently. Is my attempt to do this unethical?

Answer: Your first effort should be directed at getting the hospital to remedy the situation. That failing, you might feel compelled to resign. If you remain and do your best, you are behaving ethically. For us to declare otherwise might place an even greater burden upon our underfunded public institutions. (Section 1) (1990)

N.14

Question: Is it ethical to restrict admission of chronic psychiatric patients to a state facility to those who agree to accept a trial of clozapine therapy?

Answer: It would not be ethical for an individual psychiatrist to restrict admissions in a coercive manner. States may as a matter of public policy place some conditions upon admission which may be coercive (e.g., court ordered admission and treatment). State facilities face the dilemma of triaging psychiatric patients, given the shortage of inpatient beds in most states. For state facilities to prioritize is reasonable as long as the process involves transparency and involvement of clinicians. If psychiatrists believe such policies are unjust or place them in an unethical situation, they should protest the problematic law or regulation. (Section 1) (1993; Rev. 2018)

N.15

Question: Is it unethical for a psychiatrist to perform full physical examinations, including vaginal examinations, on patients in the clinic, office or hospital?

Answer: Performing a physical examination is not in and of itself unethical provided that the examination is medically necessary and the treating psychiatrist is competent to perform the examination. Physical examinations should be performed with the usual and customary safeguards to ensure patient safety, including the presence of a preferred-gender observer, where possible. Sensitive elements of physical examinations, such as genital and rectal examinations, should be performed by a psychiatrist only if they are medically necessary and if the psychiatrist is the only competent medical professional available to perform the examination in a time frame sufficient to ensure the patient's immediate safety. (Section 1) (1993, rev. 2019)

N.16

Question: Does the psychiatrist have an ethical obligation to use interpreters when dealing with patients of limited English proficiency?

Answer: Psychiatrists have an obligation to communicate effectively with patients about their medical condition, treatment options, recommendations, and other pertinent information such that patients may make informed decisions about their medical care. As such psychiatrists must use reasonable efforts to secure assistance in effective communication that would allow patients to make informed consent decisions. See Opinion 8.08, *AMA Council Opinions*, 2000–2001. (Section 1) (1993; Rev. 2019)

N.17

Question: Is it ethical to engage in a therapy (such as reparative or conversion therapy) to change sexual orientation?

Answer: No. Although successful and ethical treatments for legitimate psychiatric diagnoses may sometimes lead to some changes in sexual behavior, any treatment that is based on an assumption that homosexuality per se is a mental disorder, or is based on an assumption that the patient should change his or her sexual orientation, is by its nature unethical, as it violates numerous ethics principles. Such so-called “treatment” ignores established scientific evidence, demeans the dignity of the patient, succumbs to individual and social prejudice and stigma, and has often been significantly harmful to patients, families, others, and their relationships. (Section 1) (1999)

N.18

Question: Is a group contract to provide evaluations for medication purposes ethical if it prohibits a physician from discussing anything else with the patient?

Answer: Such a contract is not ethical because it places the physician in clear violation of his or her obligations under ethics principles. A psychiatrist cannot withhold information that a patient needs to make informed treatment decisions, including treatment options not provided by the psychiatrist. (See also Section 5 and Addendum 1, APA.) (Section 2) (2000)

N.19

Question: Has the APA formulated any position regarding the use of placebos in a clinical, non-research setting? I have a psychiatric colleague who regularly uses placebos with his patients who have chronic pain and chemical dependency issues with the justification that if they voice pain relief with the use of the placebo (which he informs them is active drug), then that tends to confirm that the pain "isn't real." It is my understanding that such a practice is unethical but I have not been able to find any documentation from the APA (including a thorough review of *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 2001 Edition).

Answer: The use of placebos in routine clinical practice with the specific intent to deceive the patient is unethical, and represents a violation of Section 2 of The Principles of Medical Ethics which calls for honesty in all professional interactions. This is unlike the use of placebo in research which usually occurs only under very specific circumstances, with a clear scientific justification and with multiple specific safeguards to prevent exploitation of research volunteers. You may also wish to see the section in the AMA Council Opinions entitled, Placebo Use in Clinical Practice. An excerpt from this section follows:

“A placebo is a substance provided to a patient that the physician believes has no specific pharmacological effect upon the condition being treated. In the clinical setting, the use of a placebo without the patient’s knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient.

Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use. A placebo may still be effective if the patient knows it will be used but cannot identify it and does not know the precise timing of its use. (Section 2) (2004)

N.20

Question: Three of my employees are leaving my practice, and are setting up an office within a pre-agreed upon non-compete radius of five miles. Who is supposed to inform patients of their switching practices? Are they allowed to put their contact phone numbers on the letter, which may be seen as patient solicitation, in violation of their contract? I have proposed sending a certified letter containing their emergency contact information to only patients deemed to be high risk. I will also include information on how these patients may get their medical records.

On another note, since these clinicians have violated a number of agreements in their contracts, am I allowed to terminate them and collect their keys to this building?

Answer: Your questions/concerns are largely legal in nature. You would best be served by consulting an attorney. The issue of patient abandonment has strong ethical implications, however. You must be careful not to interfere with the ability and means of the departing practitioners' patients to be able to find, communicate with, and continue to see their clinicians. For instance, the concern about "patient solicitation" cannot supersede the continuity of appropriate and adequate patient care. (Section 1) (2006)

N.21

Question: I am working with a patient currently who is being transferred to Europe temporarily for her husband's job. She has been doing well with her current mental health team and wants to continue working with us while she is in Europe. Her plan is to return to her home state every 2-3 months and would see us in person during those visits. She would like me to continue to provide her with medication management services when she is in Europe, speaking on the phone or doing telemedicine appointments monthly or as needed.

I asked the state medical board if they thought this arrangement was acceptable and they said yes. How does the APA view this arrangement?

Answer: Providing advice to a known patient who is temporarily out-of-state or out of the country is appropriate. The practice of telemedicine, including prescribing, across state or national boundaries, may be subject to licensure restrictions. The ethical psychiatrist will be respectful of the law and the licensure requirements to practice utilizing the tool of telemedicine. (Section 1) (2011; Rev. 2018)

N.22

Question: Psychiatrist had been prescribing psychotropic antidepressants for a patient who is now leaving town and "wants nothing to do with the doctor." The patient's prescription already ran out and the doctor believes he needs an immediate refill due to his severe depression. Clearly this is more of a legal issue since the doctor cannot prescribe medication after the patient chose to end the relationship. Do you have any advice on what recourse the doctor has to try and ensure the patient remains on medication?

Answer: You should first consider the legal and risk management ramifications of your inquiry. We recommend that you contact your malpractice insurance carrier to determine how to ensure the doctor-patient relationship is really terminated. From an ethical perspective, the patient can terminate the relationship. It is ethically sound for the psychiatrist to want to do something to assist with ongoing care

(beneficence) while also respecting the patient's self-determination (autonomy). You could contact the patient, in writing, stating your opinion that the patient is at risk and should seek follow-up care, and that you are available to provide referrals for ongoing care and/or provide bridge care, pending new treatment if the patient so chooses. If the patient has imminent risk of harm or meets involuntary evaluation or treatment criteria, you would be well-advised to seek that treatment for the patient. Although you had expressed that you do not believe the patient to be suicidal, we must stress that you should assess imminent risk to the best of your ability. You might find it helpful to consult a risk person and a clinician on the matter. (Section 6) (2016)

N.23

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

Answer:

This question raises three compelling issues:

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

(Section 2) (2017)

N.24

Question: I have been treating a patient with bipolar disorder, depression, borderline personality disorder, and an eating disorder. At present, I am the only physician treating the patient. The patient is not accepting or following my recommendations regarding treatment for her eating disorder (for example, I referred her to an outpatient treatment clinic but she is not attending treatment or seeing any other eating disorder

therapist/clinic); at present the patient is consuming less than 500 calories daily. Is it ethical for me to terminate the relationship?

Answer: It would be unethical to terminate the relationship until a subsequent plan of care has been established. Your patient is consuming less than 500 calories/day, and she is showing no evidence of a willingness meaningfully address her current illness. Given the urgent nature of this patient's medical situation, it may be advisable to involve any possible family members in her care and treatment. As the only treating physician in this case, it is incumbent upon you, either yourself, or by referral to another identified medical/psychiatric individual or facility to see that this clinical situation is addressed. The usual methods for initiating emergency medical treatment, including involuntary emergency evaluation and possible commitment, may need to be employed. See Section 3.1.2 of *Commentary*. (Section 6) (2018)

N.25

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

Answer: The ethical psychiatrist providing only outpatient care must provide advice and referral to one of his or her patients who is in need of hospitalization, although the psychiatrist is not necessarily required to provide such inpatient services himself/herself. At the time of beginning treatment, informed consent requires that patients should be fully informed about the limitations of the treatment offered, including the limitation that the treating psychiatrist does not practice in an inpatient setting. In addition, the psychiatrist should have a clear plan of advice and referral to ensure that adequate care will be available for the patient should inpatient care be needed. (Section 6) (2018)

N.26

Question: I work in a hospital in an area with a sparse population of psychiatrists. In cases of emergency, I may treat adolescents on occasion. Despite the fact that I am not a child and adolescent psychiatrist, my employer has asked that I begin to treat patients as young as 4 years old. I am concerned that it is unethical for me to provide this treatment because I lack training and experience with this patient population. However, although my employer has advertised for a child and adolescent psychiatrist, the facility has not been able to hire one.

Answer: Given that you do not have the education or training to practice with children below the age of 12-14, it would be unethical for you to do so on a regular basis. Section 2.3 of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* expressly states that a physician who regularly practices outside of his area of competence is unethical. Competence is determined by peer review boards or other appropriate bodies. The *APA Commentary on Ethics in Practice*, Section 3.1.2, recognizes that professional competence means practicing within accepted standards of care, remaining current, and sometimes working with supervision and/or consultation. Professional competence includes recognizing the limits of one's skills and referring patients when possible or seeking consultation from a more experienced clinician on issues where the psychiatrist's competence is not clear. *Commentary*, Section 3.4.5., notes that in small or underserved communities it may be ethical for a psychiatrist to

practice outside of the usual scope of practice *if her training is closely related, there is urgency, and the psychiatrist possesses the most readily available relevant expertise*, but that in such a case the psychiatrist should have appropriate supervision and access to competent consultation.

Two ethical conclusions emerge from this. If you do not believe you are competent to handle certain ages of children even with ready access to consultation, it would be unethical to do it. If you do believe you can competently handle particular age groups, you should have ready access to consultation from a board certified child and adolescent psychiatrist (e.g. Skype, telepsychiatry, etc.) to be able to consult as needed to ensure the patient gets competent care. If there are cases where you are still not comfortable treating the patient, you need to refer them to a board certified child and adolescent psychiatrist.

Given that you are not board certified in child and adolescent, it would not be ethical for you to assume this role unrestricted (e.g. without supervision or consultation) or to assume it at all if you are not comfortable that you can do it competently with expert consultation. If you do assume this position, it should only be temporary until a board certified child and adolescent psychiatrist for the hospital can be found.

You should inform the hospital administration of your concerns regarding the request, as the hospital may need to reconsider what ages it can safely and ethically treat given that they do not have a board certified child and adolescent psychiatrist no matter how underserved the area is. The hospital could seek locum tenens child psychiatry coverage, or as a more immediate alternative seek a child psychiatrist via telepsychiatry. (Section 2)
(2019)

N.27

Question: I work for a large hospital system doing inpatient work. We are housed in a new inpatient psychiatric facility, which was not originally intended for this purpose. The problem is that everyone in the space can hear what everyone else is saying in other rooms. Sometimes our staff has meetings off site because of this issue. The hospital system has called in a company that could provide sound mitigating equipment so that this would cease to be a problem, but the request for the equipment is being reviewed at the hospital system headquarters, by a person not familiar with the special confidentiality issues related to psychiatric care. Is this a problem?

Answer: Psychiatrists have an ethical obligation to protect patient confidentiality. Protecting a patient's confidences and privacy is treating the patient with respect and dignity, a core principle of medical ethics. *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, provide direction for the psychiatrist seeking our opinion:

Section 1 states: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." Section 4 states: "A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law."

While patients are free to reveal information about themselves to each other (although staff should attempt to protect vulnerable patients from doing so), staff cannot breach the patient's confidentiality. The psychiatrist has a duty to protect confidential information of the patient.

Unfortunately, the scenario in which a treatment facility has open space in which sound privacy does not exist is not uncommon, especially in some older buildings housing inpatient units. It is more surprising that it would happen in a new inpatient psychiatric building. The psychiatrist should take steps to ensure that confidentiality is maintained, even in this setting.

This starts with a discussion with the facility medical director or any other clinical administrator urging him/her to strongly and more effectively advocate for urgent implementation of the sound mitigating equipment. In the interim, while waiting for the sound mitigating equipment, perhaps they could designate areas on the unit where they could have private conversations with patients or come up with other creative ways to ensure confidentiality. (Sections 1, 4) (2019)

N.28

Question: I have been prescribing my patient an amphetamine and an antidepressant. My state has a prescription drug monitoring program that requires me to check the database at least annually. After checking the database and speaking with the pharmacist I learned that my patient had obtained extra amphetamine pills by talking the pharmacist into refilling their prescriptions early. I have tried several times to contact my patient about this, but they will not return my calls or schedule an appointment, so I would like to terminate the relationship. I can send a prescription for a 30-day supply of antidepressants to the pharmacy, but am concerned about sending a prescription for an amphetamine, as I believe my patient may either be selling the extras or taking more than prescribed. Is it ethical to terminate the relationship? What should I do regarding the amphetamine prescription? I do believe that my patient needs medication to function effectively.

Answer: You can ethically end the relationship in the scenario presented, as you have no obligation to continue treatment if the patient is unwilling to come in for an appointment and discuss the issues at hand; however, you also are not obligated to summarily discharge a patient for obtaining inappropriate prescriptions, or for that matter, illegal drugs, especially in the absence of further discussions. It may be worthwhile to consider trying to engage the patient and assess whether a substance use disorder is present prior to making a final decision about termination.

If you decide to terminate the treatment relationship, it is important to properly inform the patient, offer alternatives, and document that you have done so. In this case, it is recommended that you communicate your decision to terminate by sending a letter to the patient via certified mail. The termination letter could include a paragraph indicating that you may consider working with the patient in the future (although there is not necessarily an obligation to include this). The letter should, however, include a list of other providers, crisis centers, etc.

The amphetamine should probably not be renewed under this situation, but the patient should receive proper notice and be given alternatives for treatment with another prescriber. Oftentimes the risks of prescribing to a patient who may be diverting and/or misusing an amphetamine outweigh the risks of going without an amphetamine for a short period of time. However, sudden discontinuation of the

antidepressant presents a different set of clinical risks. Although you are not obligated to renew any medications under the current circumstances, you could choose to renew a small amount of antidepressants with instructions for the pharmacist to tell the patient that they must see you, as their psychiatrist, to arrange for transition of care and that you will not renew another prescription. This option may be worthwhile to consider, especially if you are concerned about rebound depression and collateral risks if the patient suddenly stops taking the antidepressants.

Lastly, it is alarming that the pharmacist did not reach out to you, as the psychiatrist, before providing additional amphetamines. The pharmacist's actions, as described, are very concerning and it would be worthwhile to investigate the situation, including a possible report to the Board. (Section 6) (2019)

N.29

Question: I am a psychiatrist and I practice TMS. I am active on a FaceBook TMS support group. People ask questions and I answer them. I cite most of the data from the Clinical TMS Society. I don't have any affiliation with any TMS manufacturer. I don't mention my practice at all. I have been told that it is unethical to answer questions without saying that I am a psychiatrist every time I write an answer. The FaceBook group admin has not raised any problem with my typical action and I post to the group with my real name. Am I doing anything unethical?

Answer: It is deceptive to answer questions on any psychiatric topic and treatment intervention, including TMS, using your training, knowledge and experience without identifying yourself as an expert (a psychiatrist). The depth and quality of your responses would alert some on the forum that you are likely a physician and cause them to act on your advice. If an unfortunate incident arises from following your advice and they identify the source of their information, it would be difficult to hide under the fact that you have not identified yourself as a physician - it could be argued that you are in fact a physician giving medical advice under false pretenses.

It would be much better for the psychiatrist to preface all responses with a permanent disclaimer, something along the lines of "although I am a psychiatrist, this is not professional advice as I am not familiar with the specifics of your unique situation; please contact a psychiatrist in your area with more questions." (Section 2) (2019)

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, in a timely manner, offer reasonable 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 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). If the current psychiatrist has trouble locating alternative treatment providers, local psychiatric associations, state

medical boards, and the insurer if there is one, may provide information. 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 and other mental health professionals. To ensure that treatment with a new provider is scheduled and appropriate to the needs of the patient, the psychiatrist should consider reaching out to the new provider. This additional assurance is an ethical and practical acknowledgment of psychiatrist shortages and the persistent lack of access to mental health care in marginalized communities.

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 and/or seek consultation from a colleague.

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. If the patient consents, the community psychiatrist should be open to providing information and assistance to the inpatient psychiatrist and clinical team. 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; Rev. 2023)

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. (Section 1) (2023)

N.37

Question: I'm aware of a variety of ways other psychiatrists screen patients prior to evaluation, including by having office staff ask about symptoms or behavior such as suicidal thinking or past attempts, or previous psychiatric hospitalizations, and declining to serve patients that may be seen as troublesome or problematic. Is screening patients before evaluation ethical?

Answer: This is a very important question that does not allow a simple answer. In the current era of concerns about access to care, with a recognition of historical and continuing inequities, and of implicit as well as explicit bias and discrimination in healthcare, screening to place limits on practice understandably falls under the microscope. Society desires physicians to increase their availability for care of patients in need. On the other hand, acknowledgment of physician burnout and the need for work-life balance, fears of career-changing accountability for unpredictable outcomes of suicide or violence, and compensation for many psychiatric services that is substantially poorer than for other physicians' services, among other factors, may all motivate psychiatrists toward placing, or attempting to place, limitations on whom they are willing or preferring to serve.

Some types of screening are not only ethically sound but may be required. Limitations which psychiatrists place on their practices are ethically sound when these limitations are consistent with the psychiatrist's choice of specialty or subspecialty, their training and continuing education, and their assessments of their own competencies and their abilities to deliver appropriate care within their practice structure and resources. In contrast, screening to exclude patients from the physician's services may be ethically questionable when such screening seems to be biased or discriminatory, or designed to exclude patients whom the physician is trained and competent to treat but who are seen as potentially troublesome or inconvenient.

There is a clear tension between physicians' duties to their patients and the society they serve and the physician's freedom to choose. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry may be seen as actually or potentially in conflict in this matter. Principle 1 states: "*A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights,*" with an annotation specifically opposing discrimination against a number of historically vulnerable groups. Principle 7 holds "*A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public*

health,” and Principle 9 that “*A physician shall support access to medical care for all people.*” On the other hand, Principle 6 states “*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.*” While Principle 6 may justifiably aim to protect physicians from the imposition of types of practice or compensation by the government, for example, it would be unreasonable to treat it as a principle overriding all other duties and responsibilities of physicians.

In circumstances where ethical principles conflict with each other about what should be done, a balancing of these principles is necessary. Some might argue that careful consideration, assessment, and balancing of principles is the responsibility of the individual physician, rather than of the profession. However, in considering limiting their practices, careful and thoughtful physicians with good intentions will likely reach different conclusions about which types of limitation are ethically allowable or not allowable based on their own balancing of ethical principles.

There are pertinent perspectives beyond the judgments of individual physicians. Medicine is a profession which has long been appreciated as having intrinsic goods or ends, among them the restoration or improvement of health, the minimization of suffering and disability, and the care of the person seeking the physician’s help. Ethicists have referred to this as an “intrinsic morality” of medicine, apart from the individual judgments of physicians. International experts considering the goals of medicine have recognized that there has been evolution in the goals of medicine over the centuries, but still articulate lists along similar lines. Certain dispositions of physicians (along with their professional promises and commitments) foster the accomplishment of these intrinsic ends of medicine. A critical one of these dispositions is an altruistic beneficence, oriented to the patient’s good, and sensitive to the broader values of the patient.

There are certainly many other perspectives pertinent to the balancing of principles. Views of healthcare ethics from various ethnic or other societal groups place greater value on communities, on faith and spirituality, and on caring relationships, for example. From such points of view, it may be harder to justify actions based predominantly on individual choice.

There are certainly counterweights to consider in this balancing of principles. Choices of whom to serve occur in a social context. Society also has responsibility to keep its promises, and to support excellent practices of its physicians, and physicians perceive many societal failures to honor promises and support medical practice in such examples as unfair insurance or public payer practices and policies, a hostile malpractice atmosphere, and even in an unreasonable expectation for physicians to prevent suicide and violence in an increasingly violent society. Physicians are also encouraged to foster a work-life balance and to avoid burnout and feel obligated to attend to the safety and well-being not only of themselves, but also of their staff and their loved ones and families.

Such personal, staff, and family interests, along with financially successful practice and personal convenience, are clearly goods which physicians will seek, alongside the welfare of patients and the community. But there is arguably an intrinsic morality in the profession of medicine requiring a significant altruism and limitation of self-interest. Determining the degree of this required or expected altruism is not easy; there is no bright line. Physicians should also consider the historical traditions of medicine, the reasonable expectations of society in granting medical education and licensing, and the promises made or implied in joining the profession of medicine at the completion of formal education and training.

It would be undesirable for governments or professional societies to mandate strictly or extensively whom physicians must serve, and in what way. But a considerable responsibility falls on the profession as well as the individual physician. Before placing limitations on practice, the ethical physician should thoughtfully consider, alongside the medical profession, how to balance the health of individual patients and the community with the physician's self-interest and other responsibilities. The weight of this balance should always lean toward the needs of patients. (Sections 1, 6, 7, 9) (2024)

N.38

Question: I am a solo practitioner. I will be traveling out of the country on vacation and unable to receive calls during my travel. What are my obligations regarding coverage while I am unavailable? Some of the colleagues I would have engaged to provide coverage are unable to do so because of noncompete restrictions in their employment contracts. Would using a Locum Tenens for a short period of time be an appropriate alternative?

Answer: It is important for psychiatrists, like other physicians, to provide their patients with information about absences from the office and where to obtain medical care while they are away or unavailable. The ethical psychiatrist should provide information to their patients who try to reach them of the dates they are out of the office or unavailable, and, if the patient is unable to wait until they have returned, whom the patient may contact for urgent questions and treatment, and what to do in case of an emergency. Solo practitioners may communicate this information through a recorded message on a telephone answering machine or via an answering service.

The solo practitioner may find locating a colleague to provide coverage more difficult than those who practice in a group or institutional setting. The latter typically have a structure in place for administrative staff to direct patients to appropriate covering clinicians. If solo practitioners are unable to find a back-up local psychiatrist colleague, they may elect to provide coverage for themselves while traveling, so long as they would still be able to return patient communications within their usual time period. Additionally, locum Tenens psychiatrists or telepsychiatrists licensed in the psychiatrist's state, psychiatric advanced practice nurses and family medicine/ primary care physicians may be appropriate resources for coverage. Solo practitioners might find it useful to contact their local District Branch for coverage suggestions.

The ethical psychiatrist may also give consideration to other issues. These might include whether and how records may be made available to covering clinicians, whether providing specific information about particular patients may be helpful to the covering clinician, and whether any particular patients should be notified in advance of the absence. (Sections 1, 5, 6 and 8) (2023)

N.39

Question: Six months ago, I joined a large psychiatric company with the agreement that I was going to have full responsibility for and authority over the medical functions of my practice. However, not long ago I was informed that the company was implementing guidelines for the treatment of adult patients with ADHD and requiring that all patients be ordered to have urine drug screens in order to be prescribed stimulants for ADHD. The company also sent a copy of the policy to physicians and nurse practitioners, requesting that we sign and comply with the rule. I stood up against this policy not only because it violates

my original contracting agreement with the company but also because, in my opinion, this arbitrary rule violates my duty to honor every patient's privacy and autonomy, and right to be treated with respect. It also conflicts with my duty to support access to medical care for all people.

Answer: The content of this opinion speaks only to ethical considerations of the question presented. Private employment relationships would be governed by the terms of the relevant employment contract. This opinion does not address the terms of the employment contract between the psychiatrist and the company, including whether it would give the physician complete discretion regarding their practice, and/or whether the adopted policy would violate the terms of employment.

The Ethics Committee panel begins this response by recognizing the following limitations: the panel has a narrow and limited understanding of the facts of this situation, including no information about the patient population being served at the clinic. This response is based on our understanding that the psychiatrist inquires if they acted appropriately in raising objections to the clinic's policy as described in the presented scenario.

The psychiatrist's concern is understandable, given the potentially problematic results of a policy that appears to single out and treat differently one category of patients (i.e., patients receiving treatment with stimulants for a diagnosis of ADHD). A discriminatory policy could result in the stigmatizing of the relevant group of patients and potentially discourage care seeking.

Healthcare entities frequently institute policies to guide treatment of patients in their system, and often, there is a valid rationale for and implementation of such policies (e.g. ensuring an appropriate standard of care). However, when policies appear arbitrary or contrary to the standard of care, especially if they target a specific group of patients, it is ethical for a physician to raise questions and/or concerns about them.

For example, it may be a legitimate practice in furtherance of patient safety for a clinic to: (i) require all newly admitted patients to submit a urine sample for relevant tests at intake; (ii) require urine testing for all patients for whom a controlled medication, including Benzodiazepines, was to be prescribed; or (iii) to require routine urine testing if the clinic is one designated for treatment of substance use disorders. Similarly, a valid policy might require performance of urine testing on a case-by-case basis, where a patient's history and clinical presentation indicate a high likelihood of substance misuse.

In the scenario presented, the Ethics Committee panel encourages the psychiatrist to continue to dialogue with the company to better understand the company's rationale for the policy and to identify the psychiatrist's concern regarding potential problematic consequences for patients. The psychiatrist may also choose to present for consideration alternative interventions for addressing the intent of the policy. For example, if screening for substance use disorders due to substance use issues in the community where the clinic is located is a rationale for the policy, might the company consider as an alternative the use of other validated screening tools? (Sections 1, 2, 3 and 4) (2024)

N.40

Question: APA has been hearing from Members who are out-of-network that health plans are requesting they send in medical records before the health plan will pay claims submitted by patients. These Members typically bill the patients, who then submit the claims to the plans. Some Members

have noted that their malpractice insurance provider has informed them that private practice psychiatrists that do not accept insurance but provide superbills to their patients are being contacted by patients' insurance companies to require the physician to send medical records to them in order for the patient to be reimbursed. In addition, some psychiatrists are getting calls from the insurance companies for further information before the insurer will reimburse the patient. Members have noted that this seems like a large burden to those in private practice that have decided specifically to not accept insurance due to lack of staff for billing purposes. Are Members ethically required to send in the records in these circumstances?

Answer: In addressing questions about psychiatrists' ethical responsibilities when patient medical records are requested to support the patient's reimbursement from an insurer with whom the psychiatrist has no contract, we see it as important to address:

- the psychiatrist's ethical responsibility to follow the law;
- the agreements and contracts between doctors and patients about their treatment relationship;
- the purposes of the medical record and the psychiatrist's duties to protect it;
- the ways, both direct and indirect, that such requests may affect access to care.

1) The law is detailed and clear that patients have a right to copies of their own record, and a right to have that record sent to other parties with appropriate consent. Generally, this requirement of the law does not seem unethical, so psychiatrists should strive to comply with it. Key questions remain about the details, such as the frequency of records transmissions. Such details would appropriately be worked out in the agreements between psychiatrist and patient about their treatment relationship. Of course, these agreements should not exploit the patient, and be balanced as to the interests of the physician and of the patient, and more likely leaning toward the benefit of the patient. An agreement that limited the frequency of record transmission done solely for the purpose of reimbursement, for example to quarterly, would seem to be an acceptable ethical compromise.

If the law were interpreted to mean that records had to be immediately sent after each encounter, or on every request by a patient, APA and psychiatrists might justifiably challenge or seek changes in the law.

The psychiatrist who does not contract with an insurer has no ethical obligation to supplement the record with telephone calls. HIPAA itself does not require this: "In responding to a request for access, a covered entity is not, however, required to create new information, such as explanatory materials or analysis, that does not already exist in the designated record set." Of course, this would not prohibit the psychiatrist, with the consent of the patient, from adding this additional service voluntarily.

2) The medical record exists primarily for the good of the patient and the prevention of harm. It provides to the physician, and to others who may follow, a record of history, examination findings, diagnosis, and rationale for decisions that supports good care. The record also has an accepted secondary purpose for society, to provide evidence of a physician's competence and professional standards to licensing bodies and the legal system. The current question demonstrates a concerning use of the record as a mechanism to limit care by those who have contractual or legal obligations to pay for it. We should not accept this easily.

Psychiatrists have long recognized their duty to protect the confidentiality of the patient. This applies to all communications with others, whether verbal or in the written psychiatric medical record. The [*APA*](#)

[*Commentary on Ethics in Practice, Topic 3.2.1 \(Confidentiality\)*](#), states: “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.”

While the record, in an important sense, belongs to the patient, the psychiatrist should help the patient protect it. The present issue seems to require psychiatrists to share the medical record in ways that may not support good care or benefit the patient, and that risk unnecessary disclosures of material that should be protected as confidential.

3) There are legitimate concerns about access to psychiatric care, and these concerns are heightened by the present issue.

We have already noted our disagreement with the use of the medical record to limit care, by denying payment or placing administrative obstacles in the way of payment that may discourage patients and their physicians from pursuing such payment. The confidentiality and integrity of the psychiatric record must be protected. This limitation of access is initiated by insurers and imposed by them onto patients and psychiatrists. If the law supports or seems to support the use of the record in such ways, psychiatrists and their professional associations should seek to change such law or regulation for the good of their patients.

Others may have concerns about the actions of psychiatrists that may also limit access. Of course, the very practice of setting fees for professional service, long recognized as ethically acceptable, creates some limit to access. The many contemporary arrangements around how patients pay these fees or seek to have their insurers pay them may also indirectly limit access to care. Psychiatrists make choices about which arrangements they accept, and enter agreements or contracts with patients to define the details. Psychiatrists should balance these realities and needs with an emphasis on maintaining access to care in their clinical practices and through their ongoing advocacy.

The present issue asks for clarification about how the ethical psychiatrist may handle burdensome administrative tasks imposed from outside the physician-patient relationship that may indirectly limit access to care, including by leading to physician burnout or even early retirement. To recapitulate:

- The psychiatrist should provide access to records to which the patient has rights, but this should have reasonable limits agreed to by physician and patient.
- The psychiatrist should advise and assist the patient in conserving the confidentiality and integrity of the psychiatric record in the face of outside intrusions.
- The psychiatrist has legitimate interests in preventing non-clinical burdens and inconveniences from making it very difficult or undesirable for the psychiatrist to continue practice. They also have a legitimate interest in resisting practices which limit access to care. The ethical psychiatrist will always treat the good of the patient as primary, seeking to balance the tensions of the psychiatrist’s inconvenience and burden in the interests of the patient.

(Sections 1, 2, 3, 4, 6, 8, 9) (2024)

O. PROFESSIONAL LISTINGS, ANNOUNCEMENTS

O.1

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

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

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

It is not ethical to claim a competence not possessed. The ethics committee would want to know what the psychiatrist’s actual training and experience were. The title “psychoanalyst” is not owned exclusively by any organization. Thus, a person might not be unethical in using that title, even though he or she was not a graduate of an accredited training center, if training from other sources reasonably related to the task of being a psychoanalyst had been received. (Section 2) (1978)

O.2

Question: Can an ethical psychiatrist list himself in a professional directory?

Answer: While the answer to this question is generally yes, one is advised to seek guidance from the local medical society on all matters related to what can be broadly called advertising. Certainly it would be unethical for the psychiatrist to misrepresent himself or to make fraudulent claims. Deception of the public by misleading, inflated, and self-laudatory claims is to be avoided. (See Opinion 5.02, *AMA Council Opinions*, 2000–2001.) (Section 2) (1978)

O.3

Question: I plan to purchase a solo psychiatric practice and request information on the ethical aspect of this situation. What sort of notices can be sent to other physicians and how can I indicate that I am taking over a practice?

Answer: It is ethical for you to send an announcement to other physicians and agencies from whom you expect referrals that you are taking over another doctor’s practice. If you have questions about the format, your local medical society should be consulted. For additional guidance see Opinions 7.03 and 7.04, *AMA Council Opinions*, 2000–2001. (Section 2) (1980)

O.4

Question: May I send out notices to doctors and lawyers in my neighborhood stating I would appreciate referrals?

Answer: Yes, as long as the notices are not deceptive, misleading, or false. Claims of unusual or special competence would be improper. (Section 2) (1990)

O.5

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

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

P. REFERRAL PRACTICES

P.1

Question: Is it ethical for a psychiatrist to refer a patient to a qualified mental health professional who happens to be his wife?

Answer: Yes. However, the psychiatrist has the same ethical responsibilities in making that referral as he would have if the person were not his wife. He cannot refer cases requiring medical care to her, nor can he give her only token supervision. He should also make clear to the patient that the referral is to the spouse. (Section 5) (1976)

P.2

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

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

In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment. (Section 5) (1978)

P.3

Question: Is it ethical for a psychiatrist to continue to see a patient in his or her private practice whom the psychiatrist began seeing as an employee of a public clinic? Can other professional members of the clinic refer patients to the psychiatrist?

Answer: The issue is what is best for the patient, rather than for the physician or the clinic. Patients must have the right of free choice of their physician. See Opinion 9.06, *AMA Council Opinions*, 2000–2001:

Free choice of physicians is the right of every individual. One may select and change at will one's physicians, or one may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care.

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 the potential disadvantages – as well as any advantages – of transferring care to a private clinic, including coordination of care, other services

provided, and availability of urgent care services, for example. The psychiatrist should avoid any actions that could be construed as initiating or encouraging such a transfer of care. (Section 6) (1979; 1981; 2019)

P.4

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

Answer: As in this case, if a psychiatric emergency occurs, it is the responsibility of the primary care physician to refer the patient to emergency care. In addition, whether or not the PPO covers the established psychiatrist, if the established psychiatrist is contacted or involved at the time of the emergency, the psychiatrist must not abandon the patient in the setting of this emergency. The psychiatrist, however, is not required to treat the patient but at a minimum must refer the patient to timely available emergency. (Section 6) (1989; 2019)

P.5

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

Answer: Self-referral is a conflict of interest. You may take steps to manage this conflict such that referrals could be ethical by informing your patients and all other involved parties (such as additional treaters) of the financial conflict and offering alternatives to the program you own. Ethical conduct also requires that you make other arrangements for them if they object. (Section 2) (1991; 2019)

P.6

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

Answer: No, assuming the psychiatrist taking the discharge referral is the clinically proper person. This is the standard practice in the private sector attending model. (Section 2) (1991)

P.7

Question: Dr. X is the only doctor who does ECT at a large hospital. It's a very active ECT practice; he does 12 or 15 ECT treatments in a morning. He is planning on retiring and is wondering if he can essentially sell this lucrative practice. Right now, he deals directly with the insurance company for the service but uses the hospital's facilities. Both he and the hospital bill the insurance company as he is a contractor to the hospital. He gets his referrals from the hospital. Is it ethical for him to sell this practice?

Answer: Although it's not typically a practice in psychiatry, physicians and dentists sell their practices all the time, and there is nothing unethical about it. Today, many physicians' practices are actually bought by hospitals. However, this particular inquiry takes a little bit of a different twist. It's not clear what is Dr.

X's current relationship with the hospital, is he a totally independent practitioner who is a private attending physician at the hospital, or does the contractual arrangement that the doctor currently has with the hospital mean that the patients who are referred to him for ECT really belong to the hospital, and not to the doctor. In that case, there is no assurance that the hospital will continue to refer to the "buyer" physician, so Dr. X may not have anything to sell, or at very least, ethically, this nuance needs to be made known to the buyer, and written into the "bill of sale". (Section 2) (2017)

P.8

Question: If a patient requests a treatment that I am morally opposed to, I understand that I can conscientiously object to providing this care. However, given my conscientious objection, is it also ethical to refuse to refer this patient to a provider who may provide this care?

Answer: In medicine, conscientious objection is the refusal to perform legal, medically appropriate healthcare because of moral, religious or other well-considered, deeply held personal beliefs. Examples include refusal to provide abortion services, contraception, gender-affirming treatment, physician aid in dying, assessments of capacity for assisted death, or assessments of capacity to be executed. Conscientious objection is most often an objection to providing a specific procedure or service as such. By contrast, an objection to providing that procedure or service to specific persons or types of person—for instance, a refusal to provide reproductive services to homosexual couples when it is provided to other patients—may be considered discrimination even if the refusal is based on deeply held personal, religious, or moral beliefs.

While conscientious objection is generally protected by many professional codes of ethics and federal and state laws, the right of a provider to conscientiously object to providing certain types of healthcare must not interfere with their duty to care for the patient. More specifically, the conscientious objection must not negatively impact the patient's health or their access to legal, medically appropriate healthcare or information that contributes to ethically and legally appropriate informed decision-making. Physicians should not coerce patients or impose their beliefs on patients, although it may be ethically appropriate for them to inform the patient of the reason for their conscientious objection, including disclosure of their own moral beliefs and the restrictions these place on their own actions. Physicians must continue to treat patients in all other aspects of their care or determine together with the patient that a physician-patient relationship is no longer desirable and transition care appropriately.

Generally, psychiatrists who conscientiously object to a treatment or assessment requested by or on behalf of someone with whom they have an existing physician-patient relationship should refer the patient to another psychiatrist or institution where they can obtain a more comprehensive information and service as needed. In situations where the psychiatrist's moral objection is so deeply held that they decline to refer the patient, they should still ensure that the patient receives unbiased information about how to access further information about the requested treatments. *See also* AMA Code of Medical Ethics Opinion 1.1.7, available at <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience>, (*"Physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities. Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient"*). (Sections 1, 2, 3, 4, 6, 8) (2023)

Q. RESEARCH AND SCHOLARLY ACTIVITIES

Q.1

Question: What happens when an individual is unable to consent to be a research participant in a study with the potential to improve knowledge about the individual's conditions? What is the ethical position in this dilemma?

Answer: For research, proceeding without consent is unethical. Therefore, mechanisms that protect or delegate the individual's consent could be employed. For example, the preparation of an advanced directive at the time the person was competent could grant permission for a surrogate decision-maker to consent to future research participation. Alternatively, where no prior authorization exists, a protective guardianship proceeding could be used. See Opinion 2.07, *AMA Council Opinions*, 2000–2001. Psychiatrists conducting research should take care to enhance diversity and equity by working to engage populations that have been historically excluded or underrepresented. This includes that the informed consent process must be undertaken from a culturally sensitive stance. For example, consent forms should be culturally congruent and curated for optimal readability and comprehension (including taking into account the potential for literacy and linguistic disparities). (Section 5) (1977; 2019; Rev. 2023)

Q.2

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

Answer: The ethical issue is one of confidentiality. The records remain confidential notwithstanding the death of the psychiatrist. Any disclosure of the records must have the consent of the individual patient. (Section 4) (1993; 2019)

Q.3

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

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

Clarification (2017):

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

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

1. When a psychiatrist comments about the behavior, symptoms, diagnosis, etc., of a public figure without consent, the psychiatrist violates the fundamental principle that psychiatric evaluation occurs with consent or other authorization. The relationship between a psychiatrist and a patient is one of mutual consent. In some circumstances, such as forensic evaluations, psychiatrists may evaluate individuals based on other legal authorization such as a court order. Psychiatrists are ethically prohibited from evaluating individuals without permission or other authorization (such as a court order).
2. Psychiatric diagnosis occurs in the context of an evaluation, based on thorough history taking, examination, and, where applicable, collateral information. It is a departure from the methods of the profession to render an opinion without an examination and without conducting an evaluation in accordance with the standards of psychiatric practice. Such behavior compromises both the integrity of the psychiatrist and of the profession itself.
3. When psychiatrists offer medical opinions about an individual they have never examined, this behavior has the potential to stigmatize those with mental illness. Patients who see a psychiatrist, especially their own psychiatrist, offering opinions about individuals whom the psychiatrist has not examined may lose confidence in their psychiatrist and/or the profession and may additionally experience stigma related to their own diagnoses. Specifically, patients may wonder about the rigor and integrity of their own clinical care and diagnoses and confidentiality of their own psychiatric treatment.

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

- a) Some psychiatrists have argued that the “Goldwater Rule” impinges on an individual’s freedom of speech as it pertains to personal duty and civic responsibility to act in the interest of the national well-being. This argument confuses the personal and professional roles of the psychiatrist. The psychiatrist, as a citizen, may speak as any other citizen. He or she may observe the behavior and work of a public figure and support, oppose, and/or critique that public action. But the psychiatrist may not assume a professional role in voicing that critique in the form of a professional opinion for the reasons discussed above, those being, lack of consent or other authorization and failure to conduct an evaluation.
- b) Psychiatrists have also argued that the “Goldwater Rule” is not sound because psychiatrists are sometimes asked to render opinions without conducting an examination of an individual.

Examples occur, in particular, in certain forensic cases and consultative roles. This objection attempts to subsume the rule with its exceptions. What this objection misses, however, is that the rendering of expertise and/or an opinion in these contexts is permissible because there is a court authorization for the examination (or an opinion without examination), and this work is conducted within an evaluative framework including parameters for how and where the information may be used or disseminated. In addition, any evaluation conducted or opinion rendered based on methodology that departs from the established practice of an in-person evaluation must clearly identify the methods used and the limitations of those methods, such as the absence of an in-person examination.

- c) Psychiatrists have further argued that they should be permitted to render professional expertise in matters of national security and that the “Goldwater Rule” prohibits this important function. While psychiatrists may be asked to evaluate public figures in order to inform decision makers on national security issues, these evaluations, like any other, should occur with proper authority and methods within the confidentiality confines of the circumstances. Basing professional opinions on a subset of behavior exhibited in the public sphere, even in the digital age where information may be abundant, is insufficient to render professional opinions and is a misapplication of psychiatric practice.
- d) Some psychiatrists have argued that they have a responsibility to render an opinion regarding public figures based on Tarasoff duties to warn and/or protect third parties. This position is a misapplication of the Tarasoff doctrine. Actions to warn and/or protect a third party occur in situations in which a psychiatrist is providing treatment to or an evaluation of an individual who poses a risk to others and Tarasoff serves as a rationale for a limited sharing of otherwise confidential or privileged information. However, for information in the public domain, law enforcement agencies that have the same, and perhaps even greater, access to information about the individual are charged with protecting the public.
- e) Finally, some psychiatrists have argued that rendering an opinion based on information in the public domain without conducting an examination should be permissible because psychiatrists are often involved in psychological profiling. However, psychological profiling differs markedly from self-initiated public comments as described in this opinion. Psychological profiling occurs when a law enforcement or other authorized agency or authorized party engages a mental health professional to provide information about the characteristics of an individual who might have perpetrated a crime; the behavior of a suspect or other figure; other characteristics of an individual; or a prediction of future risk. The authorization for this work derives from the requester and is not initiated by the psychiatrist. It is also meant to be shared with the requester, and not the general public. Finally, as this work often lacks examination of the individual and relevant data from appropriate collaterals, the psychiatrist must explicitly address the limitations of the methods used in rendering a profile, should not opine about a diagnosis, should not include a diagnostic opinion, and must clearly state the inherent limitations in making predictions about future behavior.

Nothing in this opinion precludes the psychological profiling of historical figures aimed at enhancing public and governmental understanding of these individuals. As Opinion Q.3 states, this profiling should

not include a diagnosis and should be based in peer-reviewed scholarship that meets relevant standards of academic scholarship. Such scholarship should clearly identify the methods used, materials relied upon, and methodologic limitations, including the absence of formal evaluation of the subject of inquiry.

Q.4

Question: Would it be ethically appropriate to write a paper on the crucial nature of leadership, including political, without naming names, to address an important issue (such as the growing threat of global warming)?

Answer: Yes, it could be ethically appropriate to write a paper on the crucial nature of leadership, including to address the growing threat of climate change. Commenting in general terms about leadership qualities that would be desirable to make a difference in a policy area would be legitimate and appropriate, *provided that* the comments about the individual are not based on medical knowledge or training.

The Goldwater Rule applies to professional opinions related to individuals one has neither the clinical basis nor the permission to discuss publicly. Talking about what one wishes to see in a leader and what it would take to make a real difference in climate change or any other policy area is perfectly legitimate - provided it does not make any statements about individuals which would require the speaker to call upon his/her medical knowledge or training.

Identifying an individual as having particular behavior traits that suggests the utilization of psychiatric expertise to support an opinion of the identified leader or casting the author's comments in psychiatric terms that would suggest a professional evaluation of issues and personalities involved would not be appropriate. (Section 7) (2018)

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.

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)

R. RESIDENT, STUDENT AND OTHER TRAINEE ISSUES

R.1

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

Answer: You certainly do if you do not define your roles clearly and in advance to the student. You cannot give an administrative opinion if the student has made a psychotherapeutic contract with you. This is a classic example of dual role conflict. If the college demands that you confuse your roles, you should refuse to participate and must ethically withdraw from the arena if the college will not relent. Even a student's consent for you to make an administrative report after a period of psychotherapy does not resolve your conflict since the consent may not be freely given but coerced. The college should be advised to seek an administrative opinion from a psychiatrist not involved in a treatment relationship with the student. (Section 4) (1977; 2019)

R.2

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

Answer: Asking the wife of the patient on a date is unethical. At a minimum, the second event is a significant boundary crossing. Learning to maintain professional boundaries is a critical milestone in psychiatry residency. This resident's behavior, at a minimum, indicates a need for supervision, assessment, and education about boundaries. The ethical training supervisor must not ignore these events and instead engage in careful monitoring and assessment of the resident's ability to learn and practice within the ethical norms of the profession. (Section 2) (1987; 2019)

R.3

Question: In a training program in psychotherapy, do trainees need to obtain informed consent from patients in order to present the patient's therapy in class discussions and in supervision groups?

Answer: No, provided that the patient's confidentiality and identity are preserved and patients are aware of the supervisory processes. In addition, the confidentiality of the material presented, even if deidentified, should be a condition of the supervision. (Section 4) (1993; 2019)

R.4

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

Answer: A doctor-patient relationship is established when a psychiatrist provides treatment to a patient; this includes provision of "split treatment. Parents are typically an integral part of the treatment of children

or adolescents. For example, parents must provide informed consent when psychotropics are prescribed to a minor in most instances, thereby assuring their active participation. Romantic involvement either during or subsequent to treatment with key family members may be construed as exploitation of the patient and family; it could be a method by which a psychiatrist meets his or her own needs. Furthermore, this romantic involvement may discourage the original patient and other family members from seeking subsequent treatment with the trusted psychiatrist. Romantic involvement with key family members is also unethical. (Section 2) (2003)

R.5

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

Answer: Ethical practice requires informing the residents of the expectations of and limitations on confidentiality at the beginning of the process group. This training experience should maintain confidentiality in order to assist the residents in the training process. However, refusing admission of patients could be unethical (including admission refusal on the basis of any protected trait such as ethnic origin, race, sex, gender identity, creed, age, socioeconomic status, or sexual orientation). An exploration of the reasons residents refused patient admissions would need to occur to understand the ethical implications, including exploring whether any implicit bias against a community may be playing a role in the admission refusals. Psychiatrists have an ethical responsibility to address unethical conduct of other psychiatrists (and trainees in this case), which could be most ethically achieved in situations in which the limits on confidentiality are established at the outset. (Section1) (2006; revised 2018; 2023)

R.6

Question: As a resident, it can be daunting to provide care to a patient who is reporting suicidal or homicidal ideation with accessibility to firearms. Given the recent political climate around firearms and mental health, how do we navigate discussing firearm safety while balancing patient risk?

Answer: As mental health professionals, psychiatrists have an ethical and clinical responsibility to discuss firearm safety with their patients. This has become increasingly relevant as gun violence that includes both homicide and suicide has reached new heights during the COVID-19 pandemic.

The burden of gun violence in the US not only outpaces all other developed nations, but is a matter of social equity because it disproportionately affects young adults from minoritized groups.² Among non-Hispanic Black persons between ages of 15-24, for example, guns are the leading cause of death.³ Firearm use in both suicide and homicide costs the US roughly \$280 billion annually.⁴ Recent data published by the CDC reveals that 54% of gun related deaths were suicides, while 43% were homicides.⁵ To be clear, the vast majority of individuals with mental illness are not violent, and studies repeatedly show that mental illness contributes to only approximately 4% of all violence. This is important, as it contradicts public perception that gun violence and all other forms of violence are caused by mentally ill individuals, which further stigmatizes our patients. Nevertheless, since gun violence is a public health issue, psychiatrists must participate in its prevention by addressing it with their patients, especially suicidal patients in whom

access to guns increases the risk of completing suicide.⁶ Moreover, psychiatrists can address prevention through legislative advocacy. Legislative efforts like the 2022 Safe Communities Act underscore the importance of the issue of gun safety in communities and neighborhoods.⁷

Consequently, discussions of firearm safety must have a place in patient-physician collaborations. This is not only because firearms pose a risk to household and family members as well as patients, but because public health solutions like legislation, safety locks, and gun safes are available.

Given the importance and prevalence of gun ownership, psychiatrists can remain empathetic about the cultural norms and values of gun-owning patients and communities. A caring and non-judgmental psychiatrist is both collaborative and culturally sensitive, using therapeutic rapport to keep patients safe. Psychiatrists should familiarize themselves with the literature that identifies persons with a history of intimate partner violence, substance use disorders, or homicidal or suicidal ideation as particularly worthy of attention when discussing firearm safety.⁸

Ethical principles including beneficence, fidelity, and nonmaleficence support decisions affecting patient safety. Offering counseling and information in a respectful manner results in informed decision-making. The duty to initiate safety discussions overcomes any sensitivity practitioners and patients may have in addressing such a personal issue. Patients with a risk of violence may consequently require practitioners to consider access to weapons alongside the usual Tarasoff obligations. Addressing access to guns should consequently be part of a psychiatrist's risk assessment.⁹

When discussing firearm safety with patients, psychiatrists can therefore keep in mind a number of professional commitments to patients and their families. These may include discussing the risks associated with firearm ownership and strategies for reducing those risks, as well as consideration of the patient's cultural and personal values. (Section 1; Section 5; Section 7; Section 8) (2023)

References

1. <https://www.cnn.com/2022/10/06/health/firearm-homicide-suicide-rates-increase-2021-cdc/index.html>- full text
2. 4 Brady Center to Prevent Gun Violence. (2015). The Truth About Suicide & Guns. Washington, DC: The Brady Center to Prevent Gun Violence Available at: <https://brady-static.s3.amazonaws.com/Brady-Report-Suicide-and-Guns.pdf>.
3. National Center for Injury Prevention and Control, CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Leading Causes of Death Reports, National and Regional, 1999-2010. Atlanta, GA: http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html.
4. Follman M, Lurie J, Lee J, West J. The true cost of gun violence in America. Mother Jones. Available at: <https://www.motherjones.com/politics/2015/04/true-cost-of-gun-violence-in-america/>.
5. Gramlich J. What the data says about gun deaths in the U.S. Pew Research Center. April 26, 2023. Accessed September 14, 2023. <https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/>.
6. Swanson JW, McGinty EE, Fazel S, Mays VM. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Ann Epidemiol*. 2015 May;25(5):366-76. doi: 10.1016/j.annepidem.2014.03.004. Epub 2014 Apr 29. PMID: 24861430; PMCID: PMC4211925.
7. <https://www.cnn.com/2022/07/30/us/gun-control-laws-2022/index.html>

8. <https://www.psychologytoday.com/us/blog/psychiatrys-think-tank/202307/are-your-guns-safe-in-your-home>
9. <https://www.psychiatry.org/getattachment/59f11139-8e98-463e-94bc-3be2cff58ec6/Resource-Document-2011-Violencerisk.pdf>
10. <https://safetyindementia.org/>