A Practical Update on Ethics in Clinical and Forensic Neuropsychology

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Objectives

- To demonstrate common ethical dilemmas in clinical psychology and how to best resolve them, via:

- 1) Review of recent ethical violations and the incidence and most common type of violations
- 2) Assessment of a model used to achieve more than avoidance of egregious misconduct
- 3) Utilization of illustrative cases and principles
- 4) Analysis of how to resolve perceived unethical conduct of other Psychologists
- 5) Make sure you get the right CE credits for this reporting year!

- NO CONFLICTS OF INTEREST TO REPORT

Topics to covered (as time allows!) through review and/or actual cases

- Release of psychological raw data
- Bases for Assessment
- Multiple Relationships
- Vulnerable Populations
- Duty to Report Unethical Practice of other Psychologists
- Confidentiality and Privacy

But First….

A Fun Game!

Fictionary

- A gamer finds and announces the most obscure word they can find in a dictionary
- Others attempt to determine the true definition, provided by the one with the dictionary, from false ones made up by rest of players
- A variation/reversal here: Of the four following ethical vignettes, which one is so bizarre that you think it was the one I made up?

Ethical Fictionary: Case 1

- "When she (psychiatric inpatient) asked to leave the room, psychologist Dr. E fondled her, exposed himself and requested a sex act, threatening that she wouldn't be able to leave the (Chicago) hospital if she did not comply. So she did what she was told.
- The woman then called her sister and told her what happened. When the woman was discharged, Dr. E gave her his business card with his cell phone number written on it and a $20 bill.
- He later drove to her home, sat outside in his car and called her. He took her to a cell phone store and bought her a phone using the name "Sam Doe." The next day, he returned to her home with five $20 bills and pleaded with her not to tell about their sexual encounter."

Case 2

- “Dr. L asked the female patient for a sample of her ex-husband's DNA so that the psychologist could "perform a spell" on him, the suit contends. The suit also claims the therapist told the patient "men were a lower form of life than women and that men would soon die off the planet."

  In a previous lawsuit, another patient accused Dr. L of having written out witch's spells for the patient to practice in order "to resolve her mental problems and attain her goals in life." The litigation seeks $1 million in damages from the psychologist’s employer (a Chicago hospital).”

Case 3

- “There, using a daily program of hypnotism and high doses of medication, her therapists (a psychiatrist and psychologist) "recovered" her "memories“, including the patient’s rape on a satanic altar by her father and cult members; her participation in the cannibalization of her own aborted fetuses and those of others (parts of up to 2,000 people consumed); and the abuse of her own children. The patient was supposed to have been a "high priestess" of the cult, in a national and possibly even an international conspiracy existing for many generations. And her personalities blossomed to number over 300 while she was under care. While all this was going on, the patient’s young children (ages 4 and 5) were also hospitalized for nearly three years at (a Chicago hospital) and sucked into the same bizarre "therapy". All in all these cases cost the insurance company $3 million dollars”

Case 4

- “A psychologist is fined for failing to disclose on a federal loan deferment application and on psychology license application that he has previously been convicted of:

- 1) Simple Battery ; (2) Aggravated Battery ;
- (3) Aggravated Assault, Resisting Arrest, Attempted Auto Theft,
- (4) Burglary ; (5) Trafficking in Dangerous Drugs,
- Trafficking in Marijuana ; (6) Trafficking in a Controlled Substance;
- (7) Criminal Trespass to Land ; (8) Criminal Damage to Property ;
- (9) Patronizing a Prostitute ; and (10) Battery)”

Which Case is Fictional?

- Sex Abuse/Coercion of a Psych Inpatient?
- Use of Witchcraft to Destroy Ex-Husband(s)?
- Implanting Notions of Satanic Abuse?
- Lying about Extensive Criminal Hx?

All are True!

- Please ignore this issue:
- “Is it ethical for a lecturer on Ethics to mislead the audience on how many Fictionary examples are True/False?”

You can’t make this stuff up

- 1) Revocation because he was convicted of a criminal act that requires registration under the Sex Offender Registration Act. Suspension for allegedly engaging in sexual misconduct with a patient while employed at a facility in the state.
- 2) Probation for violating professional boundaries. Suspension for violating professional boundaries.
- 3) Reprimand: Failed to adequately document her treatment of a patient and failed to question the primary treating physician more regarding certain medication protocols. Fine: Failed to adequately document her treatment of a patient and failed to question the primary treating physician more regarding certain medication protocols.
- 4) Assessed a $10,000 fine for failure to disclose a past criminal history in applying for licensure.

Far-Fetched and Extreme?

- All occurred recently in Chicagoland
- Found through search of IDFPR website ethics reports and subsequent Googling in some cases

What is prevalence of unethical misconduct?

- Impossible to know as only outcome variable is that of published findings from state board or professional societies
- Two surveys (1999, 2001) found that 11% of the psychologists in their surveys had responded to a state board complaint (*but not clear how many complaints were justifiable/founded*)
- It is also not known what percentage of putatively unethical acts are reported

What are the most common types of ethical violations?

- Only “eyeball” analysis can be done (Knapp and VandeCreek, 2012) but seemingly:
- 1) Multiple relationships (sexual and non-sexual)
- 2) Alleged incompetence in diagnosis and treatment
- 3) Disputes arising out of child custody evaluations
- 4) Fee disputes
- 5) Premature termination/abandonment

How can certain people (psychologists) be so unethical?

- Any group of people will have its share of sociopaths/criminals?
- Otherwise “good” people make mistakes because of ignorance or poor judgment?
- Otherwise “good” people can be compromised at vulnerable times because of personal/psychiatric/substance abuse problems?
- One or more of the above factors are enabled by the Kitty Genovese phenomenon (e.g. others do not wish to be involved, diffusion of responsibility)?

What should the goal of "ethics" be?

- Avoidance of the most egregious examples of (non) criminal misconduct?
- Avoidance of things that could lead to loss of licensure or other formal complaints?
- Rather than focus on the floor/minimal thing to do to avoid trouble, but instead aspire to the highest standards which will be maximal benefit to psychologists' patients, students and research subjects? (hint: this is correct answer)

"Positive" Psychology

- "Positive ethics parallels the developments of *positive psychology* as a scientific endeavor. 'Positive psychology attempts to shift the goals of psychology from an almost exclusive focus on pathology and healing to a science that helps 'to articulate a vision of the good life'" (Seligman & Csikzentmihali, 2000; quoted in Knapp and VandeCreek, 2012)

Positive Ethics

- The goal of positive ethics is to shift the emphasis away from an almost exclusive focus on wrongdoing and disciplinary actions toward an articulate vision of high ethical standards. Positive or active ethics also considers how individual psychologists can help institutions promote individual and social well-being.

A Comparison of Floor and Positive Ethics

Moral Domain	Floor Approach	Positive Ethics
Nondiscrimination	Avoiding discrimination	Promoting understanding and appreciation of traditionally disenfranchised groups, such as developing a "gay affirmative" orientation
Informed Consent	Fulfilling legal responsibilities such as ensuring that patients sign an informed consent form	Striving to maximize patient participation in development of goals of the evaluation or therapy
Confidentiality	Avoiding prohibited disclosures	Striving to enhance trust

Use of a 5 step model to achieve Positive Ethics

- 1. Identify or scrutinize the problem
- 2. Develop alternatives or hypotheses
- 3. Evaluate or Analyze Options
- 4. Act or Perform
- 5. Look Back or Evaluate

Eight Step Problem-Solving Model

Adapted from Koocher & Keith-Spiegel, 1998

1. Describe the situation.
2. Define the potential ethical-legal issues involved.
3. Consult ethical-legal guidelines (APA, NASP, IDEA, etc.).
4. Evaluate the rights, responsibilities, and welfare of all affected parties. Be sensitive to ethnic and cultural factors.
5. Generate a list of alternative decisions possible for each issue.
6. Enumerate the consequences of each decision. Evaluate the short-term and long term consequences of each. Consult with respected colleagues.
7. Present any evidence or likelihood that the consequences or benefits from each decision will actually occur.
8. Make the decision consistent with ethics and law. Take responsibility for your decision.

APA Ethical Principles of Psychologists and Code of Conduct

Principles: A. Beneficence and Nonmaleficence;

B. Fidelity and Responsibility; C. Integrity;

D. Justice; E. Respect for People's Rights and Dignity. **Principles are *aspirational***.

Standards: 1. Resolving Ethical Issues; 2. Competence; 3. Human Relations; 4. Privacy and Confidentiality; 5. Advertising and Other Public Statements; 6. Record Keeping and Fees. Standards are ***enforceable rules of conduct.***

The problem is…

- Practitioners don't always know that there is a problem or dilemma, and;
- "Ethics" isn't necessarily limited to avoiding harm or not committing egregious acts

Donald Rumsfeld may have been wrong about some things, but…

"There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know."

Or in other words….

- Is "unskilled and unaware of it" analogous to "unethical and unaware of it"?

Unskilled and Unaware

- The phenomenon was first tested in a series of experiments published in 1999 by David Dunning and Justin Kruger of the Department of Psychology, Cornell University. The study was inspired by the case of McArthur Wheeler, a man who robbed two banks after covering his face with lemon juice in the mistaken belief that it would prevent his face from being recorded on surveillance cameras.[4] They noted earlier studies suggesting that ignorance of standards of performance is behind a great deal of incompetence. This pattern was seen in studies of skills as diverse as reading comprehension, operating a motor vehicle, and playing chess or tennis.

Unskilled and Unaware

- Dunning and Kruger proposed that, for a given skill, incompetent people will: tend to overestimate their own level of skill;
- fail to recognize genuine skill in others;
- fail to recognize the extremity of their inadequacy;
- Dunning has since drawn an analogy ("the anosognosia of everyday life")[with a condition in which a person who suffers a physical disability because of brain injury seems unaware of or denies the existence of the disability, even for dramatic impairments such as blindness or paralysis.
- If you're incompetent, you can't know you're incompetent. […] the skills you need to produce a right answer are exactly the skills you need to recognize what a right answer is.

So, let's get educated!

Case 1:When, if ever, is it permissible to release "raw data" to others?

- A patient reports cognitive and behavioral problems since undergoing surgery 6 months ago, and self reports that anesthesia was done incorrectly. They are referred by their physician because of concerns about work functioning. The patient mentions during the interview they are considering litigation but haven't retained an attorney. Three months after the neuropsychological evaluation is completed, the patient calls and asks for a complete copy of their file, including a copy of the test forms/raw data.
- It is suspected, but not known, that the patient will forward the raw data to an attorney

What do you do?

- Send the file per this verbal request?
- Send the file upon patient making a proper written release/request?
- Ask the patient to have their attorney call if and when the attorney is retained?
- Don't send the file regardless?
- Call Legal Affairs because you have no idea?

Known knowns, Known unknowns, or Unknown Unknowns?

- Its complicated because this request is potentially at the intersection of copyright law, APA and other professional ethical guidelines, state law and federal law (HIPAA)
- 5 demands, not necessarily congruent

Why is release of raw data even a concern?

- If our questions and answers are in the public domain, then people can prepare for the examination in advance (bar exam Qs on web?)

- *Examples*
- A child's mother demanded a copy of the WISC from me so she could coach her child ahead of a requested re-evaluation, saying my "springing" it on him during the present exam was unfair
- Wetter and Corrigan (1998) survey showed that half of personal injury attorneys would help their clients prepare for psychological exams if they had access to tests in advance, particularly those measuring effort

APA Ethical Principles (9.04) Test Data vs. Materials

9.04 release of test data (a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data (*Grote note: questions and answers usually intertwined on test forms)*

. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release.

Psychologists may refrain from releasing test data to protect a client/ patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security)

- b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order

APA Ethical Principles (9.11)

9.11

Maintaining test security

The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data.

Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

What the heck?

- Don't release Block Design blocks but do release WAIS-IV form showing responses (and stimuli)?
- What is reasonable effort?
- When would there be chance of substantial harm or misuse?
- How does this relate to state law/HIPAA?

State Law

- Half of all states actually have laws referring to release of psychological raw data
- Illinois is one of them!

State law (Illinois)

- Sections 3(c) of 740 ILCS 110 of Mental Health and Developmental Disabilities Act:
- Paragraph 803 (c) Psychological test material whose disclosure would compromise the objectivity or fairness of the testing process may not be disclosed to anyone including the subject of the test and is not subject to disclosure in any administrative, judicial or legislative proceeding.

What does HIPAA say?

- HIPAA generally gives patients complete access to their records, but:
- HIPAA 45 CFR 45 164.508, 164.523(a)(1):

"Patients do not have the right of access to information compiled in reasonable anticipation of, or use for, in a civil, criminal or administrative procedure"

- Celia Fisher, chair of ECTFR: "HIPAA constraints are not at issue" in consideration of raw data release in legal cases

What takes precedence when federal, state law, and ethical principles are contradictory?

Is it Federal>State>APA?

But since our license usually depends on compliance with state law, is it instead

APA>State>Federal?

What trumps what? (according to The Monitor (1) and my opinion (2)

- State law is greater than HIPAA
- State law and HIPAA trump APA ethics

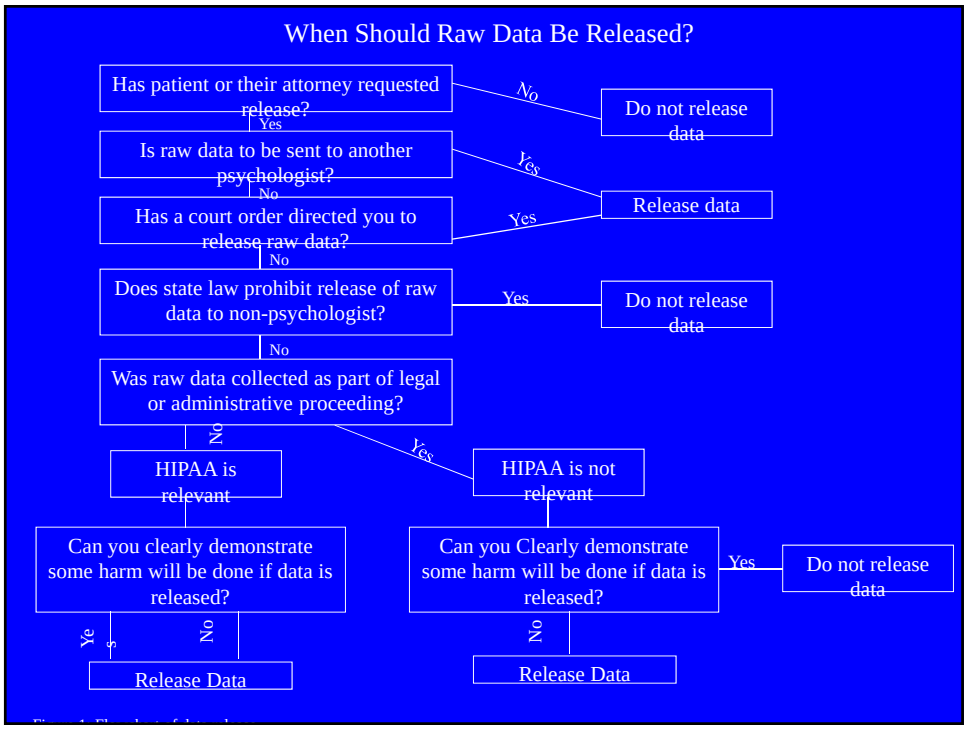
- Note: Some believe that APA ethics trumps law. Deciding the potential cost/benefit of (non) compliance may determine one's view

What the heck? (part two)

- How do you balance:
  - APA: Raw data vs. test materials
    - anticipate misuse; reasonable efforts
  - State law (Ill): compromise objectivity
  - HIPAA: forensic proceedings

Use of Flowcharts

- Takes advantage of situations that are “dichotomous”
- Does one have a opinion, within a reasonable degree of psychological certainty (eg p<.4999) that a patient is:
- (demented)(gifted)(competent)



Resources

- Strategies for Private Practitioners Coping with Subpoenas or Compelled Testimony for Client Records or Test Data

Professional Psychology: Research and Practice, 2006, 37, 215-222

- **Disclosure of Neuropsychological Test Data: Official Position of Division 40 (Clinical Neuropsychology) of the American Psychological Association, Association of Postdoctoral Programs in Clinical Neuropsychology, and American Academy of Clinical Neuropsychology**
  - **March 2007 TCN**
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Positive Psychology Application

- Just not knowing that APA Ethical Principles refers to release of raw data, but knowing that Federal and State law may be relevant, and that an order of precedence needs to be understood and followed.
- Knowledge of available resources

Positive Psychology Application

- 1. Identify or scrutinize the problem
- 2. Develop alternatives or hypotheses
- 3. Evaluate or Analyze Options
- 4. Act or Perform
- 5. Look Back or Evaluate

Case 2: Should we be “private detective”?

- An attorney was injured in a MVA with no or mild TBI. Now claims that cognitive deficits rend him unable to practice law. He is referred by his physician for evaluation because the patient has presented disability forms to her. In interview, it becomes unclear as to whether he the attorney still has his law license. Extended questioning results in his saying he had not renewed license, as:

Case #2

- “I’m tired of practicing law; its 50% paperwork and 50% constant arguing”
- When asked if any complaints had been filed against him, the reply is “No more than usual”
- Follow-up questions don’t help
- While he takes the MMPI-2, Google shows…

Case 2

- An attorney by this patient’s (unusual) name is scheduled for disbarment hearings in this state for allegations of embezzling $1.5 million from estate of disabled cousin/client
- What is the ethical thing to do with this information?

Case 2

- Is it ethical for a neuropsychologist to play the role of “private detective”?
- Is it appropriate to “snoop” (e.g. covertly observe patients’ gait from a distance?)
- If above answers are “no”, does that imply one must inform patients that tests of effort/validity will occur and should these be specifically pointed out in advance?

Case 2

- Do the 2002 Ethic Principles comment?
- Stds. 3.10, 9.03 Informed Consent (Assessments) …“explanation of the nature and purpose of the assessment, fees, involvement of third parties”…
- 9.01 Bases for Assessments …opinions are based on “information and techniques sufficient to substantiate their findings”

Case 2

- To what degree does “need to inform” conflict with or supersede “need to substantiate” findings?
- No gold standard; seemingly dependent on particulars of examiner, examinee and particular situation….but…

Case 2

- 11 to 23% of job seekers lie about education
- Malingering, or lack of consistent effort, is not uncommon, particularly among patients seeking compensation (disability, litigation, etc.)
- Warning that tests of effort included did not change the problem

Case 2

- RESOLUTION

  Claimant failed two tests of effort and showed non-credible pattern of performance

  Report pointed out that patient's answers raised questions about whether he still had license to practice law, and asked to amend report if physician or disability carrier later obtained relevant records

Case 2

- Concern that Google "hit" may not be the same individual being evaluated
- Records later sent which confirmed that claimant was scheduled for hearing (and later lost license via Google search some months later); no request for amended report

Case 2

- Clinician must decide to what degree the need to obtain “truth” conflicts or coincides with need to inform and/or maintain a “level playing field”
- Explicit warnings not mandated by APA
- “It is important you always do your best because I’ll be looking at that. Let me know if you ever feel you can’t give your best effort... Any questions?”

Positive Psychology Application

- Recognize the potential benefits and costs of using social media (Facebook stalking), internet search engines, and covert observation to evaluate patients, trainee applicants and research subjects and be prepared to defend errors of omission and commission

Multiple Relationships

When is it permissible to become intimately, financially or socially involved with a:

-patient you evaluated or treated?

-a student you taught or supervised?

-act as an "expert" for a case you clinically treated/evaluated?

Boundaries

- *"Refers to the rules of the professional relationship that set it apart from other relationships. Boundaries set limits, provide structure, and thereby prevent harm to patients. They create an atmosphere of safety that allows a relationship to develop so that the patient can reflect on personal experiences without worrying about the needs of the psychologist"*

Knapp and VandeCreek, 2012

Many Boundaries are Relative

- Some “multiple” relationships are not necessarily harmful, and unavoidable, including the classic example of the psychologist in a small town or rural area that can’t help but interact with patients who are their neighbor/plumber/parent at children’s school, etc.

What is that makes a Dual Relationship Harmful?

- Inherent vulnerability of patient/student/research subject
- Unawareness or indifference on part of psychologist to this power differential
- Blurring or crossing of the lines in how this power differential is exploited, either in reality or perception
- In whose interest is the psychologist acting?

Multiple Relationships

- While some multiple relationships may be judged as “ok”, others never will be under any circumstances
- Everyone knows that a romantic/sexual relationship with a current patient is prohibited, but what about persons who no longer are patients?

Sexual Relationship with Former Patients

- The Minnesota Board of Psychology has disciplined Terry Z, a Golden Valley psychologist, for having a sexual relationship with a former patient.
- The board suspended his license indefinitely, it said in a disciplinary action released Tuesday.
- The board said that Z treated a patient between 2001 and 2004 for individual and couples counseling. Within several months of ending their professional relationship, Z and his client saw each other socially, then they engaged in sexual activity, the board said.
- Z violated state statute and board rules by having a sexual relationship with a patient within two years of terminating a professional one, the board said. It suspended his license for 21 months. To have his license reinstated, Z must undergo a psychological evaluation, agree to treatment if recommended, and take courses in professional protocols. He must also pay a fine of $2,500.

- (as cut and pasted from www.suemypsychologist.com)

Minnesota Statute

- **604.20 DEFINITIONS.**
- **Subdivision 1.General.**
- The definitions in this section apply to sections 604.20 to 604.205.
- **Subd. 2.Emotionally dependent.**
- "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to believe that the patient or former patient is unable to withhold consent to sexual contact by the psychotherapist.
- **Subd. 3.Former patient.**
- "Former patient" means a person who was given psychotherapy within two years prior to sexual contact with the psychotherapist.
- **Subd. 4.Patient.**
- "Patient" means a person who seeks or obtains psychotherapy.
- **Subd. 5.Psychotherapist.**
- "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, member of the clergy, marriage and family therapist, mental health service provider, licensed professional counselor, or other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Minnesota Statute

- **Subd. 6.Psychotherapy.**
- "Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.
- **Subd. 7.Sexual contact.**
- "Sexual contact" means any of the following, whether or not occurring with the consent of a patient or former patient:
- (1) sexual intercourse, cunnilingus, fellatio, anal intercourse or any intrusion, however slight, into the genital or anal openings of the patient's or former patient's body by any part of the psychotherapist's body or by any object used by the psychotherapist for this purpose, or any intrusion, however slight, into the genital or anal openings of the psychotherapist's body by any part of the patient's or former patient's body or by any object used by the patient or former patient for this purpose, if agreed to by the psychotherapist;
- (2) kissing of, or the intentional touching by the psychotherapist of the patient's or former patient's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts;
- (3) kissing of, or the intentional touching by the patient or former patient of the psychotherapist's genital area, groin, inner thigh, buttocks, or breast or of the clothing covering any of these body parts if the psychotherapist agrees to the kissing or intentional touching.
- "Sexual contact" includes requests by the psychotherapist for conduct described in clauses (1) to (3).
- "Sexual contact" does not include conduct described in clause (1) or (2) that is a part of standard medical treatment of a patient.

APA Ethical Principles

- **10.08 Sexual Intimacies with Former Therapy Clients/Patients**
  (a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.
- (b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient ***bear the burden*** of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient

Multiple Relationships

- A 1977 survey showed that 85% of self-reported incidents of therapist-patient sex involved male therapists, and 90% of sexual –misconduct complaints filed with APA involved male therapists (1993)
- This is perhaps helpful to remember those in an “at risk” group, but its also helpful to remember that multiple relationships aren’t limited to sexual/romantic interactions, but can include
- Financial and business interactions
- Gift giving and receiving
- Touching and hugging
- “Psychological voyeurism”
- Giving a condolence card to a bereaved patient (?)
- Becoming involved in a patient’s litigation?

Differences between being a treater and an expert

	Treater	Expert
Purpose	Diagnose and treat ADVOCATE	Assist in decision
Relationship	Helping Role	Obective/neutral
Who is being served	Patient	Decision maker
Response of pt.	More reliable?	Less reliable?
Classification of limits of reasoning	Optional	Very Important
Written Report	Brief	Lengthy
Court Testimony	Not expected	Expected
Scrutinizability	Low	High

At a minimum, in IME exams, make sure the client understands that:

- Confidentiality is limited/not there
- You are there to understand, not to improve/treat them
- You are limited in what feedback you can give directly to examinee

Faculty/Student Relationships

- While many faculty have married current or former students or trainees in the past, more institutions prohibit or warn about this

University of Miami, as reported in NY Times on August 2, 2013

In Mr. McGinn's telling, his relationship with the student, a first-year doctoral candidate who worked as his research assistant during the 2012 spring semester, was an unconventional mentorship gone sour.

It was "a warm, consensual, collaborative relationship," an "intellectual romance" that never became sexual but was full of "bantering," Mr. McGinn said in a telephone interview. The terms of his agreement with the university, he said, prevented him from saying much more. But "banter referring to sexual matters," he added, isn't always "sexual banter."

With apologies to Jeff Foxworthy…

- You might know you're skating on thin ethical ice……
- If you have to say that not all bantering about sex is sexual bantering…..

Vulnerable Populations

- Some or all patients/students/research subjects may be inherently vulnerable to exploitation because of power differential, emotional/psychiatric vulnerabilities, socioeconomic problems, lack of freedom to control one's decisions/whereabouts/activities

Violations of Ethics in Research Settings

- Often has involved prisoners, children, students and the mentally ill
- Tuskegee (syphilis/minority men)
- Cincinnati (radiation/minority women)
- Willowbrook (hepatitis/dev. delay children)
- Oregon/Wash (radiation/prisoners)

Famous Psychology Experiments

- Stanley Milgram – studies on obedience
  - No actual subjects suffered physical harm
  - Strategic use of deception caused significant mental anguish, and withdrawal from research was severely limited
- Philip Zimbardo – prison milieu and roles
  - Significant mental anguish
  - Withdrawal from research was severely limited

Vulnerable Populations

- The most important theme common to these examples of misconduct is that the research subjects lacked power, autonomy or social status. They were often viewed as less-than-human or expendable by those conducting the research.

Positive Psychology Application

- Are you dealing with "vulnerable" populations?
- What is the reality, or the potential perception, of exploitation?

What to do if one suspects a colleague psychologist is acting in an unethical manner?

- *Lack of competence* to practice ("because Trails B is at less than the 1st percentile, and Trails A is at the first percentile, the patient must have dysfunction of the left frontal lobe")
- *Impairment of behavior* (drinking on the job)
- *Inappropriate behavior* (deriding a colleague in a public setting)
- Should one do something or not?

Case #3 Duty to Report?

- Clinical referral complains of memory problems but your testing suggests that patient is depressed. Patient is in therapy, and signs consent so that his psychologist can release therapy notes, previous test results and raw data, and summary
- Psychologist does not respond to written request so call is made
- Psychologist is called, and is very pleasant but explains that he can't release therapy and testing records because they're handwritten and illegible

Case 3

- A request is made for the records anyway but the psychologist says it would be unethical for him to release illegible progress notes
- However, he would be willing to type up records if paid "several thousand dollars"

Case 3

- A search of the state's "confirm license" website shows no psychologist by that name
- A search of Yellow Pages (3 consecutive years) reveals a psychologist by that name
- A call to state to see if website is out-of-date indicates individual had doctorate and applied for psychology licensure but twice failed EPPP and never was licensed (warning: they gave me EPPP scores without my even asking!)

Case 3

- After consulting with colleagues, the psychologist is contacted again and again requested for records, but he still refuses
- When asked about Yellow pages/state discrepancy, he blames the mistake on Yellow Pages and has never claimed to be psychologist
- When confronted about perceived possible need to resolve/report, he says "knock yourself out"
- What should be done at this point?

Case 3

- After further consulting with colleagues, a decision is made to report to state
- A few weeks later, investigator calls to follow-up on report; asks if there is further evidence that psychologist practiced as a psychologist (engaged in activities solely restricted to licensed psychologists)
- As is, Yellow Pages ad is equivalent of “traffic ticket” and not worth pursuing

Case 3

- Investigator states he’ll look into it further and call back later
- A couple weeks pass and investigator does call back but sounds intoxicated, saying to me “Dr. Johnson I’m calling up follow-up on your report that Dr. Smith conducted sexual misconduct”
  (Johnson, Smith are pseudonyms)
- Investigator says case likely to be closed
- What should be done at this point?

Case Example #3

- At suggestion of colleague, state board member contacted to ask for input
- Board member is upset, asks that written summary of events be sent to him
- Now, the investigator is investigated, and head of state section calls to discuss
- RESOLUTION: A year or so goes by, and notification is received that therapist is fined $500
- Would one do it again?

Avoiding the Bystander Phenomenon

- Responses to Perceived Unethical Practices in Clinical Neuropsychology: Ethical and Legal Considerations

- Grote, Lewin, Sweet & van Gorp (2000), The Clinical Neuropsychologist, 14, 119-134

On what grounds might one be sued for reporting another?

- Defamation
- Unjustifiable Litigation
- Tortuous Interference with Existing or Prospective Contractual Relations
- Antitrust Violations

However…

- "Truth" is a defense for each of the previously-mentioned actions, and a psychologist may be prosecuted and/or found in violation of ethical principles for failing to report the known misconduct or incompetence of another psychologist

How to proceed?

Determine…

1. that an ethical principle/law has been violated
2. the significance of the violation
3. the reliability and persuasiveness of the evidence of violation
4. whether personal feelings for the colleague are affecting your perception
5. whether you can act without breaching confidentiality
6. the need to consult with colleagues on how/whether to proceed

How to proceed?

Determine…

7. whether you should contact the colleague informally?
8. which organizations to contact?

Wednesday Tribune's Headline

Agency: Dorothy Brown's husband lacks psychologist license

- On his website, Cook promotes his "Family Wholeness Institute," says he is the holder of a Ph.D. in psychology and lists several areas of expertise, ranging from "Existential Psychotherapy" to hypnosis.
- "He offers a compassionate therapeutic approach that includes recognized and accepted psychotherapies, training for behavioral changes, as well as Existential Psychotherapy ... and hypnosis," the website states. "He is eager to apply his experience and compassion with clients as they begin to address issues that will help them improve their quality of life and attain a sense of fulfillment."
- The civil complaint by state regulators cites Cook's online description. Those claims "constitute the unlicensed practice of a clinical psychologist," which carries a fine of up to $10,000 per violation, the complaint states. The aim is to get Cook to stop representing himself as a clinical psychologist, said Susan Hofer, spokeswoman for the regulatory department

Confidentiality and Privacy (Case 5)

- You see an elderly man for a dementia evaluation and the report is sent to the referring physician. A few weeks later, the daughter (a physician at another hospital) calls to ask that the report be sent to a neurologist at her hospital for review. She points out that doctor to doctor transfer, under HIPPA, does not require written release.
- What do you do?

APA Ethical Principle

- **4.01 Maintaining Confidentiality**
  Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

APA Ethical Principle

- **4.02 Discussing the Limits of Confidentiality**
  (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
- (b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
- (c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

Confidentiality and Privacy

- Mental health records have special status under HIPPA, state law, and hospital bylaws
- Poll of local colleagues reveals that each requires specific written release, even if “mental health” issues are not necessarily implicated or evaluated
- Discrepancy between how we handle requests for release versus how we bill (medical/mental health)?
- RESOLUTION: Patient later sent in written release

Confidentiality and Privacy

- Discuss at outset with patient who will get report and information, and under what circumstances
- May be preferable to get this in writing
- Stick to guns when others telephone in requests
- May be preferable to cut others off on phone and hang up rather than seeing what they have to say and creating situation of misunderstanding or false claims
- Document (it never happened if you didn’t write it down)

Confidentiality and Privacy (Case 6)

- You're asked to evaluate a police officer with a treated brain tumor who wants to RTW
- Neuropsychology testing is all WNL
- About two years later, you get a call from his supervisor wishing to tell you how some problems officer is now having and could you provide some input so they can help him
- What do you do?

Confidentiality

- Resist urge to be "nice"
- Stop and think
- Find excuse to hang up so you can take your time
- What do/would your colleagues think?
- Document anything that seems worthy of documentation (don't trust your memory)
- RESOLUTION: Told supervisor I couldn't confirm if I had seen patient; hung up; wrote note

Confidentiality and Privacy (Case 7)

- A consultant is referred by her firm because she wishes a RTW after being off work for a year because of medical issues and depression. She signs release for report to be sent to firm. Testing shows her to be very bright, but she fails all putative measures of frontal lobe dysfunction. She doesn't want to come in for feedback, so this is done over the phone.

Confidentiality

- She seems to take the feedback gracefully (la belle indifference?) and that seems to be the end of it. However, a few days later I receive a phone call from a man, claiming to be her husband (who is a physician) saying that his wife had laryngitis and can't talk, but they don't want any his wife's IQ scores listed in the report, saying "Its none of their business". He doesn't wait for a response, and all I can mutter is "pardon me?" before he hangs up.
- What do you do at this point?

Confidentiality

- I didn't do anything, other than write a note to a new "administrative" chart
- A week passes, and I receive three Sunday voicemails from irate patient saying she had heard me on speakerphone agreeing not to include IQ scores. Further my report is a "joke", I have no business diagnosing frontal lobe impairments as a non-physician, and "if you're smart you'll change your report. Have a nice day".
- What to do now?

Confidentiality

- Contact legal affairs and chair (private practitioners-good luck!)
- Create a separate administrative chart

RESOLUTION: Patient later rescinded release to firm (report already sent, but can you return calls to tell them she has rescinded?)

Told that she later settled with firm including her promise to not file complaints or further litigate

What to do with data/files? Scary Story Number One

"(private practice) affiliated with (hospital) has learned that, on or around February 10, 2014, an unknown party gained unauthorized access to a practice physician's personal email account, which was discovered that same day. We promptly commenced a detailed investigation of the incident. To date, MOR has not received any reports that the Protected Health Information (PHI) has been accessed or misused. The compromised account contained emails regarding surgical scheduling for 1,256 patients. We have mailed letters to individuals whose information may have been contained in that email account.

The data in the email account may include one or more of the following: name, date of birth, surgical description or code, surgical date and special surgical instructions. The compromised email account did not contain patient financial information, such as Social Security numbers, bank account numbers or credit card numbers"

What to do with data/files Scary Story Number Two

- A doctor was forced to pay a hefty fine for dumping his patients' financial and medical information in the summer of 2010.
- We first covered the story about Dr. XY in mid-June 2010. Now, Dr. XY has paid $40,000 as a fine, according to a statement released by the Attorney General's Office.
- Dr. XY owns and operates a psychological testing and treatment facility
- His office illegally disposed of 1,000 patient files by dumping them at a Recycling Center in June of 2010.
- Officials said the files contained info for 1,600 people with data such as: names, addresses, dates of birth, Social Security numbers, drivers' license numbers, insurance account The records were accidentally discarded in a public recycling bin and thrown out by the doctor's sons during a move from one office to another

What to do with data/files: Scary Stories Three and Four

- A psychologist takes a briefcase and laptop home to work on reports over the weekend; the car is stolen while she stops at the grocery store
- A psychologist tries to catch up on a long airline ride by reviewing records, and happens to sit next to an official of a regulatory agency who sees the psychologist's name and files a complaint with her employer

What to do with patient files/data?

- What information is appropriate to store on laptops, and what is plan if laptop is stolen?
- Are desktop computers any more secure?
- Can you refer to a patient name when sending a page within the hospital, or while texting?
- What information can be shared by email or fax and under what circumstances?
- What information should be included in reports that go into EMRs? What security is offered by "break the glass"?
- How do you dispose of drafts or other PHI?

Is your email encrypted or HIPAA compliant?

- "What exactly do we mean by **individually identifiable health information**? Well, any data you obtain from a patient while you are administering health care service that can be used to identify the patient (e.g. the patient's name, Social Security Number, health plan beneficiary numbers, and a whole lot more) can be considered as individually identifiable health information.
- If you belong to a covered entity and are caught committing unauthorized disclosures of PHI as a result of poor email security, you can be held liable. The fines start at $100 per violation but can climb up to $250,000, depending on the circumstances."
- http://www.sendinc.com/blog/2011/06/how-to-achieve-email-compliance-with-the-hipaa-hitech-acts/

Suggestions: Plan A

- Handwrite your reports like I did in the (very late) 1980s!
- Get rid of all technology invented prior to introduction of the personal computer

Suggestions: Plan B

- Email: Encrypted Only?
- Fax: Is the recipient standing by?
- Laptops: Encrypted and De-identified both for reports and test scoring?
- Desktops: Locked by cable, behind locked door?
- Texting: MRN and room number?

Suggestions: Plan C (part 1)

- **Never use a personal email account when communicating with patients via email, or when communicating *any* patient information. Always use your hospital email account, and only that account.**
- **Email communication that contains patient health information must be encrypted**. You can encrypt email messages by setting the sensitivity of the message to "confidential" or selecting the "Send Encrypted" button on the Microsoft Outlook email menu ribbon.
- **Patient information never should be sent via instant messaging, social networks, text messaging, file transfers, electronic faxing or text paging**.

Suggestions Plan C (part 2)

- Email that is used to communicate with a patient is considered part of the patient record and must be entered in the patient record.
- Never use email, even hospital email, to communicate information about a patient's treatment for or history of HIV/AIDS, sexually transmitted disease, ***alcohol or substance abuse, mental illness***, pregnancy or pregnancy termination or genetic testing results, unless the patient specifically has authorized such communication.
- Email should not be used to communicate with minor patients unless authorized by the patient's parent or guardian

Reminders/Summary

(1) Be aware of the APA Ethical Code as it impacts clinical practice; be aware of recently published literature

(2) Anticipate ethical dilemmas before they occur through use of Positive Psychology and resources and resolve them similarly

(3) What are your Known Knowns and Unknown Unknowns?

(4) Practice all professional activities at the highest level!

THANK YOU!!