

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 419-424

ETHICS CASE

Balancing Practice Policies with Patient Needs

Commentary by Eric Goepfert, MD, and Brian Kroener

Dr. Rekai is a psychiatrist who has been working in a private practice with several other physicians for quite some time. The practice recently went through a difficult legal action in which allegations were made about a psychiatrist's conduct during a house call. The action resulted in an out-of-court settlement, and the practice put a temporary suspension on house calls while the system and processes were reviewed. In the interim, the clinic psychiatrists were advised to see patients in the office or link them to emergency services if an office visit was not possible. All of the practice's clients received notices, and verbal and written consent were obtained to ensure that they understood the temporary change in the policy. Psychiatrists who continued to make house calls would risk suspension from the practice.

One day, the practice receptionist received a phone call from a patient who was frantic and repeatedly asked to speak with Dr. Rekai. Dr. Rekai took the call. It was Rebecca, a usually stable patient, who was having a crisis. Dr. Rekai believed that Rebecca should be seen immediately and suggested that she go to the emergency room (ER) or call an ambulance to take her there, but Rebecca adamantly refused.

Dr. Rekai and the receptionist attempted to reach the managing partner (who had overseen the change in policy), but she was out of the office and unavailable. Dr. Rekai had no patients scheduled for the next few hours and contemplated going to Rebecca's house despite the clinic's prohibition on house calls.

Commentary

Dr. Rekai's available options for a plan of care are intertwined with external arrangements that force her to consider factors outside of the patient-doctor relationship. Without necessarily intending to do so, a clinical practice's policies may oppose the ethical standards of individual clinicians' practice of medicine. These ethical standards may be dictated by oaths or codes central to the training, practice, or licensure of individual practitioners in social work, psychology, or medicine. Thus, in certain situations, employees may be left to choose between professional ethical obligations and their employment. One example, described by Frederic Reamer [1], concerns the administration of a juvenile correctional facility that requested staff social workers to notify the administration when a juvenile resident was found to be an undocumented

immigrant. In this instance, the administration's request clearly contradicted the ethical principle of confidentiality and may have exposed the youth to harm, violating the ethical principal of nonmaleficence.

The policy of Dr. Rekai's medical group does not as clearly contradict professional ethical standards, but it may harm patients. In the wider health care context, evidence supports the safety and effectiveness of home visits for psychiatric care, from community-based care for chronic mental illness to emergency in-home psychiatric consultations [2-4]. It is clearly a very effective way of engaging patients who would not go to a clinic or office visit. For patients with limited mobility or who are economically disadvantaged, home visits may enhance access to psychiatric care. Additionally, home visits may help more ambivalent patients who would not travel to office-based appointments. These patients may end up not receiving care if they cannot access home visits, which are not commonly offered anymore. Abiding by her clinic's temporary policy may cause harm to Dr. Rekai's patient.

So how should Dr. Rekai think about helping her patient while weighing the various ethical, clinical, and practical factors? Making a home visit to the patient may be ethically sound but is in conflict with a utilitarian view of justice toward the other patients served by Dr. Rekai, due to her medical group's policy prohibiting home visits. If Dr. Rekai were to breach her medical group's policy to make the house call and therefore be suspended from practicing, she would not be able to provide necessary care for her other patients. Thus, despite our opposition to the policy, we cannot recommend that she break it.

So what should Dr. Rekai do next?

Treating the Patient While Abiding by the Policy

Assess risk of harm. One of Dr. Rekai's first challenges concerns assessing her patient by telephone for risk of suicide and of harm to others. Although a single systematic and predictive suicidality assessment method has not been endorsed at this time, a form of systematic assessment protocol is now commonplace in most psychiatric practices. Evidence-based risk factors, such as gender, age, psychiatric history, family history, and substance use, have been identified that will assist Dr. Rekai in her assessment of the patient [5]. The clinical state of this patient's crisis may imply suicidality or increasing symptoms without suicidal thoughts. Another area of concern is whether the patient intends to harm another person. Dr. Rekai should use evidence-based risk factors [6] and possibly validated, structured assessment tools such as the HCR-20 [7], Violence Risk Assessment Guide [8], or Classification of Violence Risk [9] to perform a multifactorial risk assessment for violent behavior. However, mitigation of modifiable risk factors for suicide, such as psychiatric syndromes (depression, anxiety, psychosis, and maladaptive personality characteristics), substance use, and coping techniques, are the targets of intervention for Dr. Rekai and her patient now. The most important

intervention is inquiring about the patient's access to lethal means of suicide, or to endangering public safety, and eliminating the means, if necessary.

Try to convince the patient to come into the office. If Dr. Rekai is not reassured by telephone regarding the safety of her patient, but the patient will not agree to come to the office, Dr. Rekai could share with the patient her dilemma of needing to establish that the patient is safe, being unable to do so by phone, and being prohibited from making house calls. She could also explain that an office visit is meant to prevent the necessity of a mandated emergency room evaluation. In this case, the harm caused by coercing the patient to come into the office could prevent greater, imminent harm resulting from either the patient's preventable acts or the trauma of an involuntary emergency evaluation.

Telepsychiatric care. Dr. Rekai could also provide psychiatric care by telephone, possibly which may allow her to respond effectively to Rebecca's needs while maintaining her professional relationship with her medical group and thus with other patients. This issue was discussed in Freudenberg and Yellowlees' prior *Journal of Ethics* case response on telepsychiatry [10], drawing on a 2013 review by Hilty et al [11]. Telepsychiatry has been found to be comparable in effectiveness to in-person psychiatric assessment for clinical evaluation of patients and to be appropriate for a wide range of conditions, including depression, PTSD, substance abuse, autism, and ADHD [10, 11]. Importantly, several studies have demonstrated the diagnostic validity of several psychological assessment scales for remote, audiovisual psychiatric assessments of children, adolescents, and adults [11]. However, it is not apparent from the clinical scenario whether telepsychiatric care can meet the needs of this patient—Dr. Rekai may be concerned, for example, that this patient might not reveal important clinical information via telephone—or whether the patient is able to connect with Dr. Rekai through an audiovisual medium that would convey clear, rich information about symptoms.

We do not consider telepsychiatry encounters to be a replacement for in-person patient neuropsychiatric assessment, wherein multiple modalities of patient assessment are possible. But, given the constraints on Dr. Rekai, as long as proper technological resources and appropriate protocols for in-person follow-up are in place, this may be an appropriate option [1].

Involuntary hospitalization. If the patient is declaring herself, or if Dr. Rekai believes her to be, a danger to her own safety or that of others, Dr. Rekai has a duty (derived from the principle of beneficence) to seek involuntary psychiatric emergency care, although it restricts the patient's autonomy. Even if Dr. Rekai believes it is needed, involuntary hospitalization may cause harm to the patient-doctor relationship. Restricting the patient's freedom in this traumatic way is likely to result in feelings of betrayal and contribute to the patient's considering ending the therapeutic relationship [12, 13]. Dr.

Rekai should not casually employ involuntary hospitalization or consider it an alternative to an office visit if it is not indicated. If this form of treatment isn't urgently required, its harms—generating high costs, compromising the high standard of confidentiality for mental health records [14], interfering directly with the patient's autonomy, discouraging patients from seeking care again [12, 13], and possibly undermining long-term adherence and outcomes [12]—are not worthwhile or justified.

Concluding thoughts. Of course, if Dr. Rekai's assessment is that her patient does not require involuntary psychiatric emergency evaluation for concerns of safety but would benefit from immediate psychiatric care, she must balance beneficence with her patient's right to refuse all or parts of the recommended treatment.

In the case that her patient refuses all plans of care except a home visit, Dr. Rekai is left to weigh the risks and benefits of no care or involuntary care for her patient. Because it would be potentially devastating for Dr. Rekai to lose her practice and for her patient panel to subsequently lose access to her care, however, we cannot recommend that she breach the policy in the interest of this individual patient's needs.

Recommendations for the Practice

Why did the clinic temporarily suspend home visits? Perhaps the clinical administration sought to protect patients from further clinical boundary violations by physicians. If it is to serve the highest number of patients—a utilitarian argument—the clinic must not put its malpractice coverage or sustainability at risk. Assuming that the practice group's policy change was not legally mandated, the policy was most likely developed to mitigate risk. In this case, the ongoing threat of lawsuits against the medical group's clinicians, frivolous or otherwise, has shifted the usual way some patients receive care. Ongoing legal proceedings, judicial mandates, recommendations from legal counsel, and pressure from malpractice insurance providers may each restrict the clinicians' options. This organizational decision seems unduly restrictive and cautious, given the likelihood that certain patients need the home-based care that they receive and may be harmed by the policy.

Furthermore, the idea that patients consented to this policy change may not be entirely defensible. Seeking patients' verbal and even written consent to continue the relationship with the practice after the policy change does not necessarily mean they had much choice, if their refusal to accept the new conditions would mean they would have to find new psychiatrists. Furthermore, even if it was not coerced, no mention is made of patients' capacity to make this decision. Some of the practice's patients may not have this capacity. Capacity requires being able to communicate a choice, to understand information conveyed, to appreciate the significance of this information and its consequences, and to do so rationally. When patients suffer from mental illness, their states of mind and views about treatment can vacillate dramatically. They may not have

much insight or recollection of being depressed or disorganized when they are not experiencing these symptoms, or conversely, they may not remember their past experience of mental stability when they are in the midst of mood symptoms, panic, or psychosis. All of this casts doubt upon the idea that this policy was genuinely consented to by the patients.

The medical group should re-examine the appropriateness of this policy as a response to its recent legal difficulties, in light of the ethical challenge it places on clinicians who are attempting to do the utmost for their patients, especially those who need home-based care. In particular, the medical group should recognize that the avoidance of real or perceived legal and financial risk in providing home visit care to patients may compromise individual patient-doctor relationships and induce physicians to consider less ideal or ethically defensible treatment options. The threat of suspension from practice if the practice's doctors pursue a home visit is unreasonable and unethical as it is applied by the medical group in this case. We consider the position this policy has put Dr. Reikai in to be untenable.

The practice's physicians should ask for reconsideration the policy of forcing clinicians to pursue treatment options that may impact optimum care of patients, a just allocation of resources, and the beneficence and nonmaleficence duties of physicians. Physicians should strongly encourage their administrators to form policies that support physicians' ethical duties and minimize their ethical dilemmas.

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ISSN 2376-6980