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MEDICARE ACTION
and Current Topics in Psychology

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CMS PROPOSES LARGE CUTS TO MEDICARE:

Psychologists Urged to Respond

SAMUEL KNAPP, ED.D., ABPP
RACHAEL BATURIN, MPH, JD
ANN MARIE FRAKES, MPA

The Centers for Medicare and Medicaid Services (CMS) which regulates services to Medicare patients has proposed a series of changes that would greatly impact the practice of psychology. The proposed changes to Medicare are far reaching for many health care professionals, not just psychologists. One of the proposed changes is that the reimbursement to psychologists under Medicare would drop 10.6%. According to information from APA, only an act of Congress can reverse this drop, but now CMS needs to hear from psychologists as to how this proposed cut would impact their practices. It is imperative that psychologists act immediately to advocate for their patients and profession.

Addressing this issue is currently the highest legislative priority for PPA and for APA. PPA has sent letters to CMS and our U.S. representatives. APA's government relations staff is working with other health care provider associations and groups to stop these cuts. However, it is essential that psychologists respond individually with an unprecedentedly strong response to these proposals.

In addition to the cuts in payment, CMS is proposing changes in the procedure codes so that Group Psychotherapy (90853) and Neurobehavioral Status Exam (96121) could be performed through telehealth. However, among other requests, APA is also urging the addition of Psychological and Neuropsychological testing codes (96136-96139), and other testing codes to the telehealth list and is urging CMS to continue to pay for audio services only for psychotherapy codes.

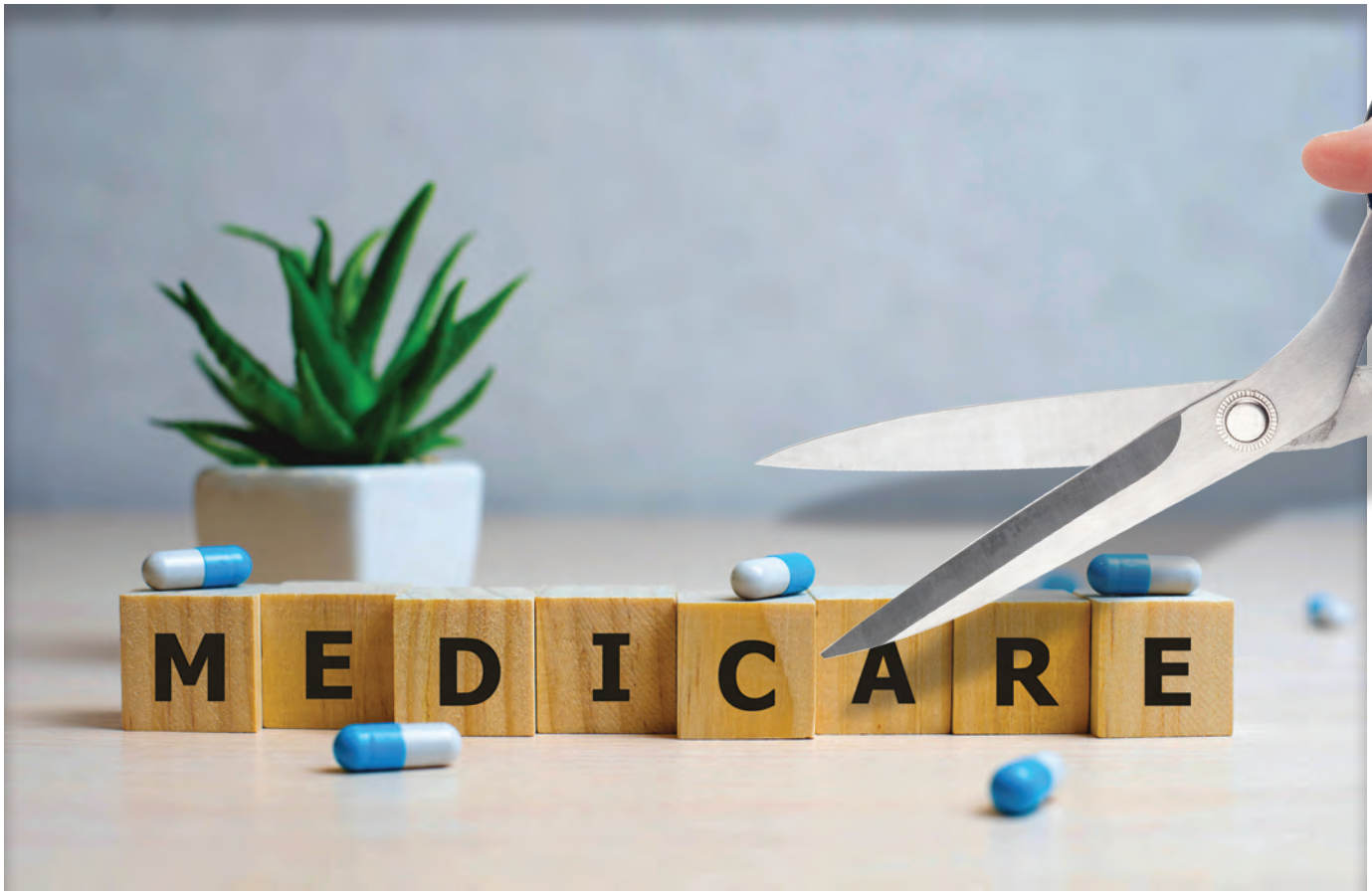
Proposed Decreases in Reimbursements Would Impact Most Psychologists

On the surface this would appear to be a problem only for psychologists who deal with Medicare patients (currently about 18% of the American population is covered by Medicare, while 21% of all Pennsylvanians are Medicare recipients). However, the impact of these rate cuts is more pervasive than it may first appear because commercial insurers often base their reimbursement rates on a percentage of Medicare rates. Therefore, as Medicare drops its rates, commercial insurers will drop their rates as well. The decision of commercial insurers to base their rates on Medicare is not surprising. These insurers deal with 30 or more different health care licensees. Instead of having to create a reimbursement structure for each of these groups; it is far easier for commercial insurers to simply defer the decision to Medicare. In addition, some reimbursement programs, such as Workers Compensation or automobile insurance in Pennsylvania are linked directly to Medicare rates. For example, Workers Compensation fees are based, according to Pennsylvania law, on 110% of Medicare rates. We saw that a few years ago when Medicare raised its rates to psychologists slightly, within a year most commercial carriers had done the same.

With the economic recession continuing, the federal government and commercial insurers are under great pressure to reduce expenses. We must do all we can to stop the cuts or at least minimize them, and to allow older adults to be able to continue to use telephone only services after the pandemic ends.

Respond Now

APA will be sending out several alerts to its members over the next few weeks. All comments must be received by 5 PM October 5, 2020.



Psychologists can use the on-line quick response alert system to respond. Unlike past quick response messages where the letters were pre-written and psychologists only had to edit them, this system requires psychologists to write their own letters. In writing these letters psychologists may:

1. Describe your practice and if you treat older adults;
2. Explain that the proposed cuts will drastically harm the ability of psychologists to provide services to this needy population (21% of Pennsylvanians are on Medicare compared to 18% of the entire U.S. population);
3. Explain that many older adults are under considerable stress caused by COVID-19 and its recommendations for shelter-in-place or the illness or loss of loved ones;
4. Describe the importance of having audio only services reimbursed for older adults;
5. If you do testing, indicate the importance of adding testing codes such Psychological and Neuropsychological Testing Codes (96136-96139), Developmental Testing (96112-86113), and the Adaptive Behavior and Treatment Codes (97151, 07152, 0362T, 97153-97158, and 03737T) to the list of codes approved for telehealth;
6. Urge CMS to allow psychologists to bill for services that they already perform, but do not get reimbursed for, such as smoking cessation (99406 and 99407) and intensive behavioral obesity treatment (G0447 and G0473);
7. Urge CMS to prohibit nurse practitioners and family practitioners from administering psychological or neuropsychological tests without appropriate supervision; and
8. Urge CMS to reimburse psychologists who are currently prescribing medications in accordance with state law.

If you did not receive APA's Practice News Directly, you can access it here https://www.apaservices.org/practice/reimbursement/government/payment-cuts-psychologists-services

More information can be obtained directly from CMS: https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-4.

RESPONDING TO PATIENTS Who Fail to Follow Public Health Precautions

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*

Psychologists will likely encounter some patients who do not follow public safety measures during this pandemic. According to Gallup polls, 14% of Americans commonly do not wear face masks while inside a public setting (Reinhart, 2020), and 31% of Americans only sometimes, rarely, or never practice social distancing (Brennan, 2020).

Unlike China, Canada, Singapore and other nations which were exposed to SARS, MERS, or other infectious diseases in recent years, the United States has not had a similar recent public health crises and no recent memory of the importance of wearing masks, keeping social distancing, or frequent handwashing. Some Americans attribute pandemics to "other countries" whom they perceive to have lower hygienic factors. Furthermore, many people have an optimism bias in which they may acknowledge that others are at risk but will minimize the risk to themselves (Wise et al., in press). For these, and other reasons, compliance with public health measures in the United States was lower than in many other countries.

How should psychologists respond when they encounter patients or other persons who flaunt public safety behaviors and risk endangering themselves and others? This would be a special concern if the patients or someone in the patients' family had co-existing medical conditions that would make the risk of infection especially harmful. Of course, the degree of risk varies across Pennsylvania with some counties showing very low infection rates where the lack of compliance with public health measures would represent far less of a health risk.

Simply giving patients public safety information is unlikely to change behavior, especially because many of them distrust authoritative government sources, or believe that partisans fabricate statistics or exaggerate risks. Direct information exchanges may be counterproductive because they may cause people to defend their positions and thus harden their attitudes.

Nonetheless some lessons learned from past public health crises and other social psychology research may apply to COVID-19 and may help psychologists to formulate more receptive public safety messages. Here are some research-based strategies that psychologists may apply in the COVID-19 pandemic:

- Listen to the patients. According to the theory of *conversational receptiveness*, conversationalists are more likely to want to continue to engage with those whom they view as receptive, even if they disagree (Yeomans et al., 2020). The elements of respectful conversation are well known to professional psychologists and include, among other things, an attempt to convey an understanding of the other person's point of view and avoiding directly telling them that they are wrong.

The failure to follow recommended guidelines does not necessarily mean that the patient is a conspiracy theorist but noncompliance may occur among those who are battling depression and fear more social isolation, or who feel denigrated by those whom they consider to be "elitist." Legitimate concerns can be dealt with directly. The term "social distancing," for example has an unfortunate connation ("physical distancing" is more descriptive) and psychologists and patients can consider ways to maintain social connections despite physical distances.

- Be Transparent. Acknowledge that much is unknown about COVID-19 and information is evolving as more data comes in.

  Transparency increases trust. Adherence to recommendations declines when the public receives contradictory information. During the SARS epidemic in Canada, the reliability of public health authorities declined when the population began to receive contradictory information, and during the early stages of the COVID-19 pandemic many Europeans and Americans saw the warnings as sensationalistic, unduly alarmist, and unreliable (The Royal Society and British Academy, 2020). Establishing credibility during COVID-19 is more problematic because information about what constitutes safe behaviors and the nature of risk has emerged over time.

  The optimal response is for psychologists to identify what they know for certain, what they believe to be true based on the latest available information, what they do not know, and what they consider to be emerging, but unproven theories. When authorities are cited, it is best to cite an authority respected by the target of the message.

- Appeal to the common good. Messages that focus on the public health benefits to others are more readily followed than messages that focus on one's personal safety. A message recipient may be more likely to say, "I have the choice to take this risk myself," but would be less likely to say, "I am willing to risk the safety of others." Messages that align with the recipients' moral values tend to be more effective (Van Bavel, 2020).

  One of the most successful anti-littering campaigns was the slogan "Don't Mess with Texas," which appealed to Texan pride and concern for the common good. Another study on hand washing in hospitals found prompts that focused on the protection of patients increased handwashing more than prompts that focused on one's individual safety (Grant & Hoffman, 2011). This is consistent with findings involving COVID-19 wherein "preliminary results suggest that public health messaging focused on duties and responsibilities toward family, friends and fellow citizens is a promising approach. . . to slow the spread of COVID-19 in the United States" (Everett et al., 2020, p. 1).

- Link prevention to the message recipients' social identity. One might encounter a patient who says, "wearing masks is not for people like me," or who identify themselves as risk takers. If possible, try to identify groups or individuals like them who endorse safe practices (National Academies, 2020).

- Avoid undue attention to socially undesirable behaviors. For example, do not focus on the poor behavior of some citizens who frequent overcrowded bars or restaurants. Instead, the more effective messages normalize desirable behaviors.

  Past studies with alcohol abuse or teenage suicide have found that communications that focus too much on problematic behaviors may exacerbate the problem by making problem drinking seem normative (National Academies, 2020). It is more effective to concentrate on the positive behaviors of others. For example, Cialdini et al. (2006) found that the most effective message to discourage stealing petrified wood from a national forest was to focus on the normative behavior of preserving the environment, rather on the destructive consequences of stealing the wood.

- Similarly, avoid repeating debunked information. Efforts to debunk information may have an opposite effect. Values and relationships are more important than facts in determining how messages are received. When faced with a debunker the message recipients often present counter arguments and, after the argument ends, they may focus more on strengthening their arguments than on reconsidering their positions (National Academies, 2020).

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CAN PSYCHOLOGISTS BECOME FRIENDS with Former Patients?

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*

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When, if ever, is it acceptable for former patients to become friends or business associates with their psychologists? Sexual relationships with patients and former patients are addressed in the Ethics Code. However, the APA Ethics Code never discusses non-sexual relationships with former patients. Instead, the Ethics Code has Standard (3.05) on multiple relationships which states that

> (a) A multiple relationship occurs when a psychologist in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

Psychologists should refrain from entering a multiple relationship if it could reasonably be expected to impair their objectivity, competence, or effectiveness in performing their functions as psychologists. Psychologists must also avoid multiple relationships when the risks of exploitation or harm increase to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment, risk exploitation, or create harm are not unethical. The APA Ethics Code also addresses the issue of how to respond if an unexpected multiple relationship exists.

> (a) If a psychologist finds that, due to unforeseen difficulties, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with regard to the best interests of the affected person and maximal compliance with the Ethics Code.

The APA Ethics Code never directly addresses the issues of former patients as friends or business associates. It is, however, clear that psychologists cannot promise "to enter into a relationship in the future" with the patient or a person closely related to the patient once the professional relationship is terminated. Also, psychologists can enter sexual relationships with former patients only in highly unusual circumstances and after two years have passed since the end of the professional relationship. But, for social or business relationships with former patients, each psychologist must look at the totality of the situation and determine how to proceed.

Consider, for example, this situation:

> A female psychologist attended the party of a friend where, among the many guests, was a woman she treated in psychotherapy in the past. The former patient was witty, gracious, and charming. Several friends went out for a drink after the party and, as they were leaving, one of her friends spontaneously invited the ex-patient to go along as well. Should the psychologist back out of the planned excursion to the bar or would it be okay for her to go along with her friends?

We could even expand on this vignette and ask, "How should the psychologist proceed if she and the former patient got along well and wanted to meet again socially in the future?" Would this be permitted? One could imagine many variations on this theme. A former patient might purchase a house in the neighborhood where the psychologist lives. Does this mean that the psychologist should exempt herself from all neighborhood events? Or a former patient may join the same synagogue or church as a psychologist. Does this mean that the psychologist should change synagogues or churches? Or a former patient may apply

1. The authors thank Dr. Brett Schur for his review of this manuscript.

for a job at the same agency where the psychologist works. Should the psychologist undercut that application, even if the former patient is the one most qualified for the position?

These were once referred to as "small town" dilemmas, because psychologists in smaller towns were more likely to encounter patients or former patients outside of work. However, similar dilemmas have occurred in large metropolitan areas, especially in small communities. For example, we know a psychologist who is a Buddhist working in a large metropolitan area. Many Buddhists seeking a psychotherapist seek him out. However, that means that when he attends Buddhist-related events in his city, the chances of encountering patients or former patients increases.

The APA Ethics Code does not address these situations directly. The proposed relationships have no sexual component to them; and Standard 3.05 would not apply because the psychologists and patients did not discuss or promise future relationships while the patients were in psychotherapy. Although the Ethics Code addresses most situations encountered by psychologists, it cannot address all potential situations and, in potential conflicts not covered by the Ethics Code, psychologists must rely on overarching ethical principles to guide their decision making. Here we would ask whether the visit to the bar and the anticipated social interaction would risk harm to the former patient and violate the overarching ethical principle of nonmaleficence (one should refrain from harming others). From another perspective, would this post-therapy relationship violate the overarching ethical principle of general beneficence where psychologists have obligations to non-patients. A third ethical principle to consider is fidelity to the prior treatment relationship.

In deciding if a patient might be harmed or there is a risk of exploitation, psychologists may wish to consider the amount of time that has passed since psychotherapy ended. Was it one year, five years, ten years, or some other length of time? Also, psychologists may wish to consider the duration and nature of the psychotherapy. Some professional relationships are intense both in terms of their emotional content, complexity, length, and frequency of meetings; other professional relationships are far less so. Seeing a patient for 10 weeks may create a much different emotional relationship than working with a patient weekly for three years. Psychologists may also wish to consider the circumstances of the termination, the former patient's personal history and mental state, and the likelihood of an adverse impact on the former patient.[2] The details and dynamics of the prior therapeutic relationship history needs to be considered when determining if a current relationship would risk harming or exploiting the former patient.

But there are also the possibilities of more subtle harms, such as the harm that could occur if the former patient felt snubbed if the psychologist avoided any contact with her at the party. Or one could imagine the ill feelings that could occur if a psychologist refused to let her children attend the birthday party of a child of a former patient when the children happened to be in the same class in school.

Next, psychologists must consider the overarching ethical principle of general beneficence, or the obligations that psychologists have to the public in general. Here psychologists must consider any possible impact that a social relationship with a former patient will have on others. For example, would the former patient talk about how she is friends with her former psychotherapist, thus leading others to assume that social relationships with psychotherapists are normative or commonly acceptable? Or would some current patients of the psychologist learn about the relationship and feel empowered or emboldened to challenge psychotherapeutic boundaries?

Psychologist may also want to consider the principle of fidelity to the patient in context of the prior treatment relationship. Starting a social relationship with a former patient would mean that this former patient should never be a patient in the future. Furthermore, one must consider how the social relationship would impact patients if they sought psychotherapy in the future. Will the fact that the patient had a social relationship with her past psychologist influence how she perceives boundaries with her future psychologist?

Psychologists need to reflect on their personal motivations to start friendships with former patients. For example, is the psychologist lonely and unable to form attachments with others in the community? Is the psychologist aware of the prior power imbalance in the relationship, and how that may influence the friendship?

Psychologists should also consider the possibility that the friendship with the past patient will turn out badly. Because the therapeutic relationship was brief and uncomplicated does not necessarily mean the social relationship would be the same. How would psychologists end or distance from the former patient/friend should they want to? Would the former patient lose both a current friend and former therapist should that occur?

No algorithm can definitively determine the propriety of post-termination relationships. I (SJK) have known of some psychologists who have developed rewarding relationships with past patients. Nonetheless, non-sexual relationships with former patients need to be considered carefully with attention to the things that might go wrong. When in doubt psychologists should err on the side of refraining from accepting the relationship. When the social encounter is unavoidable, such as when the former patient purchased a house in the same neighborhood as the psychologist, it would be indicated for the psychologist to speak to the former patient privately to ascertain their comfort level with their new social interactions.

2. Astute psychologists will note that the factors listed above to evaluate the wisdom of a non-sexual relationship with a former patient are the same ones used to evaluate the wisdom of a sexual relationship with a former patient (Standard 10.08 (b)).

ETHICAL DECISION-MAKING with SUICIDAL PATIENTS: Balancing Beneficence with Respect for Patient Autonomy

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*

BRETT SCHUR, PH.D.; *PPA Board of Directors*

Working with suicidal patients is often stressful and having a patient die by suicide may be the single most stressful event of a psychologist's career. It is a more common experience than many psychologists recognize. Suicide is the 10th leading cause of death in the United States. In 2019, about 87% of the members of the Pennsylvania Psychological Association had treated a suicidal patient, 58% had a patient with a suicidal plan, 24% had a patient attempt suicide, and 3% had a patient die from suicide (Leitzel & Knapp, 2020).

Most patients with suicidal thoughts buy into treatment, strive to be cooperative, and are receptive to the helpful services offered to them. But not always. Sometimes patients may reject the recommendations of their psychologists even if it means that their safety or lives are jeopardized. In these situations, psychologists must balance competing ethical principles to reach the optimal treatment decision. For example, a psychologist may need to decide whether to hospitalize patients against their will, or whether to disclose a patient's suicide thoughts to a loved one in order to protect the patient, even if the patient does not want that information shared. This article offers guidance for psychologists who must decide how to respond in these difficult situations.

Ethical Issues in Treating Suicidal Patients

Every clinical decision has an ethical dimension to it and a psychologist should hold an ethical theory as a framework for clinical decision-making. When a psychologist is in a stressful situation, such as working with a suicidal patient, following an ethical theory may be seen as an additional burden at that moment, more to think about when there is already too much to hold in mind. Often, this describes a psychologist who views ethics as a set of rules directing what to do or what not to do. In contrast, the psychologist who operates from a system of principle-based ethics is more likely to utilize their ethical system as a foundation for clinical decision-making. This psychologist views an ethical system as a guide that reduces stress and helps make the path to clinical decision-making clear (Knapp, Gottlieb & Handelsman, 2015).

The concept of principle-based ethics was first described by W. D. Ross who identified numerous principles that might form a basis for ethical decision-making, such as self-improvement, gratitude, fidelity, or beneficence, although he gave his list "without claiming completeness or finality for it" (1930/1988, p. 269). Later Beauchamp and Childress (2019) applied principle-based ethics to health care. They identified the moral principles that appeared most relevant to health care: beneficence (working to promote the well-being of patients), nonmaleficence (avoiding harming patients), justice, respect for patient autonomous decision-making, and fidelity or veracity in professional relationships. Knapp and VandeCreek (2004) added a sixth principle, general or public beneficence (or obligations to the public in general).

We can identify ways in which each of these ethical principles may be applied to guide decision-making when working with a patient who is actively contemplating suicide.

- Beneficence: the psychologist actively works with the patient, not only to keep the patient from dying, but to make the patient's life better (for example by improving pain management), so that suicide ceases to be such an attractive option.
- Nonmaleficence: the psychologist avoids making rash decisions which might harm a patient, for example by avoiding an unnecessary involuntary hospitalization.
- Justice: the psychologist treats a suicidal patient from a lower socioeconomic background with the same care which would be shown to a patient from a more advantaged background.
- Respect for patient autonomous

decision-making: when considering removal of access to weapons, the psychologist works together with the patient to make treatment decisions, such as those concerning the disposition of weapons.

- Fidelity: the psychologist honors the promises and agreements made with the patient and avoids making promises which cannot be kept. For example, the psychologist does not promise to "never hospitalize the patient." Rather, the psychologist may agree to work with the patient to make decisions together about hospitalization. Even if an involuntary hospitalization is indicated, the psychologist keeps the patient informed about decisions being made and the reasons for them, as much as possible, and works with the patient to arrange hospitalization in a way that will be more rather than less acceptable to the patient.

- General beneficence: the psychologist bears in mind that decisions about clinical management with a patient who is actively contemplating suicide affect other people around the patient. For example, the psychologist recognizes that hospitalizing a patient may affect the family's child-care arrangements or income. On the other hand, not hospitalizing a patient may increase the family's burden of caring for the patient.

In many cases, all six ethical principles will point to the same decision, for example regarding hospitalization. We could say that a good clinical decision will be congruent with each of the principles. However, sometimes the various ethical principles point to differing solutions. For example, the principles of beneficence and patient autonomy may conflict when addressing a question of patient access to firearms. The psychologist may not be able to implement a wise clinical decision without violating at least one of the ethical principles. Principle-based ethics provides a decision-making format to guide psychologists in those situations.

Beauchamp and Childress (2019) proposed several steps that health care professionals should follow when two or more ethical principles appear to collide, and they are considering if one overarching ethical principle should temporarily trump another. The most salient steps are to determine that (a) "good reasons can be offered to act on the overriding norm rather than on the infringed norm" (p. 23); (b) "the infringement has a realistic change of achievement" (p. 23); (c) "no morally preferable alternative actions are available" (p. 23); and (d) the preferred action must involve "the lowest level of infringement, commensurate with achieving the primary goal of the action" and "any negative effects of the infringement have been minimized" (p. 23).

Managing Suicide Risk: A Case Example

One of us (Schur) recalls receiving a phone call from an established patient1 on a Sunday morning. The patient said that he had been up much of the night thinking about killing himself. He was a generally well-functioning man and suicide had not been an issue in treatment prior to that point. However, he had developed a disk herniation. He was in excruciating pain that was not yet well-controlled. He was thinking about how worthless a life of permanent disability would be. He had a history of suicidal ideation many years ago (before this clinician knew him), but that had resolved easily. The patient said that he was already feeling a bit better, but he thought he should call anyway. I listened to him describe his pain and his fears that his pain would never be better, that he would be unable to work again, and that important relationships would lose their meaning. I expressed concern for his well-being. I offered my hope that his condition was new and still evolving and that there was substantial reason to think his herniation would improve. I suggested that it might be a good idea to have a friend hold his firearms for a while. He said that he would think about it, but he was feeling better and didn't want to give up his guns. We scheduled an appointment for the next day. At that appointment he said that the phone call had been helpful, he wanted to live, he had no more thoughts of suicide, and he didn't think it would be necessary to ask someone to hold his guns. Much later, he said that letting him make a decision about his guns had allowed him to trust me, to continue to tell me what he was thinking and feeling, and was the single most important factor in helping him through the crisis.

In contemplating this crisis, I first viewed the ethical principles of beneficence, nonmaleficence, fidelity, and patient autonomy as being at odds with one another. As I listened to the patient, I came to view all the ethical principles as being congruent. I recognized that the decision I was making entailed risk, but that forcing the issue of removing the guns also brought substantial risk. I listened carefully and accepted that the intense period of suicidal ideation appeared to have been transient, that his connection with me was strong, and that he was himself considering the risk and not dismissing it outright. I also considered whether "the infringement [of patient autonomy] has a realistic change of achievement" (Beauchamp & Childress, p. 23). I decided that, given all these factors, the harm of forcing the issue of relinquishing his firearms outweighed the potential harm of letting him make his own decision.

A psychologist working with a suicidal patient may believe that good care requires letting a family member know about a crisis. The psychologist may contemplate calling a patient's parents against the patient's wishes, believing that beneficence trumps autonomy. However, when the psychologist engages in active problem-solving with the patient, the two may arrive at a better solution, one that enhances the patient's safety while respecting the patient's decision-making. The psychologist may suggest to the patient that additional support would help, that there are people who truly care, and that the patient can ask for help without becoming a burden. The patient may fear that parents will feel

1. The patient has given permission for his story to be used for educational purposes.

burdened or will mock and humiliate her. The psychologist can ask the patient which friend or family member would be most understanding and helpful, and work with the patient to plan the least threatening or humiliating way of approaching that individual. This approach may take longer but is likely to provide the most benefit to the patient, be less intrusive to the family, and to preserve the therapist-patient relationship. It may be possible to find a solution in which all the ethical principles are congruent.

An ethical dilemma results when the psychologist cannot find a solution which upholds all the ethical principles. For example, if inpatient hospitalization is truly necessary and the patient is unwilling or unable to consent (for example if the patient is in a psychotic episode), the psychologist will be left to weigh the dominance of one ethical principle over another. The best clinical decisions generally result when the psychologist follows the criteria established by Beauchamp and Childress. The psychologist exhausts efforts to find a better solution before allowing one principle to trump another, evaluates the probability that the plan will succeed, and works to minimize harm to the overridden principle or principles. An example of minimizing harm to the offended principle is using the least intrusive intervention that is likely to preserve patient safety.

As it applies to an involuntary psychiatric hospitalization, psychologists must be certain that the benefits of the hospitalization outweigh the harms. Although such hospitalizations are clearly indicated for a small minority of patients, psychologists need to consider the potential downside of such hospitalizations, such as the harm that usually comes to the psychologist/patient relationship or that the stigma of the hospitalization will create additional problems for patients in the long term.

Also, psychologists must be certain that the statutory criteria have been met (in Pennsylvania involuntary hospitalization for suicide requires an overt suicide attempt or an action in furtherance of a threat, such as threatening suicide and then purchasing a gun). Psychologists must also exhaust other less intrusive ways to diffuse the danger which could mean, among other things, considering whether the patient would go to a hospital voluntarily or whether the patient could be safe with intensive outpatient treatment. Finally, if a decision was made to involuntarily hospitalize a patient, it would be indicated, if possible, to give patients a choice of the hospital to go to and to ensure that the reasons for the hospitalization were explained thorough to the patient.

Ethical Principles Serve as a Guide

Wise clinicians view ethical principles as a guide in stressful situations, rather than a burden. Clinicians who have long established the practice of holding ethical principles in mind as a basis for clinical decision-making, have a methodology that keeps balances relevant interests and promotes the well-being of patients and society.

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ZOMBIE IDEAS in Professional Ethics

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*
JOHN GAVAZZI, PSY.D., ABPP; *Independent Practice, Camp Hill, PA*

Zombie ideas are those that have been discredited, but still stay alive, albeit in some fearful or distorted form (Barrett, 2019). Psychology has had its share of zombie ideas, such as the idea that the brain is a kind of video camera that stores all the information accurately – if only we could find the key to retrieve it, or that ectomorphs are emotionally sensitive and moody.

Ethics has its own zombie ideas. Ethicist Bruce Weinstein (2020) has identified several of them and we added a couple more that are pertinent to the practice of psychology. Zombie ethics remain alive because individuals misunderstand essential concepts. Weinstein's list included (1) there are never any right or wrong answers in ethics; (2) what is ethical always varies according to one's culture; and (3) what is legal is always the same as what is ethical. We could add two more which are (4) punishment is always the best way to ensure or promote ethical behavior and (5) that self-care is antithetical or unrelated to ethical behavior. Our goal is to highlight some of the underlying issues with these zombie ideas, so psychologists can help kill them off.

Zombie Idea 1: There Are Never Any Right or Wrong Answers in Ethics

Another variation of this zombie idea is that all answers to an ethical question are equally valid. When we teach ethics, either in a doctoral program or through continuing education, we typically present difficult questions that require the participants to balance two or more competing ethical principles. For example, a psychologist may find it necessary to facilitate an involuntary psychiatric hospitalization to save the life of a patient (thus promoting the overarching ethical principle of beneficence), although doing so means violating the overarching ethical principle of respect for patient autonomy. This type of exercise also helps participants appreciate the complexity of the practice of psychology.

Just because there are difficult and complex cases for advanced learners to analyze does not mean that there are never any clear-cut answers to some ethical questions or that all answers are equally good. Murder, theft, sexual exploitation, or lying for personal advantage are wrong. It is always inappropriate for psychologists to use a psychotherapy relationship for their own personal gain at the expense of the patient's well-being. For example, inquiring about a potential merger from a patient who is a manager of a publicly traded company would always be inappropriate if the psychologist planned to make money from that confidential information. We believe participants know these norms already. Just because we do not spend a lot of time in continuing education programs exhorting participants to refrain from murder, theft, exploitative multiple relationships, and other obvious offenses does not mean that these are ethical behaviors.

Even in the ethically ambiguous situations that are presented in classes or continuing education programs, some decisions are clearly better than others. In the example above concerning the decision on whether to seek the involuntary hospitalization of a patient, it would be possible for a psychologist to practice poorly by doing a perfunctory job in determining what is in the best interest of the patient, failing to consider less intrusive

ways to ensure the safety of the patient, failing to treat the patient respectfully, or failing to attempt to motivate the patient to seek hospitalization voluntarily. Complex problems may sometimes have more than one reasonable solution, but they can also have many poor solutions as well.

Zombie Idea 2: All Ethics is Relative to One's Culture

Culture is very important, and it is a mistake for us to assume that everything that we do in our Western culture is normative and proper for everyone. If we fail to appreciate the richness and alternative beliefs of a patient from a different culture, then we may become like the stereotype 19th century Western explorers into Micronesia and Africa who appeared to assume that the essence of civilized behavior was to wear trousers (for men) and drink tea at 4 PM. If we are not self-reflective in our professional role, we risk cultural imperialism and misguided arrogance in believing in the superiority or normative value of our own culture.

But we should also avoid the other extreme which is to assume that we have no right to criticize the behavior in another culture. Child abuse, slavery, murder, and theft are immoral regardless of the culture. Some values are universal. Cross cultural research showed numerous common values concerning the virtues of fairness, honesty, tradition, and concern for others (Schwartz, 2012). Every major religion has some version of the Golden Rule.

For example, many years ago, I (SJK) worked with Pennsylvania coal miner families with strong ethnic identities. Sometimes the families would have harsh parenting practices that would cross into child abuse. A parent reported for child abuse may react with anger and say, "Hey, I am Polish [or German, or Czech or whatever] and we beat our kids!" It took tact to connect with the families, to identify common parenting goals, and to avoid coming across as elitist or condescending. Although parents have wide latitude in how they may raise their children, abusive or harmful parenting practices must always be addressed, regardless of the purported normality of such practices.

Zombie Idea 3: What is Ethical is Legal

For the most part, the requirements of the law are consistent with good ethics. But the law only establishes a bare minimum requirement, which can be problematic if that is the sole focus of the psychologist. For example, the law (through regulations of the State Board of Psychology) requires psychologists to be minimally competent in the work that they do. Or the APA Ethics Code specifies minimal requirements of what the informed consent process should involve. But is it really ethical to do the bare minimum? Ideally ethics would require us to strive to do our best to fulfill our obligations to patients and others. A more positive view of ethics impels us to work hard, consider the welfare of others, and to empower patients to make the most informed decisions that they can. Psychologists can do a lot of shoddy work that is entirely legal.

It can be reassuring to go to a psychologist who follows the laws, who would never engage in insurance fraud, or does not try to seduce patients. But wouldn't you prefer to work with a psychologist who is also up to date on the professional literature, obtains periodic consultation, expresses genuine concern about patients, and monitors patient progress carefully?

Zombie Idea 4: Fear and Punishment Are the Best Motivators for Ethical Behavior

We are not opposed to punishment under all circumstances, but it has its limits and it is often contraindicated. Several years ago, SJK worked for a national company delivering continuing education programs in ethics to licensed mental health professionals. Most of the participants attended because their licensing board required them to attend and very few would have attended otherwise. I learned that most of the participants had ethics classes in their training programs that emphasized punishment or humiliation. In their past ethics education, rules were taught in rote fashion without adequate appreciation for the underlying moral principles that they were supposed to represent. The consequences of misconduct were drilled into the learners. Given this background, most of them, understandably, approached an ethics course with fear or resentment. Many were quite surprised when they saw that ethics education can have a positive emphasis, avoid shaming participants, and can encourage participants to consider how they could incorporate their highest personal values into their professional work.

The goal is to have participants want to learn about ethics and to want to discuss their ethical concerns transparently with their peers. Fear and shame discourage sharing and risks forcing ethical decisions underground—where they are seldom discussed openly.

It can also be helpful to think about ethics education from the standpoint of self-determination theory which emphasizes the importance of the intrinsic motivators of behavior: autonomy, competence, and belonging (Ryan & Deci, 2008). The best ethics education takes advantage of these intrinsic motivators. Good ethics training gives learners a sense of competence that they understand how to address the ethical issues in their practices. Learners have a sense of autonomy in that they know they have the final decision on how to implement their ethical ideals. Finally, good ethics education helps create a sense of belonging by offering a methodology that helps improve relationships with patients and creates a sense of bonding with other psychologists who similarly struggle with the same or similar ethical issues.

Zombie Idea 5: Self-Care Has Nothing to Do with Ethics

Self-care has a significant role in ethical behavior. The major ethical theories all have a role for appropriate self-interest. We cannot take care of others if we do not take care of ourselves. Who wants to see a health care professional who is exhausted from trying to do everything for everybody?

Legitimate self-care means acknowledging feelings including all feelings that are generated by our work. It means taking breaks when appropriate, setting limits and learning to say no, and setting expectations that others will treat you fairly. Ironically, some of the worst

mistakes that psychologists have made occurred because of runaway compassion, or unethical altruism (actions based on spontaneous feelings of concern, without considering the long-term consequences). We agree that the ethical and moral underpinnings of psychological practice include altruism and beneficence. Simultaneously, difficulties can occur when spontaneous feelings of compassion override good clinical judgment. Therefore, empathy needs to be practiced wisely, with discretion, and in context of professional obligations.

Combating Zombie Ideas

Extensive scientific research has shown that the only way to kill a zombie is to chop its head off or seriously injure the brain (especially the brain stem area—harming the cortex does little to stop a zombie; Sheriff Rick Grimes, personal communication). Similarly, we must take a blunt instrument to the zombie ideas afflicting professional ethics through a greater understanding of what ethics really means. We can combat these zombie ideas by

- Striving to anchor our decisions on overarching ethical principles
- Appreciating the complexity of the clinical and ethical issues that we face
- Balancing firmness of belief in our values with humility in our ability to implement them
- Being self-reflective, and
- Taking care of ourselves and thinking through altruistic behaviors carefully.

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INFODEMICS:
A Pandemic Parallel to COVID-19

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*

Consider this headline.

Fantastic News! Hydroxychloroquine Helps Save Coronavirus Patients!

This headline in a major news outlet touted the benefits of hydroxychloroquine. But did the study conclude what the headline promised? Did this headline misrepresent the study or mislead the public?

The Covid-19 pandemic is accompanied by an epidemic of misleading health care information, called an *infodemic*. This has sometimes been called "fake news," although that is a general term for many different styles of disseminating false or misleading information.

Wardle (2019) identified different types of "fake news," including *misinformation* (inaccurate news spread innocently), and *disinformation* (inaccurate news designed to cause harm). The news could include fabricated content (the information is simply false), imposters news (falsely attributing information to otherwise reliable sources), false context (some accurate information that is presented within misleading or false context), or false connection (headlines, captions or visuals that do not support the content of the article). The most effective disinformation contains an element of truth to it.

The above headline would be considered an example of false context in that there was some accurate information, but the context was misleading. Arshad et al. (2020) did find that patients hospitalized with COVID-19 had a decreased rate of mortality following the administration of hydroxychloroquine. However, the headline omitted the fact that the patients also received azithromycin, a drug known to be effective in helping COVD-19 patients. Furthermore, other studies have failed to find treatment benefits for hydroxychloroquine.

Unfortunately, because of the misleading headline readers may develop a belief in a drug that is not effective or eschew important health procedures such as physical distancing or wearing masks. Lives can be lost because of this misleading information.

Although this heading occurred in a popular news site, much information comes from less reputable sources and can get disseminated widely through forwarding on social media. These fabricated or misleading news stories can become dispersed quickly through social media because of the volume, velocity, and variety of messages. Even when platforms attempt to control disinformation, they must deal with a large volume of information that is easily and quickly generated. In addition, misinformation or disinformation can come in many different forms which make it hard for algorithms to identify it.

Foreign actors including authoritarian governments invest considerable resources into disinformation which does not have the goal of persuading the recipients but has the goal of creating confusion or distrust of civil authority within democratic societies. Previously these authoritarian governments had used the internet to perpetuate cybercrime or espionage, but now their methods have expanded. Russia has targeted the United States with is disinformation campaign and has also launched similar campaigns against other European countries (Bradshaw & Howard, 2018). But disinformation is not limited to foreign actors. Both domestic and foreign based actors use bots to expand their influence (Zhang & Ghorbani, 2020). Often it involves *astroturfing* or creating illusion that the information represents a grassroots movement.

Disinformation has the immediate goal of attracting attention and generating emotions. It is often characterized by an extensive use of sensation words, such as "breaking" or "explosive." Quotations may be misused, and references are made to vague sources, such as, "It has been reported," "Experts have stated" or similar vague attributions. Notice that the headline at the beginning of this article used the term "fantastic." When articles want to convey false information they may include no references or references to links on the internal website of the author which only reiterate what was in the original story and include no independent verification of the accuracy of the information (Vereshchaka et al., 2020). Pictures or visuals are selected to evoke emotional responses, even if they have little connection to the actual content.

Misinformation is more likely to find followers when there is mistrust of authority and personal fear and uncertainty. Certainly, our times make it rife for misinformation.

What can be done to reduce misinformation or minimize its impact?

- Platforms can invest the time and resources to identify misinformation. It is not an easy task given the velocity, variety, and volume of misinformation and algorithms may not pick up all the misinformation, given its wide variety.
- Science writers must ensure that their information is accurate, understandable to the average reader, and gives information in the context of other scientific findings. The article at the beginning of this article failed because it did not give context to the study. Good science articles should also include independent comments on the study and its limitations.
- Members of the public can be better consumers of news and look at it with a certain amount of skepticism, especially if it does not have an authoritative source, give limitations to the information, or include credible references.

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SHOULD I GIVE UP MY PHYSICAL OFFICE?

SAMUEL KNAPP, ED.D., ABPP; *Director of Professional Affairs*

With many psychologists firmly embedded into telehealth and as the COVID-19 pandemic continues without consistent abatement in sight, some psychologists are considering giving up their physical offices and treating patients entirely through telehealth from their homes. Other psychologists are considering moving their offices into their homes for limited face to face services, while still conducting most of their services through telehealth. We might call this a hybrid practice. Finally, some psychologists may see relinquishing a physical office as a short-term solution until the pandemic ends; others foresee themselves conducting an entirely (or nearly entirely) telehealth practice for the foreseeable future.

Giving up a physical office has some obvious big advantages to it. Psychologists would not have to pay rent, spend time traveling to work, and may have the option of writing off the use of a home office as a tax deduction. In addition, while a risk of COVID-19 infection exists, psychologists will not have to worry about screening patients for face to face services, disinfecting offices, and so on.

But closing a physical office raises several questions that need to be considered thoroughly. Can a psychologist test or formally assess clients adequately through telehealth alone? Will some patients still need face to face psychotherapy, at least some of the time? Will a telehealth therapy alone practice alter the satisfaction that psychologists feel with their work? What legal or insurance issues should psychologists consider?

Testing and Assessments

Some portions of assessments, such as the initial interviewing or the debriefing of patients, can be easily done through telehealth. But the administration of standardized assessments through telehealth require adjustments and, for some clients, may not be entirely appropriate. Also, psychologists would need to ensure that they have sufficient space at home to store their testing materials. Consequently, psychologists considering giving up their physical offices should ask themselves if they are willing to adjust their assessment activities accordingly or to forgo them entirely.

A hybrid model may be appropriate for some forensic practices wherein psychologists do much of the work through telehealth but create a home office suitable for face to face encounters when needed. But such arrangements could be contraindicated for some psychologists. For example, psychologists who evaluate forensic patients may have good reasons to keep clients away from their homes.

The Need for a Face-to-Face Back-Up Location

If it is necessary to meet with some patients face-to-face, psychologists may wish to either convert their home office into a space where they can see patients face to face or to have an office or a physical location that they could use on short notice or "as-needed." Even now, several well respected psychologists have told me of situations where patients ordinarily seen through telehealth have requested face to face meetings to talk about particularly sensitive issues or where face to face meetings were indicated to help diffuse a crisis that involved the participation of several family members. Another psychologist, who specializes in treating patients who misuse substances, says that he often can get a more accurate picture of the functioning of his patients when he sees them face to face for an hour- as opposed to seeing them only on a screen or talking to them over the phone. If a psychologist is committed to a complete or near complete telehealth therapy practice, then it might not be worth the effort to create a face-to-face home therapy office for only a few patients. Therefore, it may be necessary to arrange with some out-of-home entity to use their physical offices as needed.

Quality of Work

Psychologists need to ask themselves if they can have a home office and maintain a high quality of work life and an appropriate work/life balance. Some psychologists love conducting telehealth therapy all day, but others find it far less fulfilling than face-to-face psychotherapy. In addition, one of the major benefits of being a psychologist is the collegiality that people feel with others in the field. Not only do professional contacts make work less stressful and more enjoyable, they improve one's quality of work because of the opportunities for consultation and the exchange of helpful professional ideas and tips. Psychologists who work in group practices or practices that share individual space have had easier access to these kinds of professional contacts. Such contacts are much less likely to occur through a telehealth only practice. Also, psychologists need to ask themselves if they would tend to over work simply because their workstation is so close and convenient.

Practical Considerations

Psychologists should also remember that they need to give a physical address for most insurance panels. This makes it easier for patients to find their home addresses. Although given the proliferation of search capabilities on the internet, no psychologists should think that they can always shield their home addresses from patients anyways. Finally, some neighborhoods have restrictions against home offices, although here the primary concern would be a home office where patients are seen for face to face services.

Short-Term Accommodations or Long-Term Plans

Furthermore, consideration needs to be given as to whether giving up a physical office would be a short-term accommodation (while the COVID-19 pandemic continues) or a long-term plan. It is one thing to make short-term accommodations to telehealth in an emergency while everyone is "doing the best they can" given the circumstances. It is another thing to make telehealth therapy a long-term preferred mode of intervention.

Long term plans to abandon a physical office need to be thought through carefully. For example, we do not know what the status of telehealth will be after the pandemic ends. Will CMS alter its rules so that Medicare patients can permanently receive psychotherapy through telehealth? If so, will HHS continue to allow telephone therapy services for Medicare patients? Will insurance companies attempt to reduce payments for telehealth services under the assumption that they should pay less because the office overhead for the health care provider will be less? We simply do not know the answer to these questions.

Also, psychologists who decide to devote themselves entirely to telehealth therapy should ask themselves if they are willing to forego the treatment of some disorders or presenting problems that are not easily amenable to telehealth treatment. This may mean changing the nature of the clientele that they are willing to treat. It is prudent to guard against the assumption that telehealth therapy is equivalent to face to face psychotherapy for all patients or all conditions. Certainly, for many conditions and many patients the outcomes of telehealth therapy and face to face psychotherapy appear equivalent. But the delivery of other services by telehealth, such as biofeedback or hypnosis, for example, have not been extensively studied. Also, some patients may benefit more from a face to face encounter. One should resist the temptation to dismiss the concerns of patients who want face to face psychotherapy as only referring to older adults who have less comfort or familiarity with technology. One respected psychologist told me that the patients who have asked for face to face services the most are adolescents.

Abandoning a full-time physical office, at least in the short-term, could make sense for some psychologists. But the long-term transition to a telehealth only or a hybrid practice requires careful consideration.

CLASSIFIED

CE QUESTIONS FOR THIS ISSUE

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Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Can Psychologists Become Friends with Former Patients?

1. A multiple relationship exists when a psychologist enters into a social or business relationship with an individual who is

a. Currently a patient of the psychologist
b. A close associate of a patient of the psychologist
c. A current patient or a close associate of a patient and is promised a future relationship once the treatment ends
d. All the above

2. Multiple relationships are inherently unethical.

TRUE
FALSE

3. The BEST definition of the overarching ethical principle of nonmaleficence is that it means

a. Promoting the well-being of patients
b. Avoiding harming patients
c. Respecting patient's autonomy
d. Billing patients fairly

Ethical Decision-Making with Suicidal Patients

4. Beneficence is

a. Involving patients in clinical decisions
b. Treating patients fairly
c. Promoting the well-being of patients

5. Justice is

a. Involving patients in clinical decisions
b. Treating patients fairly
c. Promoting the well-being of patients

6. Respect for patient autonomy is

a. Involving patients in clinical decisions
b. Treating patients fairly
c. Promoting the well-being of patients

7. According to Beauchamp and Childress, a psychologist may have one ethical principle override or trump another if

a. An effort has been made to minimize harm to the offended ethical principle
b. The proposed intervention is likely to succeed
c. The proposed intervention is better than any alternative
d. All the above

8. Involuntary psychiatric hospitalizations can harm patients insofar as they can strain the relationships between psychologists and their patients.

TRUE
FALSE

Zombie Ideas in Professional Ethics

9. According to Weinstein, some zombie ideas about ethics are that

a. There is always a right and wrong answer to every ethical problem
b. What is legal is always ethical
c. What is ethical always varies entirely by culture
d. All the above

10. **According to the authors, the best continuing education programs in ethics take advantage of the participants intrinsic desire to be competent, to feel affiliation with others, and have autonomy over their decisions.**

TRUE
FALSE

11. **Self-care is related to ethics insofar as psychologists who ensure that their basic needs are met are more capable of helping others.**

TRUE
FALSE

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The Pennsylvania Psychologist, October 2020

Please circle the letter corresponding to the correct answer for each question.

1. a b c d	4. a b c	7. a b c d	10. T F
2. T F	5. a b c	8. T F	11. T F
3. a b c d	6. a b c	9. a b c d	

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist:*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

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Calendar

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Understanding the APA Ethics Code — Intermediate
12:00 – 1:00 pm
Virtual Webinar

FRIDAY, OCTOBER 9, 2020
RXP Training Webinar Series Part 1: Understanding the Legislative Process
12:00 – 1:30 pm
Virtual Webinar

WEDNESDAY, OCTOBER 14, 2020
Four Ways to Enhance Your Suicide Assessments
12:00 – 1:00 pm
Virtual Webinar

NOVEMBER 9 – 14, 2020
Virtual Fall CE Week

Home Study CE Courses

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The Essentials of Screening and Assessing for Suicide Among Older Adults – 1 CE

Talking About Suicide: The Patient's Experience and the Therapist's Experience (Webinar) – 1 CE

The Assessment, Management, and Treatment of Suicidal Patients: 2020 – 3 CE

Act 31 CE Programs
Pennsylvania Child Abuse Recognition and Reporting: 2020 – 2 CE

Pennsylvania Child Abuse Recognition and Reporting: Extended Version 2020 – 3 CE

General CE Programs
Ending the "Silent Shortage" through RxP (Webinar) – 1 CE

*Ethics and Self-Reflection** – 3 CE

*Ethics and Professional Growth: 2019** – 3 CE

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