Journal of Clinical Psychology in Medical Settings (2018) 25:240–249
https://doi.org/10.1007/s10880-017-9537-4

Ethics and Confidentiality for Psychologists in Academic Health Centers

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Published online: 15 February 2018

Abstract
Psychologists in academic health centers (AHC) face important ethical issues including confidentiality when working with a multidisciplinary team, sharing of information through the electronic health record, obtaining informed consent in a fast-paced healthcare environment, cultural competency in the medical setting, and issues related to supervision and training. The goal of this paper is to describe ethical issues for psychologists in AHCs in the context of case examples, and to consider ethical decision-making tools to enhance clinical care. Considerations for best practices in integrated care settings will be discussed, and the APA Ethical Standards will be referenced throughout.

Keywords Ethics · Integrated care · Confidentiality · Electronic health records · Supervision

Psychologists are increasingly being integrated into healthcare settings, such as primary care, specialty medicine, and academic health centers (AHCs). The integrated care setting has unique components, including working with professionals from a variety of disciplines in a fast-paced environment. Communication is often through an electronic health record (EHR), and referrals may be made on the spot in a "warm hand-off" or as a routinely embedded member of the care team. In addition, psychologists in AHCs may see patients from a wide variety of cultures and socio-economic statuses. Finally, AHC psychologists are likely to be involved in training with medical students, psychology interns/fellows, or resident programs. There are many different models of integrated care practice in different AHCs, and ethical issues will vary among these different settings.

However, maintaining one's identity as a psychologist and adherence to the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (hereafter referred to as the Ethics Code; APA, 2010) is important regardless of the healthcare setting. Issues that may arise in such a setting include confidentiality when working with a multidisciplinary team, sharing of information through the electronic health record, obtaining informed consent in a fast-paced healthcare environment, cultural competency in the medical setting, competence, dual relationships, and issues related to supervision and training.

Case Examples and Best Practices

The goal of this paper is to describe clinical ethical issues for psychologists in AHCs in the context of case examples[1], while considering ethical decision-making tools to enhance ethical care. Considerations for best practices in integrated care settings will be discussed, and the APA Ethical Standards will be referenced throughout. The following case examples and ethical issues are not an exhaustive list of all ethical issues in medical settings, but provide a broad sampling of both typical and unique issues faced by psychologists in clinical integrated practice settings.

> **Case Example**: Ms. A is referred through a warm hand-off in a breast clinic after expressing depressed mood to her medical oncologist. The psychologist introduces herself briefly, but does not provide a written consent form or discuss the limits of confidential-

[1] The case examples described in this paper are fictionalized composite cases similar to actual cases seen in clinical practice in AHCs.

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ity. During a brief assessment, the psychologist identifies the patient as being at risk for imminent self-harm. She tells the patient she will need to be admitted for suicidal ideation, and the patient notes "I take that all back. I'm going home."

Informed Consent

Psychologists in healthcare settings have distinct challenges related to informed consent with patients. There are often time limitations in the healthcare setting, and properly reviewing informed consent may be sacrificed in the interest of quickly assessing and treating the patient. In addition, working in an integrated team poses its own challenges. Patients may be referred on the spot, who were never intending to see a psychologist or address a mental health issue at the visit. The patient may not be self-motivated for psychological treatment, or understand how the integration of behavioral health and medical services may be beneficial. For psychologists in AHCs, part of informed consent may be educating the patient about the benefit of behavioral health services and the role of the psychologist as part of the team. In addition, the patient may not understand limitations to confidentiality or how the information may be shared in the EHR. Psychologists should clarify who has access to the information as part of informed consent (Nielsen, Baum, & Soares, 2013; Van Liew, 2012).

In Ms. A's case, although the psychologist identified herself as such, it is not clear that the patient understood that she was entering into a treatment relationship, that disclosing her intention to harm herself may result in overriding confidentiality to maintain her safety, or how her encounter with the psychologist would be documented. Blanket informed consents that patients may sign or review as part of the healthcare system (Hudgins, Rose, Fifield, & Arnault, 2013) are not a replacement to review informed consent to see a psychologist, but can be helpful in setting the stage in describing psychologists as members of the multidisciplinary team. Providers might want to consider the warm hand-off as an introduction rather than starting a treatment relationship if time is too limited to review informed consent (Hudgins et al., 2013). For entering into a formal evaluation and treatment relationship, a written informed consent is ideal, with psychologists retaining a copy for their records and providing a copy to patients for their records. APA Standards 3.10 and 3.11 state that psychologists appropriately obtain informed consent (oral or written) and document services, as well as clarify who will have access to such information (APA, 2010). Generally, informed consent should be thought of as an ongoing process that continues throughout the treatment relationship (Hodgson, Mendenhall, & Lamson, 2013). The process of informed consent for treatment with a psychologist ideally may strengthen the relationship with the patient by establishing trust and clarifying the role on the team.

Best Practices for Informed Consent

- Review and document informed consent, including discussing confidentiality and the limits thereof at the outset of the relationship and thereafter as appropriate or necessary.
- Include a description of the psychologist's role as part of the multidisciplinary team in patient communications.
- Clarify the nature of the referral and the role of the psychologist with the patient.
- Help patients to understand how health behavior change is important to their medical problems.
- Obtain written consent when possible and document verbal consent for treatment.
- Inform the patient of who will have access to the notes from patient encounters.
- Ensure the patient understands the role of third parties (residents, trainees, family).
- Make informed consent an ongoing process.

Case Example: Mr. B is being referred for a presurgical psychological evaluation for weight loss surgery. In the course of the evaluation, he discloses he is an active cocaine user and tests positive for cocaine on a toxicology screen. The patient is notified by the surgery team that he is not a candidate for bariatric surgery due to active substance abuse. Further, his pain management provider sees the positive screen in the EHR, and informs Mr. B at his next visit that he will no longer prescribe opiates. Mr. B complains he was not informed that his toxicology screen results would be shared with the surgeon and other providers in the EHR.

Electronic Health Records (EHR)

Psychologists in AHCs should explain the role of the EHR as part of obtaining informed consent. In AHCs, there are varying levels of protection for behavioral health notes. Some systems may have a "firewall" that only allows mental health professionals to have access to behavioral health notes. In other systems, notes might be shared within the integrated team, while some may be open to the entire AHC clinical staff. The trend appears to be for mental health information to be treated on the same basis as general health information, although this may not be readily understood by the average patient (Clemens, 2012). For psychologists practicing in an integrated team, the

EHR is an important communication tool. True integration is impossible while separating mental from physical health, separating provider interactions, and separating records (Hodgson et al., 2013). The EHR can ease sharing information between the multidisciplinary team (Nielsen et al., 2013). Psychologists can send a copy of their report quickly and securely to relevant team members, and communicate informally through messaging systems within the EHR.

In Mr. B's case, part of the informed consent process should have included an explanation of the EHR and who has access to the psychologist's notes and toxicology report results. In most EHRs, lab results cannot be marked as sensitive or confidential, while therapy notes may be able to be marked as sensitive or confidential. Given that full integration of behavioral health notes into the medical record is novel in most systems, the psychologist may consider system intervention to educate other staff about the sensitivity of accessing psychology notes (Van Liew, 2012). By not specifically addressing the role of the EHR, and potentially betraying his trust, the psychologist puts Mr. B at risk to not engage with future mental health professionals.

In addition, many systems in the interest of transparency are allowing patients access to parts of their medical record, including laboratory results and visit notes. In addition, patients can often message their providers through a secure system linked to the EHR. These encounters are automatically documented and can increase patient satisfaction and communication.

EHR systems vary considerably, and there are likely mechanisms available to increase privacy settings on patient notes. For example, in the EPIC system used at the Cleveland Clinic, notes can be made "sensitive" to ensure that they are not released directly to the patient, and "sticky notes" can allow providers to document sensitive details that are private to the provider and cannot be viewed by others. In addition, it is recommended that healthcare systems have audit systems in place to ensure that only the patient's providers are accessing the record (Nielsen et al., 2013). Keeping notes factual and including behavioral observations, and using quotes when necessary versus making interpretations and offering opinions, can help to maintain patient dignity (Van Liew, 2012). Including only necessary information in clinical documentation is also helpful in maintaining confidentiality (Hudgins et al., 2013). Necessary information is likely to include history, symptoms, diagnosis, treatment plan, and treatment modalities used. Psychologists may want to review their notes and to edit their comments to avoid misinterpretation or harm. Providers wanting to remember potentially sensitive information (i.e., trauma details) may want to use the "sticky note" option to privately document information not needed by the rest of the team.

Best Practices for Use of the Electronic Health Record

- Share notes with the medical team when it impacts multidisciplinary team care.
- Ensure patients understand the use of the EHR and who has access to their information.
- Use the EHR to maintain communication with the team.
- Use the EHR to securely message patients versus other methods (email/text).
- Write notes as if the patient will read them.
- Keep language behavioral and neutral.
- Systems should have policies and audit practices in place.
- Only access charts with legitimate reason.
- Educate patients upfront about how the EHR helps to facilitate team communication and about the benefits of shared care.
- Educate the team about the appropriate use of the EHR and psychological notes.

Case Example: Ms. C is a woman with a BRCA2 genetic mutation, referred for a presurgical evaluation for a risk-reducing mastectomy. She is aware that her case will be discussed in a team meeting, and asks that her motivation to be there for her children is particularly emphasized to the team. Her history entails significant family trauma including sexual and physical abuse. In the course of a multidisciplinary team discussion of her case, a member of the nursing staff asks for specific details of her trauma history.

Confidentiality

Working within the multidisciplinary team engenders a delicate balance of sharing pertinent psychological information in a succinct manner and maintaining patient privacy and dignity. While contributing to the treatment team, psychologists also strive to protect patient confidentiality (Van Liew, 2012). Different disciplines have different ethical standards, and psychologists must educate other disciplines on their ethical obligations as a psychologist. Hodgson and colleagues offer a nice comparison of different disciplines, including physicians, nurses, psychologists, marriage and family therapists, counselors, and social workers on issues such as informed consent and confidentiality (2012).

While following their own ethical standards, there can often be pressure for psychologists to fit into the medical environment and be part of the group which at times can produce conflict. There may be subtle pressure to share more information than necessary by the team. Psychologists are encouraged to cooperate with other professionals

according to APA Standard 3.09 (APA, 2010). However, notably Standard 4.06 suggests that psychologists should disclose "only to the extent necessary to achieve the purposes of the consultations" (APA, 2010). Psychological aspects of patients are typically interesting to all providers, and it is important to guard against "emotional voyeurism." Psychologists should strive to share information to promote collaboration and multidisciplinary treatment, and be mindful to not share more information than necessary to fulfill that objective, which might violate patient confidentiality (Van Liew, 2012). In addition, the tendency of some team discussions to use "gallows humor" (i.e., dark humor about a serious situation such as serious disease or mental health issue) can be disrespectful of patient's rights and dignity.

In Ms. C's case, her sexual trauma details could have little impact on her psychological risks for mastectomy, although the fact that she does have a sexual trauma history in general may be important to disclose as a risk factor for posttraumatic stress disorder or sexual health problems following her surgery. Therefore, negotiating in advance with the patient that the fact she has a sexual trauma history may be disclosed to the team as pertinent to her case but not the details could be a way to resolve the ethical issue.

Best Practices for Confidentiality

- Clarify the meaning of confidentiality and limits thereof during review of informed consent.
- Guard against voyeurism.
- Keep details limited, brief, and pertinent.
- Include the patient voice for empowerment.
- Continue the informed consent process by discussing what details will be shared in team communications.

Case Example: Mr. E is applying for weight loss surgery and presents for a psychological evaluation. He notes a history of multiple psychiatric hospitalizations, including one the previous month for a suicide attempt. He notes he is not currently taking his psychiatric medication or under the care of a mental health professional. He has multiple serious medical problems that put him at risk for premature death including heart disease, sleep apnea, and diabetes. His body mass index is 65, approximately 250 lbs. overweight.

Beneficence Versus Harm

Psychologists in AHCs may be asked to provide the psychological perspective on risks and benefits of a medical procedure. In some cases, the psychological risks of a procedure may outweigh the medical benefits, and the psychologist's consult may result in a patient not receiving a procedure. Balancing beneficence versus harm may be an internal struggle for psychologists in these situations. It can be particularly difficult if the patient is told they are an excellent candidate for a procedure by one member of the team, while the psychologist expresses concerns.

When working with a multidisciplinary team, psychologists must remember the principles of nonmaleficence, beneficence, and the responsible use of power. By helping the team and weighing the risks and benefits of procedures as a group, multidisciplinary teams can make collaborative treatment decisions. Such collaborative decisions diffuse the responsibility across multiple providers, and might be viewed as more considered and thoughtful than a decision by a single provider. Psychologists thus are best served by considering themselves expert consultants/team members rather than in sole power of the team decision.

In Mr. E's case, recommendations could be made for him to establish mental health treatment and maintain psychiatric stability for a particular period of time (e.g., 1 year). The program may be well served to have a written policy regarding qualifications for procedures.

Best Practices for Beneficence Versus Harm

- Keep communication from the team to the patient consistent to avoid splitting.
- Help the patient and team weigh benefits and risks of procedures.
- Provide recommendations to optimize patients for medical procedures.
- Develop consistent policies and share with patients.

Case Example: Ms. F is a Hispanic female seeking behavioral treatment for insomnia. She arrives 30 minutes late for her appointment without explanation. She brings her 12-year-old daughter with her, and asks that she act as an interpreter. The psychologist does not speak Spanish and has very limited experience in treating patients from a Hispanic background. The psychologist explains the highlights of the written informed consent (written in English), and the patient signs quickly. As the psychologist describes keeping a sleep diary, the patient nods and smiles but does not bring the forms to the next appointment.

Cultural Competence

In an increasingly global marketplace, cultural competence will be a key skill for any health psychologist. AHC psychologists should be sensitive to healthcare literacy, healthcare

disparities, and the appropriate use of linguistic services (APA, 1990; US Department of Health and Human Services, 2013). Self-assessment is critical to be aware of attitudes, knowledge, and expertise in using skills when treating patients of a different culture (Fisher, 2014).

In Ms. F's case, the psychologist did not appear to obtain appropriate informed consent. Providers who frequently work with particular populations would do well to have an informed consent document translated for use with these populations, along with typically used psycho-education materials. In addition, AHC psychologists should be familiar with professional medical interpretation resources available at their institution. Phone interpretation systems may offer access to multiple languages with convenience. Although family members can be helpful, without professional training they may misrepresent or misinterpret key pieces of information (Bibla, Pena, & Bruce, 2015). In addition, family members have their own perspective on the issues; a professional interpreter allows the patient's (and family member's) views to be heard, without having a personal motivation.

Understanding cultural norms, while using respectful and curious questioning of the patient's unique cultural values, is essential to culturally sensitive practice. For example, Ms. F may have been influenced by *respeto*, a common Hispanic value for showing respect to authority such as doctors, when she agreed to keep the sleep diaries without potentially understanding the request or their function.

Best Practices for Cultural Competence

- Assess healthcare literacy.
- Use professional medical interpreters and clarify their role.
- Provide translations of consent forms and psycho-education in common languages when possible.
- Provide multiple teaching methods.
- Self-assess for biases for populations.
- Engage in ongoing education about cultural competence and diverse populations.

Case Example: Mr. G. is a Middle Eastern male whose primary language is Arabic and who follows Islam. He is a "VIP" patient, paying out of pocket for specialty services; in other words, a medical tourist. The psychologist arrives to see her regular 3 PM patient has been canceled to accommodate a presurgical evaluation prior to a liver transplant for Mr. G.

Medical Tourism

Medical tourism is the practice of traveling internationally for medical care that is paid for out of pocket or by a patient's government. Patients may travel for healthcare to seek beneficial treatments not available in their home country (Greenfield & Pawsey, 2014). Some medical tourists may travel to access care that is not legally permissible in their home country, while others may travel for healthcare due to lower costs in other countries. The growth in medical tourism is likely to continue given the relative ease of travel and access to information on cost through the internet (Lunt & Mannion, 2014). There are ethical concerns about the ability to provide ongoing local care after the patient returns to their home country. Psychologists must be careful to remember that they are licensed by state, as telepsychological practice can be tempting in situations with international patients who have limited time for treatment at the AHC.

A flexible approach is important when practicing with cultural sensitivity. Although not the typical approach, psychologists may accommodate an intensive therapy regimen for an international patient who will only be in the country for 6 weeks. From a systems perspective, it can be helpful to designate specific time and resources for international patients, including extended time to see and treat the patient given interpretation and cultural clarification, appropriate interpretation, and prepared translations of educational materials.

Medical tourism has the potential to create healthcare disparities between local community patients and high paying international patients (Greenfield & Pawsey, 2014; Snyder, Johnston, Crooks, Morgan, & Adams, 2016). In the case of Mr. G., the psychologist may need to self-assess his or her attitudes toward patients who are Muslim or patients receiving special treatment, as well as more generally to increase awareness about any biases related to religion, race–ethnicity, gender, sexual orientation, etc. In addition, it would be important to educate the healthcare system about the ethical obligation of justice to treat the established patient as well.

Best Practices for Medical Tourism

- Plan for reasonable care that will benefit the patient in the time allotted.
- Provide for a follow-up aftercare plan.
- Do not practice without a license across state or international boundaries.
- Do not sacrifice local community care.
- Allow for extra time to accommodate interpretation and cultural clarification.

Case Example: Mrs. H is newly diagnosed with Relapsing-Remitting Multiple Sclerosis. She presents to a major medical setting with her mother. In her appointment with the neurologist, depression was recognized, and a consult was placed to behavioral medi-

cine. The patient was seen by a postdoctoral fellow, and a document was provided for the patient to sign prior to the appointment explaining the supervision arrangement. The fellow began the assessment while the supervisor sat in the back of the room with his notebook. However, the fellow did not verbally explain the supervisory relationship, and it was unclear as to why there were two practitioners in the room.

Supervision and Disclosure Statement/Informed Consent

Supervision of students is a privilege that many psychologists take on during their career. It is an important, yet complicated, process that requires clear communication to the patient and a strong understanding of the rules that inform the supervisory relationship and role. Multiple ethical principles regulate the practice of psychology training and supervision. The Association of State and Provincial Psychology Boards (ASPPB's) Supervision Guidelines for Education and Training leading to Licensure as a Health Service Provider inform psychologists' ethical and legal responsibilities in the United States (ASPBB, 2005). Importantly, psychologists should also review, understand, and follow any state specific supervision regulations.

A supervisor has the responsibility to ensure that each patient is clearly informed of the relationship between the supervisor and supervisee. In addition to the supervisee explaining that they are working under the supervision of a licensed psychologist at the outset of the relationship, this objective is met by a supervisee disclosure statement as well as formally meeting the supervisor. This arrangement assures that the relationship is fully disclosed and that the patient has the ability to ask any questions of the supervising psychologist.

According to ASPBB Supervisory Guidelines, the supervisory disclosure statement or informed consent of supervision is a key component to ensuring that the patient is aware of the relationship. This form is to be utilized with each patient that is working under a licensed psychologist. The form is given to the patient at the initial visit and is discussed by the student and the patient. The form includes but is not limited to (1) a brief description of services provided and the office procedures, (2) the name and contact information of the supervising psychologist, (3) information about billing, (4) a statement of limits to confidentiality, (5) information on the relationship between supervisee and supervisor, and about sharing of information between the supervisor and supervisee, (6) information about the availability of the supervisor to meet with the patient upon request, and (7) a signature of the psychologist, supervisee, and the patient with one copy being maintained by the supervisor (ASPBB, 2015; Ohio Board of Psychology, 2014).

Best Practices for Supervision Disclosure Statement

- Access your state psychology board to clarify what is required to be in your disclosure statement.
- Create a document of supervision disclosure and provide to the state board to ensure that the state requirements are met.
- Train students to discuss their role as a trainee.
- Meet with every new patient the trainee treats and introduce the role of the supervisor.
- Allow the patient to ask any questions about the role of supervision.
- Provide consent forms that explain supervision in clearly understandable language.

Case Example: Dr. I is a GI psychologist who is fellowship trained in GI psychology. A student from the local graduate school is interested in health psychology and contacts Dr. I for supervision opportunities in bariatric surgery cases. The student will pay Dr. I to supervise her. Dr. I realizes that he has never had training on supervision and supervision models, or in bariatric surgery, but immediately agrees to supervise her on these cases. The student develops a robust bariatric case load with complex medical conditions and related psychological disorders and pays Dr. I a reasonable fee for his supervision time.

Supervision and Competence

Supervision is a collaborative competency-based practice between the supervisor and supervisee (Bernard & Goodyear, 2014; Falender & Shafranske, 2004). The goals of supervision are to train the supervisee in an area of specialty, to provide an avenue for the supervisee to gain competence towards independent practice, and to protect the public and vulnerable patient populations (ASPPB, 2015). Relevant ethical principles include Standard 2.05, Delegation of Work to Others (APA, 2010). In this guideline, the licensed psychologist/supervisor who delegates work takes reasonable steps to ensure that the supervisee is fully competent and qualified to perform this work. In the case above, it is clear that Dr. I has had substantial training in GI psychology, however, no bariatric psychology training. As such, Dr. I's actions were ethically problematic as psychologists cannot delegate work to supervisees for which they are not competent to treat themselves. In the case above, supervisor competency is important to evaluate. It is essential that the supervisor is competent in both clinical practice and supervision. In the above case, Dr. I was not competent in bariatric health

psychology and thus, ethically, should not be supervising a student on these cases. In addition, the psychologist did not have supervisory training. It is important to note that past supervision experience does not necessarily guarantee supervisor competence. Ideally, psychologists acting as supervisors should consistently educate themselves by way of continuing education, engage in relevant readings and consultation, and be able to clearly articulate the model of supervision that they follow. Supervisor competencies relate to the constructs of knowledge, skills, attitudes, and values (ASPPB, 2015).

Supervisors' responsibilities include (a) supervisor competency in the areas of a supervisees' training, (b) understanding the patient and the care that the student is providing, (c) ensuring the standard and quality of practice, which includes protecting the public (d) overseeing all aspects of client services, and (e) mentoring the supervisee.

Best Practices for Supervision and Competence

- Ensure that the supervising psychologist has competency in the area agreed to supervise.
- Do not assume competence in a specialty area without adequate training.
- Ensure appropriate training in supervision theory and practice before supervising.
- Identify the supervisory practice and theory that is followed.
- Self-assess for competencies.
- Engage in ongoing education about supervision.

Case Example: Dr. J is a physician employed at an AHC who was recently diagnosed with breast cancer and referred to a psychologist embedded in the breast cancer team. Dr. J and the psychologist had previously served on hospital committees together, but otherwise had little professional contact. She expresses concern about psychologically sensitive information in the EHR given her colleagues have potential access to her chart, as well as questions about interacting with the psychologist at other professional events.

Dual Relationships

Psychologists working in AHCs are likely to encounter dual relationships, as many hospital systems are self-insured. It is common to be both a colleague and a provider to other hospital staff and employees. Careful consideration and discussion of confidentiality is important, including how information will be shared in the EHR. Psychologists should additionally negotiate how they will interact with colleague-patients outside the treatment setting. A psychologist might negotiate that she will not acknowledge a colleague-patient until she is first acknowledged in professional settings. Additionally, psychologists should recognize when an outside referral will be more appropriate. For example, providing treatment for the department chair's partner is likely to create ethical problems and may interfere with the patient getting the best care possible if the psychologist is uncomfortable discussing family dynamics. The APA Ethics Code Standard 3.05 specifies: "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (APA, 2010). In the case of Dr. J, the psychologist did not have regular close professional interactions with Dr. J and was able to negotiate an acceptable documentation practice and how to interact at other potential meetings to maintain confidentiality.

Best Practices for Dual Relationships

- Discuss dual relationships during the informed consent process.
- Consider confidentiality, including appropriate safeguards in EHR.
- Discuss how to interact outside of the treatment setting.
- Discuss and document whether the dual relationship is appropriate.
- Consider outside referral as needed.

Case Example: Dr. K is a psychologist employed in the general psychology department at a large AHC. He has strong experience with anxiety treatment, and specializes in biofeedback and relaxation training. He is approached by the neurology department to work with their tinnitus patients, but has never had training or experience with that particular population.

Competence

A good understanding of the medical condition, current medical treatment, and the psychological literature related to the medical condition are a foundation for competent psychological practice in AHCs. While a solid background in the psychological literature is a must, health psychologists should also have a strong understanding of the medical condition and psychological factors affecting the condition to competently treat patients in the AHC. The APA Ethics

Code Standard 2.01a notes, "Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2010). It further explains that psychologists practicing in areas new to them undertake further study and consultation, and in emerging areas psychologists take reasonable steps to ensure competence (APA, 2010; Standard 2.01c-e.). Dr. K's skills in biofeedback and relaxation training are likely to generalize to working with tinnitus patients. However, he would benefit from shadowing the neurology team, literature review, and consultation with colleagues regarding psychological treatment of tinnitus as well as increased training about working in an integrated healthcare team and health psychology. Multiple opportunities exist for mid-career psychologists to retrain in integrated care practice throughout the country.

Best Practices for Competence

- Gain a strong foundation of knowledge about the medical condition being treated.
- Stay current in the literature of both medical updates and psychological issues affecting the medical condition.
- Consider ongoing medical and health psychology continuing education.
- Engage in interdisciplinary communication opportunities such as team meetings which often provide insights into new treatment advances.
- Practice within the limits of competence.
- Consider peer consultation or supervision to gain skills in new specialty areas.

Models of Decision Making

Psychologists in AHCs will benefit from identifying models of ethical decision making that will be helpful when confronting ethical dilemmas. Using an ethical decision-making model and documenting your decision-making process shows understanding of the ethical issues at hand, familiarity with the ethics code and ethics research, and thoughtful consideration of a solution. It is recommended that AHC psychologists document any consultation with peers, professional organizations, or other entities, along with continuing education and reading on ethical issues in a personal ethics file to demonstrate ongoing self-assessment and education. Although there are many different models of ethical decision making, we have chosen to highlight examples of multicultural ethical decision making and principle-based ethical decision making as two excellent options for psychologists in AHCs.

Multicultural Models of Ethical Decision Making

A multicultural approach to ethical decision making can be a beneficial tool for AHC psychologists. One such method involves a four-step approach of (1) self-assessment, (2) a curious approach to the patient's unique perspective, (3) ongoing learning of culturally relevant values and norms, and (4) mindful design of culturally appropriate, ethical interventions and actions (Fisher, 2014).

For example, in the case of Ms. F, it would be important for the psychologist to self-assess her knowledge regarding treatment of Hispanic patients. Given her lack of knowledge in this area, she may take a curious approach and ask Ms. F more about what she understands about the role of the psychologist and how she might be able to help her with her sleep. In addition, the psychologist may make it a priority to engage in continuing education related to Hispanic culture, investigate relevant research on insomnia treatment for Hispanic clients, and read about cultural competence. Finally, the psychologist would benefit from creative adaptation of insomnia interventions, balancing cultural competence with knowledge of existing evidence-based treatments for insomnia. For example, if Ms. F had difficulty with the sleep diary as written, a visual-based self-monitoring form may have been more effective.

Principle-Based Models of Ethical Decision Making

Using principles to help make ethical decisions can also be an effective method for AHC psychologists. Knapp and VandeCreek (2012) propose a five-step model that includes (1) identifying the problem, (2) developing alternatives, (3) evaluating options, (4) taking action, and (5) evaluating outcomes.

In the case of Mr. E, the psychologist identified the problem as beneficence (benefit that the surgery could have for patient's physical health and life expectancy) versus non-maleficence (risk that the surgery could have on patient's mental health and suicide risk). The alternatives were to (1) deny the patient weight loss surgery, (2) recommend weight loss surgery, (3) recommend alternative weight loss strategies, and (4) recommend a delay of surgery with a period of demonstrated stability and mental health care. By consulting the multidisciplinary team, the psychologist and the team were able determine the strategy that seemed to best help the patient and avoid harm (mental health treatment/delay of surgery).

AHC psychologists may feel isolated at times as part of the multidisciplinary team. Different disciplines can have different ethical standards, and it can be difficult to explain psychology's unique perspective on ethical issues. It can be helpful to have formal or informal relationships with other health psychologists in the AHC or through professional

organizations to form a consultation network. In addition, AHCs may have additional resources such as a bioethics department, legal department, or peer consultation groups that may be helpful. Board certification (American Board of Professional Psychology) can be a process that provides competency assessment in standards for ethical practice.

Best Practices for Ethical Decision Making

- Consult with colleagues.
- Document consultation or other steps in the ethical decision-making process.
- Use institutional resources (bioethics department, legal department).
- Consult with professional organizations (Association of Psychologists in Academic Health Centers, APA Practice Organization, state psychological associations, and state psychology boards).
- Consider ABPP/Board Certification.
- Be familiar with other disciplines' ethical codes and boundaries.
- Educate other disciplines regarding the ethical obligations of psychologists.
- Educate healthcare systems about psychologists' ethical standards.

Conclusions

Psychologists practicing in a hospital or academic medical settings have complex relationships with patients, medical providers, and trainees. Psychologists in medical settings will likely encounter ethical dilemmas at some point in their careers; confidentiality, informed consent, electronic medical records, beneficence versus harm, cultural competence, dual relationships, medical tourism, and supervision of trainees are areas that can pose ethical dilemmas.

Additional issues that psychologists may face in AHCs include ethical billing and documentation, psychological testing in AHCs, and ethical issues for psychologists working as educators, researchers, administrators, and other leaders in AHCs. Future research on the ethical practice of psychologists in hospital settings is important to inform best practices. Hospital-based psychologists are encouraged to understand the important challenges in this setting, to stay up to date in the literature, to engage in continuing education on ethical issues, to apply principles-based or multicultural ethical decision-making tools, to consult with colleagues, to engage in self-assessment, and to enhance self-awareness. Psychologists who practice in medical settings should be guided by the APA Ethics Code, their state psychology board rules and laws, ASPPB guidelines, and emerging research and training.

Compliance with Ethical Standards

Conflict of interest The authors Kathleen Ashton and Amy Sullivan declare that they have no conflict of interest.

Human and Animal Rights All procedures were in accordance with the ethical standards of the institutional research committees and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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