

Ethics in Practice: The Importance of Informed Consent

Chair: Patrick B. McGrath, Ph.D.

Presenters: Jeffrey E. Barnett, Psy.D., ABPP

Simon A. Rego, Psy.D.

Yuhuan Xie, M.D.

Anxiety and Depression Association of America

Miami, Florida

4/12/15

The Role of Informed Consent in Clinical Practice

JEFFREY E. BARNETT, PSY.D., ABPP
LOYOLA UNIVERSITY MARYLAND

Disclosures

- I am a past Chair of the Ethics Committee of the American Psychological Association and a past member of the Maryland Board of Examiners of Psychologists. I am presently the chair of the Ethics Committee of the American Board of Professional Psychology.
- All statements made in this presentation are my own and do not represent the policies or recommendations of the above organizations or of any others.
- I receive no industry sponsorship and have no conflicts of interest to report.

Agenda

- Overview of Informed Consent
- Case Examples of Ethical Dilemmas
- Recommendations
- Questions
- Case Examples and Discussion

What is *Informed Consent*?

A legal and ethical ***obligation*** to provide information to clients ***before*** a clinician initiates treatment or services.
- Knapp & VanderCreek (2012)

The **foundation** of the therapeutic relationship.

A ***process*** in which the clinician shares information necessary for the client to make a ***reasoned*** decision about engaging in treatment or services offered or recommended.

- Barnett, Understanding Informed Consent

Benefits

- Promotes client autonomy
- Fosters collaborative relationship
- Reduces risk of exploitation or harm
- Improves therapeutic relationship
- Facilitates ethical practices
- Reduces anxiety by clarifying expectations and demystifying the treatment process

Brief Review of History of Doctrine of Informed Consent

- 19th & 20th centuries: “Doctor-knows-best-system”
- 21st century: series of malpractice cases that ruled on the potential harm to clients by health care professionals

Selected Case Law

- 1914: *Schloendorff v. Society of NY Hospital*
 - Clients must be provided with necessary information to make treatment decisions and to be able to refuse treatment
 - Each person has the right to decide what is done to them.
- 1957: *Salgo v. Stanford*
 - Clients must *understand* information provided in informed consent in order for it to be valid
- 1972: *Canterbury v. Spence*
 - Clients must be allowed time to ask questions during informed consent process
 - Defined *minimal information* as what a reasonable person would need to make the decision
- 1985: *Osheroff v. Chestnut Lodge*
 - Clients must be provided with information about all reasonably available treatment options and alternatives

Four Requirements for Valid Informed Consent

- Competence to Give Consent
- Volition (voluntariness)
- Comprehension
- Documentation
- Consent vs. Assent

Essential Elements of Every Informed Consent Agreement

- ⦿ Right to refuse or withdraw without penalty
- ⦿ Nature and anticipated course
- ⦿ Fees and billing
- ⦿ Involvement of 3rd parties
- ⦿ Limits of confidentiality
- ⦿ Potential risks of treatment
- ⦿ Relative risks and benefits of reasonably available alternatives, including no treatment

Additional Considerations

- Determine *who* is the client
- Provide as early as possible
- Ensure provision of informed consent occurs as an *ongoing* process
- Provide verbally and in writing
- Ascertain client understanding

How Much Information is Too Much?



Readability of Notice of Privacy Forms

- ⦿ 0% of patient privacy forms were shown to be as easy to read as comics
- ⦿ 1% as easy to read as J.K. Rowling's *Harry Potter and the Sorcerer's Stone*
- ⦿ 8% as easy to read as H.G. Wells' *The War of the Worlds*
- ⦿ 91% as easy to read as professional medical literature or legal contracts

(The Numbers Game, 2005)

Readability of Informed Consent Documents

- It is recommended that informed consent documents be written at the fifth or eighth grade reading level.
- In one recent study of 114 informed consent documents used for participation in research studies in medical schools, the average readability level was 10.6, 2.8 grade levels above that which was required by those institutions' Institutional Review Boards (Paasche-Orlow, Taylor, Brancati, 2003).

Documenting Informed Consent

- In one recent study, only 51% of the mental health professionals surveyed reported conducting and documenting an informed consent process for psychotherapy in their practices.
- Further, only 25% of those surveyed acknowledged utilizing a written informed consent agreement with their clients. (Croarkin, 2003)

Although there exists no accepted standard of informed consent, we have guidance in the form of four criteria for valid informed consent, essential elements, ethics code, and case law.

Relevant Ethics Code Standards

- ◎ **3.10 Informed Consent**

(a) When psychologists conduct research or provide assessment, therapy, counseling or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards [8.02, Informed Consent to Research](#); [9.03, Informed Consent in Assessments](#); and [10.01, Informed Consent to Therapy](#).)

Relevant Ethics Code Standards

- (b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

Relevant Ethics Code Standards

- (c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.
- (d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards [8.02, Informed Consent to Research](#); [9.03, Informed Consent in Assessments](#); and [10.01, Informed Consent to Therapy](#).)

Relevant Ethics Code Standards

- ◎ **10.01 Informed Consent to Therapy**
 - (a) When obtaining informed consent to therapy as required in Standard [3.10, Informed Consent](#), psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards [4.02, Discussing the Limits of Confidentiality](#), and [6.04, Fees and Financial Arrangements](#).)

Relevant Ethics Code Standards

- (b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available and the voluntary nature of their participation. (See also Standards [2.01e, Boundaries of Competence](#), and [3.10, Informed Consent](#).)

Relevant Ethics Code Standards

- (c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

Relevant Ethics Code Standards

● **3.04 Avoiding Harm**

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

Underlying Virtues

- Beneficence
- Nonmaleficence
- Fidelity
- Autonomy
- Justice
- Self-Care
- The role of these virtues in ethical decision-making

Ethical Decision-Making

(From Barnett & Johnson, 2009)

- Stage 1: Define the Situation Clearly
- Stage 2: Determine Who Will be Impacted
- Stage 3: Refer to Both Universal Ethical Principles and the Standards of Your Profession's Code of Ethics
- Stage 4: Refer to Relevant Laws/Regulations and Professional Guidelines
- Stage 5: Reflect Honestly on Personal Feelings and Competence

Decision-Making Model (cont.)

- Stage 6: Consult with Trusted Colleagues
- Stage 7: Formulate Alternative Courses of Action
- Stage 8: Consider Possible Outcomes for All Parties Involved
- Stage 9: Make a Decision and Monitor the Outcome
- Stage 10: Engage in an Ongoing Assessment and Modification

Discussion

- For integrative psychotherapists, what information would the average or typical client need to make an informed decision about participation in this treatment versus reasonably available alternatives versus no treatment?

Discussion (cont.)

- ◎ As integrative psychologists:
 - What information should you be sharing with your clients?
 - How might you modify how you implement the informed consent process?

List of Common Pitfalls

- ⦿ Obtaining consent from minors, inpatients, prisoners, mandated clients, cognitively impaired clients
- ⦿ Understanding when and how to share information
- ⦿ Knowing how much information to share
- ⦿ Recognizing the impact of diversity
- ⦿ Knowing how to handle unique situations with third-party requests, supervision, and research requests

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Case Examples and Discussion

Simon A. Rego, Psy.D.

Montefiore Medical Center, Bronx, NY

Yuhuan Xie, M.D.

Institute of Mental Health Singapore

Disclosures

We have nothing to disclose

Ethical Dilemmas!

- Gay porn
- Borderline – The musical
- Caught in a compromising position
- Blog attack
- Just for you

Case 1- A minor youth

17-y.o. lived with parents, admitted for paranoid delusions into a setting for substance use.

His symptoms fluctuated throughout the hospital stay. After being in the hospital for about one month, most of his symptoms went away, but a fixed belief that his parents physically abused him as a child persisted.

He refused to take any antipsychotic medication, but his parents refused to take him home without treatment because they felt that his fixed belief was a delusional thought and he was a danger to his family and community.

Patient did not allow us to contact his school and at a certain point he also withdrew the consent to allow us to talk with his parents.

Main Challenges

- **Diagnostic difficult due to inability to verify the past history of abuse**
- **Patient's capacity to give informed consent**
- **Safe disposition plan**

Diagnostic clarification

- **Child protection service**
- **Ongoing assessment for mental status**
- **Behavioral observations**

Informed consent

- **Four Requirements for valid informed consent**
- **Competence to give consent- ?**
- **Volition (voluntariness) - No**
- **Comprehension - ?**
- **Documentation**

Competence to give consent

- Age
- Diagnosis of Mental illness
- Capacity Assessment

Capacity Assessment

- Understanding the medical condition?
- Understanding the natural course of the medical condition?
Yes, after being provided with information.
- Understanding the proposed treatment intervention? Yes.
- Understanding the consequences of treatment or intervention refusal-?
- Understanding viable alternatives-?
- Understanding the potential risks/benefits of alternative treatments?

Outcomes

- Diagnostic difficulty due to inability to verify the past history of abuse-Paranoid delusion.
- Patient's capacity of given informed consent-Patient eventually acknowledged the need for treatment.
- Safe disposition plan-Gradual transition back to community.

Case 2: A Minor

- 14-y.o. lived with mother and 16 older sister who also has a 2-y.o. son. She was emotionally and physically abused by her older sister at home in the past.
- Child protection service involved due to sister's son, but mother remains custodian of all children.
- Patient was bullied at school for her sexual orientation and other issues.
- She felt emotionally connected with school counselor but not family members.

- ① School brought the child to inpatient service for admission when child reported SI which seemed to be triggered by the sister and her son returning home.
- ① School insisted on not informing the mother because they felt the mother was not competent and that the child might run away if the mother was present.

Main Challenges

- **Informed consent for inpatient treatment**
- **Safe disposition plan**

Four Requirements for valid informed consent

- **Competence to give consent?**
- **Volition (voluntariness)-yes**
- **Comprehension?**
- **Documentation**

Competence to give consent

- **Age**
- Law in Ontario, Canada: “The *Act* does not identify an age at which minors may exercise independent consent for health care because the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. Physicians must make a determination of capacity to consent for a child just as they would for an adult.”

Health care decisions for minors under 12

- Divorced and Separated Parents: Consent needs to be given by two parents unless one has sole custody.
- Common Law: Absent adoption, only the natural parents can consent on behalf of a child.
- Spouses: A spouse of a parent with sole custody under a divorce settlement.
- Legal Guardian: In situations of a custodial relationship which exists because a minor is being raised as if in the legal custody of a person (“in fact” or de facto custody, even though no legal custody has actually been granted), the child’s natural parents should be consulted to obtain a consent.
- Foster Care: A foster parent cannot consent to treatment on behalf of a child.
- Adoptive Parents: Adoptive parents have all the legal rights of natural parents.

Outcomes

- Mother, school, and CAS were invited to an intake meeting.
- Mother and CAS were involved in discharge meeting, school was absent due to school break.
- A meeting was scheduled to involve the school in decisions about the future mental health care of the child.