Abstract: This paper describes the legal and ethical aspects of informed consent, including the requirements for disclosure of information. It reviews current issues related to informed consent and offers practical suggestions for integrating informed consent into clinical practice.

Résumé: Application des principes du consentement éclairé à la pratique clinique en psychiatrie
Cet article décrit les aspects légaux et éthiques du consentement éclairé, y compris les exigences de divulgation de l’information. Il examine les enjeux actuels liés au consentement éclairé et offre des suggestions pratiques pour intégrer ce dernier à la pratique clinique.

Key Words: informed consent, psychiatric disorders

Informed consent to medical treatment is a legal concept that took its place in modern medicine with the 1960 case of Nathanson v Kline (1). In that case, a failure to inform the patient of possible surgical risks formed the basis of legal liability for negligence. In the 1980s, it became clear through case law that the need to obtain informed consent extended to treatment with medications (2,3). Since then, there have been no substantive changes in the legal requirements for informed consent (4,5). However, some new issues regarding informed consent and psychiatry have emerged. This paper highlights some of these issues and offers practical suggestions for incorporating informed consent into clinical practice. It describes the legal and ethical aspects and discusses problems particular to psychiatry.

Legal Aspects
For consent to be valid, it must be specific, voluntary, informed and given by a capable patient. Although there is no universally agreed-upon legal standard for disclosure, five areas are usually covered: diagnosis; treatment; consequences of treatment, with risks and benefits; alternatives to treatment; and prognosis with or without treatment (6). In a landmark decision, the Supreme Court of Canada ruled that physicians should reveal the nature of the proposed treatment, the seriousness of the proposed treatment and the material risks of the proposed treatment and that they should answer any specific questions posed by the patient (7). This ruling was upheld in a more recent ruling (5): physicians are required to disclose whatever a reasonable person in the patient’s position would need to know to make an informed decision. Thus, the particular circumstances of the patient constitute an important consideration in disclosure.

Legal Exceptions
Informed consent is necessary whenever a medical treatment is administered. There are, however, four situations in which the legal requirement for informed consent is relaxed: incompetence of the patient, emergency situations, therapeutic privilege and waiver. If a patient lacks the capacity to consent to a treatment, the local jurisdiction laws regarding substitute decision-makers are invoked. In emergencies, a physician can administer a treatment without patient consent. Therapeutic privilege can be used when the physician feels that disclosure would harm the patient sufficiently to negate the benefits of an autonomous and informed decision. The concept of therapeutic privilege allows physicians to modify only the degree of disclosure—the ensuing basic treatment must still be explained to the patient. Patients may waive their rights to receive explanations or to ask questions. Here also, however, physicians must still explain the basic aspects of the proposed treatment. These legal exceptions are important concepts for psychiatrists, who are often called upon to treat patients in emergency situations, to treat patients who lack capacity to make decisions and to treat patients whose disorders influence their ability to tolerate detailed explanations. Exceptions should be used sparingly and with appropriate documentation to support their rationale.

Ethical Aspects
Three main ethical principles inform the ethical analysis of informed consent: autonomy, beneficence and nonmaleficence, and the fiduciary principle. Autonomy, the concept that a person has a basic right to self-determination, is frequently cited as the ethical basis for informing people so that they can make their own decisions. This takes precedence over the principles of beneficence and nonmaleficence (that is, doing what benefits...
the patient and doing no harm). The fiduciary principle, or the principle of partnership, emphasizes the importance of the patient–physician relationship of trust. This partnership is ethically more important than any contractual aspect of consent, such as the signing of a form. It is the partnership that allows psychiatrists to balance respect for patient autonomy, to the extent that they are able to exercise it, with “paternalistic” actions intended to benefit patients.

Practical Aspects
In clinical practice, the doctrine of informed consent provides a mechanism for collaborative decision-making (8). An explicit, consent-related discussion of the proposed treatment should take place early in the relationship. Ideally, it should occur prior to the initiation of treatment. However, it is important to keep in mind that consent is not a one-time agreement. A more useful approach is to consider the ongoing nature of the partnership and the constantly fluctuating state of the consent. Consent should be open for discussion and potentially retractable at any time during the course of treatment (9). Clinicians should initiate a periodic review of therapeutic progress together with a renewal of the consent to treatment (10).

Patients requiring psychiatric treatment often suffer from severe mental illness that can impair insight, judgment and cognition. Thus, their capacity to make informed decisions regarding treatment may be limited (11). Every effort must be made to respect the autonomy of patients. Nevertheless, when mental illness impairs patients’ capacity to make decisions about their care, physicians should take measures allowed by provincial laws to pursue the treatment that they deem to be in the patient’s best interest. This may include consulting a substitute decision maker, employing a community treatment order or obtaining an order from the court to administer treatment. The legal process can sometimes delay treatment initiation, sometimes resulting in harm to the patient. Therefore, every effort should be made to minimize the time taken to determine a patient’s capacity (12).

Although psychiatric illnesses can impair patients’ abilities to understand information and to consent in a fully voluntary manner, they do not necessarily do so. Most psychiatric patients retain the capacity to participate in the process of informed consent. Dunn and Jeste reviewed methods used to enhance understanding of information presented and found that multiple learning trials, corrective feedback and the use of better organized or simplified consent forms improved understanding (13). Thus, attention to these matters may enhance the authenticity of the consent process in psychiatric practice.

Tardive dyskinesia is a particular concern of patients with severe mental illness (14,15). Patients must be told about this side effect if they are to make an informed decision regarding long-term treatment with an antipsychotic medication. However, when a patient suffers from acute psychosis, therapeutic privilege can sometimes be invoked, and details regarding long-term side effects can be temporarily postponed. Such cases must be carefully documented, and full disclosure should take place once the patient’s condition has improved. Some authors have advocated the use of a signed, written consent form (15), but written consent does not necessarily protect against liability. Careful documentation, ongoing education and provision of opportunities for collaborative decision-making may be more effective and can provide the same level of legal protection.

It is important to document the consent-related discussion in the medical record, and a progress note is the most appropriate place to record it. (A signed consent form can serve as documentation, but this will be used in the minority of cases.) The key elements of valid informed consent—information, capacity and voluntariness—should be included. Therefore, the following points should be noted: the fact that the discussion took place; the major points of the discussion, with particular attention to diagnosis, proposed treatment, risks and benefits, alternatives to treatment and prognosis; special concerns raised by the patient; the decision communicated by the patient; the patient’s capacity to consent to the treatment; and the absence of duress.

In contrast to its application in regard to treatment with antipsychotic medication, the application of the doctrine of informed consent to psychotherapy has been less clear. Legal liability in the case of psychotherapy is difficult to prove (6). The case of Osheroff vs. Chestnut Lodge was an attempted suit on grounds of failure to provide information about alternative treatments (16). In that case, a physician with a narcissistic personality and suffering from depression was treated with psychodynamic methods in a private hospital. He later improved with somatic therapy at another facility and sued the first hospital for not having informed him of alternative treatments. The case was settled out of court, and no legal precedent was established. It did, however, raise the possibility of legal liability with respect to informed consent and psychotherapy. It would therefore be prudent for psychiatrists to develop ways of talking about psychotherapy that are consistent with legal and ethical principles (9).

Psychotherapy records and other psychiatric records may contain sensitive and deeply personal information about patients. These records should not be released without patient consent. The usual standards of disclosure apply: before the information is released, the patient should understand to whom the information will be disclosed, what information will be disclosed, how the information will be used and what the potential consequences might be (17).
Despite the consensus that informed consent is legally and ethically necessary, as well as being recommended by both the Canadian and American Psychiatric Associations, psychiatrists may not be documenting it consistently. Schachter and Kleiman studied the charts of 30 psychiatrists treating patients with antipsychotic medication and found that the informed consent process was documented only 23 per cent of the time (18). They noted that physicians who spent more time reading the medical literature were more likely to document informed consent.

I hope that this brief discussion of informed consent will serve as a review of key concepts, an overview of contemporary issues and an impetus to consider the practical aspects of informed consent in clinical work. Observing the legal and ethical principles described above, with attention to practical details, will help physicians develop an atmosphere of collaborative decision-making with their patients.

References


Quotable Quotes ● Citations dignes de mention

“Our biggest concern is that a large group of psychiatrists will retire within the next 10 years. So we believe that early grooming of undergraduate students for a career in psychiatry would be a good long-term solution to the shortage.”

Dr. Jean-Marie Albert, who spoke to Psychiatric News about the downward trend of medical students choosing a career in psychiatry in Canada and about ways to reverse the trend. The article appeared on June 7, 2002.

“An increasingly important factor for graduating students is the rising debt they have accumulated. That may deter prospective students who perceive that psychiatrists work hard and that their remuneration is modest, compared with that of other specialists.”

Dr. Michael Myers, who was also interviewed by Psychiatric News on methods to recruit more students into psychiatry.

“Notre principale préoccupation est qu’un large groupe de psychiathres vont prendre leur retraite dans les dix prochaines années. Nous croyons donc que le conditionnement précoces des étudiants de premier cycle à une carrière en psychiatrie serait une bonne solution à long terme à la pénurie.”

Le Dr Jean-Marie Albert, qui s’est adressé à Psychiatric News à propos des étudiants en médecine qui ont de moins en moins tendance à choisir une carrière en psychiatrie au Canada, et à propos des façons de renverser cette tendance. L’article est paru le 7 juin 2002.

“Un facteur de plus en plus important pour les étudiants diplômés est la dette croissante qu’ils ont accumulée. Cela peut éloigner des étudiants éventuels qui croient que les psychiatres travaillent dur et que leur rémunération est modeste, comparativement à celle d’autres spécialistes.”

Le Dr Michael Myers, qui a aussi été interviewé par Psychiatric News sur les méthodes pour recruter davantage d’étudiants en psychiatrie.