American Psychiatric Association Resource Document on Principles of Informed Consent in Psychiatry

Informed consent has legal, ethical, and clinical dimensions.

a. From the legal perspective, it requires physicians to disclose certain classes of information to patients, and to obtain their consent before initiating medical treatment.

b. In its ethical dimension informed consent encourages respect for individual autonomy in medical decision making.

c. As a clinical process, informed consent offers a mechanism for collaboration between physicians and patients in identifying clinical problems and selecting appropriate treatment.

Although legal requirements (which may vary across jurisdictions) define the minimum criteria for an adequate informed consent process, the ways in which they are implemented and the degree to which they are augmented will reflect appropriate concern with ethical and clinical considerations. Of course, psychiatrists should be familiar with the laws in their jurisdiction relevant to informed consent.

Legal Principles of Informed Consent

The principles governing the law of informed consent can be summarized as follows.

1. In general, informed consent should be obtained from all adult patients prior to the initiation of psychiatric treatment, and from minor patients who are legally authorized to provide consent. For minors who cannot provide consent, it should be obtained from parents or other legal custodians.

2. Psychiatrists should offer patients or others from whom consent is being obtained information about the nature of their condition, the nature of the proposed treatment, benefits of the proposed treatment, risks of the proposed treatment, and available alternatives to the proposed treatment along with their benefits and risks.

3. Legal standards may require physi-

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cians to disclose the information that a reasonable practitioner in a similar situation would disclose ("professional standard of disclosure"); or the information that a reasonable patient would find material to his or her decision ("materiality standard"); or may specify exactly which information should be disclosed.

4. Exceptions to disclosure requirements fall into several categories:

a. *Emergencies*: When the time required for disclosure would create a substantial risk of harm to the patient or third parties, full disclosure requirements may not apply.

b. *Waiver*: Patients may waive their rights to receive information. To be meaningful, this should be a knowledgeable waiver, i.e., patients should be made aware that they have a right to receive the information, to designate a surrogate to receive the information, or to be informed at a later date.

c. *Therapeutic privilege*: Some jurisdictions permit information to be withheld when disclosure *per se* would be likely to cause harm to patients (e.g., when a patient with an unstable cardiac arrhythmia would have his or her situation exacerbated by the anxiety attendant on full disclosure of the risks of treatment). The harm cannot result from patients' decisions not to receive the proposed treatment. This exception must be construed narrowly lest it undermine the general principle of informed consent.

d. *Incompetence*: Incompetent patients may not, as a matter of law, give an effective informed consent. State law generally provides alternative mechanisms by which consent can be obtained, and requires disclosure to a substitute decision maker.

e. *Involuntary treatment*: Many states allow psychiatric treatment to occur without patients' informed consent when countervailing policy objectives can thereby be achieved. This occurs most commonly when patients' refusals of treatment are specifically overridden following clinical, administrative, or judicial review. Some states also make general exceptions in the context of civil, criminal, or outpatient commitment.

5. Existence of an exception to disclosure requirements does not necessarily mean that patients do not retain the right to give or withhold consent to treatment. For example, patients retain the right to consent even if they waive their right to disclosure (unless they also waive their right to make a decision and designate an alternative decision maker) or if therapeutic privilege has been invoked as the basis for limiting disclosure.

Clinical Aspects of Informed Consent

Although the law establishes the required dimensions of informed consent, clinical experience suggests the value of augmenting these required practices in several ways, consistent with physicians' ethical obligations to respect patients' autonomy and to promote their well being. These clinical aspects of informed consent should not be seen as standards to be followed concretely in all situations, but as ideals to be shaped according to the specific circumstances of a patient's condition and treatment.

1. Whatever the governing legal stan-

dard of information disclosure, it is desirable for patients to receive that information that they find most relevant to their decisions. This can be accomplished by encouraging patients to ask for additional information after a basic disclosure has taken place.

2. Information disclosure need not occur at a single point in time, but can—and often should—proceed in stages, with additional information provided in an educational manner as patients are able to assimilate it. Ability to assimilate information often improves as patients' symptoms—including anxious, depressive, and psychotic symptoms—begin to resolve. Periodic redisclosure should occur when patients' conditions, the risks and benefits of treatment, or available alternative treatments change.

3. Even when an exception to requirements for disclosure exists (except in cases of waiver and therapeutic privilege), it is generally desirable for patients to be given as much information as they can assimilate from the usual disclosure. This is true for minors for whom treatment consent is obtained from their parents or guardians, as well as for adults. This practice facilitates physician-patient collaboration in treatment and may permit more knowledgeable participation in and adherence to treatment by the patient.

4. Printed forms may have some value in documenting that disclosure has occurred and that patient consent has been obtained. The information on such forms generally is not a substitute, however, for direct discussion between clinicians and patients. An alternative to the use of forms is for psychiatrists to write a note in patients' charts indicating that a consent discussion has occurred and whether consent was obtained. Careful documentation may be valuable in the event of subsequent claims that a valid informed consent was not obtained.

Another way in which the law of informed consent can be augmented by clinical experience is when legal principles fail to provide clear guidance for practitioners faced with special problems or issues related to informed consent. Some of these problems may be particularly likely to arise in psychiatric treatment.

5. *Incompetence*: Some psychiatric patients may lack the capacity to decide about treatment as a result of their disorder. When readily available mechanisms exist for obtaining formal determinations of incompetence and having legally authorized decision makers appointed, it will usually be desirable that they be pursued. In many instances, however, such mechanisms are not readily available (e.g., no resources exist to initiate legal proceedings for appointment of a substitute decision maker). This circumstance may leave physicians and patients in a legal gray zone. Patients require care and often acquiesce to proposed treatment. In such cases, psychiatrists might consider pursuing second-best options, including: obtaining consent from patients' family members, as typically occurs in general medical practice; involving institutional review committees or patient advocates in authorizing care; obtaining a second physician's opinion prior to proceeding with treatment. Psychiatric facilities, whether inpatient or outpatient, may find it useful

to develop defined procedures for responding to these situations, rather than leaving clinicians to devise their own responses.

6. *Limited impairments in patients' decision-making capacities*: Psychiatric patients may exhibit impairments in their decision making that are limited in either extent or duration.

a. *Extent*: Some psychiatric disorders can impair decision-making functions to some extent, but not to the point where patients would be considered legally incompetent. In such cases, clinicians have generally made disclosure in a fashion that takes patients' limitations into account. This may include simplifying elements of the disclosure, offering information in smaller amounts stretched out over time, and repeating disclosure several times. The implication of these accommodations to patients' impairments is that some patients may be asked to consent to treatment (when it needs to be implemented promptly) before having received a disclosure comparable to that offered to non-impaired persons. This may be the preferred approach when delay in treatment is undesirable from the patient's perspective and alternative decision-making mechanisms are unavailable.

b. *Duration*: Particularly when first hospitalized for an acute psychotic disorder, patients may manifest impairments of decision-making capacities that are likely to resolve quickly, especially if effective treatment can be implemented. Even if patients' impairments are of sufficient magnitude that they may be found legally incompetent, pursuit of formal adjudications may be impossible (e.g., no resources for the purpose exist) or simply unwise (e.g., delay would be substantial, such that patients who acquiesce to proposed treatment would be likely to recover adequate decision-making capacity by the time a hearing would taken place). Common practice in many places has been to initiate short-term treatment of such patients, even in the absence of a fully adequate consent, obtaining such consent as soon as patients' condition permits it. This practice should be acceptable (although it, too, may fall into a legal gray zone) when recovery of decision-making capacities is likely to occur quickly (e.g., within two weeks). Such an accommodation recognizes patients' interests in rapid treatment and in avoiding procedures (i.e., declaration of legal incompetence) that are stigmatizing and may unnecessarily restrict patients' freedom. If long-term treatment is required, it may be preferable for psychiatrists to consider these patients incompetent, and follow the procedures suggested in section 6 above.

Not all disclosures by psychiatrists to patients fall into categories traditionally subsumed under the law of informed consent. This is the case for the issues addressed in sections 7 and 8 below.

7. *Psychotherapy*: Informed consent developed in the context of invasive procedures and has since been extended to treatment with medication. There has always been uncertainty as to the extent to which the doctrine of informed consent is applicable to psychotherapy. Although discussions about treatment may fit poorly into some psychotherapeutic approaches, recent changes in practice that

emphasize short-term, problem-focused therapies are more accommodating (or even encouraging) of such interactions. Whether or not required by the law, it seems reasonable to encourage psychiatrists to discuss with their patients the nature of psychotherapy, likely benefits and risks (where applicable) and alternative approaches (both psychotherapeutic and non-psychotherapeutic) to their problems.

8. *Confidentiality*: Psychiatrists have been required by their ethical code to reveal to patients likely limitations on confidentiality in certain settings. Given the large number of exceptions to the general principle of confidentiality, it does not seem reasonable to ask psychiatrists to disclose them all. Rather, patients should be told at the outset of treatment about risks to confidentiality that are evident to the treating psychiatrist, and should be told in the course of treatment about additional risks as they appear to be relevant to their cases.