Legislating Human Rights: Informed Consent and The Pennsylvania Mental Health Procedures Act†

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Introduction

A controversial trend in American Law is the imposition of civil libertarian ideals into the doctor-patient relationship within the field of psychiatry. In keeping with this trend, the Pennsylvania legislature passed a comprehensive Mental Health Procedures Act in 1976.[1] A major purpose of the legislation was to protect individual civil rights. It was in this context that a detailed provision for "informed consent" for admission to psychiatric hospitals was written into the 1976 law. This paper explores the outcome when a piece of social legislation attempts to impose standards of behavior on the already existing relationship between psychiatrist and patient. The early phase of implementation of the 1976 Pennsylvania Act is discussed, as well as the reaction of mental health professionals to its passage. The findings give some insight into the difficulties of changing social behavior through legislation.

Background

Since the French Revolution there has been a trend in western industrial societies to include members of increasingly large sectors of the population within the status of independent individual with all the rights and duties attendant on that status. As Durkheim[2] has pointed out, the concept of the individual has become "sanctified" in modern industrial societies. Recently this process of inclusion has been extended to mental patients. Thus, several court cases decided in the 1970's have tightened the requirements for mental health commitment while others have found that hospitalized mental patients have a constitutional right to receive treatment.[3,4] A further refinement of the extension of rights is the concern of recent legislation to control the doctor-patient relationship and to push it in a new direction.

Traditionally, the doctor-patient relationship was seen as one in which a great imbalance of power existed.[5] In legal terms, the doctor was viewed as having a fiduciary duty to the patient — that is, as having a

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duty to exercise the highest standard of care in providing treatment. The patient, on the other hand, was viewed as being the passive recipient of treatment, whose major obligation was to pay the doctor's bill. The modern viewpoint conceptualizes the doctor-patient relationship more in terms of a consumer contract. As noted by Redlich and Mollica, "The fiduciary system in which a patient puts his trust in the physician's ability and willingness to make crucial decisions, is being replaced by a contractual system."[6] It is in this context that informed consent to treatment has become an important human rights concept in the medical field.

The foundation of the doctrine of informed consent both reflects and enforces the ancient concern of Anglo-American law with the individual's right to be free from the conduct of others that affronts bodily integrity, privacy and individual autonomy. Since individuals are assumed to be self-determining, they may make a choice as to their acceptance or nonacceptance of treatments available. The doctrine also seeks to promote intelligent and rational decision-making by patients by making relevant information about treatment available to them.[7] However, it was not until the 1960's that the princple of informed consent developed into a full-blown doctrine to which courts now generally adhere.

There is more to the doctrine of informed consent, however, than the mere provision of information. The doctrine itself is still evolving, but the key constituents, culled from scholarly and judicial commentaries, require that *information* given to a *competent* individual will result in the person's *understanding.* The precondition of this process is that the individual be a *free actor* and the culmination of the process is that understanding will result in a *decision* concerning treatment.[8]

Despite a voluminous theoretical literature examining the intricacies of the concept of informed consent,[9,10] empirical work in the area has been limited and has focused primarily upon whether psychiatric and other medical patients can or do understand information that has been given them, rather than determining at the outset how or whether such information is disclosed to the patient.

In describing a sample of patients' records detailing their presentation at a hospital, Owens[11] casts doubt on the ability of patients with disordered thought processes to give informed consent. Similarly, Olin and Olin[12] found a lack of comprehension on the part of a sample of mental patients as to the terms of their voluntary status. Problems of understanding are not confined to mental patients only. A study comparing schizophrenic patients and medical patients as to their knowledge of the medication prescribed them found that medical patients knew less than schizophrenic patients of the risks and side effects associated with treatment.[13] Lack of compliance with treatment regimens may be attributed to the nature of the communication between doctor and patient.[14,15] Observations have shown that physicians often communicate in jargon[16] and that patients often forget to

mention all their medical problems and confuse or forget certain instructions concerning their diagnosis or treatment.[17]

While useful in illuminating relevant components of the doctor-patient relationship, none of these studies details the process of obtaining informed consent and whether and how the relevant information about treatment has been given. To determine the viability of the concept of informed consent in psychiatric practice, the Law and Psychiatry Program of the University of Pittsburgh therefore engaged in a study of treatment negotiations between staff and patients in three settings within an urban psychiatric hospital including an admission unit, an outpatient clinic specializing in the treatment of schizophrenic patients, and a clinical research ward structured as a therapeutic community. The purpose of the overall study was to obtain descriptive data on the operating procedure of each unit, and to document the ways in which staff members obtained consent from patients. It was hoped thereby to pinpoint any constraints to the obtaining of informed consent which might derive from the logic of the procedures of the various settings, or from values and expectations of staff and patients.

This paper is addressed to findings in the first of the three settings we observed, the admission unit, in which 22 of 48 patients that we studied were admitted to the hospital as voluntary patients.

The admission unit provided a unique setting in which to study the provision of information because the type of information to be provided the patient to obtain his/her informed consent was specified by law. The Pennsylvania Mental Health Procedures Act of 1976[1] and its implementing regulations[18] went into effect shortly before our observations began. The Regulations, promulgated by the Pennsylvania Department of Public Welfare, define informed consent to include the following elements:

1. An understanding that the treatment proposed will involve outpatient, partial hospitalization, or inpatient status;
2. A willingness to be admitted to a designated facility for the purpose of examination and treatment as prescribed;
3. That such consent is given to the proposed treatment voluntarily without coercion or duress;
4. That he or she has been provided with a full explanation of the proposed treatment and rights and responsibilities of persons in voluntary treatment.[19]

The regulations prescribe a series of forms, to be signed by or given to the person seeking voluntary admission, which incorporate these elements. Some elements are made a part of the forms themselves, such as a recitation, "I voluntarily give my consent without any coercion or duress, to receive inpatient treatment. . . ." which appears on the voluntary consent to inpatient treatment form. Other elements are represented on the forms as blanks to be filled in by admitting personnel, including the name of the treating facility, the findings of the

initial evaluation of the patient, the description of proposed treatment, and the description of proposed restrictions and restraints. These forms were clearly intended as a vehicle for providing information to the patient concerning treatment.

Methods

To document the admission procedure, two observers placed themselves in the unit at different times of the day and night for a period of seven weeks.[20] These seven weeks consisted of two blocks of time extending over a three-month period. The first three-week period began two weeks after the Mental Health Procedures Act went into effect, a time when compliance to the law was expected to be at a

TABLE I
DEMOGRPAHY OF VOLUNTARY ADMISSION PATIENTS

No.	Age	Race	Sex	Highest Level of Education Completed	Occupation (Last Known Occupation)	Primary Admission Diagnosis
001	30	W	F	Some College	Homemaker (Design Ass't.)	Depression
002	17	W	F	11th Grade	Student	Anorexia Nervosa
003	64	W	F	8th Grade	Unemployed	Depression
004	51	W	F	4th Grade	Homemaker	Depression
005*	41	W	M	Ph.D.	Physicist	Manic/Depressive (Manic phase)
006	38	W	F	High School	Homemaker	Depression
007*	23	B	M	Some College	Unemployed (Factory Worker)	Schizophrenia
008*	46	B	M	10th Grade	Unemployed (Carwash Worker)	Organic Brain Syndrome
009*	24	W	F	High School	Homemaker (Secretary)	Depression
010*	59	W	M	6th Grade	Unemployed (Upholsterer)	Alcohol Abuse
011*	36	W	F	Some College	Maid	Schizophrenia
012*	51	W	F	Some College	Homemaker (Bookkeeper)	Depression
013*	20	W	M	Some College	Unemployed	Heroin Abuse
014*	31	W	M	Some College	Photographer	Depression
015*	30	W	F	High School	Homemaker	Depression
016*	55	W	M	B.S.	Unemployed (Pharmacist)	Drug Abuse
017*	22	W	F	10th Grade	Unemployed	Schizophrenia
018*	41	W	M	11th Grade	Unemployed (Factory Worker)	Drug Abuse
019*	52	W	M	8th Grade	Mechanic	Anxiety Neurosis
020	20	W	F	10th Grade	Homemaker	Schizophrenia
021	24	W	M	8th Grade	Restaurant Worker	Violent Behavior
022*	18	W	F	Some College	Student	Schizophrenia

*Indicates a "complete case" — *i.e.*, all major interactions between patient and staff were observed by at least one observer. It should be noted that most of the "incomplete cases" were virtually complete. So far as can be inferred from observations of other similar cases, no significant information exchanges were missed because of observers not being present during all interactions. "Incomplete cases" most often resulted from conflict in scheduling, as when two patients being followed by the observers were simultaneously interviewed by two clinicians, making it necessary for the observers to choose one case to follow; in two cases from staff members requesting that the observers not be present during a crucial stage of staff-patient negotiations; and in one case from the father of a minor patient, who had herself consented to the observation, questioning the presence of observers.

maximum, as staff members, having recently been bombarded with explanations of the Act and the procedures it required, would be attempting to follow its dictates. The second four-week period began ten weeks after the Act went into effect, a time when the Act's requirements were expected to have been incorporated into the routine admission procedure.[21]

Patients who entered the unit were approached by the researchers and/or — depending upon the pragmatics — by the hospital staff, and the nature of the study was explained to them. Only those patients who consented were observed.[22] A census of patients appearing at the unit within different time periods was obtained, such that data on a wide variety of patients as well as staff members from different shifts was collected.

TABLE II
ADMISSION UNIT STAFF MEMBERS

Professional Background	No. Observed
Psychiatrist	7
Psychiatric Resident	7
Medical Student	5
Registered Nurse	6
Social Worker	1
Receptionist	1
TOTAL:	27

One observer spent time with staff members, the other with patients, in order that the perspective of each group of persons be obtained. The observers took notes while the patient was seen by a clinician who obtained information on a presenting problem. The staff observer was then present while the clinician summarized the information for a psychiatrist. Both observers were present when the psychiatrist talked with the patient. The psychiatrist then left to discuss the case in the staff room and was accompanied by the staff observer. Meanwhile, the patient observer remained with the patient and conducted an open-ended interview to tap the patient's perception of what had just occurred.[23] Because of the unobtrusive nature of the observations, the sample has some of the features of an opportunity sample. The researchers observed the first full transactions available during the hours of watching, and when observations were completed the next patient was approached.[24]

In order to obtain the informed consent of staff members, the protocol (which gave the design and purpose of the study) was posted in the staff room. As staff members were told of the purpose of the study, the researchers were able to gain some indication from them of the likelihood of admission for patients prior to the patients' being seen. When choices were possible as to which patient was to be observed, emphasis was placed on observing these sicker patients, so that the total sample is a stratified one with an over-representation of admitted patients.

TABLE III
BREAKDOWN OF STUDY SAMPLE BY DISPOSITION AND COMPARISON WITH ADMISSION UNIT NORM*

Category	Study Sample No.	%	Admission Unit Norm No.	%
Voluntary Admission	22	46	395	25
Involuntary Admission (Emergency)	3	6	71	4
Involuntary Admission (Extended)	1	2	3	0
Referral to Hospital Clinic	15	31	858	52
Referral to Other Institutions	2	4	198	12
Refusal of Treatment	2	4	20	1
No Treatment Recommended	0	0	35	2
Other	3	7	58	4
TOTALS:	48	100	1638	100

*No official hospital statistics were compiled for this unit during our observations (September to December, 1976). The figures presented here are based on monthly reports for September to December, 1977, which the Director of the admission unit believes closely approximates the activity of those same three months of the preceding year.

In all, 48 patients were observed of whom 22 were admitted voluntarily to the hospital. The sample is reasonably representative of the type of patients seen in this unit save for the over-representation of admitted patients (see Table III). The fact that the hospital requires admitting patients to go through financial interviews and a physical examination, as well as being seen by a psychiatrist and a clinician, *i.e.,* a psychiatric nurse or social worker trained to admit patients, means that each case typically took from 2 to 5 hours and involved several staff members, who often acted simultaneously. Neither the Act nor hospital policy specifies whether the clinician or the doctor has the primary responsibility for informing the patient and getting his/her consent, so the giving of information can take place in either of the interviews. Since analysis is based upon what the patient is known to have been told, those cases in which all the relevant patient-staff interactions were seen will be discussed.

After we left the setting, key staff members (including those responsible for training other admissions unit staff) were interviewed and debriefed about our observations. Their opinions about the 1976 law, its requirements, and the difficulties they experienced in implementation were solicited and recorded.

The work was also complemented by simultaneous monitoring of the reactions of psychiatrists, civil libertarians, and others concerned with the mentally ill, to the changes in the Pennsylvania law. A running log was maintained of their official reactions to the Pennsylvania Mental Health Act and recommendations to the Department of Public Welfare.

The bulk of the raw data thus consisted of extensive notes on the interactions which individual patients had with staff members, including virtually verbatim dialogue recorded by the patient observer who had previously learned speed writing. These notes were read and summarized along a variety of legal and sociological dimensions as they related to the model of informed consent described earlier. While the use of the case

study method does not allow generalization to populations, it nevertheless allows for detailed documentation of the idiosyncratic. The data thus serve to generate hypotheses as to the nature of the social processes in operation within this setting, and suggest some of the difficulties which may be faced by those attempting to implement informed consent.

Findings

A careful analysis of the observation notes reveals that the degree to which the specific legal requirements of the Act and Regulations were implemented by the admission unit staff can be grossly categorized according to the number of cases in which the minimum requirements of the law seem to have been met. In addition, all of the cases can be minutely examined to determine exactly how the legal requirements were met or not met in specific circumstances. The following paragraphs present a gross analysis of the numbers of cases in which the requirements were met, as well as citing specific examples of how particular legal requirements were dealt with by the treatment staff. In relation to the requirements specified by the Regulations, our observations revealed the following:

Inpatient Status

For informed consent to hospitalization, the Regulations require that the patient understand that the treatment proposed will involve inpatient status.[25] This requirement appears on an admission form as the statement: "I voluntarily give my consent . . . to receive in-patient treatment . . ." All of the 22 patients signed this form and apparently at least knew that inpatient status was involved, although one woman told an investigator in a follow-up interview, "I thought I was signing myself out when I signed myself in." The information was generally conveyed to the patient by means of a staff member asking "Do you want to come into the hospital?" rather than by an explanation that treatment would involve inpatient status. In addition, in almost half (10) of these cases the patients told our observer that they had come to the hospital specifically to seek admission. This suggests that an explicit *explanation* is not always necessary for patient understanding.

Designated Facility

The Regulations also require that the patient be willing to be admitted to the designated facility for the purpose of examination and treatment.[26] This willingness is to be manifested by the signing of a form on which the name of the designated facility, which is represented by a blank, is to be written by staff. In 2 of the 22 cases observed, the name of the designated facility had not been filled in before signing, and in one other case, a patient was permitted to sign a form on which he had first purposely scratched out the name of the designated facility. The staff rarely presented this information as part of the treatment information. Rather, the subject was introduced by the question "Do you know

where you are?" which was viewed by the staff primarily as a diagnostic technique to measure orientation. The staff member would then mention the name of the hospital only if the patient was unable to do so.

Voluntariness

Another requirement is that consent be given voluntarily to the proposed treatment.[27] Thus, the patient must be free from coercion and unjustifiable pressure when consent is obtained. Coercion, as defined by a recent authoritative report issued by the National Commission for the Protection of Human Subjects, occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance (Belmont Report, 1979).[28] While in some cases the staff applied pressure on patients,[29] in only one case where the patient was admitted voluntarily did the staff behavior rise to the level of actual coercion. Specifically the threat of commitment was never used by staff against patients who came to the hospital voluntarily, but in the case of one man brought to the hospital involuntarily, one staff member used coercive tactics while another gave the patient to believe that there were options available to him. The nurse emphasized that if he did not sign in as a voluntary patient, he would be committed — while the psychiatrist told the patient that he recommended that he be hospitalized but that it was "ultimately your decision." The staff did, however, more frequently permit other persons to exercise coercion. In one case, for example, the wife of a heroin addict threatened to leave him if he did not immediately sign himself into the hospital. The issue of family involvement is, however, more complex, since we observed a continuum of cases involving quasi-substituted decision-making when relatives made decisions and patients either did not protest or protested intermittently.[29]

The Belmont Report defines unjustifiable pressures as occurring when persons in positions of authority or commanding influence urge a course of action on a subject. Only one case was observed in which a person could be said to be submitting to unjustifiable pressure by non-family members. A university police officer, who had brought the patient to the admission unit, was permitted to be present when the patient signed the papers and, in fact, ordered him to do so. In two cases, after patients vacillated about their willingnes to be admitted, the staff reminded them of the many hours already spent with the patient and the necessity of signing in immediately so as not to lose the opportunity for a bed. It could be argued, however, that given all the facts of the case, pressure of this type is "justifiable."

Treatment

The regulations require that a full explanation of the types of treatment in which the patient may become involved is to be written on a form and signed by both physician and patient.[30] Such written explanations were usually very general and very brief, consisting of a statement that "patient will be observed and further treatment discussed with the attending physician" and covering less than 3 of the 7 lines

provided on the form. In addition, the patient was usually (14 cases) given some further explanation such as "You will be on the tenth floor," "You will probably be given medication," "You will be given tests," etc. In one case, the patient, a young woman whose admission diagnosis was schizophrenia (paranoid type) asked many questions and was given an extremely detailed explanation of prospective drugs and testing. It was stressed to one other patient, a heroin addict, that he would receive no drugs to aid in his withdrawal. In two of the cases, no information other than that appearing on the form was offered, and in one of these cases, that of the man ordered to sign in by a police officer, the form was blank when signed! The information was then filled in above the signature, resulting in a finished product indistinguishable from a properly completed form. Surprisingly, this description of proposed treatment was more detailed than most, reading:

1. Hospitalize for purpose of protecting others from violent behavior;
2. Reinstitution of Butyrophenone (Haldol)
3. Referral to out-patient service.

One other patient who received no explanation was considered an emergency case, in that he had suffered a suspected seizure during the initial interview and was thereafter rushed through the admission process with minimal delay.

Rights

There are two forms concerning the patient's rights while in treatment which the Regulations required to be given to voluntary admission patients.[31] One of these, labelled "Bill of Rights," notifies patients that they are entitled to all civil rights not specifically limited by court order,and that, subject to restrictions directly related to treatment, within the institution they have the right to assemble peaceably, participate in patient government, consult an attorney in private, have their complaints adjudicated, receive visitors, send and receive mail, have access to a telephone, practice the religion of their choice, possess personal property and participate in the development and review of their treatment plans. This "Bill of Rights" is to have appended to it the names, telephone numbers and locations of available advocacy services, and a signed receipt for it is to be obtained from the patient if possible.[32] This "Bill of Rights" was not provided to any patients during our observations consequent to a staff misunderstanding as to whether this form needed to be provided before admission. The staff believed this form was to be given upstairs on the hospital floor. That staff did not consider it necessary to give patients the form to provide them with relevant information on which they might base a decision until after they had signed into the hospital indicates a fundamental misconception of the purpose of this portion of the Regulations as they relate to informed consent.

That such a misunderstanding arose was in part explained by the number and variety of agencies responsible for the actual implementation

and monitoring of the Act. The procedures to be followed cascaded from the State Department of Public Welfare to the local county mental health administration, to the hospital director, to other hospital consultants and administrators, to the director of the admission unit, to the field personnel responsible for implementing the Act. As in the childhood game of Telephone, some information was lost along the way.

The other rights form, labelled "Explanation of Voluntary Admission Rights," includes the right to an explanation of proposed treatment, restrictions and restraints before admission, the right to participate in the formulation of an individualized treatment plan which must be drawn up within 72 hours of admission, the right to withdraw from treatment at any time [see below for a discussion of restrictions on this right] and the right not to be transferred to another facility without consent. Nine patients were either shown this form or came across it while leafing through their admission forms, and eight of these were observed to read it. In addition, in four of these nine the clinician read the form to the patient and one patient also received a point-by-point explanation. Two other patients who did not read the form received some verbal information about rights: the son of a woman who did not understand English translated the form line-by-line into her native language, and the man who suffered a suspected seizure was asked if he remembered what he had been told about rights previously, and informed of his right not to be transferred without consent. One woman, in great discomfort from possible tardive dyskinesia, was rushed through the admission process with minimal delay and consequently was given no explanation of rights. This was noted on her chart by the clinician, indicating that, in this case, the provision of rights information was regarded with importance. Rights were mentioned without explanation to one other patient; four received no information.

Restrictions and Restraints

As mentioned above in the discussion of "Rights" the Regulations provide that a patient may withdraw from voluntary treatment at any time by giving written notice to the treating facility.[33] However, the Regulations also provide that the patient may, at the time of admission, be asked to sign a form agreeing to remain in treatment for a certain number of hours (up to 72) after notice of withdrawal has been submitted. This is a substantial restriction on the patient's liberty, in that during the 72 additional hours he or she remains hospitalized, application may be made for involuntary commitment. This possibility of involuntary commitment during this 72-hour period was not clearly explained to any of the 22 patients observed, although 11 patients at least saw or heard it mentioned via the Voluntary Admission Rights form which read:

You may be asked to agree to remain in the facility for a specified

period of time up to 72 hours after you request discharge. If, when you request discharge you are asked to remain for this period of time, someone will immediately explain why to you. The facility may institute involuntary commitment proceedings during this period.

The only patient who commented on this section, a young woman who exclaimed, "That sounds gruesome!" subsequently checked choice "B" on the admission form (below), indicating that she wished to leave immediately upon expressing her written desire to do so. Her comment was spontaneous and not in reference to any explanation from a staff member.

The admission form read:

I understand that I may: (Check and complete A or B)

A. Leave this hospital upon written request with _____ hours
(up to 72)
notice. The reasons for giving notice before I leave have been explained to me.

B. Leave at any time I express my desire to leave in writing.

The admission form seems to indicate that the patient, not a staff member, should fill out this section. Yet only eleven patients checked one of the boxes themselves and wrote in a number of hours when applicable, and one of these patients checked the box and wrote in the number of hours *after* she had already signed the form. Two patients were told explicitly by staff members what to write. One other patient checked Box A before signing, but '72' hours had already been written by a staff member before the form was shown to her. Similarly, on another form on which '72' hours had been filled in, a staff member checked the A box after the patient had already signed it. In two cases, Box A had already been checked and '72' written in before the patient was shown the form. Three others signed blank forms which were later filled in by the staff. On one other form, it is clear that this section was filled in by a staff member rather than the patient, but our data does not indicate whether this was done before or after signing.

Although the form reads: "The reasons for giving notice before I leave have been explained to me," only 12 patients received any explanation, and these were quite vague. For example, one woman was told:

I told you we would keep you here at least for two days, but we would like to keep you here longer if they think you need it, but if you decide to leave before that time, we would like you to give us a few days notice, OK?

The Regulations also require, via the forms, that the patient be

informed of proposed restrictions and restraints. The typical restriction section of the form read "Ward routine" or "Ward is locked." The only explanation that most patients (8 cases) received was "the door to the ward will be locked but the door to your room won't be." One patient, the heroin addict, was given information concerning restrictions on his access to drugs and visitors through whom he might receive them. In six cases, restrictions and restraints were not mentioned at all. Assumedly, most of these patients had an opportunity to read that section on the form, but one, the man ordered to sign in by a police officer, is known to have signed a blank form. This is significant because restrictions, added after he had signed, read: "Seclusion and restraint if patient becomes violent." Neither seclusion nor restraint was mentioned on any of the other forms reviewed.

Initial Evaluation

In addition to the elements of informed consent discussed above, the Regulations also require the findings of the examining physician's initial evaluation to be written on a form signed by both physician and patient. Nowhere does the law enumerate what must be included in this evaluation, but clearly it should be detailed enough to inform the patient of what the physician sees as his or her psychiatric problem. Typical evaluations read: "Depressed lady on Librium," "24-year-old lady with depression and difficulty organizing her thoughts," "Patient has not been sleeping well and is hyperactive," and filled less than 3 lines of the 7 provided. Two patients discussed above, the man who was ordered to sign in by a police officer and the man who suffered a suspected seizure, signed blank forms upon which no evaluations had been written. Even in those few cases in which this evaluation was written in some detail, it was often couched in medical jargon incomprehensible to the average patient. For example, one man was shown the following:

(1) ↑B.P.
(2) Periph Vasc Disease
(3) ASCVD w/CHF (Treated)
(4) 1° AD – unipolar
(5) Paresis (L) ulnar distribution

Only #4 is a psychiatric diagnosis, meaning, in simple terms, that the patient's problem is primary depression. Such evaluations demonstrate the need for some explanation to be provided to the patient beyond that appearing on the form, and this was done in 12 cases. However, these too were very brief and general, in ten cases consisting solely of such statements as "you are suffering from anxiety," "you hear voices and they are telling you to do something to harm yourself" or "you are to be admitted because you are depressed."

The Efficacy of Written Consent

Patients were also asked, as part of the admission procedure, to sign a form which stated: "I confirm that this treatment has been explained to me including the types of medications which I may be given and the kinds of restraints or restrictions to which I may be subjected." With one exception, no patient questioned this statement or expressed dissatisfaction with the amount of information given, even when asked to sign this confirmatory statement *before* being shown the descriptions of proposed treatment.[34]

This suggests that patients did not read the consent forms carefully, and/or that they did not feel responsible for what they signed. Similarly, it appears that staff may view the legal admission requirements as mere formalities to be completed rather than as means of providing information to the patient.[34] This is borne out by comparison of the patient evaluations appearing on the legally-mandated forms with those recorded on the in-house admission forms, in which the staff went into much greater detail. For example, one woman's legal form read: "Responding to hallucinations of an imperative self-destructive nature." In contrast, her in-house evaluation read:

> This 36 y[ear] o[ld] W[hite] S[ingle] F[emale] was brought by Campus Police from [medical hospital emergency room] for evaluation. She has been behaving strange at work this morning and her boss sent her to [medical hospital emergency room] for evaluation and she had Benadryl 50 mg. at 8 AM at [medical hospital emergency room] & then was sent here. [Patient] appears sloppily dressed and her eyes are looking up at the ceiling because she says "Voices are telling me to look at the ceiling and jump off the window." She states she has been having active auditory hallucinations for past 2 years and have (sic) been coming to [out-patient clinic] for follow-up care. She was seen at [out-patient clinic] by [doctor's name] 10/4/76 and had Prolixin D. 40 I.M. She is also taking Cogentin 2 mg T.I.D.
>
> She is too preoccupied c her "voices" at this time to give me any concrete information at this time. She states she is allergic to Penicillin but has no other medical problems at this time.
>
> Her next appt. at [the out-patient clinic] is scheduled for 10/18/76 at 3:30 p.m.
>
> Imp: Schizophrenia

Such detailed explanations were not provided to patients. The patients were generally not given enough information on which to base a rational decision about whether or not they wished admission. This is contrary to what the law intended.

Value Conflicts with the Requirements of Informed Consent

In the process of observing, and in our later questioning of staff and

patients, we also noted that perceptions of the functions of the unit by both staff and patients translated into ways of behaving which were often at odds with the procedure of obtaining informed consent. The values of the clinicians and psychiatrists may dictate that they treat a sick patient irrespective of whether he/she is in agreement with the treatment — for example, if the patient is believed dangerous or is not capable of giving informed consent, while the institutional setting of which the staff is a part requires that this be done as quickly and efficiently as possible. In practice, these values translated into specific staff problems and objections to implementing the informed consent requirement as specified by the Regulations.

The spontaneous comments and behavior of the staff in the admission unit (plus the staff remarks made to us after the observations were completed) showed that the staff viewed the legal requirements of the 1976 Act as overly complex, time consuming, and for a variety of reasons, generally not worth doing. For example, it was the staff perspective that although patients were supposed to be informed at admission about the treatments they might receive once hospitalized, this requirement was impractical because the admission unit staff were functioning more as "evaluators" than treaters. Admission staff indicated they did not always know what treatments the patients might receive once hospitalized or even what the more extended in-hospital evaluation of the patient might eventually reveal. Staff also noted that each hospital ward treated patients somewhat differently. It was, therefore, their opinion that they could not inform patients about the likelihood (possibility) of restraint or seclusion. While the admission unit staff did, of course, know considerable information about the patient (*e.g.,* why they believed admission was indicated) and they also knew which treatments, including medications, were generally employed in the hospital for treating certain conditions, they told us that writing this material on the patient's informed consent forms would be "duplicative" of effort. Given perceived time constraints, the staff believed it more important that they record the full medical and social history on the patient's chart (for use by the ward physician) than to write detailed information for patients to read or to consider on the informed consent form. (Of course, staff also failed to give much information orally to the patient about treatments to be received.) Staff also noted that it was their experience that patients were not interested in the informed consent forms. Patients did not read them and they did not understand them. Staff believed that patients would not remember what was on the forms anyway. Finally, because patients had usually told the staff they were willing to be admitted *prior to the information disclosure,* the information was, from the staff's perspective, "redundant." Staff noted that while it was important for patients to "consent" to hospitalization, the forms and the paperwork were mainly a formality.

It was perhaps no surprise then that six months after the new law was

in place (and two months following our observations), an intra-hospital memo to staff indicated that only a minimum of information should be communicated to the patient on the informed consent forms. Concerning the initial evaluation, the memo stated, "In practice, this is usually very brief including for 'Initial Findings,' for example, 'Depressed Man;' " and "the 'Description of Proposed Treatment' is general and frequently states simply 'The patient will be evaluated thoroughly and further treatment will be discussed with his attending physician.' The 'Description of Proposed Restrictions and Restraints' usually only includes mention that the main door of the ward is usually kept locked." Concerning the 72-hour provision, it was stated in the hospital memo, "Allow patient to check box 'A' or 'B', but encourage him to check 'A' and give 72 hours notice." The promulgation of this hospital memo furnishes independent evidence that the observations we made were not just a function of staff uncertainty about procedures, nor did they represent mainly insufficient training of staff about the forms. The staff behavior represented instead their judgment about what was appropriate and feasible under the circumstances. As stated by one key staff person, "In order to perform at all, we have to perform illegally."

Patient Attitudes

Patient interviews by the observer confirmed that the center was viewed for the most part as a place where they could receive the help they needed. The desire to make rational choices and weigh risks and benefits of any information concerning treatment was exhibited by very few. In fact, the need to have complete faith in the all-powerfulness of the doctor seemed to be an overriding motivation for many who saw the hospital as a last resort sought after a long series of difficulties in their home environment. Many patients expressed a very active desire to come into the hospital. They conceived of the interview with the clinician and the psychiatrist as being a process in which relevant symptoms had to be presented in such a way that the staff would decide upon hospitalization. As one woman who was told by the doctor that she would be admitted expressed it, "It's like you used to feel in high school taking a test." Thus, ironically, though patients may have actively decided before coming to the hospital that they wanted to be admitted, they demonstrated the most helpless and hopeless aspects of their characters and delivered themselves into the hands of the physicians in order to be assured of admission.[35]

In summary, within the framework of the admission unit, informed consent (at least that version of it contemplated by Pennsylvania legislators) was rarely obtained. The staff viewed the obtaining of consent as a mere formality and gave it low priority while the patients failed to exert the degree of pressure necessary to gain sufficient information.

Attitudes of Other Psychiatric Professionals in Pennsylvania

It is also fruitful to consider the more general attitudes of selected but

influential psychiatric professionals in Pennsylvania about the legislative aspects of informed consent. Parsons[36] notes that in order for positive institutional change to occur, it is necessary to furnish new alternative definitions of the situation which are positive for those involved, and in particular that they be not far removed from the symbols and prestige standards previously current. But our evidence indicates that many Pennsylvania psychiatric professionals viewed the new mental health act negatively, charging that it contained a strong anti-physician bias. The psychiatrists objected to the erosion of their power and the detrimental effect of state interference upon the therapeutic process. They felt that there was a high degree of inappropriate influence on them. Typical of the responses we collected was that of the director of one psychiatric hospital who, in a letter to the sponsor of the bill (written three months after the new law was implemented) wrote, "Where people are freely and voluntarily seeking help, the State has no business intruding itself into the therapeutic process." In a letter to the same senator written six months after the new procedures were implemented, the Pennsylvania Psychiatric Society made objections to the use of forms as suggesting "an adversary position between the patient and treating facility from the outset." Seven months after the Act went into effect, the chairpersons of the departments of psychiatry of Pennsylvania teaching hospitals urged the removal of voluntary patients from the scope of the Act, thus affirming their view that the medical profession should be trusted in its treatment of voluntary patients.

Discussion

Our observations pose problems for both the theory and pragmatics of informed consent as this relates to admission to the hospital for psychiatric patients. Certainly there was considerable discrepancy between the information disclosure mandated for psychiatric patients by the Pennsylvania law and what information was actually disclosed in the admission unit we studied.

Our study sample was a relatively small one, and explanations for this divergence must remain tentative. Nevertheless our observations revealed that neither hospital staff nor patients viewed the Pennsylvania requirements for informed consent or admission as either very functional or relevant to their concerns. Informed consent to admission (as defined by the Pennsylvania law) was usually not obtained for several interrelated reasons: because psychiatrists were upset by the law and found it impractical to implement, because hospital staff did not perform the consent procedure well, and because patients were typically passive and either unattentive or unmotivated to consider the informed consent matter seriously or to press for more information.

These observations do not, of course, mean that the goal of achieving informed consent for hospitalization for psychiatric patients can never

be realized. But, without doubt, the issues we discuss here must be considered by policymakers if the informed consent doctrine is ever to become meaningful in this type of setting. The problems we documented did not result merely because additional "shake down" of procedures was required before informed consent was obtained from patients. Instead (as we discuss in other papers in this special symposium),[29,34] barriers to consent in this setting were many; these barriers related to the structure of the care delivery system, the mechanics of the mandated procedures, and the attitudes and behaviors of both sets of participants (staff and patients) concerning the feasibility and desirability of obtaining informed consent. Rather than the newly touted "contractual model," the more traditional model of the doctor-patient relationships in which doctors know and patients accept was viewed by the majority of persons in this setting as the most efficient and comfortable way to institute treatment for the patient.[37]

The implications of the data are several. Unless (and until) more complete information is given to patients prior to hospitalization, we will not learn whether informed consent for admission to psychiatric hospitals is either possible or desirable. Whether staff resistance towards giving such information can be successfully overcome is another matter. But assuming our observations are representative of what occurs in other settings, it may also be premature to conclude (as others have done) that patients cannot understand about admission to psychiatric hospitals.[12,38] For patients may not have been told what they might want to know.

The purpose of this paper is not to take a pro- or an anti-informed consent stance. Nevertheless, we believe that the issues we discuss need to be considered by both legislators and regulation writers when idealistic doctrine is promulgated and required by law. If our observations are replicated by others, we may need to conclude that ensuring that psychiatric patients give informed consent to hospital admission is not an achievable end. To reach the goal of obtaining informed consent, we could, of course, require more training of staff, more monitoring of procedures post implementation, and more reinforcement for proper behavior by both staff and patients, including both positive and negative reinforcements. Such a response to our observations risks, however, other dangers, *viz,* an infinite regress of regulations, rewards, punishments, and monitoring procedures wherein the reality of doctor-patient interactions in the health care arena is continuously discounted in deference to an idealistic wish.

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19. *Ibid.*, § 7100.2.2.2.B
20. After staying in the unit overnight when no patients were seen, we decided to discount the time period 12 midnight to 9 a.m. from observation. Staff members also confirmed that few patients were ever seen at this time.
21. There were, however, no differences in the findings between the first and second periods of observation. The results from both periods of observations are therefore reported together.
22. Two patients refused any observations whatsoever. Staff refused to allow any observations of one patient. For four other patients, only partial (but largely complete) observations could be made because either the patient, the patient's relatives, or the staff objected to the presence of observers during one phase of the admission procedure. (See also Table I in text.)
23. Interview Guidelines: Admission Unit Patients. What kinds of things do you think they do here? How do you think that might benefit you? *After Psychiatric Interview & Treatment Decision:* Can I now ask you a few questions about what just went on with the doctor and the clinician? (1) What kind of treatment are you going to have? What do you expect to get from it? (2) Did you know anything about this kind of treatment from before, either you were given it or you know somebody who had it? (3) Do you have any worries about the treatment? (coming into the hospital?) (4) Do you feel that you were given enough information about the treatment? (if no) — What else would you like to know? Do you know anything about alternative kinds of treatment? (5) Do you think it's necessary for you to understand the treatment? (if not) Why not? (6) Do you feel that there was any pressure put on you from the staff or others to accept this treatment? (if yes) — How do you feel about this? (7) Why do you think you were asked if you would consent to this treatment? Do you think you might have refused it? (8) Do you feel that you came to a decision about this treatment, or that it was just presented to you? (If answer is "I came to a decision") — At what point did you decide? What kinds of information led you to the decision? (9) Can you tell me a little bit about what you understand your rights are? When can you leave the hospital? What do you have to do in order to leave? How long do you think you will stay here? (10) Can I now ask you about the forms you signed? Can you tell me which ones they were? What kinds of information did you agree to have released when you signed the financial form? Can you explain about the release of information to the county? (Refers to form concerning release of information.) See Lidz CW: The weather report model of informed consent: Problems in preserving patient voluntariness. Bull Am Acad Psychiat Law (this issue).
24. Observations may, of course, be biased in this type of ethnographic study. Bias was minimized, however, in this study because of the non-obtrusive methods of the observers. While the observers took notes, they did not systematically question staff during the study period, nor were patients systematically questioned by the patient observer until their interactions with the staff were complete. No notes were taken or questions asked when the observers first entered the setting so as to "desensitize" the staff to the observer's presence.

There were, furthermore, many "demand characteristics" of the admitting process, characteristics which made it necessary for staff to go about their usual business of evaluating patients and achieving what they viewed as proper dispositions for patients. Finally, to the extent that staff "performed" for us, such a tendency would (we believe) have made it more likely (rather than less) that the staff attempt to comply with the requirements of the law. We believe that the problems in implementing informed consent that we report here were more likely reduced than induced by our observations.

The staff person most responsible for the day-to-day running of the admission unit also indicated to us when debriefed at the conclusion of the study that the "observers didn't get in the way at all."

25. 6 Pa Bull § 7100.2.2.2.B.1
26. *Ibid.*, § 7100.2.2.2.B.2
27. *Ibid.*, § 7100.2.2.2.B.3
28. Belmont report. In: Federal Register 44(76):23192-23197, April 18, 1979
29. For further discussion of these issues, see Lidz CW: The weather report model of informed consent: Problems in preserving patient voluntariness. Bull Am Acad Psychiat Law (this issue)
30. 6 Pa Bull § 7100.2.2.2.B.4
31. *Ibid.*, § 7100.1.10.3; 7100.2.2.1.B
32. *Ibid.*, § 7100.1.10.2
33. *Ibid.*, § 7100.2.6.1
34. For further discussion of the usefulness of forms in obtaining informed consent, see Zerubavel E: The bureaucratization of responsibility: The case of informed consent. Bull Am Acad Psychiat Law (this issue)
35. More extensive findings concerning these and items covered in the patient interview will be reported in future publications.
36. Parsons T: The problems of controlled institutional change. In: Essays in Sociological Theory. New York, Free Press, 1954, pp. 238-274
37. Although we do not have fully comparable data to report, pilot observations made in this same admission unit on 23 patients prior to the change in the law (when compared to the above observations) showed that the newly mandated procedures had little effect in altering the general nature or extent of information disclosure by staff to patients. There was more information given about the "72-hour hold provision" under the new law than occurred under the old law. At the time of our pilot observations, the Pennsylvania law allowed for retention of voluntary patients for up to ten days (after they requested to leave), but this provision was hardly ever discussed in the admission unit. Of course, even under the 1976 law, the information that was given by admission staff to patients about the "72-hour hold provision" was frequently incomplete or misleading.
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