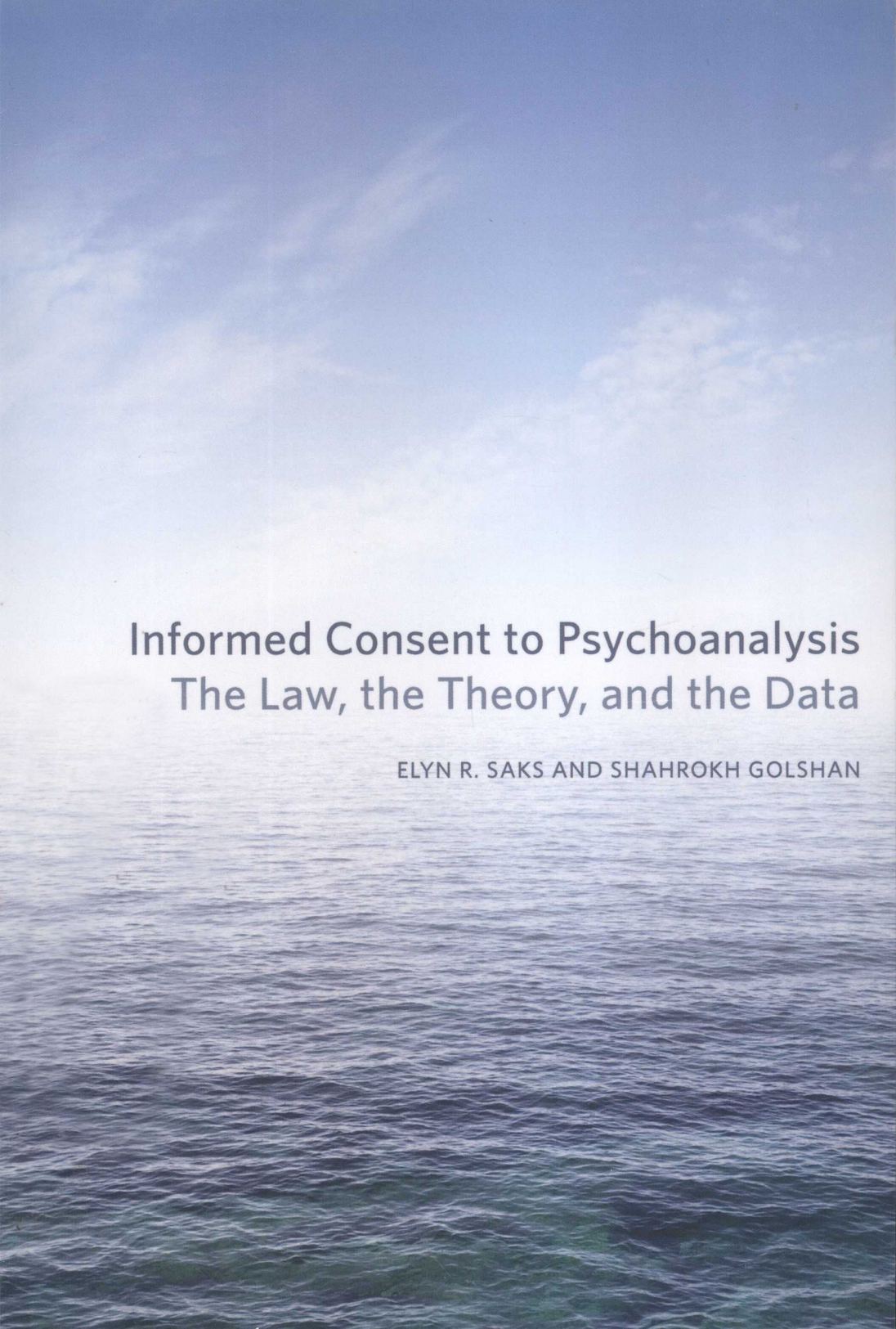

Informed Consent to Psychoanalysis
The Law, the Theory, and the Data

ELYN R. SAKS AND SHAHROKH GOLSHAN

INFORMED CONSENT TO PSYCHOANALYSIS

PSYCHOANALYTIC INTERVENTIONS

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INFORMED CONSENT TO PSYCHOANALYSIS

Contents

Introduction

Psychoanalysts have been up in arms about certain legal intrusions into the analytic space. For instance, inroads on confidentiality have been a great concern (see, for example, Bollas and Sundelson, 1995); indeed, the American Psychoanalytic Association has devoted considerable resources to lobbying in Congress and intervening in lawsuits so that privacy may be better protected (see the American Psychoanalytic Association's "Essential Privacy Principles for Quality Health Care" and the American Psychoanalytic Association amicus briefs in *Jaffee v. Redmond* [1996] and in *Maryland v. State Board of Physicians v. Ilasi* [2007]).

At the same time, legal actions have turned on the failure to disclose alternatives in the case of psychiatric and psychological treatments for certain conditions (see, for example, Klerman, 1990; and Packman, Cabot, and Bongar, 1994). The issue here is whether patients claiming injury from the treatment procedure would have refused the treatment had they been adequately informed, among other things, of the nature of, and iatrogenic problems associated with, the treatment.

The fundamental legal and ethical problem is whether informed consent (IC) is a good idea and what constitutes adequate informed consent. There are a small number of court cases that discuss informed consent to therapy. There are also a considerable number of state statutes and regulations that imply IC is required. In addition, the clinical organizations' ethical codes do require informed consent of some kind (American Psychoanalytic Association, American Psychiatric Association, American Psychological Association, National Association of Social Workers; see Appendix A), and in many states, Codes of Ethics are incorporated into state law. So it would appear that a full informed consent is a requirement for therapy in many states, and it is not unthinkable that it could come to be so in many other places as well.

Whether informed consent is required by law or professional ethical standard, it is important to consider whether it is a good idea: If it is not, we should repeal or not enact informed consent laws in this context. In other words, we would do well to ponder the desirability of an informed consent[1] requirement in this context so that we may better inform a public debate. Could a requirement for informed consent actually impair an analysis in destructive ways? Or is it rather the only proper course, given the need to respect patients and ally them with the goals of the treatment? Indeed, is adequately informed consent a condition as well as an effect of a therapeutic alliance?

We might think of the matter another way. Most psychoanalysts say something early in the treatment process about the psychoanalytic procedure. The question is not whether to inform patients about treatment but exactly what information to give a patient and how to present that information. Perhaps more important, why should clinical psychoanalysts disclose everything they do?

Note, in this connection, that we focus on "psychoanalysis" and "psychoanalytic procedure" but recognize that many of the same issues and concerns apply to psychoanalytic psychotherapy. We also don't make a distinction between psychoanalysis and psychoanalytic psychotherapy. This issue is controverted but beyond the scope of our work.

The central goal of this book is to examine the advantages and disadvantages of an informed consent requirement for psychoanalysis. The book is divided into several chapters. In Chapter 1, we review the law and literature on informed consent: What can we learn from the law about whether informed consent is necessary and what informed consent should look like? What do the legal and psychologic/psychiatric commentators say about the elements of informed consent and the pros and cons? The review of the law will help us determine if informed consent is now required as a matter of positive law in the various states. The review of the literature will reveal what others have identified as important issues in considering the informed consent doctrine in the context of therapy. For example, what do commentators identify as the main components of informed consent in the psychoanalytic context?

[1] By speaking of "an" informed consent, we do not mean to imply that this is something done only at the beginning of the process. In a "process view" of an informed consent, an informed consent unfolds over time in the course of the treatment.

Chapter 2 of this book, the theoretical part, will explore the psychoanalytic dimensions of informing patients, among other things, of the benefits and risks of psychoanalysis. For example, is informed consent even possible? If so, is it countertherapeutic?

Chapter 3 is empirical. It reports on a survey of a significant number of analysts throughout the country. A random sample of four hundred members and candidates was selected to learn about their informed consent practices and their views on an informed consent requirement. The response rate was fairly low. This is a pen-and-paper survey that asks quantifiable questions (for example, "Do you tell prospective patients about the risks of psychoanalysis?" "Do you disclose malignant regression as a risk?" "Do you disclose alternatives like short-term therapy?" "Do you think on balance the informed consent process has been more therapeutic or more countertherapeutic?").

The survey provides an estimate of the beliefs and practices of analysts and their perceptions of the likely and actual effects of these practices. We will also obtain a better sense of what motivates analysts in their practices regarding informed consent. We are particularly interested in whether psychoanalysts believe that an informed consent requirement serves or detracts from the therapeutic goals of psychoanalysis or might even be construed to do both at the same time. Similarly, we are interested in understanding how analysts might deal with potential conflicts between the values behind informed consent and the patient's treatment interests. University of Southern California's University Park Institutional Review Board granted approval for the human subjects portion of this study.

The fourth chapter of this book discusses our Results—both intuitive and counterintuitive—with some thoughts on how to understand our findings.

Then, after discussing in Chapter 5 limitations of our study and future research that would be useful, we briefly lay out the contours of our own ideas about the optimal informed consent policy in the psychoanalytic context in the Afterword. We follow this with a Conclusion, which summarizes our findings.

The ultimate goal of this book is to arrive at an understanding of the pros and cons of an informed consent requirement, as well as an account of the different practices, and beliefs about those practices, that analysts have. It is also important to explore what underlies the variability we find in our results. Is the hypothesis that ambivalence in analysts explains this variability borne out?

This book fills an important gap in the literature. First, this book reviews the law on informed consent. We look at the few legal cases on informed consent to try to develop a conception of the contours of the legal landscape. To the same end, we look at statutes and regulations in the fifty states. We also look at the disciplines' Ethics Codes. Then we examine legal and psychologic/psychiatric commentary on IC in this context. One purpose of the book, then, is to scrutinize the law and literature on this issue to help answer the question about whether some form of informed consent for psychoanalysis is indeed required as a matter of positive law.

A second goal of this book is to consider whether an informed consent requirement for psychoanalysis *should* be part of the law as a normative matter. This examination will involve looking at the extent to which informed consent is desirable or even possible from a psychoanalytic perspective. This part of the book could therefore represent a potential contribution to the law—and to the way in which psychoanalysis is practiced—by adumbrating the legal issues, as well as the psychoanalytic considerations, that informed consent to treatment implies.

Finally, a third purpose of this book is to collect and report data on what analysts do and how they think about what they are doing when they embark on psychoanalyzing a patient. There is very little professional literature currently in this vein. What psychoanalysts think about what they tell patients to expect from psychoanalysis could be of great use in formulating policy concerning informed consent. In this regard, this book could make an important contribution to our understanding of a central ethical principle governing the delivery of medical and psychological care.

A study combining psychoanalysis and the law of informed consent follows an important tradition. Psychoanalytic understandings of the doctor/patient relationship have, to date, influenced many discussions of informed consent, although in contexts other than psychoanalysis. Katz (2002), for example, speaks of transference in the informed consent process. To study in a rigorous and nuanced way what psychoanalysis can tell us about an informed consent requirement is likely to have much wider significance than merely helping us formulate sensible legal rules in this particular area. Psychoanalysis can contribute to an understanding of a practice—obtaining informed consent—that has, in the last forty years, radically changed the delivery of health care in America.

1. Law and Literature on Informed Consent

The Cases, Statutes, and Regulations

Is there a legal requirement to obtain informed consent? Reviewing relevant cases and statutes bearing on informed consent to psychotherapy should help us gauge that. Naturally, there is less urgency for mental health professionals sorting through what to disclose or not if there is no legal informed consent requirement. There are very few cases that imply such a duty on the part of mental health professionals in the context of psychotherapy. On the other hand, many state statutes and regulations seem to require informed consent to therapy. In addition, Ethics Codes of the professions raise their own expectations, and many states incorporate the disciplines' Ethics Codes into state law. (Of course, even if the statutes do not incorporate the Ethics Codes, the codes themselves impose an informed consent duty or the professional risks disciplinary sanctions.) Naturally, if the law is unclear and things are in flux, our study might enable us to better shape the direction of the law. Even if the law is clear, thinking about whether there *should* be an informed consent requirement may lead us to advocate for change.

We turn first to a discussion of informed consent cases.

Informed Consent Cases

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body.
>
> *Schloendorff v. Society of New York Hospital*, 1914

We showcase two general informed consent cases here, drawing out the important features of this doctrine. We then spend time on the most famous informed consent case in the therapy context, the Chestnut

Lodge case. While this case settled out of court, there is considerable literature about it and it seems to have affected practice. We then very briefly review some other relevant cases.

Canterbury v. Spence (1972), a seminal informed consent case, was also a very sad case. A teenaged boy with back pain had an operation without being informed of the risk of paralysis. A day after his operation, as he attempted to reach a bathroom when no staff was present, he fell from his hospital bed. A few hours later, the lower half of his body was paralyzed, and he had to undergo another operation. Now, years later, instead of back pain, "he hobbled about on crutches, a victim of paralysis of the bowels and urinary incontinence. In a very real sense this lawsuit is an understandable search for reasons" (*Canterbury v. Spence* at 776).

Canterbury v. Spence discusses a number of important informed consent issues that are rather technical—for example, the informed consent action is a matter of negligence rather than battery. It also covers the element of "cause" (did the failure to disclose cause the injury?) and how to understand the cause element, namely, as a matter of whether a reasonable person in the patient's situation would have declined treatment had he or she been informed of the risks.

In its decision, the court also discusses some exceptions to the doctrine—for example, so-called "therapeutic privilege" (when the doctor can elect not to inform the patient if he or she believes it will be too destructive to the patient psychologically); the right not to inform of very remote risks or things the patient knows already anyway; and the right not to disclose if the patient expresses the wish not to be informed.

We would like to focus on why disclosure is important and how to measure the doctor's disclosure obligation: What must he or she disclose in this context?

Why then is disclosure important? The epigraph at the beginning of this section is a good place to start: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." The court goes on to note that true consent is the informed exercise of choice, and that entails that one be able to evaluate the options available and the risks attendant upon each. Also the average patient has little or no medical knowledge and is dependent on the doctor to provide information. "From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible." As the court says later in the decision, "It is evident that it is normally

impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification" (*Canterbury v. Spence* at 783).

The court also later underscores how dependent the patient is on the doctor: "The patient's reliance on the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence on the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject" (*Canterbury v. Spence* at 783).

We turn now to the important question of the doctor's disclosure obligations. The court addresses this in two ways: by identifying the sorts of things that must be disclosed and by articulating a general standard for measuring disclosure.

Under the first, the court speaks several times of the usual elements of a disclosure: The physician must generally inform the patient "in nontechnical terms as to what is at stake: the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment and no treatment" (*Canterbury v. Spence* at 783). The court reiterates this later: "The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternative to that treatment, if any, and the results likely if the patient remains untreated" (787–88).

A most important question in the context of informed consent is the general standard for measuring the doctor's disclosure obligations. One possibility, which a number of states adopt, is the "professional standard": What would a reasonable doctor disclose in this kind of case? A more progressive standard is the "objective, patient standard": What would a reasonable patient in this patient's situation find material to her decision? And the third standard is "subjective": What would this patient deem material to his decision?

The jurisdictions are roughly split between the first and second. *Canterbury*, and all the more progressive states, adopts the patient-based standard. The courts provide a number of reasons for their choice. For example, *Canterbury* notes that there is no real professional standard and the questions aren't so technically complex as to require expert testimony. In addition, the court notes that what to disclose is "ofttimes a non-medical judgment and, if so, is a decision outside the ambit of the special standard" (785). But to adopt the professional standard is to "bind the disclosure obligation to medical usage"; and this in turn is "to arro-

gate the decision on revelation to the physician alone" (784). This surely doesn't make sense if the decision is largely nonmedical.

More generally, "any definition of scope (of duty to disclose) in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself" (786). Indeed, "respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves" (784).

The court therefore adopts the objective, patient-based standard: "The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision" (786). The court, quoting from a commentator, defines materiality in this way: "A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy" (787).

We discuss briefly another seminal case, *Cobbs v. Grant*, in which a man went into surgery for a duodenal ulcer and, over time, suffered a number of problems requiring a number of additional surgeries—for example, he had to have his spleen removed, which was a 5 percent risk of the first surgery. He later developed another ulcer, another risk of the earlier treatment. A third operation was then required, which removed 50 percent of the patient's stomach. Yet another hospitalization was necessitated when the patient began to bleed internally as a result of the premature absorption of a suture, another inherent risk of surgery.

We first want to discuss a number of areas of agreement between *Canterbury* and the Cobbs. *Cobbs* agrees that an informed consent action is a negligence issue, as well as the elements of required disclosure: "Therefore, we hold, as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to the proposed therapy and of the dangers inherently and potentially involved in each."

The duty of the physician is more generally to provide "any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment" (8). The court also adds some important reasons for adopting an objective, patient-based standard: "Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebu-

lous that doctors become, in effect, vested with virtual absolute discretion. . . . Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected" (9).

The court adds that the doctor's expert function is to supply the medical data on which the patient relies: "But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of those risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone" (9).

The court, citing *Canterbury*, summarizes: "In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision" (10).

We would like now to turn to the context of informed consent to therapy in particular. The most famous case is *Osheroff v. Chestnut Lodge*. This case did not reach the courts but settled. Still, there was a lot of press about it, as well as scholarly articles, and, anecdotally, it seems to have affected practice to a considerable degree.

Osheroff was a 41-year-old nephrologist. He was consulting a psychiatrist for depression. Antidepressants were not effective, and he was advised to check himself into Chestnut Lodge Hospital, a very famous psychoanalytically informed hospital. The Lodge diagnosed him as having a narcissistic personality disorder as well as depression (his own expert denied the former), and believed that intensive psychotherapy was the way to treat him. He was on no medications, although he asked for them quite frequently.

Over the course of seven months of in-patient treatment, he deteriorated terribly: "I was waking up at 4 every morning, pacing so much that my feet deteriorated. I lost 40 pounds, I deteriorated mentally and physically, I lost a whole life. I had a million-dollar medical practice, I lost that. I lost my status in the medical community, I lost the respect of my patients, I even lost contact with my children" (*New York Times*, October 1990).