

David Brendel, "Response to 'Psychiatric Diagnoses and Informed Consent,'" *The Journal of Clinical Ethics* 29, no. 2 (Summer 2018): 100-1.

Response to "Psychiatric Diagnoses and Informed Consent" by Andrew Clark

David Brendel

ABSTRACT

A patient's rights to informed consent and self-determination in psychiatric treatment are well enshrined, but the same rights have not yet been meaningfully extended to patients with regard to psychiatric diagnosis. Andrew Clark's essay entitled "Psychiatric Diagnoses and Informed Consent" in *The Journal of Clinical Ethics* empowers both psychiatrists and patients to rethink who "owns" the process of clinical assessment and of bestowing diagnostic labels that may have far-reaching consequences. Clark's article represents a noteworthy breakthrough in the field's ongoing journey toward enhancing informed consent, personal dignity, and patients' active involvement in their own care.

Andrew Clark's essay in this issue of *The Journal of Clinical Ethics* is a remarkable contribution to the ethics and philosophy of psychiatry, and his key points are deeply relevant in a wide range of clinical settings.¹ A patient's rights to informed consent and self-determination in psychiatric *treatment* are well enshrined, but the same rights have not yet been meaningfully extended to patients with regard to psychiatric *diagnosis*. In the latter case, psychia-

trists are still considered to be authoritative subject-matter experts whose conclusions carry the weight and objectivity of medical science. Clark importantly and compellingly problematizes this predominant view. In so doing, he empowers both psychiatrists and patients to rethink who "owns" the process of clinical assessment and of bestowing diagnostic labels that may have far-reaching consequences.

Most of the diagnoses included in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition² (*DSM-V*) are clusters of symptoms, some of which are self-reported by patients and others of which are objectively observable. There is enormous overlap of symptoms across diagnostic categories. For many patients seen in office-based practice, stressful life events—such as those that occur in high-pressure work settings—can cause significant anxiety. When severe, this anxiety may present as distressing beliefs that the boss or coworkers are actively trying to undermine or otherwise harm the patient. The psychiatrist here faces the question of whether the current diagnosis is an anxiety disorder or a psychotic disorder with paranoid features. In my clinical experience, these situations are common and either diagnosis is often justifiable. How should a psychiatrist in such cases establish a diagnosis, share it with the patient, enter it in the medical record, and potentially disclose it on insurance forms or disability applications?

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The decisions taken by psychiatrists in these situations can be momentous, for the many reasons that Clark deftly points out. For example, being diagnosed as “anxious” versus “paranoid” means different things to different people. Some patients may feel alarmed or ashamed to be labelled as psychotic, and thereby experience a worsening of their condition. In that case, the psychiatrist could have protected the patient’s fragile emotional state by more gently providing the equally justifiable diagnosis of an anxiety disorder. On the other hand, some patients may appreciate and benefit from being directly informed that they possibly or likely have crossed a threshold into psychosis. It may grab their attention in a productive way, engendering greater motivation for and adherence to a rigorous treatment plan, which may include short-term use of an atypical antipsychotic medication.

The consequences of sharing an anxiety disorder diagnosis versus a psychotic disorder diagnosis with insurance companies or other outside stakeholders also can be profound. A psychotic disorder diagnosis may help a patient to receive appropriate short-term disability benefits, which may be critical for the patient’s financial stability as he or she recovers. But at the same time, it may compromise the same patient’s future applications for life insurance or long-term disability coverage. Because of these considerations, psychiatrists should exercise caution when documenting a psychiatric diagnosis in the medical record. The patient’s informed consent should be sought beforehand, after a thorough discussion of risks versus benefits. Clark is on point in suggesting here that the informed consent process is just as critical with regard to diagnosis as it is to treatment.

For this and other reasons that Clark elucidates, psychiatric diagnosis ought to be viewed as a complex process that should include serious consideration of the patient’s point of view, personal values, and understandable self-interest. At its best, the process of diagnosis in psychiatric settings is a kind of “thought partnership” between patient and clinician. Nuanced conversations about the implications of psychiatric diagnoses can empower both of them in their respective roles. When the patient is an active participant in these conversations, he or she is much less likely to be blindsided and stressed later by the implications of a particular diagnosis. A consensus about the diagnosis can also help the patient to achieve greater insight into the condition and “buy in” to the treatment plan. These conversations can also aid clinicians, because they may furnish more data about patients’ state of mind and openness to

treatment. Informed consent around diagnosis can also protect clinicians from later complaints from patients that a diagnosis harmed them emotionally, socially, financially, or otherwise.

Some people come to see psychiatrists to talk over life stressors, emotional challenges, and relationship issues they are facing—not to receive a potentially stigmatizing diagnosis. It is essential, right up front, for the psychiatrist to ensure clarity about the goals and objectives of a meeting with a patient. If the patient does not seek a psychiatric diagnosis (or actively expresses a wish *not* to receive one), psychiatrists should take the request seriously and respect the patient’s wishes. Absent a formal diagnosis, insurance and payment questions may come into play if the patient is not paying out of pocket for the services. This can create a pesky problem, but one that should be addressed at the outset and with the fundamental goal of respecting the patient’s wishes. Unless such a patient presents an imminent safety risk based on a clear psychiatric disorder, no diagnosis should be imposed, entered in the chart, or shared with anyone else outside the consulting room.

Clark’s article represents a noteworthy breakthrough in the field’s ongoing journey toward enhancing informed consent, personal dignity, and patients’ robust involvement in their own care. It should breed continued discussion and debate about the logistics of engaging patients and their loved ones in critical conversations around the process (and potential consequences) of psychiatric diagnosis. Psychiatric training ought to include curricular material on this key aspect of patient-centered care, and education of the public should help patients and their loved ones to understand better what to expect when seeing a psychiatrist. We owe Clark a debt of gratitude for bringing this under recognized issue to light in such an articulate manner and for encouraging positive, real-world changes in clinical practice.

NOTES

1. A. Clark, “Psychiatric Diagnoses and Informed Consent,” in this issue of *JCE* 29, no. 2 (Summer 2018).
2. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, Va: American Psychiatric Association, 2013).