

Is It Proper for Psychologists to Discuss Medications With Clients?

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Situations are analyzed in which psychologists might be asked for information about the efficacy or side effects of pharmacotherapy. The ethics and legality of providing information about physician-prescribed treatments by members of the health care delivery system who are not physicians are considered. Those articles in the psychologist's ethical code bearing on the issue are also discussed. Relevant court cases and statutes in the professions of nursing and pharmacy are examined. For these professions, the findings in relevant cases, coupled with the manner in which recent legislation has been written, suggest that nonphysician members of the health care delivery system can discuss treatments, including medications, prescribed by physicians. The question of a duty of psychologists to discuss medications in the context of obtaining informed consent is raised.

A psychologist was seeing a 10-year-old girl and her father, who was the noncustodial parent. The father had initiated treatment because he was concerned about his daughter's distress resulting from the disagreements between himself and his ex-wife.

Shortly after the divorce of the parents, the daughter was placed on fluoxetine (Prozac) by a psychiatrist. The mother had initiated pharmacological treatment for the daughter out of concern for the daughter's considerable distress generated by the turmoil of the divorce. One day, the father made inquiry of the psychologist about any known effects of Prozac taken during childhood on adult sexual functioning and on the development of puberty. The father had already discussed his concerns with the daughter's psychiatrist and had been told by the psychiatrist that Prozac did not affect puberty. However, the father questioned the psychiatrist's response. The psychologist indicated that she did not know about Prozac's impact on puberty but offered to do a *Medline* search at the university where the psychologist taught. The psychologist further offered to call Eli Lilly (the pharmaceutical company that markets Prozac) to make further inquiries. The *Medline* search was disappointing. A search of the literature yielded no human studies investigating the issue of reuptake-blocker impact on the development of puberty. Further, the company representative indicated that "safety and efficacy of Prozac in the treatment of depression in children

has not been established." The psychologist conveyed this information to the father.

The father then contacted his wife requesting that the medication be withdrawn because of the lack of information about its safety. The mother was outraged, particularly with the psychologist, whom the mother felt was "practicing medicine without a license." On learning of the mother's accusations, the psychologist telephoned the ethics committee of the state psychological association. The psychologist learned from a member of the ethics committee, who is both a psychologist and a lawyer, that there are no clear precedents on this issue in psychology.

Several occurrences have raised the likelihood that psychologists will have occasion to discuss medications with clients. In April of 1993, the Agency for Health Care Policy and Research (AHCPR) issued guidelines for the treatment of major depression by primary care physicians. The guidelines advise that severe states of depression be medicated immediately. Those patients with less severe cases of depression should be medicated if they fail to improve within 6 weeks or fail to remit completely within 12 weeks (AHCPR, 1993). Pharmacotherapy is becoming available for the treatment of a wider range of conditions than in the past. Pharmacotherapy is available for anxiety, obsessive-compulsive disorders, alcoholism, anorexia, premenstrual syndrome, schizophrenia, and hyperactivity (Bernstein, 1988; Volpicelli, Alterman, Hayashida, & O'Brien, 1992). Psychiatrist Peter Kramer (1990) has advocated the use of Prozac for the personality of the introverted and subdued.

The implementation of the guidelines as well as the trend toward medicating a wider variety of conditions can potentially lead to a dramatic increase in the percentage of the population receiving medications. Some of these individuals may seek psychotherapy from a psychologist along with their medications. During the course of psychotherapy, it is plausible that the client will discuss concerns about his or her medications with the psychologist. An initial question addressed to the psychologist might be, Should I continue on the medication as prescribed? There may also be questions about the relative risk and efficacy of psychotherapy versus drug therapy. Discussions can also include questions about the side effects of medications. Here, proper attribution of drug side effects to the medication, as op-

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posed to psychological causes of distress, will be crucial. Should a client opt to discontinue an antidepressant or anxiolytic medication, both of which are associated with withdrawal effects (Bernstein, 1988), psychologists will need to develop protocols for assisting clients to reduce withdrawal distress. Proper treatment for reducing withdrawal distress will no doubt involve accurately apprising clients of those symptoms that can be expected as a result of drug withdrawal. Thus, there are many scenarios under which psychologists will be placed in a position to be queried about pharmacotherapy.

This article will examine the legal and ethical limits on psychologists in discussing medication issues with their clients. We begin the article by looking at how the courts and state practice acts have handled this issue of legality with other professions: first with pharmacy and then with nursing. We had to focus on the evolution of case law and legislation in these other health care fields because there are no statutes or court cases that directly address the legality of psychologists discussing physician-prescribed treatments with their clients. However, the courts have looked at the identical questions being examined in this article, in the context of nursing and pharmacy: Under what conditions should professions without prescription privileges be permitted (and at times required) to discuss medication issues with patients?

The rulings of the courts on cases in pharmacy and in nursing can offer a best guess as to the legality of psychologists imparting information about medications. Despite differences between the three professions, representatives from each are at times called on to offer advice or information about drugs that can only be prescribed (for the most part) by physicians.

The courts and state licensing authorities have also looked at the potential harm to the doctor-patient relationship of having nonphysicians provide information about medications and other physician-prescribed treatments. How these legal institutions have dealt with other health care professionals in looking at overlapping professional obligations can be informative for psychologists. In fact, the conclusions from the prior analyses are applied to the field of psychology in the next section of this article. This assessment of the legality of psychologists discussing medications with their clients is also followed by an examination of ethical standards that bear on the issue. Next, we examine the implications of recent developments in informed-consent doctrine on the legal duties of psychologists. Finally, we offer a conclusion about the legality of psychologists discussing medications with their clients and offer a recommendation for practice.

The Field of Pharmacy

Since the late 1970s, there has been a flurry of cases in which suits have been brought against pharmacists for failing to warn patients about the effects of medications. Plaintiffs in these cases have argued that pharmacists have a duty to warn patients about the harmful effects of medications prescribed by physicians. Guidelines for regulating the activities of professionals whose obligations to patients overlap have emerged from the court holdings in these cases.

Before several recent cases, there was a consistent line of decisions that held that pharmacists did not have a duty to warn

patients about the effects of their medications. The courts based their decisions on two factors: scope of practice considerations and concerns about protecting the physician-patient relationship. With regard to scope of practice, the courts had ruled that a duty to warn clients about medications was the responsibility of the prescribing physician. Litigation had established the doctrine of "learned intermediary." The learned intermediary doctrine had been developed in product liability suits brought against pharmaceutical houses for failure to warn patients of the dangers inherent in the use of a product. According to this doctrine, the physician, and not the product manufacturer, had the responsibility for conveying appropriate warnings and directives for product use to the product consumer (Day & Marks, 1991). When the issue of the duty of pharmacists to warn regarding medications was raised in the courts, the fact that physicians clearly had already been assigned this responsibility under the learned intermediary doctrine was invoked.

An additional consideration for the courts in determining whether pharmacists should have a duty to warn patients about medications was the protection of the physician-patient relationship. The relative priority assigned by the courts to preserving the physician-patient relationship can be traced through adjudication on pharmacist duty-to-warn cases. Concern about protecting the physician-client relationship was articulated in the case of *Ingram v. Hook's Drugs, Inc.* (1985). In declining to assign a duty to warn to the pharmacist, the court stated the following:

The decision of weighing the benefits of a medication against potential dangers that are associated with it requires an individualized medical judgement. This individualized treatment is available in the context of a physician-patient relationship which has the benefits of medical history and extensive medical examinations. It is not present, however, in the context of a pharmacist filling a prescription for a retail customer. The injection of a third-party in the form of a pharmacist into the physician patient relationship could undercut the effectiveness of the ongoing medical treatment. (pp. 886-887)

Despite the reluctance to assign a duty to the pharmacist to warn, the court in *Ingram v. Hook's Drugs, Inc.* (1985, p. 885) further distinguished that it was not agreeing with the defendant's claim that provision of a warning, should a pharmacist choose to provide one, was prohibited by the state licensing act. Although the *Ingram* court recognized the importance of protecting the physician-patient relationship, the court chose to refrain from stating that a pharmacist's warning of potential dangers was prohibited by the state licensing act.

Concern about preserving the physician-patient relationship has been voiced in other case holdings as well. At issue in the case of *Eldridge v. Eli Lilly & Co.* (1985) was the plaintiff's charge that the pharmacist had been remiss in failing to warn either the patient or physician of Darvon's lethal potential at the dosage indicated in the prescription. The court stated the following:

To fulfill the duty which the plaintiff urges us to impose would require the pharmacist to learn the customer's condition and monitor his drug usage. To accomplish this, the pharmacist would have to interject himself into the doctor-patient relationship and practice medicine without a license. (p. 553)

In the case of *Ramirez v. Richardson-Merrell, Inc.* (1986), the court held as follows:

To impose a duty to warn on the pharmacist, however, would be to place the pharmacist between the physician who, having prescribed the drug presumably knows the patient's present condition as well as his or her complete medical history, and the patient. Such interference in the patient-physician relationship can only do more harm than good. (p. 88)

Similarly, in *McKee v. American Home Products Corp.* (1989), in declining to assign a pharmacist with a duty to warn, the court stated, "Unnecessary warnings to the patient could cause unfounded fear and mistrust of physician's judgement, jeopardizing the physician-patient relationship and hindering treatment" (p. 1054).

The holdings in the *Ingram v. Hook's Drugs, Inc., Eldridge v. Eli Lilly & Co., Ramirez v. Richardson-Merrell, Inc.,* and *McKee v. American Home Products Corp.* did honor the view that warning by a pharmacist could jeopardize the physician-patient relationship. In *Leesley v. West* (1988), the plaintiff argued "requiring warnings to prescription consumers from sources other than the physician need not impair the physician-patient relationship and will help to ensure that patients actually receive essential warnings" (p. 763). Without joining the issue of how a pharmacist's warning might alter the physician-patient relationship, the court spoke to the desirability of such warnings. The court held as follows:

We do not conclude by this decision that warnings beyond those given by the physician are harmful or to be discouraged. We simply decline to subject pharmacists to liability for failure to give warnings which the physician has not requested. (p. 763)

Whereas in the previously cited cases the courts declined to assign a duty to warn to the pharmacist, a departure from this line of thinking was apparent in *Kirk v. Michael Reese Hospital and Medical Center* (1985), which recognized a duty for hospital pharmacists to counsel patients on drug use as part of the discharge process. The findings in *Riff v. Morgan Pharmacy* (1986) also represented a departure. Here, the court ruled that the pharmacist should have warned that the particular prescription for Cafegot suppositories exceeded the manufacturer's recommendations. The court held with regard to the role of the pharmacists vis-à-vis the physician, the pharmacist "has an affirmative duty to be, to a limited extent, his brother's keeper" (p. 1253). In this court holding, concern about encouraging a health care delivery system with built-in checks and balances eclipsed the concern to protect the physician-patient relationship.

The case of *Dooley v. Revco Drug* (1990) also raised the issue of a pharmacist's duty to warn. Here the situation involved the simultaneous use of drugs whose concurrent administration could be harmful. The pharmacist had filled a prescription for an antibiotic for a child who had received numerous prescriptions for theophylline from the same pharmacy. The lawyer representing Dooley argued that Revco Drug had proclaimed in its advertisements to have a database on each client to enable the pharmacists to catch concurrent prescriptions of contraindicated drugs. The court declined to issue a summary judgment absolving the pharmacist of a duty to warn. The court ruled

that the case should go to a jury trial as "the pharmacist's duty to his customers is a disputed issue of fact preventing the grant of a summary judgement" (Day & Marks, 1991, p. 116).

The *Riff v. Morgan Pharmacy, Kirk v. Michael Reese Hospital and Medical Center,* and *Dooley v. Revco Drug* cases reflect a different conceptualization from the courts about the role of pharmacists. In each case, the court recognized the value of extending a duty to pharmacists to talk to patients about their drug treatment. These cases have extended the pharmacist's scope of responsibility. Despite these alterations in the philosophy of the court, the previously mentioned *McKee v. American Home Products Corp.* case of 1989 occurred subsequent to *Riff v. Morgan Pharmacy* and *Kirk v. Michael Reese Hospital and Medical Center* and represented a return to the prior doctrine assigning overriding importance to preserving the physician-patient relationship.

Day and Marks (1991) have predicted that the role of the courts in regulating the overlapping professional roles of pharmacists and physicians will be eclipsed by the actions of legislatures as they pass laws authorizing professional practice. Shifts extending the scope of pharmacist responsibility are evident in emerging state and federal laws. Recent federal Medicaid legislation mandates that pharmacists will include patient counseling with all prescriptions (Brushwood, 1992, p. 56). Twelve states have statutes mandating that pharmacists counsel the patient with every prescription (Brushwood, 1986, p. 149). In Washington state, the Pharmacist Practice Act (1989) includes in its definition of practice, "the providing of information on legend drugs which include, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices." Consistent with these legislative trends, schools of pharmacy have issued guidelines for pharmacists in training to function as counselors to patients about medications (Duckworth, 1988). The trends reflect the changing obligations of pharmacists to discuss medications with clients. Clearly the scope of the practice of pharmacy overlaps the scope of the practice of medicine. How the extended scope of pharmacist responsibility will affect the physician-patient relationship is not yet known. The bottom line emerging from litigation and statutes in the field of pharmacy is that it is legal for nonphysicians to discuss physician-prescribed treatments. In fact, nonphysician professionals may have a duty to discuss treatments that were prescribed by others in particular situations.

The Field of Nursing

The question of whether a nurse can ethically discuss alternative physician-prescribed treatments when requested to do so by a patient was directly addressed in the case of *Tuma v. Board of Nursing* (1979). Tuma, a nurse, was administering chemotherapy to a patient in the terminal stages of leukemia. A discussion ensued with the patient about the relative merits of laetrile. Tuma did not offer advice but provided information. The patient requested that Tuma make an appointment to discuss with herself and her relatives the alternative of laetrile treatment. Tuma agreed to this request, although with obvious hesitation, as evidenced by her articulated reflection that the discussion was "not exactly ethical" (*Tuma v. Board of Nursing*, 1979, p. 713). Later, the physician who had prescribed the chemo-

therapy, along with hospital personnel, filed a complaint with the nursing board. The complaint was a charge of "unprofessional conduct." No charge of "practicing medicine without a license" was initiated. A hearing officer rendered a decision to sanction Tuma. This decision was affirmed by the Board of Nursing for the state of Idaho. Tuma appealed this decision to the Supreme Court of Idaho, arguing that one "cannot be punished for acts the doing of which at the time done had not been proscribed by the legislative definition, or by any definition of the standards by the Board" (*Tuma v. Board of Nursing*, 1979, p. 715). The court held as follows:

We find nothing in the statutory definition of "unprofessional conduct" which can be said to have adequately warned Tuma of the possibility that her license would be suspended if she engaged in conversations with a patient regarding alternative procedures. (p. 711)

The court found for Tuma, determining that the Board could not sanction her for unprofessional conduct "without some Board of Nursing rules or regulations to adequately warn her that such actions were prohibited" (*Tuma v. Board of Nursing*, 1979, p. 711).

The original hearing officer's conclusion that Tuma's conduct was unprofessional was affirmed by the Nursing Board of Idaho. How other nursing boards might construe similar conduct is an unanswered question. A survey of 12,500 professional nurses found that 83% approved of her action (Markus, 1989). The substance of the argument in the *Tuma* court case was that *unprofessional conduct* was never defined, although the court held that licensing boards have an obligation to issue standards of practice (*Tuma v. Board of Nursing*, 1979). State nurse practice acts still leave ambiguous the term *professional* (Cushing, 1988, p. 440). In New Hampshire, which has one of the few statutes that elaborates on the definition of *unprofessional*, the following language is used:

Dishonest or unprofessional conduct, including, but not limited to, intentionally harming, abusing or exploiting a patient, defrauding or harming the public in matters related to the practice of nursing, willfully failing to maintain accurate and complete nursing records, acts of omission or commission when practicing nursing as set forth in rules adopted by the board pursuant to RSA 541-A, and violating disciplinary orders or settlement agreements approved by the board. (Nurse Practice Act, 1976/1991, p. 200)

Historically, medical treatment has been delivered concordant with a hierarchical system of treatment delivery. The doctor was in charge of the case. The doctrine of noninterference in the doctor-patient relationship was invoked as a desirable standard. Nurses had no independent relationship with patients. They were extensions of the physician, present only to carry out the directives of a higher authority. Reflecting the hierarchical arrangement, nursing boards established by the state nurse practice acts were subject to veto from state medical boards (Hadley, 1989; Murphy, 1984).

Times have changed. Nurses have carved out an independent niche. There are areas in which they diagnose and carry out treatments. Whereas doctors are viewed as diagnosing and treating diseases, nurses "diagnose and treat patients' responses to health problems which may include responses to disease or

medical treatment" (Murphy, 1984, p. 174). Forty states have amended their nurse practice acts in line with an expanded role for nurses that is not limited to acting under the supervision or direction of the physician (Cushing, 1988, p. 447). Beyond the creation of an independent arena of function for the registered nurse is the new category of nurse practitioner. In a number of states, nurse practitioners are licensed to diagnose and treat, including prescribing of medications independent of physicians. Consistent with the new trends, nursing boards are no longer subject to the authority of the state medical board (Hadley, 1989).

Given the expanded, independent role of nursing, it is not at all clear that discussing physician-prescribed treatments with clients would be viewed as exceeding nursing's scope of practice. Indeed, Tuma's case was strengthened by the fact that the Idaho nursing board was on record as endorsing a standard of care requiring a nurse to "promote, and participate in, patient education based on the individual's health needs, and involve the individual and family for a better understanding and implementation of immediate and long term goals" (Cushing, 1988, p. 443).

In writing practice acts, state legislatures have failed to specifically join the issue of what constitutes interference in the physician-patient relationship, whether the physician-patient relationship preservation should take precedence over other concerns, and whether discussion of treatments prescribed by another treatment provider is unprofessional. The *Tuma* case offers a case law precedent. Unless the state nurse practice act identifies discussion of alternative treatments as unprofessional, a nurse cannot be found guilty of unprofessional conduct on the basis of such discussion. As with pharmacy, the courts, with respect to the profession of nursing, have effectively assigned a priority to having a system of checks and balances in the delivery of medical treatment. Suit has been successfully brought against nurses for administering physician-prescribed treatments that the nurse should have realized were patently harmful. Nurses are supposed to bring obvious mistakes to the physician's attention. If the physician does not change the questionable order, hospital authorities are to be notified (Benninger, 1988). Thus, nurses have a legally recognized second-guessing role.

The courts have elected to create a system of checks and balances in the delivery of health care. Concern for patient safety seems to have eclipsed concern about protecting the physician-patient relationship. The legal system has elected against the creation of a system in which only a physician may discuss physician-prescribed treatments.

The Field of Psychology

The courts have not seen fit to charge nurses and pharmacists who discuss medications with patients as practicing medicine without a license. Neither the courts nor state practice acts have prohibited such activity. Given the precedent established in other professions, it is unlikely that a psychologist's discussion of medication could be construed as practicing medicine without a license. Extrapolating to the case presented at the beginning of this article in which a psychologist imparted informa-

tion about medications, there is no basis in case law for assuming this activity is illegal.

Beyond the standard of legality is the standard of ethical conduct. Several articles in the American Psychological Association (APA) Code of Ethics (APA, 1992) are potentially relevant to the issue of discussing medications with clients. Sometimes clients will be taking medications at the time when they initiate treatment with the psychologist. The client then will have an established relationship with a prescribing physician. The APA Code of Ethics speaks to the issue of interprofessional relationships. When a psychologist is considering the treatment of a client who is being medicated by a physician, the section on the ethical code pertinent to relationships with other professionals is applicable. The code states (APA Code of Ethics, 1992, 4.04)

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential patient's or client's welfare. The psychologist discusses these issues with the patient or client, or another legally authorized person on behalf of the client, in order to minimize the risk of confusion and conflict, consults with the other service providers when appropriate, and proceeds with caution and sensitivity to the therapeutic issues. (p. 1605)

Following from the code, an effort to contact and collaborate with the fellow professional might be made. Conflicts are likely to be avoided through discussion with the fellow professional. However professional disagreements around life-threatening issues can be envisioned. For example, a psychologist may learn that a patient taking phenelzine sulfate (Nardil) is failing to follow dietary restrictions. If the physician is informed about the patient's behavior but determines that the Nardil prescription should be continued, does the psychologist have an independent duty to warn the patient? Another sensitive situation might arise should a client inquire about which treatment (psychotherapy alone, pharmacotherapy alone, or a combination of both) is the best choice for a particular problem. Here, the psychologist may provide findings from relevant research. Given these delicate situations in which a psychologist might be commenting on physician-prescribed treatments, the psychologist's ultimate goal should be to ensure the client's welfare.

There is an additional consideration governing discussion of medications with clients. Ethically, psychologists should not assume responsibilities outside their areas of expertise (Section 1.04 of the Code of Ethics). If a discussion with a client about medication occurs, the psychologist has an obligation to ensure that all information imparted is thorough and accurate. When a psychologist lacks command of the facts, the psychologist should refer the client to another professional.

Informed Consent

All states, with the possible exception of Georgia, require that informed consent be obtained from the patient before initiation of treatment (Lidz et al., 1984). With regard to informed consent, case law demands that risks and benefits of both the proposed and alternative treatments be explained (Reisner, 1985, p. 133; Rosoff, 1981, p. 46). Some state statutes (e.g., New York, Florida, Oregon, Pennsylvania, Washington, Kansas, Oregon) also speak directly of the necessity to include the dis-

ussion of alternative treatments in any process of obtaining informed consent (Rosoff, 1981, pp. 75-186).

Although the prior standard for imparting information had been disclosure according to the custom in the community, *Canterbury v. Spence* (1972) changed the standard, at least for those within its jurisdiction. The dicta expressed in *Canterbury* provided as follows:

The topics importantly demanding a communication of information are inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of the harm threatened. A very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summons [*sic*] discussion with the patient. (pp. 787-788)

The holding in *Canterbury v. Spence* required the physician to disclose information about treatments and alternatives that any reasonable person in the patient's role would find relevant in making a decision. In subsequent litigation (*Cobbs v. Grant*, 1972), the thinking in *Canterbury v. Spence* was affirmed. The court held, "The patient's right to self decision is the measure of a physician's duty to reveal" (p. 11). The court was saying that any information relevant to a client's decision making should be imparted by the treating professional. In determining the scope of information that must be imparted in the process of obtaining informed consent, unless a state statute specifically provides another standard, the standards established in *Canterbury v. Spence* (1972) and *Cobbs v. Grant* (1972) may apply.

The duty to explain treatment alternatives in the process of obtaining informed consent is becoming increasingly clear for psychiatrists. *Osheroff v. Chestnut Lodge* (1984) was the first time the issue of informed consent was raised with regard to psychotherapy (Reisner, 1985). The facts were as follows.

Osheroff, an internist, received diagnoses of depression and narcissistic personality. His distress had failed to ameliorate with pharmacotherapy, so he was withdrawn from medications while he received psychotherapy at Chestnut Lodge. After discharge from Chestnut Lodge, Osheroff sued Chestnut Lodge for improper treatment, arguing that pharmacotherapy was the treatment of choice. Further, he alleged that Chestnut Lodge had failed to secure informed consent and failed to engage in a thorough discussion of treatment alternatives. In January 1984, the state of Maryland Health Claims Arbitration Board found Chestnut Lodge liable and awarded \$250,000 to Dr. Osheroff. Subsequently, the court to which the ruling was appealed held that proper procedures had not been followed. While awaiting further appeal, the case was settled out of court. (Malcolm, 1990)

Within the psychiatric community, the case of *Osheroff v. Chestnut Lodge* has been widely publicized (Klerman, 1990). The publicity surrounding the case has probably convinced many of the wisdom of obtaining informed consent.

The courts and state legislators have clarified the requirements of informed consent for physicians. There is a question, however, whether state informed consent legislation applies to psychologists. Most often, the language in the statute refers to physicians, although sometimes in the statute, the term "health

care professional" is used (Rosoff, 1981). To date, no suits have been brought against a psychologist for failure to obtain informed consent (Reisner, 1985, p. 134, and review of the cases under the section "Physicians and Surgeons, 15 (8) *General Digest 1992-1993 Decennial Review, 1986-1991*). However, legal scholars (Appelbaum, Lidz, & Meisel, 1987, p. 15) have suggested that informed consent applies to psychologists, social workers, podiatrists, optometrists, physical therapists, chiropractors, and other professionals who offer treatment.

The requirement that alternative treatments be discussed in the process of obtaining informed consent raises questions for psychologists. Is a psychologist rendering a diagnosis based on the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) for which pharmacotherapy has established efficacy obligated to discuss medications as a treatment alternative? If the same informed consent standards mandated by statutes are applied to psychologists as are applied to physicians, the answer is probably "yes."

The APA Code of Ethics (4.02) indicates "Psychologists obtain appropriate informed consent to therapy or related procedures, using language that is reasonably understandable to participants." The code requires that consent be obtained for the treatment plan. The code is less clear on whether alternative treatment strategies must also be discussed. The only phrase that might be construed as relevant to the issue of discussion of alternative treatments is in Section 4.02: "psychologists consider such persons' preferences and best interests."

The case might be advanced that a client seeking services from a nonphysician mental health provider has implicitly decided against pharmacotherapy. Thus, the psychologist is relieved of the burden to explain the alternative of pharmacotherapy. However, even if it is assumed that the client has made an informed choice of a psychotherapy alternative, would a psychologist be viewed as negligent for failing to raise the third option of a combination of drug and psychotherapy to address the client's problem?

If the same standard of informed consent that obtains for physicians also applies to psychologists, then the psychologist must ensure that each client has a reasonable understanding of both the psychotherapy and pharmacotherapy options for treatment. If the psychologist lacks competence in explaining the costs and benefits of alternative treatments, then referral to a professional who is competent may be required.

A Second Look at the Question

This review began with the focus of whether a psychologist could address the questions of clients about medications. Case law pertinent to the practice of nursing and pharmacy, and recent legislation concerning pharmacists, suggests that discussing medications with clients under the care of a treating physician is not only permissible but, in particular situations, required. Both nurses and pharmacists have responsibilities to patients who are also under the care of physicians. An analogous situation exists for psychologists and physicians. Often, physicians and psychologists have responsibility for the care of the same patient. Extrapolating from legal decisions in nursing and pharmacy, there is nothing illegal about psychologists discussing medications with clients. Prudent practice and the APA

Code of Ethics dictate the need for coordination of care when a client is under the care of two professionals. However, discussion about the care provided by another professional may be necessary when the client's best interests are served by such a discussion.


Whereas this review initially examined the question of whether psychologists could legally and ethically exercise the option of discussing medications with clients, the language of court decisions raises the issue of whether psychologists, like pharmacists and nurses, might, under some conditions, have a duty to discuss medications with clients. Forty-nine states have statutes mandating informed consent. Many state statutes define informed consent as including discussion of proposed as well as alternative treatments. Legal experts believe that state statutes apply to all members of the health care delivery system. If informed consent legislation applies to psychologists, then the statutes mandate that psychologists ensure that clients are informed about the relative merits of pharmacotherapy treatment options. These statutes require that psychologists either discuss medications themselves or refer to a professional who will. To meet the needs of their clients, it is becoming increasingly imperative for psychologists to be knowledgeable about medications.

References

- Agency for Health Care Policy and Research. (1993). *Clinical practice guidelines: Depression in primary care: 2. Treatment of major depression* (AHCPR Publication No. 93-0551). Rockville, MD: U.S. Department of Health and Human Services.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597-1611.
- Appelbaum, P. S., Lidz, C. W., & Meisel, A. (1987). *Informed consent: Legal theory and clinical practice*. New York: Oxford University Press.
- Benninger, B. R. (1988). Nursing malpractice—The nurse's duty to follow orders. *West Virginia Law Review*, 90, 1291-1313.
- Bernstein, J. G. (1988). *Handbook of drug therapy in psychiatry* (2nd ed.). Littleton, MA: PSG Publishing.
- Brushwood, D. B. (1986). *Medical malpractice: Pharmacy law*. Colorado Springs, CO: Shephard's McGraw Hill.
- Brushwood, D. B. (1992). *Medical malpractice: Pharmacy law* (Supplement). Colorado Springs, CO: Shephard's McGraw Hill.
- Canterbury v. Spence, 464 F.2d 772 (1972).
- Cobbs v. Grant, 502 P.2d 1 (1972).
- Cushing, M. M. (1988). *Nursing jurisprudence*. San Mateo, CA: Appleton & Lange.
- Day, J. A., & Marks, C. (1991). Duty to warn of potential drug interactions: The pharmacist's role. *Trial Diplomacy Journal*, 14, 107-118.
- Dooley v. Revco Drug, *Decennial digest* 10th Series, Part 1, 1986-1991. v. 30. St. Paul, MN: West Publishing (1992).
- Duckworth, F. A. (1988). The potential liability of pharmacists arising from announcements of new standards and codes of practice. *Food Drug Cosmetic Law Journal*, 43, 1-15.
- Eldridge v. Eli Lilly & Co., 485 N.E.2d 551 (1985).
- General digest* 8th Series, Vol. 14, 1992-1993 (pp. 835-839); Vol. 15, 1993-1994 (pp. 1007-1012). St. Paul, MN: West Publishing.
- Hadley, E. H. (1989). Nurses and prescriptive authority: A legal and economic analysis. *American Journal of Law and Medicine*, 15, 245-299.

Ingram v. Hook's Drugs, Inc., 476 N.E.2d 881 (1985).
 Kirk v. Michael Reese Hospital and Medical Center, 483 N.E.2d 906 (1985).
 Klerman, G. L. (1990). The psychiatric patient's right to effective treatment: Implications of *Osheroff v. Chestnut Lodge*. *American Journal of Psychiatry*, 147, 409-418.
 Kramer, P. D. (1990, March). The new you. *Psychiatric Times*, pp. 45-46.
 Leesley v. West, 518 N.E.2d 758 (1988).
 Lidz, C. W., Meisel, A., Zerubavel, R., Carter, M., Sestak, R. M., & Roth, L. (1984). *Informed consent*. New York: Guilford Press.
 Malcolm, J. G. (1990). *Treatment choices and informed consent: Current controversies in psychiatric malpractice litigation*. Springfield, IL: Thomas.
 Markus, K. (1989). The nurse as patient advocate: Is there a conflict of interest? *Santa Clara Law Review*; 29, 391-421.
 McKee v. American Home Products Corp., 782 P.2d 1045 (1989).
 Murphy, C. (1984). The changing role of nurses in making ethical decisions. *Law, Medicine, and Health Care*, 12, 173-185.
 Nurse Practice Act, (1976) 326B New Hampshire Rev. Stat. Ann. §12(c) (Supp. 1991).
 Osheroff v. Chestnut Lodge Inc. et al., 490 A.2d 720-724, Md. App., April 10, 1985. N01016 September term 1984.
 Pharmacist Practice Act, 5 Wash. Rev. Stat. Ann. §18.64.011 (1989).
 Ramirez v. Richardson-Merrell, Inc., 628 F. Supp. 85 (1986).
 Reisner, R. (1985). *Law and the mental health system: Civil and criminal aspects*. St. Paul, MN: West.
 Riff v. Morgan Pharmacy, 508 A.2d 1246 (1986).
 Rosoff, A. J. (1981). *Informed consent: A guide for health care providers*. Rockville, MD: Aspen.
 Tuma v. Board of Nursing, 593 P.2d 711 (1979).
 Volpicelli, J. R., Alterman, A. I., Hayashida, M., & O'Brien, C. P. (1992). Naltrexone in the treatment of alcohol dependence. *Archives of General Psychiatry*, 49, 876-880.

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