# Practice Challenges and Ethical Decision-Making


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During my (Max's) doctoral training, I came across a situation where a chief resident was describing a patient in a very unprofessional manner. The resident was clearly frustrated with the patient's lack of motivation around their health, shaming the patient's weight in front of his colleagues. As I was hearing the conversation in the huddle room next door, my anger rose very quickly. The resident then proceeded to mock the family's weight, joking about their health habits. A challenge for confronting this resident that day was that there were two encounters that demanded this person either be consulted on or part of the team visit. I was advised to wait until the following week to process these feelings with the resident. Although the conversation was not easy to initiate, I learned that there were deeper issues present that impacted the resident's views of the patient. Through a few more follow-up conversations, there were some cultural aspects of the patient that I brought to the attention of the resident. These were blind spots in the resident's training that were not indicative of his clinical competencies but rather lack of cultural awareness of the population he was serving.

When working in the healthcare field, one will always come across several practice and ethical challenges that tests one's moral compass. These situations not only pertain to patient issues but to colleagues and the entire organization (Bazerman & Tenbrunsel, 2012). A new therapist often does not recognize or anticipate these challenges that will arise during their training, largely due to entering a new context

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with unknown roles and responsibilities (Curtis & Christian, 2012; Hall et al., 2015). Although most ethical issues can be largely avoided, BHPs face a tougher challenge when the ethical conduct applies to a work partner or friend in the workplace. What is described in this chapter are real-life ethical dilemmas and practice situations that pertain specifically to therapists working in medical and healthcare settings. These issues not only affect how the therapist responds to patient care, but how one handles internal conflicts that push their decision-making and morals to different places. As a White male, I have increasingly focused on the areas of power and privilege within the context of care in medicine. I also have worked on how my personal ethics, morals, and beliefs might contradict other colleagues' perspectives, where learning to navigate and negotiate this terrain is always an evolving process.

Ethical decision-making is often seen as gray area for professionals working in medical settings. Whereas providers know the appropriate legal steps after a patient states a plan for suicide, navigating through challenges such as power and privilege, cultural sensitivity, and best clinical practices become less concrete (Thompson et al., 2016). Ethical decisions in healthcare require that BHPs consistently make sound decisions that help protect themselves, their care team, and the patient. Training programs often lack the necessary preparation for new training interns and students for situations that require immediate decision-making in medical settings or appropriate times to consult around a clinic issue (Bischoff, Springer, Reisbig, Lyons, Likcani, 2012; Hall et al., 2015). When BHPs get thrown into these tenuous situations, many often struggle with navigating the appropriate action or steps in a new setting.

## Common Ethical Dilemmas for Therapists in Practice

Those who chose to practice in healthcare settings must anticipate potential ethical dilemmas. Some of these situations are inherent challenges within the medical system, whereas others test the moral compass of therapists in their everyday practice. Practitioners always need to be aware of adhering to their code of ethics in a given discipline (Bazerman & Tenbrunsel, 2012). Often, there are gray areas of practice and professional work that place therapists in tough spots to make confident decisions. Unlike many traditional psychotherapy practices where a therapist may operate as a solo provider, addressing practice challenges on collaborative teams requires skillful navigation on the part of the BHC (Curtis & Christian, 2012; Robinson & Reiter, 2016). The following are some ethical issues that often come up for clinicians and present both moral and ethical dilemmas.

### *Informed Consent*

Just like in routine psychotherapy services, medical clinics and organizations have protocols for informed consent of services for patients (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). Hospitals have become so efficient at collecting con-

sent that a "blanket" consent will often cover the communication and information provided from multiple providers in the patient's care. Consent becomes a trickier process when the BHP provides quick consults or warm handoffs from physicians where the conversation may not warrant a patient encounter (Hodgson, Mendenhall, & Lamson, 2013). However, do patients know the scope of your work and goals of your services even in these brief conversations? Do patients know the scope of psychotherapy services even if they are not established patients? These areas should not be glossed over in appointments even if patients may be seen for a one-time consultation or encounter.

Therapist may need to revise their policies for how their clinics and practice settings manage informed consent around all types of mental health services. The patient needs to be aware of their control of the treatment process and their rights of not having to see a BHP if requested. BHPs should also make it a routine practice of explaining their role to patients and their understanding that they might be engaging in a behavioral treatment or intervention. Providing verbal consent to patients and families may be necessary in times where sensitive issues or topics may have to be addressed in appointments. Any safety or risk issues such as self-harm, partner violence, or previous traumas often warrant permission from the patient to speak on these issues in front of family or other friends.

## *Addressing Medical Errors*

One of the most challenging and humbling experiences of new providers of any discipline is to admit your mistakes to patients and/or family members. The admission of a medical error not only takes a certain amount of humility but a willingness to use the patient's frustrations as a learning experience (Khoo et al., 2012; Mazor, Roblin, Greene, Fouayzi, & Gallagher, 2016). Therapists often do not realize that they may be brought into these conversations, especially during work in hospital or inpatient settings. Families may direct their frustrations to behavioral health providers on physician errors around failure to report test results, missed diagnoses, or medication errors. The BHP must decide how to not only bring this information back to the provider, but how the care team will negotiate this error with patient and/or family.

If you are in a situation where a mistake happened, showing a clear sense of compassion and forgiveness of the situation is a top priority. This should be the case regardless if the BHP was part of the initial error. BHPs are a part of the team in which patients may view the scope of a problem as the fault of the entire set of providers involved. The therapist's interpersonal skills can help repair and find resolve for the patient or family during these conversations. Nevertheless, the medical team, specifically the provider at fault for the error, has a legal responsibility to discuss this error with the patient and/or member in charge of their health decisions (Khoo et al., 2012; Rosser et al., 2005).

## *Secret Keeping*

Medicine can be a very vulnerable place for patients to disclose their information about personal health, emotional, or family issues. Often, there is an internal script that patients carry regarding what their providers might judge them by as a result of a medical issue, lifestyle choice, or healthcare decision (Rolfe, Cash-Gibson, Car, Sheikh, & McKinstry, 2014). Although BHPs are trained to be open about discussing a range of clinical and personal patient topics, situations get complicated when the BHP is requested to hold secrets. Patients might triangulate therapists into making sure that their doctor or specialist does not know about a confidential issue or situation in their lives.

For instance, a patient may have multiple sexual partners and recently contracted an STI. This patient confides in you not to tell their physician, in hopes that the physician will not think badly of them or shame them for not adhering to safer sex practices. As the therapist, it is important to explore the patient's hesitation to keep this issue a secret from the physician and, possibly, other care providers. Also, BHPs have the responsibility not to withhold important health information from their care team. The aspect of secret keeping needs to be highlighted to the patient in this appointment and outlining the risks of withholding this information for more time (Richards, 2009).

## *Boundaries Around Scope of Practice*

All mental health professionals adhere to a scope of practice as part of their code of ethics. This parameter allows therapists to work within the bounds of areas such as diagnosis, assessment, treatment interventions, and types of services that can be provided. In health care, therapists often work with patients where overlapping medical and medication concerns are present (Bischoff et al., 2012; Edwards & Elwyn, 2009). BHPs ride a fine line between therapeutic conversations of medical and pharmacological issues and giving straightforward medical advice of decision-making of one's condition or illness (Hall et al., 2015).

It is important for therapists to be consciously aware of their questions, curiosities, and treatment recommendations for patients around health and medication issues. Therapists might be put on the spot to give advice about a particular antidepressant medication or decision about getting a particular procedure done. A new therapist should not feel insecure about their lack of knowledge of a topic or condition but rather refer the patient's questions to their current physician or specialist in that area. For example, patients who have a history of failed response for antidepressant medications are recently prescribed a new SSRI for depression. Although a BHP cannot give direct advice about stopping or readjusting medications for depression, they can provide elements of psychoeducation of the risks of withdrawing their medication early. Additionally, the patient can receive some behavioral strategies to help improve their mood while deciding how dedicated they are to take their medication.

### *Reporting Unethical Behavior*

Unethical behaviors and situations can range on a large spectrum in healthcare settings. Some situations may involve a colleague talking bad about a patient or colleague in public. Extreme situations may involve provider–patient relationships, falsifying documentation in charts, or overcharging for procedures and codes that add to large amounts. Whatever the case, therapists can often be placed in the uncomfortable role of reporting inappropriate behaviors of colleagues and other staff. These situations place a high degree of anxiety and vulnerability on the part of the BHP, where the risk of fracturing close relationships with a care team is a possibility.

Several factors can go into one reporting or bring up an unethical issue in their practice setting. New BHPs should have a decision-making process for how one would go about addressing this issue and to which providers. Therapists in training should also have a conversation with their supervisors about how to go about a situation in their practice setting, should something arise. More experienced clinicians can benefit from having good rapport with their administrative staff in case of any unethical conduct that needs to be communicated or processed.

### *Family Decision-Making/Power of Attorney*

In certain medical situations, families will have to make very difficult choices around their loved one's health. For end-of-life patients, family members not only reorganize their priorities around the person's care but also honor the wishes of the patient during hard circumstances (Yadav et al., 2017). In hospital settings, a family without a designated power of attorney (POA) may have to choose who will assume this responsibility and decide whether the member gets a "full code" for procedures to be continued to keep the patient alive. Some families not only lack a POA for their loved one but have trouble understanding the definition and responsibilities of this role. The BHP and healthcare team have a responsibility to not only educate the family about a healthcare POA, but process any cultural, spiritual, or familial areas that impact the family's decision to determine their loved one's health.

Therapists must navigate a difficult path with families concerning end-of-life issues and scenarios. These conversations may take the form of family meetings in a consult room in the hospital or in a larger conference room in a primary care clinic (Curtis & Christian, 2012). Often, the BHP will gather all members' perspectives of the POA issue and help families best negotiate what is best for the patient (Milte et al., 2015). Despite who takes the legal responsibility to be the executor of healthcare decisions of the patient, the therapist can skillfully find ways for the family to be involved in the care moving forward.

### *Access of Services by Minority Populations*

Patients from underserved or underrepresented populations are often challenged to get adequate healthcare services and coverage. This population not only underutilizes mental health care services (Wilson & Schild, 2014) but often has strong cultural or personal values that go against the use of these services. Additionally, the power dynamics of a doctor or other health specialist to request mental health services may place minority groups in a submissive role when making decisions about their care. Therapists should consider the culturally sensitive nature of minority populations in practice. BHPs have to be sensitive in offering services at an affordable, cost-effective rate for patients and families, all this while administration and operations may put increased pressures on productivity and revenue generation of their job. Certain social determinants of health should routinely be assessed in healthcare settings to gain a fuller scope of the patient's barriers to care (Cunningham, 2009). Areas such as housing, transportation, access to medication refills, and family supports make a significant difference in how often patients follow-up with their care team.

## Case Study

*Jasmine is an African American female in her late 20s and started practicing in a primary care clinic for her doctoral fellowship. Because she is the only behavioral health provider on the staff, she has garnered lots of referrals and consultations around the clinic. Her director has already seen the impact she has made in improving patient care and coordination with other colleagues. Dorothy, one of the nurses on her team, has been going through some difficult personal struggles in her life. She recently lost her husband to cancer and is currently living with her mother due to financial problems in the family. Others in the office have noticed a considerable change in mood in the last three months. Although her director has suggested that she take a leave of absence, Dorothy is insistent on continuing to work because it takes her mind off of the stressful events in her personal life.*

*One day, Dorothy knocks on Jasmine's office door and needs to talk to someone. Dorothy confesses to Jasmine that she is really going through a difficult time and needs to borrow some money. She promises to pay back Jasmine and to honor her word. Jasmine says that she would need to think about the situation first before making any rash decisions. Later that week, Jasmine gets an email from her director at the clinic. The director feels that Dorothy would benefit from seeing Jasmine on a periodic basis to talk about her mental health issues. The director would also be open to Jasmine touching base with him about any updates from Dorothy from these consultations. Jasmine now feels like she is in a bind, wanting to help Dorothy without making their professional relationship compromised.*

*After a few consultations with her supervisor, Jasmine decided to have a brief meeting with Dorothy in a separate office in the clinic. Jasmine expressed her wor-*

*ries about seeing Dorothy as her therapist and exchanging money where these issues would present a boundary issue for Jasmine. Jasmine also expressed that she did not want either situation to affect their professional relationship, considering that they work collaboratively on many of the same patients. Jasmine encouraged Dorothy to talk with her boss about the financial issue to see what other resources or supports could help. Jasmine's supervisor had a follow-up conversation with the clinical director to clarify Jasmine's decision not to be Dorothy's therapist and how this role could pose a dual relationship problem going forward.*

This dual relationship dilemma is becoming increasingly common in health care settings. It is commonplace for physicians to treat staff and other providers as part of routine medical care. The ethics are different, however, for behavioral health services provided to professionals in the same clinic. Jasmine was caught with the dilemma of wanting to help a colleague but without jeopardizing the ethics of a dual relationship with someone in her same practice. The merging of medical and behavioral health fields in integrated care practice has been one of the biggest challenges in regards to confidentiality of the care team. Jasmine should realize that although her director feels that Dorothy would benefit from periodic consultations for her emotional issues, this would blur the work boundaries even further. Additionally, Jasmine must navigate the hierarchical structure and gender issue of confronting her director about this dilemma. Her conversation with the director should not only take Jasmine's perspective into account but an opportunity to educate the director about the ethical differences between medical providers and behavioral health providers. For a new intern, this can be a very difficult position to face, given the need for Jasmine to gain trust and connection with her care team at the start of her rotation.

## Practice Challenges in Routine Care

In addition to ethical concerns and dilemmas that happen within the scope of medical practice, there are practice challenges that BHPs need to consider in their settings. These challenges can often deal with space, communication with the patient, and/or understanding of health concerns and cultural considerations in clinical encounters.

- *Office space and practice locations.* In many clinics, the BHP will not always see the patient or family in a therapy office. Sessions can be conducted in an exam room, conference room or common room that is shared by other providers. Anticipating interruptions and overhead pages are a common distraction in sessions. Additionally, these settings may not have the most comfortable seating options for patients and/or members to have during a longer session. When the BHP does not have the resources of a traditional office, he or she must adjust their style of therapy to align with the presenting problems of the patient or family.
- *Gender issues that may arise during an encounter.* Patients often have challenges disclosing certain personal information due to the gender of the physician

(Bertakis, 2009). BHPs may be brought in for consultations to help alleviate these concerns of patients and/or family members. In the hospital settings, BHPs routinely encounter such examples, where the pace of the conversation, sensitivity to the gender-specific issues and volume of speech needs to be altered to adjust to the patient's situation. Some examples of sensitive gender issues may include partner violence, sexual dysfunction issues, or previous trauma-related conditions.

- *Confidentiality in the hospital setting.* Another challenge on inpatient services is the lack of true confidentiality when speaking with patients. The patient might be sharing a room with another patient or have an exposed room where those in the hall might be able to hear (Hodgson et al., 2013). Nurses, medical assistants, specialists, and other providers will frequently enter the room at unexpected times and unintentionally interrupt the conversations. Therapists should remind the patient about the possibility of the conversation being open for others to hear and handling ongoing disruptions in rooms.
- *Health literacy and health education.* A major shortcoming that health care providers continue to overlook is the literacy and education of patients surrounding their healthcare decisions (McCune, Lee & Pohl, 2016). Aspects such as socioeconomic status, race, ethnicity, age, and educational level can make a large impact on how patients manage their health issues. Many patients struggle with knowing how to organize medications, read labels and information, understand complex medical terms, and complying with a long-term treatment from a provider. When BHPs offer an intervention, skill, or technique for the patient to consider, one should also assess for the patient's level of understanding this recommendation and what supports could help with the follow-though of the plan of care.
- *Using interpreters for sessions.* Some patients, for whom English is a second language, may need an interpreter (in-person or phone) to help translate sessions. Therapists should consider ways to adjust their conversations in these types of sessions (Jacobs, Ryan, Henricks, & Weiss, 2018; Kalina, 2015). The pacing of questions and time allowed for translation to be communicated back to the therapist is a learning curve for many new therapists. BHPs must also be sensitive to any cultural issues in how questions are answered and how the interpreter constructs the information going two ways.

- One specific case stands out for me (Max) around the issue of interpreters and health education.

This example occurred when I was rounding with a family medicine team in a hospital. A Puerto Rican patient and her mother were in the room with five providers on the family medicine team (one BHP, one physician, one medical resident, one pharmacist, and one case manager). The physician was Spanish-speaking and willing to interpret the conversation for the patient, mother, and medical team. When the doctor began to ask questions, the patient's mother became increasingly frustrated. The mother interrupted the physician and said, "You are speaking the wrong kind of Spanish." The patient asked the physician if she could call the interpreter to finish

the conversation. Although the physician was respectful and supportive of their decision, the encounter extended an extra 15 minutes because of locating an interpreter, allowing translation time, and processing all the patient's concerns. The patient also reiterated to the physician and team that her mother does not understand all of the medical terms and medications that the other doctors have discussed. The physician was very brief with the mother and left the room to attend to other patients on the floor. The pharmacist and resident spent an additional 10 minutes going over the list of medications and what they are used for.

After the team finished rounding, both the therapist and team went back to the room to process any concerns or questions they had. The patient said that she was appreciative that they heard her concerns and did not like the tone of the previous physician. This also became a learning experience for the residency team where they had to admit as a group that they did not hear the family's concerns effectively. Respecting the culture and language of patients and family members in the hospital setting is a very important competency for all health care providers. BHPs often have this role of listening to patients' frustrations, concerns, or opinions as a result of decisions made by the care team.

## Conclusion

Legal and ethical considerations will always exist for mental health professionals who work in interdisciplinary settings. While each professional discipline has their own code of ethics to follow, many ethical challenges in medicine are considered new territory for beginning therapists in their training or career. Even more unknown ethical decisions and challenges exist for BHPs in secondary and tertiary care settings (Bazerman & Tenbrunsel, 2012). As the roles of therapists expand in an ever-changing United States health care system, the work tasks, scope of practice and autonomy of decisions will continue to be an evolving issue moving forward.

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