

Chapter 20

The Ethics of Integration: Where Policy and Practice Collide

Cathy Hudgins, Sandra Rose, Peter Fifield, and Steve Arnault

For anyone working in an Integrated Primary Care (IPC) setting, ethical challenges routinely arise due to a variety of contextual and procedural factors. Situations can become more complicated when diverse professionals interface, each holding to their own discipline's code of ethics. Medical family therapists (MedFTs), along with healthcare providers, are asked to adhere to both the ethical standards of their specific disciplines and the legal standards set forth by state and federal guidelines, all of which can differ by specialty. If this issue was not complicated enough, there are additional and often differing sets of guidelines embedded in IPC contexts, including the specific policies established by the setting. Efforts to comply with multiple regulations can serve as a challenge when laws and ethics do not cleanly interface with contextual policies that are intended to protect the patient. This tug of war can actually impede optimum care when they conflict.

This chapter addresses some of the common ethical issues that arise in IPC settings and offers practices that MedFTs and other IPC providers can use while keeping patients at the center of care and protecting their rights. Wherein practitioners of MedFT are the focus for this chapter, the information provided here is applicable across the system of IPC providers, including differing types of behavioral health providers (BHPs). Greatest attention is given to policy and practice implications for MedFTs who function in IPC settings, including guidance via federal and state statutes when applicable on how to maximize patient care in the context of an integrated system.

C. Hudgins (✉)

Center of Excellence for Integrated Care, North Carolina Foundation for Advanced Health Programs, Cary, NC, USA

e-mail: cmhudgins@radford.edu

MedFT Ethics

Whether practicing in an IPC or a traditional specialty behavioral healthcare setting MedFTs are bound by their discipline-specific ethical standards. We have chosen to focus on the challenges identified as most prominent in IPC practice and research, including (a) client confidentiality; (b) informed consent; and (c) exploitive, dual, and multiple relationships. Before discussing these challenges specifically, it is important to review the role that ethical guidelines play in IPC settings.

Throughout this chapter, case studies will be presented to illustrate concepts. The following decision-making model will provide a framework for each case study discussed in this chapter, assuring that most aspects of a situation have been explored in a standardized manner. Providers are encouraged to process ethical dilemmas as they are encountered by moving through the steps outlined in the following decision-making model (developed by the authors of this chapter):

1. Clarify the facts and their context.
2. Explore the applicability of federal and state statutes.
3. Explore the applicability of professional codes of ethics.
4. Consult agency policy and procedure manual.
5. Seek supervision or consult with a colleague of equal or greater experience.
6. Define options with consideration of the clinical ramifications.
7. Implement and document.
8. Critique the process.

By navigating through these steps, the result as noted by Runyan, Robinson, and Gould (2013), will be “care [that] will come closer to the bar of compassion when the patient (rather than our disciplines) is the focus of care (p. 7).” All of these ingredients are steps that providers should navigate when faced with ethical challenges, but in IPC, providers do not and should not feel as though they are managing these eight steps in isolation.

Despite the assumption of uniformity in IPC systems, contexts all have at least some subtle differences. For example, statutes governing IPC may differ from state to state. Thus, providers would be wise to research and understand the healthcare statutes and rules impacting the care of patients who cross state lines or who reside in a different state from the provider [i.e., couples whereby one partner is deployed elsewhere]. This would also apply to providers who practice in multiple states (e.g., trauma responders, multiple state licensees). Legal and ethical standards also differ between BHPs and primary care providers (PCP) of all types, including nurse Practitioners, physician assistants, and physicians. Therefore, policies and protocols for information sharing, informed consent, and confidentiality require careful review under federal and state law, as well as per professional code of ethics and context specific guidelines. Discrepancies are most apparent in the laws and ethics

that involve patient confidentiality and informed consent and those which determine the relationships between providers and patients.

Currently, there is a resounding call in health care for laws, rules, and ethical guidelines to be revised and align more with an IPC model (Hudgins, Rose, Fifield, & Arnault, 2013; Runyan et al., 2013). The following section will address common ethical challenges in IPC, including aspects of case law that set a precedent and act as guidance (Hudgins et al., 2013) on how to manage ethical violations, Health Insurance Portability and Accountability Act laws (HIPAA, 1996), and Federal Alcohol and Drug Confidentiality Laws (42CFR-Part 2; Substance Abuse Services, 2011), as well as policy implications and practice considerations.

Confidentiality

Confidentiality is the ongoing process of protecting the information shared between provider and patient as part of care. Grounded in federal and state law, and codified by professional guilds, this process forms the foundation of the therapeutic relationship and establishes trust and confidence in a provider's ability to understand and treat patients. In IPC settings, confidentiality is one of the most difficult responsibilities to navigate. Expectations for privacy by those who have been trained in relatively closed environments (e.g., traditional or specialty behavioral health practices) may seem unrealistic to those operating in IPC settings, where there are relatively open physical spaces, easy flow of information, and an immense volume and velocity of patient and provider interactions (Reiter & Runyan, 2013; Runyan et al., 2013). To further complicate these matters, requesting and receiving receipt and release of information from a patient, and then sharing patient information between providers, can be a complex process: One that providers must quickly and seamlessly navigate or face ethical challenges.

Federal Statutes

Providers may sometimes feel as though they are in the cross fire between federal statutes and flexibility in offering best patient care. These experiences may be amplified in IPC settings where providers strive to strengthen the collaboration between patients and their diverse care team. Unfortunately, some are left feeling conflicted about their interpretation of the law and their belief in practice toward efficient patient care. The bottom line is that federal laws must be followed for patient protection in all settings, with HIPAA being the most prominent guideline.

HIPAA

HIPAA includes provisions for patient safety and dictates rules for communication of protected health information (PHI), irrespective of provider type (HIPAA, 1996). Thus, conduct pertaining to confidentiality should be clear to both provider and patient. However, under this relatively liberal law, PHI may be communicated to a PCP for treatment purposes without a patient's authorization, provided a patient is notified of the provider's privacy policies. Most healthcare settings require a written signature by the patient acknowledging that healthcare information is communicated for health purposes in this way. It is then the dual accountability of providers to follow the PHI provisions and for patients to understand the implications for documents signed.

No distinction is made in relation to confidentiality between medical and behavioral health (in relation to these contexts) according to HIPAA, except in the case of "psychotherapy notes." HIPAA defines these notes as that which is created by a "mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session, and are separated from the rest of the individual's medical record (Section 45CFR 164.501; HIPAA, 2007)." The definition excludes "medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date" even when conducted by a BHP.

There is minimal guidance regarding how to differentiate "psychotherapy notes" from "progress notes" in the electronic medical record (EMR). However, the consensus appears to be that typical BHP encounter notes would not fall under the definition of psychotherapy notes, as they are not documenting "process-oriented" notes of traditional psychotherapy. Moreover, psychotherapy notes are, by definition, separate from the rest of the healthcare record. However, separation of records alone does not render a behavioral progress note to then become a psychotherapy note. Some examples of psychotherapy note content include: clinician interpretations, transference and countertransference content, relational problems, and specific sensitive detail of past sexual abuse. Psychotherapy notes differ from regular clinical records and receive special confidentiality protection under HIPAA (2007; Section CFR 45, Part 164.524) from other clinical records, which may be exchanged without *specific* permission from the patient. Furthermore, physically integrating the psychotherapy information into one document does not make the excluded information protected. By adhering to standard progress note structure (such as a SOAP note format), one might minimize unnecessary or overly inclusive information in an encounter note that does not benefit patient care or provider treatment options.

According to Reitz, Common, Fifield, and Stiasny (2012), there is very little consensus on best practices for securing and maintaining confidentiality within IPC documentation processes to ensure HIPAA compliance. One approach is to

construct confidentiality protocol such that providers limit the sensitive content in BHP encounter notes and permit widespread access across healthcare providers and to those managing payment, all of whom are well trained on respectful, accountable, and effective confidentiality practices. Alternatively, some EMR systems enable security settings to be associated with specific charts and the BHP or other providers can set the appropriate security level (e.g., labeled as “behavioral” health or “substance use”) at time of entry, with access on a need-to-know basis among staff. EMR security audit trails can be undertaken as well, to ensure compliance with healthcare context security protocols.

42CFR Part 2

MedFTs practicing in IPC settings that provide specialized substance abuse services must maintain an additional layer of confidentiality to protect patient information. The Federal Drug and Alcohol Confidentiality Law (42CFR Part 2) imposes restrictive rules upon providers who are designated within “programs,” by dictating the protection of alcohol and drug information. A covered “program” is one that receives federal funds (such as a Federally Qualified Health Clinic or programs reimbursed by Medicare) and meets the following criteria:

1. If a provider is *not* a general medical care facility, then the provider meets Part 2’s definition of a “program” if it is an individual or entity that holds itself out as providing, *and* provides alcohol or drug abuse diagnosis, treatment, or referral for treatment.
2. If the provider is an identified unit within a general medical care facility, it is a “program” if it holds itself out as providing, *and* provides, alcohol or drug abuse diagnosis, treatment or referral for treatment.
3. If the provider consists of medical personnel or other staff in a general medical care facility, it is a program if its primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment *and* is identified as such specialized medical personnel or other staff within the general medical care facility (SAMSHA, 2011, p. 6).

Many MedFTs in IPC settings offer some substance abuse services, including screening, assessment, and perhaps some elements of treatment or management. Both behavioral health and healthcare providers are covered by this regulation if they “primarily” assess or treat substance abuse disorders, as in criteria three listed above. Consistent with this interpretation, is guidance from the Legal Action Center, which states . . .

Generalist mental health providers who work in general health centers are NOT ‘programs’ covered by 42 C.F.R. unless they meet the definition of a ‘program’ because they are part of (1) a specialized unit or, are (2) specialized staff (whose primary function is to provide drug or alcohol diagnosis, treatment or referral), as defined in Part 2’s definition of a program (K. O’Neil, Personal communication, May, 26, 2011).

Generalist BHPs and PCPs who do not meet the three requirements do not require special authorization from the rest of the treatment team for alcohol and drug information, thus confidential information is more freely exchanged to maximize collaborative treatment efforts. Specialists, such as Licensed Alcohol and Drug Counselors or PCPs who predominantly prescribe Suboxone or who practice in specialized substance abuse units within a health center may be examples of “programs.” These providers require the specific patient Part 2 authorizations to release alcohol and drug information to other providers even within the same treatment team or healthcare system. These providers must also obtain Part 2 authorization to provide an alcohol or drug diagnosis or other substance abuse information to third-party payers for reimbursement. Given the sensitivity of this information, even if not required, it is prudent that patients be specifically notified via informed consent materials that confidential content related to alcohol and drug information is exchanged with PCPs within the IPC system. They should also be made aware that this information will be transmitted to third parties for billing and, if the system’s policies permit, to outside healthcare professionals who may be referred for their care.

The Legal Action Center’s Web site ([Legal Action Center](#), n.d.) provides model forms, including that which combines HIPAA and Part 2 elements as well as sample Qualified Service Organization Agreements (QSO). All of these can facilitate communication between professional organizations and Part 2 covered entities. These recommendations can then be cross-checked against other mandatory guidelines, such as state laws and discipline specific professional code of ethics.

State Statutes

Requirements for procedures related to the exchange of confidential communication is not limited to federal law, but must also be followed via state statutes. In many states, for example, confidential discussions between patients and physicians, as well as between patients and BHPs, are defined similar to communication between lawyers and their clients. However, the licensing statute for the four behavioral health disciplines regulated by the omnibus New Hampshire Board of Mental Health Practice (e.g., Clinical Mental Health Counselors, Clinical Social Workers, Pastoral Psychotherapists, and Marriage and Family Therapists), not only prescribes specific language which must be included in informed consent materials provided to patients, but also includes the specific means for delivery of materials to patients in order to assure confidentiality. The cumbersome provisions of this law were obviously not borne in the context of IPC, where MedFTs meet patients in exam rooms to discuss behavioral health modifications. MedFTs and other providers who practice in IPC settings should check their state licensing statutes to determine what specific laws apply to practice in their specialty and how this might differ from that of their healthcare colleagues.

Case Law

Case law illustrates how some courts may elevate communication between a licensed BHP and a patient, beyond that of a PCP and patient. Although the privacy protections for patients of PCPs and MedFTs are similarly viewed by statute, a court ruling in New Hampshire singled out the importance of privilege between a Psychologist and patient beyond even that of a doctor–patient and a lawyer–client. In the case of *Berg v. Berg* (2005), the opinion of the New Hampshire Supreme court asserted that the therapist–patient privilege may be even more compelling than that behind the usual physician–patient privilege because of the greater demand for confidence and trust that the patient needs to enter treatment and the need to make disclosures important for psychotherapy versus that which may be required in the treatment of physical ailments. The court cited an opinion by the New Jersey Supreme Court, which noted that communication “will frequently be even more personal, potentially embarrassing, and more often readily misconstrued than those between attorney and client. Made public and taken out of context, the disclosure of notes from therapy sessions could have devastating personal consequences for the patient and his or her family (Section II).”

What may be implied from this case, as well as that from HIPAA’s unique treatment of psychotherapy notes and Part 2 regulation, is that the greater the sensitivity of the information generated and documented, and the greater harm that could result from disclosure, the more confidentiality safeguards must be built into practices by the MedFT. This is usually not a problem when the focus of treatment is on lifestyle management or health behaviors. However, patients may view the role of the MedFT differently than they do their PCP’s, offer information that may exceed the minimal sensitivity seen in a typical 15-min medical encounter, and expect more privacy in communications with MedFTs. This may result, for example, in more willingness to admit alcohol and drug abuse, marital concerns, or disclosures related to sexuality. Thus, MedFTs must navigate complex circumstances with their healthcare peers who share confidentiality as collaborators, while also honoring MedFT–patient relationships when sensitive information is shared (e.g., having an affair, gambling addictions). In these cases, informed consent procedures pertaining to access of charts or exchange of information must be adequately addressed with patients. In particular, both collaborating colleagues and patients must understand the MedFTs’ role, how it differs from therapists who function in traditional therapy contexts, and how information is shared among the team.

Professional Code of Ethics

All behavior health and medical disciplines have a code of ethics that offer clarity in regard to the expectation for confidentiality within the provider–patient

relationship. All codes of ethics describe the limits of confidentiality, release of information, and use and protection of patient information. The challenge within IPC settings is not a lack of awareness for confidentiality, but in the lack of understanding among providers in how these codes overlap or diverge from one another. MedFTs, because of their relational training, are uniquely attuned to the system's needs, so finding balance between their ethical codes and those of their colleagues should be a skill in which they can contribute to the collaborative team. Flexibility, communication, and cross-training are key strategies found to increase the IPC team's ability to navigate these ethical quandaries in a fast-paced, complex healthcare environment (Hodgson, Mendenhall, & Lamson, 2013; Reiter & Runyan, 2013).

To help understand how team members from diverse professions perceive confidentiality, Curtis and Christian (2012) provided a comprehensive discussion of ethical guidelines across disciplines, including an interpretation of ethical codes for both PCPs and BHPs. These authors use excerpts from five professional codes of ethics to suggest how to resolve the quandary of whose ethics trumps whose when collaborating. Ethical issues related to sharing information and mandated reporting (key elements related to confidentiality) are the focus of this resource. They prefaced these recommendations with the note that even seasoned IPC team members may experience conflict when attempting to develop policies and protocols related to confidentiality. Hodgson et al. (2013) also provided a review of nine leading professional organizations' ethical guidelines, including those written for MedFTs, and use clinical case studies to illustrate issues related to confidentiality and informed in IPC settings.

What follows is a case study pertaining to confidentiality, followed up with the decision-making model (described earlier in the chapter) that MedFTs can use to navigate federal, state, and professional codes of ethics.

Case Study: Confidentiality Decision-Making Model

Mr. Johnson, a 53-year-old male is seen with his wife for a follow-up appointment. He has been diagnosed with renal failure, and the focus of the session is on the lifestyle adjustments the couple will need to make to promote health, intimacy, and overall quality of life. During the session, Mrs. Johnson brings up the fact that her husband typically drinks several beers every evening. Upon this disclosure, Mr. Johnson becomes angry with his wife and initially denies the alcohol use. After some discussion, he relents but asks that the MedFT not disclose his drinking to his PCP primarily because his physician is the son of his boss.

Discussion: This case represents a common dilemma faced in an IPC setting. When considering the eight elements of the decision-making model, the MedFT should first review the facts that were shared by both husband and wife and then consider relevant statutes. Applying the decision model we come to understand Mr. Johnson's situation more clearly. Mr. Johnson appeared to feel betrayed by

his wife and seemed concerned about the information about his alcohol use getting back to his boss and thus feared losing his job. A review of the applicable statutes reveals that 42 CFR Part 2 may come into play providing protection to the substance use information. However, after a careful review of the statute and consultation with her supervisor, the MedFT thinks that she, and the practice in which she works, do not meet the criteria as a “program” under this statute. Therefore, they believe 42 CFR part 2 does not apply to this context. The code of ethics and the practice’s policy and procedure manual both speak to upholding the patient’s rights and the primacy of the patient’s right to decision-making. Further, Mr. Johnson signed the practice’s participation agreement indicating that he understands and agrees that mental health and substance abuse information is shared among providers. The MedFT is aware that the patient has the right to rescind this at any time and has effectively done so.

The situation now rests on the clinical ramifications of the MedFT’s choice of action. She needs to weigh the risks of telling or not telling the PCP about the use of alcohol which may impact the prognosis of Mr. Johnson’s renal failure. Additionally, she is concerned about her ongoing therapeutic relationship with her patient, understanding that Mr. Johnson will see her revealing this information as a breach of trust. Ethically, it is paramount to engage in conversation with Mr. Johnson regarding the importance of this information and how his alcohol use directly relates to his overall medical care. This conversation may help him to see that his wife is acting out of concern. It is often beneficial in these situations to point out the dilemma that the MedFT is in and partner with the patients to find a solution. In this case, reassurance from the PCP that the information will be held in confidence may be the key. Mr. Johnson may either realize that the trust with this PCP is genuine, thereby strengthening his relationship with his healthcare team or he may need to get a referral to new providers so that he can better address all aspects related to his health. This situation would then be documented accordingly, and then processed by the MedFT and the healthcare team or between the MedFT and her supervisor. Debriefing often helps providers to attend to strengths and challenges in handling an issue, but can also help to construct new policies when necessary.

Policy and Practice Implications

To date, there is very little guidance or explanation of healthcare policies related to confidentiality specifically for MedFTs in IPC settings. Although, more and more resources are emerging to clarify current laws and policies guiding practice (Collins, Hewson, Munger, & Wade, 2010), a more definitive interpretation is still needed. In addition, national- and state-level laws as well as professional ethical standards need to catch up with the evolving ethical issues presented by IPC models.

As it stands, confidentiality in IPC settings is governed by more than ethical codes. In all cases, the most restrictive guideline is the one in which the setting must adhere. When it comes to policy and practice implications, more than one source recommends consulting with an attorney or executing in-depth analysis of state and federal laws, in addition to professional ethics prior to developing any policy or protocol (Collins et al., 2010; OCCIC, 2010; Saviano, 2008). This step may help to avoid fines and other legal actions. Furthermore, due to the increased influence that IPC is wielding on state and federal law reform, sources across the board stress that it is critical for providers and stakeholders to stay abreast of changes related to confidentiality (Hudgins et al., 2013). Awareness of these changes in laws and other policies related to practice are central to providing competent care. In state-level legislation, there are few resources that draw direct comparisons between behavioral health and other healthcare laws. A clearer understanding of the relationship between these laws could help to provide a framework for additional policy changes, particularly when integrating behavioral health services into primary care settings.

It is clear that when IPC systems include substance abuse treatment in the array of services, 42CFR Part 2 compounds the challenges of exchange and release of information. The SAMSHA—HRSA Center for Integrated Healthcare Solutions and the LAC offer some of the most specific information and links to resources for providers treating patients who seek substance abuse treatment in integrated systems. These organizations offer recommendations and resources regarding many population-based patient care issues, including sample forms of agreement between providers and minors. However, formalized policies and guidelines grounded in best practices for confidentiality in IPC settings would be most beneficial for MedFTs when faced with complex patient situations, particularly situations with multiple family members and supports persons who are involved in the patient's care.

Informed Consent

Informed consent procedures also present quandaries when MedFTs and other BHPs partner with healthcare providers on IPC teams. Informed consent commonly refers to the process of providing information to a patient prior to treatment concerning patient rights and the provision of treatment information necessary to make informed decisions (Hudgins et al., 2013). Informed Consent is an ongoing procedure to ensure that the patient is aware of all of the potential risks and costs involved in a treatment or procedure. The elements of informed consent may include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment. It may also include the “notice” that is required by federal or state laws and/or professional ethical codes concerning the patient rights.

Federal and State Statutes

Guidance related to informed consent exists within federal laws, which prescribe specific kinds of notice necessary for patients receiving treatment (e.g., HIPAA & 42CFR Part 2 notices). HIPAA (1996), for example, has clear guidelines for provision of informed consent regarding notice to patients of their privacy rights. While traditionally considered apart from treatment decisions requiring consent, decisions concerning PHI sharing are arguably as important, and costs and benefits of releasing PHI should be part of the informed consent process.

Managing PHI and ensuring informed consent from all participating providers can become more challenging when primary care visits are integrated with sensitive issues such as behavioral health diagnoses or alcohol and drug use. In these instances, many providers may become involved in care but patients may not be clear that BHPs are part of the healthcare team, unless consent for treatment is especially clear. Therefore, consent documents must not only be written in accordance with HIPAA guidelines but should also be reviewed orally (when possible) so that patients can ask questions about consent processes, as well as questions about the providers who may be part of their care team. With widespread dissemination of information now possible through electronic health records, the potential harm and benefits are further magnified.

Given the ease of transferability in healthcare records, state laws are beginning to mandate more specific patient protection procedures (Koocher & Keith-Spiegel, 2008). Such procedures are imperative given that front desk staff members are typically charged with providing patients with informed consent guidelines in healthcare settings (AMA, n.d., Curtis & Christian, 2012). Ultimately, it is up to MedFTs and other BHPs, as well as PCPs, to make clear the patient's rights to make an informed choice regarding care. As mentioned previously, in some instances it is not clear when, how, and from whom informed consent is attained in an integrated setting.

Seeking and receiving consent are ongoing processes that must be revisited with each new provider, procedure, or treatment option. Requesting consent rests on all providers and other IPC staff in a system; therefore, everyone in the healthcare context should know how to access legal counsel or at least be familiar with federal and state laws when developing informed consent policies, protocols, and forms, and keep abreast of these as states make changes to laws to accommodate IPC practices. A best case scenario is to defer to the most stringent requirements related to consent that pertain to the kind of services rendered and makeup of the healthcare context (Saviano, 2008).

Professional Code of Ethics

While many ethical guidelines across disciplines have some code related to informed consent, AAMFT Ethical Code 1.2 gives one of the clearest guidelines for relational providers . . .

Informed Consent. Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person if such substitute consent is legally permissible. (AAMFT, 2012)

An aspect of informed consent that is not as clear in this definition, but is also carried through other parts of professional codes of ethics, is appropriate representation of scope of practice and credentials. For example: “Marriage and family therapists do not represent themselves as providing specialized services unless they have appropriate education, training or supervised experience” (AAMFT Code of Ethics, Section 8.8). Individual state license regulations often guide behavioral health providers (i.e. psychologists and mental health counselors) to identify their scope of services, which includes specifying their background and training as well as the risks and benefits of the services they provide. Consents of this nature may be difficult for workflows to accommodate in the medical setting, especially at point of contact such as during warm handoffs or brief behavioral health encounters.

Consent quickly can become a bigger issue if the provider is not explicit and intentional about his role within an integrated care setting. Role identification may remove any question about the function of that provider within the integrated system (Curtis & Christian, 2012). Role expectations are influenced by a number of factors, including patient’s prior experiences with healthcare providers, as well as how a provider introduces behavioral health service. An introduction by a PCP can influence a patient’s expectations regarding the role of a MedFT, whether operating as a behavioral health consultant focusing on a lifestyle change or entering as a relational therapist to work on marital issues. A suggested introduction by a member of the IPC team might be: “we have a member of our team that specializes in helping people with [insert specific presenting problem here].” If the MedFT is introducing herself to the patient, she would want to identify her license and her role on the treatment team. This not only reduces false expectations but also additionally assists the MedFT to focus on a specific behavioral intervention and seek consent accordingly. This process is important via face-to-face interactions at the initial introduction and subsequent visits, but also in how provider services are advertised to the patient population in the waiting rooms, company brochures, and

Web sites. What follows is a case study and the corresponding decision-making model for informed consent.

Case Study: Informed Consent Decision-Making Model

A MedFT working in a small community health center is asked to go into the exam room to meet with a woman whom the PCP describes as “distraught.” The woman is crying and visibly shaking. Initially, the patient is so upset that she is unable to verbalize her concerns. The MedFT acknowledges her emotions and waits until she is calm enough to explain. Upon discussion, the woman states that her PCP determined the need for a behavioral health consultation after she reacted to her diagnosis of Crohn’s disease. The woman, who has a history of behavioral health problems, which have required that she be involuntarily committed several times, became anxious when the PCP stated that he was going to get the BHP to come in to assess her current behavioral status. In this case, the patient did not grant informed consent. Since the patient signed her consent when she entered into services with the PCP several months ago, the PCP believed that he did not need to ask for her permission to bring the MedFT to see her in the room.

Discussion: The first step in the decision-making model for a MedFT would be to clarify the facts regarding whether the patient consented to speak with the MedFT. In this case, the role of the MedFT, his credentials, scope of practice, and the intention and potential outcomes of the consult. This approach is consistent with both HIPAA and 42 CFR Part 2. Further guidance can be found in professional codes of ethics related to clarity on services provided and consent for services received. The policies and procedures of the practice ask that each patient be made aware of the presence and role provided by the MedFT and that the patient sign an acknowledgment that she understands and consents to this service, which this patient has done. An appropriate next step in creating an alliance with the patient would be to revisit the informed consent once the MedFT comes into the room and proceed only if the patient is interested in services. The MedFT may want to let the patient know that he is asked by providers to come in and meet with all consenting patients in the practice, when they receive a new diagnosis to ensure that patients have psychosocial support systems as they adjust to the new diagnosis. This is done to help the patient know that she is not singled out for behavioral health care. Documentation would then be completed based on outcomes from the appointment, including a note about the review of consent policies. This situation would then give the providers an opportunity to review policies about consent and encourage one another to bring up consent when other providers are involved in their patient’s visit.

Policy and Practice Implications

In many of the IPC system manuals to date (Hudgins et al., 2013), the patient is given initial paperwork upon entering the system that describes the role and scope of behavioral health services. One blanket informed consent is commonly provided in initial paperwork during patient registration and justified by some practitioners through the notion that behavioral health is part of health, no different than provision of other services in the primary care setting. Hodgson et al. (2013) noted that a blanket consent process assumes that the patient has or can understand the consent and all that it encompasses, but that consent should not just occur prior to registration. A variety of sources agree with this perspective, asserting the belief that informed consent in any setting should occur through ongoing communication about treatment options (Barnett, 2007; Striefel, 2009). Once is not enough, especially if the provider does not take the time to make sure that the patient is making as much of an informed choice as possible regarding his or her care.

There are few prescriptions for language or method of delivery regarding consent in the literature. However, Curtis and Christian (2012) conducted a review of all of the professional codes of ethics for both BHPs and PCPs. Their review clarifies and provides important policy and practice recommendations pertaining to consent. They suggest that all patients receive an initial written informed consent, which would require not only a signature prior to service provision during registration but also a verbal consent during the initial interaction with the patient. These implications are perhaps especially important for patients who are illiterate or have lower level reading skills, speak or read in a language that is different than what is given to them via documentation, or experience physical challenges that impair their reading (e.g., poor eyesight, cognitive impairments). Curtis and Christian offered a sample script to highlight a way of introducing BHP services for verbal consent of treatment. What follows is an adaptation to their script, in order to better align with the role of a MedFT.

Hello, Mr. Martin, I'm Jordan Smith, and as Dr. Fernandez explained, I am a medical family therapist and I have been working with this clinic to ensure that patients get comprehensive care. This care may include collaboration with your primary care provider on experiences in your life such as, sleep hygiene, pain management, or family stressors. I'd like to make sure you have this packet of information related to my education, areas of competency, confidentiality, and who to contact if you have grievances about the services I provide. All of this information is listed in this brochure, which is for you to take with you following this visit. Dr. Fernandez asked that I meet with you so that together we can find some strategies that might help alleviate some of the symptoms you mentioned. I know that I just gave you a lot of information, so please let me know what you understand and what questions you have. (See original script in Curtis & Christian, p. 129)

A final concern about consent, that is central to IPC systems, is the need to balance consent provision with efficiency of care. Most IPC settings are "busy and fast-paced and do not have the staff or infrastructure to maintain and coordinate multiple or detailed, time consuming consents" (Collins et al., 2010, p. 35). While MedFTs and other BHPs are charged with helping the system seek and maintain

consent, MedFTs may also assist in creating policies or implementing changes that may ease flow or procedures pertaining to the consent process.

In addition to the information exchange and informed consent, there are additional ethical issues that arise in IPC settings. The most recent and comprehensive review of arising ethical concerns in IPC can be found in the special edition on ethics in the journal *Families, Systems & Health* (2013), including issues such as dual relationships and termination/provider abandonment as major concerns.

Exploitive, Dual, and Multiple Relationships

Exploitive, dual, and multiple relationships relate to any situation whereby multiple roles exist between a therapeutic affiliation and an academic, supervisory, personal, or familial relationship. By nature, these relationships involve complications such as, a conflict of interest or a positive or negative bias that is able to influence treatment processes or outcomes. Dual relationships can occur when colleagues within a healthcare context request behavioral or medical treatments from other colleagues. This may be even more common in rural settings, where a child's coach may also be her healthcare provider (Smalley, Yancey, Warren, Naufel, & Pugh, 2010). In any case, MedFTs must be aware of boundaries that cannot be crossed when treating patients that they may know from other contexts.

Professional Code of Ethics

All of the major discipline-specific organizations (e.g., American Association for Marriage and Family Therapist, American Psychiatric Association, American Psychological Association, National Association of Social Workers, and National Board for Certified Counselors) provide ethical guidelines for therapeutic boundaries and dual relationships. For example, according to the AAMFT Code of Ethics 1.3. . .

Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken (AAMFT, 2012).

In contrast, guidelines provided for healthcare providers (American Medical Association, American Nurse Association, American Academy of Nurse Practitioners, and American Academy of Physician Assistants) view dual relationships differently. It is common practice for a healthcare provider to provide care to

employees and colleagues. In addition, the nature of family practice is founded on seeing multiple members of the same family over time. AMA codes encourage PCPs to treat peers in healthcare settings (Kanzler, Goodie, Hunter, Glotfelter, & Bodart, 2013), while other ethical guidelines, such as those endorsed by the APA (2010), AMHCA (2010), and AAMFT (2012) recommend that the MedFT take considerate precautions when engaging in these types of dual relationships. This apparent difference in perspective may cause conflict within the IPC team, especially when a MedFT is asked to treat another staff member or his or her family members. Without clear communication about ethical guidelines, staff members and healthcare providers may not understand why a MedFT would refer a patient to another provider even though she is equipped to see the patient.

Case Study: Multiple Patients in a Rural Setting Decision-Making Model

Mr. Parker is a 53-year-old man presenting in his rural Federally Qualified Healthcare Clinic, for treatment of hypertension, diabetes, and panic attacks. His wife, an employed medical assistant at this healthcare facility, has encouraged her husband to become a patient in order to receive care for his medical conditions. She is working that day and becomes visibly anxious as she watches her husband walk into the exam room. After the initial exam, the physician and MedFT discuss a treatment plan in the exam room with the patient. The physician asks to be excused while the MedFT and patient work on specific goals. During a follow up visit with the MedFT, the patient arrives and states his wife wants to attend the session with him. She is not working that day and you see her sitting in the waiting room awaiting your decision.

Discussion: Reviewing the facts in relation to the ethical decision-making model shows there are several issues at play here. Clearly, there exists a potential of a dual relationship between the persons providing care for this patient (MedFT and PCP) and the patient's wife is also an employee at the same healthcare practice. There are no clear federal statutes relative to this dual relationship situation. Ethically, the MedFT must review his code of ethics relative to dual relationships and note that the MedFT will make every attempt to reduce the risk of exploitation of the client. Noting that the wife was not working at that time of the visit suggests that she would not be violating an agency policy or procedure by joining her husband in the session. The MedFT at this point must make very clear the patient's confidentiality rights with an explicit presentation of informed consent for treatment from the MedFT. Furthermore, a clear conversation regarding dual roles must be conducted with the patient's wife, clarifying that she is not the client but an agent providing supportive and relevant information for the accurate treatment of the patient. At that point, the MedFT could proceed with gleaning information from the couple as he may with any other couple and conduct the session in a similar fashion.

If the wife voices that she wishes to continue on as a client, a second phase of evaluation pertaining to dual roles must occur. After defining the problem,

Low Power	Mid-Range Power	High Power
Little or no personal relationship	Clear power differential present but relationship is circumscribed	Clear power differential with profound personal influence
Brief Duration	Intermediate Duration	Long Duration
Single or few contacts over short period of time	Regular contact over a limited period of time	Continuous or episodic contact over a long period of time
Specific Termination	Uncertain Termination	Indefinite Termination
Relationship is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again	Professional function is completed but further contact is not ruled out.	No agreement regarding when or if termination is to take place

Fig. 20.1 Dimensions for ethical decision-making (Gottlieb, 1993, p. 5)

resourcing state and ethical standards and consulting policy and procedure, the next step is to define options and consider clinical ramifications. Figure 20.1 on the following page provides a decision-making model to guide the MedFT in this situation. First the MedFT evaluates the level of power; in this case there seems to exist a mid-range power. The duration could be established by resourcing clinical policy. Many integrated facilities focus on short term (eight session or fewer) behavioral health models. If this was the case, the intermediate duration would be most appropriate with a specific termination agreement discussed. Using this model, the MedFT is able to deduce that this relationship has mid to low potential to negatively impact the patient and thus could reasonably proceed with integrated care.

Policy and Practice Implications

Dual relationships pose potential ethical complications in any setting; however, rural and IPC settings have been known to pose a higher risk for compromising the therapeutic relationship (Smalley et al., 2010). IPCs are similar to rural healthcare settings in that the providers all exist in a microcosm; a referral may be down the hall or across town. Either way, there is a high likelihood that both provider and patient relationships are complicated by overlapping roles (Davis & Roberts, 2009).

Unfortunately, sometimes the MedFT may be the only BHP for miles around. With high rates of depression, drug use, and suicide in rural areas (Smith, 2003; Zur, 2006), BHPs are greatly needed and, seemingly, equally avoided. Due to the high level of transparency (i.e., small talk and the likelihood that most people know one another) in small communities, many community members that would need services may avoid them due to the chance that they are known by most workers in a healthcare context (Eberhardt & Pamuk, 2004).

Linville, Hertlein, and Prouty-Lyness (2007) asserted that “the patient’s interpersonal relationships are believed to play a key role and collaboration exists between the family therapist and the other health care practitioners” (p. 86). Taking this whole-person concept and placing it into a small, very cohesive, and transparent culture can make antiquated guidelines regarding therapeutic dual relationships literally impossible to follow. Contrary to current ethical guidelines, appropriate dual relationships may lead to more effective and rewarding healthcare outcomes (Davis & Roberts, 2009), and thus, current-day policies need to catch up with the potential for positive outcomes via these relationships in integrated care settings.

Although there are currently no ethical decision-making tools specifically developed for dual relationships in IPC, Gottlieb (1993) offered a decision-making matrix (see Fig. 20.1) that could prove useful when evaluating potential dual and multi-relationships. The basic premise of this model is to evaluate each dual relationship scenario by following the three dimensions shown below. The results provide insight into the potential dangers of the dual relationship according to three dimensions: power, duration, and termination. The further to the right each relationship falls (in each dimension), the more likely the dual relationship should be avoided.

Upon recognizing the potential for dual relationships, MedFTs must be careful in determining the next best options for the patient. While most medical providers are not restricted in who they can care for (e.g., someone that they know or work with), MedFTs may be perceived as abandoning their patients if they experience a dual relationship with an individual or family and are not able to serve as their provider. Terms pertaining to termination of services seem to be clearer in traditional behavioral health contexts, but could certainly still apply to IPC settings. Termination and provider abandonment refers to withdrawal from treatment of a patient without giving sufficient notice or providing a competent replacement within a reasonable amount of time to continue the therapeutic process. An abrupt disruption in treatment has the potential to harm the patient and taint their future therapeutic relationships or therapeutic outcomes. In contrast to the episodic nature of treatment in specialty behavioral care, the provider–patient relationship in IPC may be life-long. As such, patients may present episodically for treatment at critical junctures, such as with first diagnosis of healthcare conditions or when facing other stressful life events. In this sense, a patient may always be seen as a patient in primary care. Therefore, awareness that a dual relationship now exists can complicate care, particularly for those who have received healthcare services at this location for most of their life, but are just now receiving care from a MedFT.

Preparing in advance for potential dual relationship scenarios is important. Situations resulting in a termination may require risk management from both a clinical and legal perspective. Often, this is triggered by unilateral terminations from services, such as when providers discharge a patient for medication contract violations, overusing or diverting controlled medications, or exhibiting “abusive behavior” (e.g., yelling or threatening staff, stealing agency property, or repeated no shows). Bottom line is that policies should be created for each setting, such that patients know through their informed consent documents what circumstances are considered dual relationships and what scenarios may result in termination of services. When inevitable, termination should always include provisions for continuity of care. This is often achieved through a certified letter listing local alternative treatment options and an offer to manage emergencies for a defined length of time, and sufficient medications to cover a reasonable period to establish care with a new provider.

In response to common challenges associated with dual relationships, a new paradigm is emerging moving away from the complete avoidance of multiple and dual relationships to a more practical management of dual relationships, especially in rural communities (Barbopoulos & Clark, 2003; Schank & Skovholt, 2006). It is feasible to think that these types of policy and procedure shifts could be extended into IPC settings and other small communities, whereby providers may establish new policies related to managing the risks without impeding the therapeutic benefits. Solutions to these types of problems are not easily found; however, the current consensus in IPC literature is to consult with the team and communicate all of the potential risks to the patient prior to proceeding (Runyan et al., 2013). Until a unified IPC code of ethics is established, this type of collaborative decision-making allows all members of the team, including the patient, to determine the most ethical, informed choice for managing multiple and perhaps complex relationships.

Conclusion

Definitive ethical guidelines and policies for provider teams in IPC settings are developing as this model of care evolves. IPC literature and journals, such as the special edition on ethics in the journal of *Families, Systems, & Health* (2013), are being published as policy catches up to practice. In the meantime, MedFTs and other IPC providers should be aware of their profession’s ethical codes and become more attuned to the codes that govern the work of their team members from other disciplines. Those practicing within an IPC system would benefit from open and ongoing collaborative interdisciplinary dialogues about federal regulations, state laws, and ethical standards along with healthcare protocols that may best address all considerations within their IPC system. Interdisciplinary cross-training and discussions will promote the highest level of ethical IPC (Hodgson et al., 2013). Ultimately, ethics are about protecting the rights of the patient and those most vulnerable in the system or relationship.

Discussion Questions

1. What happens if the wife, husband, and an adult child of the same family all are referred for behavioral health individually? As the only MedFT in this setting, how would you proceed?
2. If you treat this family as a unit, as well as the patient individually in IPC, into whose chart or charts would the notes be entered?
3. How would you document a patient's disclosure of drug use in an IPC setting, especially if he or she asks that you not tell the PCP or other members on the treatment team? What factors would you have to take into consideration?
4. What ethical guidelines governing your profession have the potential to impede the therapeutic processes in an IPC setting?
5. What steps would you need to take to develop a new policy in an IPC if an ethical challenge emerged?

References¹

- American Association for Marriage and Family Therapy. (2012). *User's guide to the AAMFT code of ethics*. Washington, DC: The American Association for Marriage and Family Therapy. Retrieved from http://aamft.org/imis15/Content/Legal_Ethics/Code_of_Ethics.aspx
- American Medical Association. (n.d.). *Informed consent*. Retrieved from <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page>
- American Mental Health Counselor Association. (2010). *AMHCA Code of Ethics*. Retrieved from <http://www.amhca.org/assets/content/CodeofEthics1.pdf>
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- Barbopoulos, A., & Clark, J. M. (2003). Practicing psychology in rural settings: Issues and guidelines. *Canadian Psychology, 44*, 410–424. doi:10.1037/h0086962.
- Barnett, J. (2007). Seeking an understanding of informed consent. *Professional Psychology: Research and Practice, 38*, 179–182. doi:10.1037/0735-7028.38.2.179.
- Berg v. Berg. (2005). Retrieved from <http://www.courts.state.nh.us/supreme/opinions/2005/berg112.htm>
- Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). *Evolving models of behavioral health integration in primary care*. New York, NY: Milbank Memorial Fund.
- Curtis, R., & Christian, E. (2012). *Integrated care: Applying theory to practice*. New York, NY: Routledge.
- *Davis, R. & Roberts, R. (2009). *Handbook for rural healthcare ethics: A Practical guide for professionals*. Retrieved from <http://geiselmed.dartmouth.edu/cfm/resources/ethics/chapter-05.pdf>
- Eberhardt, M. S., & Pamuk, E. R. (2004). The importance of place of residence: Examining health in rural and nonrural areas. *American Journal of Public Health, 94*, 1682–1686. doi:10.2105/AJPH.94.10.1682.

¹ An asterisk has been used to note references that the chapter authors recommend for further reading.

- Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy, 30*, 41–48. doi:10.1037/0033-3204.30.1.41.
- *Health Insurance Portability and Accountability Act of 1996, 46 C.F.R. 164.501–524 (2007).
- Hodgson, J., Mendenhall, T., & Lamson, A. (2013). Patient and provider relationships: Consent, confidentiality, and managing mistakes in integrated primary care settings. *Families, Systems & Health, 31*, 28–40. doi:10.1037/a0031771.
- *Hudgins, C., Rose, S., Fifield, P. Y., & Arnault, S. (2013). Navigating the legal and ethical foundations of informed consent and confidentiality in integrated primary care. *Families, Systems & Health, 31*, 9–19. doi:10.1037/a0031974.
- Kanzler, K. E., Goodie, J. L., Hunter, C. L., Glotfelter, M. A., & Bodart, J. J. (2013). From colleague to patient: Ethical challenges in integrated primary care. *Families, Systems & Health, 31*, 41–48. doi:10.1037/a0031853.
- Koocher, G., & Keith-Spiegel, P. (2008). *Ethics in psychology and mental health professions: Standards and cases* (2nd ed.). New York, NY: Oxford University Press.
- Legal Action Center. (n.d.). Alcohol and Drug Publications. Retrieved from <http://lac.org/index.php/lac/130>
- Linville, D., Hertlein, K. M., & Prouty-Lyness, A. M. (2007). Medical family therapy; reflecting on the necessity of collaborative healthcare research. *Families, Systems & Health, 25*, 85–97. doi:10.1037/1091-7527.25.1.85.
- Ohio Coordinating Center for Integrated Care and the Ohio Department of Mental Health. (2010). *Integrated care: Confidentiality and release of information fact sheet*. Retrieved from <http://www.occic.org/documents/Integrated%20Care%20Confidentiality%20and%20Release%20of%20Information%20Fact%20Sheet%202-10.pdf>
- *Reiter, J., & Runyan, C. (2013). The ethics of complex relationships in primary care behavioral health. *Family Systems and Health, 31*, 20–27. doi:10.1037/a0031855.
- Reitz, R., Common, K., Fifield, P., & Stiasny, E. (2012). Collaboration in the presence of an electronic health record. *Families, Systems, and Health, 30*, 72–80. doi:10.1037/a0027016.
- *Reitz, R., Simmons, P. D., Runyan, C., Hodgson, J., & Carter-Henry, S. (2013). Multiple role relationships in healthcare education. *Families, Systems & Health, 31*, 96–107. doi:10.1037/a0031862.
- Runyan, C., Robinson, P., & Gould, D. A. (2013). Ethical issues facing providers in collaborative primary care settings: Do current guidelines suffice to guide the future of team based primary care? *Family Systems and Health, 31*, 1–8. doi:10.1037/a0031895.
- Saviano, E. (2008). *Maintenance and disclosure of mental health records in the primary care clinic setting*. Retrieved from http://www.ibhp.org/uploads/file/MentalHealthRecordMaintenance_article.pdf
- Schank, A. J., & Skovholt, T. M. (2006). *Ethical practices in small communities: Challenges and rewards for Psychologists*. Washington, DC: APA Books. doi:10.1037/11379-000.
- Smalley, K., Yancey, C., Warren, J., Naufel, K., & Pugh, J. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology, 66*, 479–489. doi:10.1002/jclp.20688.
- Smith, A. J. (2003). Rural mental health counseling: One example of practicing what the research preaches. *Journal of Rural Community Psychology, 6*, 1–13. doi:10.1023/A:1025663311100.
- *Striefel, S. (2009). Ethical behavior in medical settings. *Biofeedback, 37*, 119–122. doi:10.5298/1081-5937-37.4.119.
- *Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services. (2011). *Applying the substance abuse confidentiality regulations 42 CFR Part 2* (Revised). Retrieved from http://www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf
- Zur, O. (2006). Therapeutic boundaries and dual relationships in rural practice: Ethical, clinical and standard of care considerations. *Journal of Rural Community Psychology, 9*, 1–49.