

A Conceptual Framework for Considering Informed Consent

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Abstract

Practice research finds that many practitioners do not regularly provide clients with full informed consent (Burkemper, 2004); that biases influence social workers' judgment of competency and the nature of information disclosed (Palmer & Kaufman, 2003; Zayas, Cabassa, & Perez, 2005); and that violations relating to informed consent were among the ten most common complaints against social workers between 1986 and 1997 (Strom- Gottfried, 2003). An additional concern, one not adequately addressed in the literature, concerns the information disclosed to clients about the efficacy of interventions.

Key words: ethics, social work ethics, informed consent, consent, social work education

Introduction

Informed consent is an important ethical and legal responsibility for social workers and other professionals, and professional literature reinforces the importance of obtaining a valid or good consent with clients. However, the majority of articles address the procedure rather than the basis for informed consent in ethics, its base in human rights, or its place in the professional relationship. Instead, the focus is on lists of items that should be covered and documented to show that informed consent was obtained. The limited research available on practitioners obtaining informed consent finds that many practitioners do not regularly provide clients with full informed consent (Burkemper, 2004); that biases influence social workers' judgment of competency and the nature of the information disclosed (Palmer & Kaufman, 2003; Zayas, Cabassa, & Perez, 2005); and that violations relating to informed consent were among the ten most common complaints against social workers between 1986 and 1997 (Strom-Gottfried, 2003). An additional concern,

one not adequately addressed in the literature, is the information disclosed to clients about the efficacy of interventions.

Kutchins (1991) referred to informed consent as a “time bomb ticking for social workers” (111) due to the adverse nature of some information and the likelihood of social workers failing to provide full information about the effectiveness of interventions offered. The conflicting values of paternalism and self-determination underlie these issues. As the profession increasingly focuses on the need for evidence based interventions, the relationship between interventions used and informed consent demands a closer examination.

This article introduces a heuristic model from bioethics to use in teaching social work students about informed consent. This model is based on the work of Gert, Culver, and Clouser’s (1997), *Bioethics: A Return to Fundamentals*. Our intent is to re-introduce informed consent as a process based in ethics. Gert et al. (1997) consider informed consent through a moral analysis leading to a process that respects clients and meets legal requirements. Rather than learning procedures by rote, students learn the meaning and importance of informed consent with the goal of providing a full informed consent process as part of a relationship, rather than as a checklist to meet policy requirements.

In an already full curriculum with requirements to teach many complex topics around values, ethics, theories, and practice, where does informed consent fit? Time constraints too often in both the classroom and practice result in emphasis on procedure over thoughtful consideration. However, there may be ways to bring the procedure and the conceptualization of informed consent together. We suggest that drawing on Gert’s et al. (1997) work on informed consent, wherein the procedures clearly emerge from ethics, is a productive step in this direction. Their concepts of common morality, moral rules, and moral ideals are introduced as the theoretical underpinning of their conceptualization of informed consent. Instead of a checklist, Gert et al. (1997) provide an analytical model, one in which familiar elements of informed consent are considered, but through a thoughtful understanding of the underlying ethical concepts. In this way, legal or policy requirements are met while achieving the ethical process of informed consent. It is believed that if one has an understanding of the morality underlying informed consent, one is more likely to think through a thorough process that serves to enhance the professional relationship, gain client trust (and possibly result in fewer complaints) , and meet documentation needs.

Common Morality, Moral Rules, and Moral Ideals

Gert et al. (1997) argue that a common morality exists and can be explained. Key features of common morality include:

- The need for a clear process of distinguishing between that which is and is not a moral concern (not all dilemmas are moral dilemmas).
- A public morality that is applicable to all persons at all times—one to which most rational people would agree to abide.
- Prohibitions—following *rules* that avoid harm, and *ideals*—proactive behaviors that are encouraged but not required, that prevent harm or bestow benefits in particular cultures and situations; and
- An understanding that paternalistic actions must be justified according to this system—i.e. would it be acceptable for others to act in the same way in similar situations?

Thus, when considering possible actions, we decide whether to do something that is moral or not based on this common morality. It is during this process of considering the violation of moral rules that help is often sought (a lawyer, a counselor, a minister).

The common morality is based upon behaviors that are generally understood to be prohibited in order to be a moral person. Prohibitions or moral rules take the form of things one is required to *not* do. These are general and commonly recognized, in that they are known to everyone to whom they apply, are to be followed with impartiality, and are considered to be universal across cultures (Bryan, 2006; Gert, 2004). Violating or attempting to violate any of these rules or increasing the risk of occurrence of any action that is prohibited is an immoral act. If one intends to violate a rule, the action must be justified in a systematic manner (Gert, 2004).

Moral ideals are intentional acts, those done voluntarily in order to prevent or relieve suffering (Beauchamp & Childress, 2001; Gert, 2004). They are proactive behaviors that are encouraged, but are not required, in which people go out of their way to prevent or relieve harm to others. In general, justification is not needed if a person chooses not to take action that is a moral ideal. For example, most people would like everyone to try to prevent harm, but it is not expected that everyone can or will prevent harm in every single situation every day.

Individuals approach moral situations with impartiality and consider the consequences of possible actions by balancing the harms that may result from each alternative with an understanding that any decision in favor of a benefit means there will be lesser or greater harms

resulting from the decision (Gert et al., 1997). The balancing of harms is also critical to the informed consent process.

Valid Consent

Professional codes of ethics and licensing laws require duties that are expressions of the moral rules, for example, the duty to cause no harm, disability, or pain. Sometimes this is specified as a duty to cause no pain without consent from the patient and with no measure of benefit if pain is caused (Gert et al., 1997). Professional duties also emerge from moral ideals. These are actions that the general public would be encouraged but not required, to do; however, they may actually be required as part of a professional duty contained within the realm of one's work. For example, a person sitting in a hospital emergency room has no duty to help others who are suffering there, but a medical professional does have such a duty (Gert et al., 1997). Therefore, as professionals, social workers (or physicians, nurses, etc.) have a moral obligation to not violate moral rules and often have the moral obligation to be proactive—to follow moral ideals that individuals who are not members of the profession may not be required to follow.

Gert et al. (1997) view valid or informed consent as a duty that emerges from moral rules. The duties include:

1. The social worker has a moral requirement to provide adequate information about treatment to the client. Failing to provide adequate information constitutes a violation of the moral rule that prohibits deception. Because a social worker has a moral duty to provide information, not telling the client is a violation. The authors argue that the phrase “adequate information” is a reminder for the professional to not deceive.
2. The social worker should not coerce clients into consenting. To do so would be a violation of a moral rule, depriving one of freedom.
3. The social worker must assess the client's competence prior to using the intervention to which the client consented. The client must be able to rationally decide about the kind of treatment involved before the social worker can take action. A risk of harm to the client exists if he or she is not capable of making a decision in the situation at hand. Freedom may be deprived and/or pain caused if the client is not capable of consenting to an intervention that may cause some harm. The social worker is also required to assess competence if a client refuses consent, because this may or may not be a rational decision, as noted by Gert et al. (1997) and the *NASW Code of Ethics* (1999). The professional has a duty to treat some clients who lack the capacity to consent and refuse treatment if there is greater harm caused by not treating. In social work this is often expressed as a duty to protect vulnerable clients.¹

¹ For example, children may wish to remain in an abusive setting rather than agree to leave or intervening with adults who refuse when their behaviors place themselves or others at greater risk of harm. (p. 151-152).

The duties for valid consent included in Gert et al. (1997) common morality are similar in nature to the elements noted in the social work practice literature: 1) the disclosure of information, 2) voluntariness, and 3) competence (Congress & Lynn, 1994; Davidson & Davidson, 1996; Fogel & Ellison, 2005; Kutchins, 1991; Manning & Gaul, 1997; Palmer & Kaufman, 2003; Reamer, 1987, 1999; Regehr & Antle, 1997; Strom-Gottfried, 1998; Strom-Gottfried & Corcoran, 1998; Torczyner, 1991). In social work, as in bioethics, there is variation in the operationalization of each of these concepts across the literature. As noted previously, with few exceptions (e.g., Reamer), informed consent in social work literature is generally comprised of lists of items to be documented and interpreted as a procedure based in policy and law rather than ethics. Gert et al. (1997), however, perceive it as an essential moral obligation. The criteria and the moral rules with which they are associated will now be reviewed.

Competence

For informed consent to be considered valid, the person consenting must be judged to have the capacity to consent, and to be competent to make the decision at hand (Congress & Lynn, 1994; Davidson & Davidson, 1996; Fogel & Ellison, 2005; Kutchins, 1991; Gert, Culver, & Clouser, 1997; Manning & Gaul, 1997; Palmer & Kaufman, 2003; Reamer, 1987; Regehr & Antle, 1997; Strom-Gottfried, 1998; Strom-Gottfried & Corcoran, 1998; Torczyner, 1991). Generally, capacity or competency to consent is judged by the professional or person who is seeking consent from a potential client or research participant. Reamer (1987) noted there is little to no consensus on how social workers determine the competency of clients. Professionals may judge competence based upon the client's diagnosis or condition rather than the actual capacity to make the decision at hand such as the assumption that mental retardation, mental illness, a physical condition, or age precludes capacity to consent or competency (Manning & Gaul, 1997). The conceptualization and the way in which competence is assessed vary across social work literature, in practice, and across professions.

Reamer (1987) suggests looking at capacity to consent on a continuum; some conditions may diminish capacity but not entirely preclude it. Competency varies over time according to specific decisions to be made, the context in which they are to be made, the problem situation, current physical and/or mental condition, and skill levels of the individual (Gert et al., 1997; Manning & Gaul, 1997; Palmer & Kaufman, 2003; Torczyner, 1991; Zayas et al., 2005).

A familiar criterion of competence is that the client can understand and appreciate the information disclosed and the situation. That is, the client is able to understand the information and appreciate its meaning in her/his life (Manning & Gaul, 1997; Parry, 1981; Strom-Gottfried, 1998; Zayas et al., 2005). Generally, if clients cannot understand information communicated in an appropriate way and cannot identify ways in which their lives will be affected by the information and intervention, they likely will be judged to not have competency to make a particular decision. Standard tests of cognitive ability may assist in the process but should not serve as the sole method to assess competence. Additionally, incompetence cannot be assumed based on a mental health or developmental disorder diagnosis (Manning & Gaul, 1997).

The following sections examine competence using the common morality framework more closely and will include associated concepts of rationality, paternalism, and the justification of paternalism.

4.1 Competence in the Common Morality Framework

We consider four factors that would interfere with the process of determining competence. An individual is determined competent to make a rational choice if

She does not have a cognitive disability preventing her from [1] understanding and [2] appreciating the relevant information or [3] coordinating that information with her own stable values, and she does not have a [4] mental malady [sic] involving a volitional disability that interferes with her ability to make a rational decision. If none of these disabilities [factors]...is present, she is competent to make a rational decision, even if she is presently making an irrational decision. (Gert et al., 1997, p. 146)

The presence of any one of these four factors interferes with one's ability to make a rational decision of a certain kind, and provides a marker to the person determining competence, which helps define the nature of the client's difficulty with competent decision making under these circumstances. If the person is making consistently irrational decisions, then he must be considered incompetent to make that kind of decision. Thus, Gert et al. (1997) assess competence based on one's ability to make a rational decision. The assessment involves first determining the presence of irrationality. The next step is to identify the presence of any of the four interfering factors that may be causing the inability to make a rational decision of the kind at hand. If one is correct about

the presence of irrationality, at least one of the four factors is involved and the person may be incompetent to render an informed, rational decision.

Competence and Rationality

It must be determined whether the person has the ability to understand and to make a rational decision of a particular type. The rationality of the choice is considered, and, if the choice is irrational, then it may be necessary to override the client's decision, concluding that she or he is not competent to make this specific decision. To determine the rationality of a decision, the following criteria are used:

Consider what information is needed to make a rational choice. This is related to harms—what harms are associated with the information that one would want to know? Does the client's choice of action increase harm while offering no benefit?

A rational choice would either

- Decrease or eliminate harm
- If there is some harm, it is balanced by benefit
- There is evidence that the person made rational choices in the past in difficult situations
- There is not an illness, emotion, or cognitive disability that would preclude the ability to make a rational decision (Gert et al., 1997)

Competence and Paternalism

Paternalism is inherent to social work. By nature of the profession, social workers have a duty to others—to protect rights, to intervene when high risk is assessed, to provide services or assistance often by a required authoritarian duty rather than by request of the vulnerable individual, and provide (or not provide) information (Reamer, 1993). Simultaneously, social workers have a duty to respect individual self-determination and strengthen empowerment of self. The process of informed consent includes sensitive decisions about acting paternalistically, how much information is given to clients, and assessing understanding of the information. Our desire and responsibility to do the best for clients may result in coerciveness by providing partial information.

Choosing not to act paternalistically may conflict with employment responsibilities, whereas acting paternalistically may conflict with ethical responsibilities. Decisions about these choices call for justification of the professional's actions (for employers, clients, society, or ethical practice). Additionally, although the professional and client may agree that paternalism is acceptable when done for the benefit of the client, they may disagree on the definition of "benefit"

(Abramson, 1985). When is paternalism justifiable? Commonly, if a client's choice of action places herself or others at risk for harm, paternalism may be justifiable (Abramson, 1985; Gert et al., 1997). Is it justified to prevent physical harm, emotional harm, a harm related to denial of rights (choices) or adequate information (including lying by omission)? Does an individual have a right to harm herself? Can one harm self if it does not harm others?

John Stuart Mill (1859/1963) claimed that one has a right to self-harm; paternalism is justifiable only if an individual's action or choice would result in "...physical or moral" harm to others (although he did not specify the parameters of harm). On the other hand, Arneson (1980) notes Gerald Dworkin's claim that focusing on the individual's good is an acceptable reason to act paternalistically. When the resulting good outweighs the harms for the individual client, it would be something a rational person would agree to, and the paternalistic act is the least restrictive action. These two views illustrate a common struggle-do we focus on the individual or the larger group/society when determining actions? Often, our employing institutions determine the priority. Bias again influences the determination of definitions and severity of harms (Palmer & Kaufman, 2003; Zayas et al. 2005), and plays a role in determining whether the client is competent to independently make choices.

The discussion of paternalism and the underlying theoretical basis for justifying it in social work is presented very briefly here to illustrate the complexities involved for the professional. As a result of socialization within the profession or employing agencies, the paternalistic intervention may be used with an eye toward risk management for the institution rather than the ability or rationality of the client. We introduce the common morality framework as a concise, clear alternative to assist in determining whether paternalism is justified in the informed consent process. The focus of common morality on the moral dimensions of informed consent and on harms resulting from interventions reinforces the fact that the process is about the client, not the institution. Justification indicates a need for clear documentation of actions; a framework strengthens this aspect, as well.

With respect to competence and paternalism, Gert et al. (1997) argue the professional must first determine that the client's choice is indeed irrational, and then determine whether the intervention is justifiable. As an example, consider a man with dementia who refuses to have a Band-Aid put on a small cut on his arm. Gert et al. (1997) state "...it would rarely be morally

justified to force the Band-Aid on him, despite the fact that he is not competent to refuse. Competence is not determined by the seriousness of a patient's situation, but the justification for overruling a refusal is." (p. 145) In this case, there is no justification—there is no reason to violate a moral rule (or the client's self-determined choice) just to make the patient wear a Band-Aid. It is not a life-saving intervention, nor are there serious harms that would be prevented or relieved by the Band-Aid. The violation of the patient's freedom by going against his wishes would be more harmful than what good the Band-Aid might do. Paternalistic actions always violate a moral rule, but there are times when they are appropriate. For example, paternalistic laws exist to assure the protection of our safety while violating our freedom. These include the requirement to wear seat belts and not use cell phones while driving.

Paternalism occurs when a professional (1) believes that her action is for the client's good, (2) acknowledges that the action will violate at least one moral rule, thus requiring justification, (3) knows she does not have the client's permission either in the past, present, or immediate future to take the action, and (4) acknowledges that the client believes (possibly incorrectly) that he knows the best choice for himself (Abramson, 1985; Gert et al., 1997). The moral burden of proof lies with the professional; justification of the action is assessed using the same process as any other rules violation in the common moral system, asking: (1) Would rational people agree that the moral rule should be violated in this situation? (2) Would it be okay for others to violate this rule in a similar situation? (3) Would it be okay for everyone to know that these rules were violated and this action taken?

5. Adequate Information

The NASW *Code of Ethics* Standard 1.03a (1999) states, "Social workers should use clear understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions." (p. 7). Much of the literature in social work cites these components as basic requirements, followed by additional items such as agency information; evidence of social worker's competency and training; confidentiality limits; insurance coverage; and alternative treatment and its risks, benefits,

and side effects (Kaplan, 2008). These are among the many items identified as part of adequate information.

Generally, the concept of adequate information is seen as the information an objective person would want to know in order to make a rational decision (Gert et al., 1997; Katz, 2003). There are situations in which only one intervention choice seems rational; however, often there is more than one rational choice, each with some risk of the possibility of causing some amount of harm and possibly preventing or reducing some amount of harm. This comparative information should be provided to the client (Gert et al., 1997). The social worker should have competence in the area of treatment under consideration, including knowledge about the evidence of the effectiveness of alternative interventions.

Clients' behaviors, beliefs, culture, and values will influence their perception and prioritization of risks and benefits; and these may well differ from the social worker's perceptions. For instance, one client may view the medication side effect of loss of libido as too great a harm and prefer alternative medication or no medication. Another client may not see loss of libido as a harm to avoid. The social worker has the moral obligation to provide the information needed for the client to make a personal choice. However, the professional's personal values about the potential loss of libido may influence the information provided.

It is important for the client to personally rank the alternative interventions and associated harms so a rational choice can be made according to his priorities. This ranking also serves as an additional guide to assessing rationality. That is, it would be unreasonable for the client to decide on a choice that is not prioritized by his own ranking. The social worker can also consider a question to consider the rationality of the client's choice—would another competent social worker recommend the same treatment? Although the social worker would not argue with the client in favor of a specific intervention, if there is a reason to believe there is one that best fits the client's rankings and preferences, she should inform the client (Gert et al., 1997).

The act of assisting clients by disclosing information and their ranking of harms is essential to the process and requires a relationship between the professional and client, difficult since this may be one of the first times they've met. A standardized informed consent form completed during intake, a billing office, or a waiting room with administrative staff will not meet the moral obligation of the social worker. Not providing full information that enables clients to make rational

decisions by ranking the harms involved in each alternative deprives them of freedom to make their own decisions. Anything less than full disclosure is deceptive, thus immoral (Gert et al., 1997).

How much harm should be a possibility before informing the client? The severity and likelihood of its occurrence must be considered, as well as whether or not a rational person would want to know about the harm before making a decision. Gert et al. (1997) argue for care in thinking about the wording used in communications—informing a client that a medication will decrease the risk of heart attack by 50% may be heard (then ranked) differently than stating that it will decrease the risk of heart attack from 1 in 100 to 1 in 200. Consider the variations in perception and choices in social work services if clients are informed more specifically about the risks of relapse in addictions, anger management for domestic violence perpetrators, treatment for pedophilia, or risks related to other psychological or social interventions. It is recommended that wording risks in relation to numbers, for example, “...the number of persons needed to subject themselves to the harms of treatment, before, on average, one person is helped who would not otherwise be helped” (p. 166). This illustration of the relationship between perception and the language used in the informed consent process also serves as a reminder that clients’ literacy, native language, and beliefs will influence their understanding of information and resulting choices.

All medical procedures require consent. As in social work practice, all interventions require informed consent, because all choices affect people’s lives, even if the associated harm is minimal and ranked lower. However, this brings up a concern in social work practice--the lack of empirical evidence on the efficacy of some interventions that are older but commonly used in some settings (Kutchins, 1991), and newer, non-traditional interventions (Reamer, 2006). Information on harms should include: those that are financial, that the treatment may be carried out with less risk of harm at a facility different from the current one, and the harms and benefits of no treatment as an alternative. A conversation determining whether the client wants to make the decisions and hear the information or prefers others to be a part of the process is appropriate, as well (Gert et al., 1997).

Lack of Coercion

For informed consent to be valid, there must be no coercion from the social worker. The common morality framework views coercion in relation to one’s role—thus, coercion by the

professional is inappropriate and occurs when the social worker intentionally brings about the harm that causes the client to consent to the intervention. An intentional threat of harm that is strong enough that it would be logical for any rational person to act in the desired way is considered coercive, and this type of harm violates the moral rule to not deprive one of freedom (Gert et al., 1997). Strong recommendations by a professional, when there is full information along with sufficient evidence of a best treatment choice, are not considered coercion, as there is no threat of harm.

Ideal Consent

Valid consent is concerned with the moral rules, requiring the client to be given adequate information, the client to be competent to make a rational decision in the situation, and the professional to not use coercion to influence the client's choice. When valid consent is obtained, the professional can provide the intervention even if there is some degree of harm that results from it, because the client has been informed of it and has consented to it.

Ideal consent goes a bit further as it is based on moral ideals, those proactive actions meant to prevent or alleviate suffering or harm. In the case of consent, this includes the strategies a social worker takes to prevent the client from making an irrational or unreasonable choice in decision-making. A choice is considered irrational or unreasonable for a particular individual if his or her decision is not aligned with his or her personal rankings of harms and benefits (Gert et al., 1997).

In this proactive role, the social worker may challenge the choices made by the client if they do not seem rooted in her or his personal rankings of harms and/or if the choice is irrational or unreasonable in the particular situation. In ideal consent, it is appropriate for the social worker to consider whether another party is attempting to coerce the client, and to intervene to stop or prevent coercion. For example, if the social worker believes the client's spouse or family members are attempting to manipulate the client into a choice of interventions, the social worker may advocate for the client to make an independent choice that fits personal considerations of harms and benefits.

Another tactic that may be used to assure ideal consent is to suggest to a client who is unsure after initially agreeing to the intervention, to take a few days, a time out to re-think the decision. Lastly, the way in which information is communicated can influence the choices clients make. When information is given in a variety of ways, as in the previous discussion on the

communication of efficacy rates, a proactive stance is taken to enhance the client's ability to understand the information.

Conclusion

As the common morality framework is based in clarifying that which is not moral rather than what is moral, the informed consent process emphasizes harms—meeting the moral rule requirements of prohibition of harms as well as moral ideals actions of preventing or reducing harm. Therefore, the framework leads to items that should be included in valid consent, as they are associated with consideration of harms. This is critical to the conceptualization of informed consent as a moral obligation rather than a procedure to meet legal or policy requirements. Informed consent is, at its core, about morality—about reducing or alleviating suffering or harm of people. Following procedures to show documentation that a client consented to services or research changes its emphasis to the meeting of institutional rules instead of moral duty to clients. Informed consent is about enhancing the client's ability to make his own decision about which specific harms and the severity of harms he is willing to experience to reach the longer term goal of relieving his suffering. One might determine what information to provide a client by assessing which possible harms may be associated with it—are there harms associated with a treatment, with the number of sessions the client will need to attend, or with agency management or funding affiliation? Consider how thinking about harms can change the nature of the information we provide to clients.

Although several authors in social work literature argue for understanding informed consent as a process, a part of the professional relationship (Burkemper, 2004, Hepworth, Rooney, & Larsen, 2002; Kutchins, 1991; Pollack, 2004; Reamer, 1987; Torcyner, 1991), there remains an absence of discussion on conceptualization of the elements of informed consent and how to find a common ground for the process. There is little discussion or consensus on the philosophical basis for determining adequate information, the source of the moral obligation to do so, or how this should guide the content of adequate information.

Faden and Beauchamp (2003) refer to two senses of informed consent. Sense 1 is the process, the autonomous act of authorization and its elements. The client's understanding of what is being authorized is part of this sense, as are the professional's duties and ethical reasons for obtaining informed consent. Sense 1 can be analyzed by evaluating the extent to which ethical

principles are upheld. Sense 2 involves the policies, the institutional rules, and laws that require actions or documents in the process. The professional requirement to disclose information to the client and the accompanying documentation (evidence of the act) are part of this Sense 2. Commonly, it is only Sense 2 that receives focus in practice, the signing of forms to comply with legal requirements. Sense 2 is clearly reflected in the social work literature with its emphasis on the documentation of itemized checklists of what is included in informed consent. Sense 1, however, is often absent.

There is wide variation in what is taught about informed consent in social work education, as well. There appears to be general agreement in the literature that informed consent consists of three elements: 1) the disclosure of information, 2) voluntariness, including absence of coercion, and 3) competence or capability to make the decision (Congress & Lynn, 1994; Davidson & Davidson, 1996; Fogel & Ellison, 2005; Kutchins, 1991; Manning & Gaul, 1997; Palmer & Kaufman, 2003; Reamer, 1987; Reamer, 2006; Regehr & Antle, 1997; Strom-Gottfried, 1998; Strom-Gottfried & Corcoran, 1998; Torczyner, 1991). However, the way in which each of these three elements is conceptualized varies, resulting in inconsistent recommendations for the content of informed consent in practice. The complexities and conceptualizations of these elements are seldom addressed, and social work texts, which also vary, may confuse students or offer contradictory explanations (Kaplan, 2008).

Results of one study noted that the sample of MSW level social workers examined based their morality upon authority, not critical reasoning processes. These individuals do not recognize the complex and conflicting duties and values related to informed consent, paternalism, and coercion. This means it is more likely for them to follow the institution's definitions and expectations than critically thinking about these concepts and their relation to morality (Kaplan, 2006). Education's purpose is to enhance critical thinking, to teach students to understand the underlying theoretical base of informed consent, and to balance duty to individuals and duty to society. A framework that is logical, taught consistently, and takes into account the complexities involved in informed consent without teaching it as an intake form would better prepare our students for the profession.

A return to discussions of the underlying ethical standards and duties can lead to a more complete understanding of informed consent and its purpose. It is time to critically consider the

meaning and importance of informed consent as an essential part of clients' rights, as integral to professional helping relationships, and it is time to move informed consent out of the waiting rooms and billing offices.

Rather than being overwhelmed by the complexity of informed consent or reducing it to a standardized form clients and research participants must sign, it should be understood as a duty, an expression of social work values, and an act of advocacy for human rights. Social work education should include elements of Faden and Beauchamp's (2003) Senses 1 and 2. Gert et al.'s (1997) common morality framework is recommended as an effective means through which to offer this important educational content.

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