

# Informed Consent for Case Reports

## *The Ethical Dilemma of Right to Privacy Versus Pedagogical Freedom*

Stephen B. Levine, M.D.  
Susan J. Stagno, M.D.

*A new international standard of editorial policy calls for written informed consent by the subject of every case report. Although this appears to be ethically appealing, the authors posit that in some situations, requesting informed consent may be unethical, can harm patients, and may erode the use of case reports as a valuable teaching method in psychiatry and psychotherapy. The authors discuss concerns regarding this new policy for mental health publication based on issues of transference, countertransference, best interest of the patient, and practicality.*

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When physicians decide to write about a patient for publication, they are apt to encounter internal tensions about the project. These tensions signal the presence of the physician's ethical dilemma. It is the result of a clash of professional obligations: the responsibility to preserve patient privacy and confidentiality conflicts with the aspiration to advance the field. The purpose of this article is to consider this ethical dilemma in the light of recent developments in medicine.

In 1995, an international committee of 12 biomedical journal editors finalized guidelines regarding the publication of case reports.<sup>1</sup> Journals represented included *Annals of Internal Medicine*, *British Medical Journal*, *Canadian Medical Journal*, *Journal of the American Medical Association*, *Lancet*, *Medical Journal of Australia*, *New England Journal of Medicine*, *New Zealand Medical Journal*, *Tidsskrift for den Norske Laegeforening*, and *Western Medical Journal*. Also represented was the National Library of Medicine. Their guidelines supported, in the following language, patients' rights to autonomy and privacy over physicians' need to contribute to the fund of knowledge:

Patients have a right to privacy that should not be infringed without informed consent. Identifying information should not be published in written

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Received November 2, 2000; revised January 15, 2001; accepted January 24, 2001. From the Department of Psychiatry, Case Western Reserve University, Cleveland, Ohio. Address correspondence to Dr. Levine, 23230 Chagrin Boulevard, Suite 350, Beachwood, OH 44122. Copyright © 2001 American Psychiatric Association

descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that the patient be shown the manuscript to be published. Identifying details should be omitted if they are not essential, but patient data should never be altered or falsified in an attempt to attain anonymity. Complete anonymity is difficult to achieve, and informed consent should be obtained if there is any doubt.

### THE MEANING OF THE NEW POLICY

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Since Hippocrates, physicians have understood the need to guard patient privacy. Physicians have also felt an obligation as professionals to advance public health with single case reports or case report series. Before this new standard was articulated, countless case reports appeared in various medical literatures without patient permission. Authors disguised identifying features to ensure anonymity and concentrated on scrupulous accuracy as to what was medically relevant. The new standard favors patient privacy over professional education. It implies that the social values of educating professionals and improving public health are generally less compelling than the rights of patients or their guardians to control what is said or shown about them. The editors have committed themselves to resolving the ever-present tensions between individual and social virtues in favor of privacy rights. They will not publish a manuscript, however scientifically or educationally worthy, when anonymity cannot be absolutely guaranteed or informed written consent has not been obtained.

The editors are correct in recognizing that risks to privacy exist whenever a case is published. Even with written informed consent, the patient bears three uncontrollable risks:

1. A reader may correctly deduce the patient's identity from details of the social circumstances and then inappropriately use this information.
2. A reader with a specific purpose, such as an investigative reporter, may make a vigorous effort to identify and expose the patient in the media.
3. Over time, the patient may come to feel violated, or taken advantage of by the doctor, or feel otherwise negative about having given consent.

Without informed consent, the risk is that the subject of the case report might discover that he or she has been described without approval and might seek legal redress. Written informed consent eliminates only this risk. It protects both the author and the journal or publisher, but it fails to protect the patient from future personal negative consequences of being the subject of a report.

Privacy has always been a legitimate concern. The traditional editorial policy was not abandoned because of widespread harm to patients; rather, the tenor of the times has caused the pendulum swing. The policy was developed in light of the loss of confidentiality in medical records in evolving health care systems, increasing professional and lay public use of the medical literature on the Internet, and several lawsuits brought against physicians for reporting cases without patient permission.<sup>2,3</sup>

On the surface, the prospect of increased protection of privacy and confidentiality seems particularly compelling for psychiatric patients. When mental health professionals provide details about a patient's symptoms, feelings, conflicts, motives, and capacities, far more of the patient's unique psychological sense is exposed than in a typical medical report. When sexual life is described, deeper levels of privacy are exposed. However, other matters need to be considered before the biomedical journal guidelines are applied to psychiatry and become a legal and ethical standard. These begin with the observation that the new standard was designed and discussed without specific reference to the practice of psychiatry. No psychiatric journal editor was part of the committee. In this policy, our concerns were at best an afterthought. Once again, psychiatry has proven to be a stepchild within the family of medicine.

### BACKGROUND FOR THE ARGUMENT AGAINST INSISTING ON WRITTEN INFORMED CONSENT

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#### Literature Review

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In 1905 Freud<sup>4</sup> wrote of his uneasiness about publication of a detailed history, and he concluded in the introduction to the case of Dora, whose identity was ultimately discovered:

[T]he physician has taken upon himself duties not only towards the individual patient but towards science as well; and his duties towards science mean ul-

timately nothing else than his duties towards many other patients who are suffering or will some day suffer from the same disorder. Thus, it becomes the physician's duty to publish what he believes he knows of the causes . . . and it becomes a disgraceful piece of cowardice . . . to neglect doing so, as long as he can avoid causing direct personal injury to the single patient concerned. (pp. 7–8)

Seventy-three years later, when ethicists raised objections to describing grief processes without patients' consent, the solution to the conflict between privacy and physicians' desires to further the fund of knowledge no longer seemed so clear.<sup>5,6</sup>

Stoller<sup>7</sup> discussed the tension between the need to protect patients and the need to be objective in reporting about them and our process with them. He was, however, skeptical that our objective version could actually be accurate. He confessed that, for a long time before he instituted an informed consent policy, he had not thought about the issue. Subsequently, he came to believe that the patient should have editorial rights to the manuscript. At the beginning of therapy, Stoller informed his nonanalytic patients that he planned to have his secretary transcribe tape recordings of all of their sessions. In claiming never to have had a patient refuse to be written about or taped in 25 years, he wrote, "I would be naïve to think that this record of cooperation proves unambivalent compliance." His latter writings avoided obligations to privacy by reporting on interviewees with unusual sexual lifestyles who had never been his patients and who wanted to be discussed.<sup>8</sup> Stoller concluded that the ethical problems involved in getting patients' informed consent to publish may be insoluble.

Lipton<sup>9</sup> searched the psychoanalytic literature in 1991 and could find nothing written about the issue of asking patients for permission to publish. He then questioned 15 analysts, half of whom favored asking for permission. Most, however, had not sought consent prior to publishing their cases. Lipton described his attempts to obtain informed consent from two patients, one currently in analysis and the other a former patient contacted by phone. He generally favored asking permission "when circumstances permit" and noted that there might be situations when informed consent was unnecessary or inappropriate. He emphasized that every patient reacts in different, evolving ways to being asked for permission: "Clearly, there can be no hard-

and-fast rules." His final advice was to be as careful as possible to do no harm. However, he made no specific recommendations for how to accomplish this.

Lipton noted that a psychoanalytic committee recently had abandoned its attempt to formulate a policy about informed consent. In that committee, Klumpner and Frank<sup>10</sup> voiced concern over three negative consequences of protecting patient privacy in publications: 1) ideas that are based on the authority of the writer rather than data; 2) lack of accuracy in case material, and 3) the untrustworthy practice of making up cases as evidence. They observed that a large percentage of frequently referenced psychoanalytic articles contained no case material, presumably because of concerns about confidentiality.

### Published Objections to the New Policy

Four objections to the new standard have been thus far raised. Epidemiologists expressed concern about the risk entailed in withholding data on epidemic diseases.<sup>11,12</sup> Hospitalists noted the need to warn others about ever-changing presentations of Munchausen's syndrome.<sup>13</sup> Psychiatrists cautioned that having some of their vulnerable patients read about themselves might harm them, even with consent. They also wondered how patients with dementia or other cognitive deficits would be able to provide informed consent.<sup>14</sup>

### Two Undesirable Solutions

Two potential approaches to the issue of publishing case reports are problematic:

*Recognize that the detailed psychiatric case report is a thing of the past.* The argument might be advanced that it does not matter that a case report can serve as a source of learning and inspiration for the young, stimulation for the more experienced clinician, and hypothesis generation for researchers, or as a model for understanding and respecting the struggles that underlie symptoms. Many case histories fall far short of these potentials. Psychiatry now envisions its future as moving toward molecular and neurophysiological explanations of dysfunction and disease. This paradigm shift makes reporting the details of people's lives less relevant. Given our current social concerns about the erosion of privacy, we should accept that it is time to bid farewell to

the detailed case. If case histories must be presented, they can be invented to illustrate the writer's points.

This attitude is undesirable because even with the soon-to-be-discovered molecular pathophysiology of psychiatric illness, it is unlikely that the psychosocial aspects of people's lives will be rendered irrelevant. Even biological psychiatric interventions are delivered within the doctor-patient relationship. This process needs to be thoroughly explored in every generation. The case history is a time-honored vehicle for exploring this topic and should not be abandoned. Inventing case histories or taking the elements of several lives and combining them into one case—processes that are commonly employed in popular psychology books—must be rejected as varieties of scientific deceit.

*Wait until therapy is long complete to ask permission for publication.* Waiting limits the opportunity for substantive discussions between the therapist and the patient about the meanings and ramifications of being the subject of the doctor's report. Moreover, psychiatrists never can be sure that their work with a particular patient is over; many people return to therapy after a long absence. Waiting also increases the risk that the patient will be untraceable or will have died.

### A Review of Three Current Journal Policies

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In an illuminating article that published the opinions of five academicians and one lawyer, the *British Journal of Psychiatry* announced a new policy in 1995:

If an individual patient is described, his or her consent should be obtained. The patient should read the report before submission. Where the patient is not able to give informed consent, it should be obtained from an authorized person. When the patient refuses to give consent, then the case study can only be written up if personal details and dates and other information which identify the patient are omitted to ensure that there is no breach of confidentiality. Contributors should be aware of the risk of complaint by patients in respect of defamation and breach of confidentiality, and where concerned should seek advice.<sup>15</sup>

The editor's discussion of his decision emphasized his legal concerns regarding the risk of complaint. Unlike the International Committee of Biomedical Journal Editors' policy, however, the *BJP* policy permits acceptance of a case report without informed consent if anonymity is ensured.

The policy of the *Archives of General Psychiatry* is research-oriented and succinct:

A statement of informed consent for human investigation should be made in the text. Authors must ensure that patient confidentiality is in no way breached. Do not use real names, initials, or disclose information that might identify a particular subject.

The *American Journal of Psychiatry* instructs authors:

Ethical and legal considerations require careful attention to the protection of a patient's anonymity in case reports and elsewhere. Identifying information such as names, initials, hospital numbers, and dates must be avoided. Also, authors should disguise identifying information when discussing patients' characteristics and personal history. Manuscripts and Letters to the Editor that report the results of experimental investigation and interviews with human subjects must include a statement that written informed consent was obtained after the procedure(s) had been fully explained. In the case of children, authors are asked to include information about whether the child's assent was obtained.

The above policies do not fully reflect an awareness of the subtle issues involved with obtaining consent. But the two American journals do not require that the patient read and approve the manuscript.

### The Policy's Negative Impact on Teaching Psychotherapy

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The new standard has not been considered as it applies to teaching about various types of psychotherapies. In the current climate it is far more difficult, for ethical reasons, to write about cases. Because of this, the new policy limits detailed descriptions of the actual processes of the doctor-patient relationship, illustrations of how symptoms are worked through in different forms of therapy, hypotheses about cause and effect that emerge from psychotherapy, and detailed explications of the multiple dimensions of a single psychopathology in a patient's life. The policy limits communication about the richness of our work. Case histories without informed consent become sanitized when they do not reveal the personal struggle underlying the symptomatology. Case histories with written informed consent limit what the doctor may report and risk falling below the standard of scrupulous reporting of what the doctor

thinks is medically accurate. The policy inhibits the writings of academicians, who are often stimulated by a fascinating clinical observation. Here is one example.

A psychiatrist learns from a woman who was referred for sexual aversion that this problem, as well as fibromyalgia, migraine headaches, and chronic fatigue syndrome, developed immediately after discovery of her husband's affair last year. Eight years previously, she had developed the same problems after her first discovery of his betrayal; her symptoms then lingered for 3 years.

Considering that each of her four separate persistent disorders is officially of unknown etiology, the clinician might consider writing a detailed case report. Because her sexual aversion disappeared after eight sessions of therapy, describing the essence of the therapist-patient dialogue might add to the compelling value of the manuscript. If the psychiatrist has to ask the patient for permission, however, he or she risks harming the patient.

#### Privacy Is Not Entirely What It Seems

Although it is commonly stated that everyone is unique, people are actually simultaneously unique and similar.<sup>16</sup> Patients perceive their conflicts, motivations, social circumstances, and psychological symptoms to be unique. Shame about their personal failures and illnesses exaggerates their sense of uniqueness and reinforces their reasonable expectations for rights of medical privacy and confidentiality. If every life were actually unique, however, clinicians would be unable to understand and assist people with their difficulties in living or overcoming their psychopathology. To be valued by patients, clinicians must accurately perceive people's uniqueness. But to be useful to them, we also have to perceive their commonalities with others.<sup>17</sup> Among people's important commonalities are their psychological development (the tasks of individuating, loving, working, parenting, aging); their need to cope with adversity (disappointment, anger, loss, disagreement, and interpersonal conundrums); and their techniques for overcoming psychiatric disorders. Clinicians manage this unique/similar paradox with various levels of skill. A well-constructed case history can help with this process because while it is about one person, its purpose and its focus concern the patterns that are applicable to

others. Coles<sup>18</sup> refers to this pedagogical process as "the call of stories."

One of the privileges of being a psychiatrist is becoming immersed in the patient's subjective world—a world that is largely unknown to patients' spouses, children, parents, and friends. The more skillfully a case history explores this internal world, the less recognizable the patient becomes to others. Here, as an example, is a moment of a deeply personal, shame-ridden revelation in psychotherapy.

After the children were in bed, I intended to accomplish two tasks. I wanted to unpack some of the many boxes left over from our move and make some calls for an organization asking for time and money from people. Rather than doing these unpleasant things, I gave in to my urge to go to the kitchen and began eating handfuls of cookies and spoonfuls of peanut butter. I wasn't hungry. I feel so guilty about my lack of control. My self-esteem plummeted. I don't know why I am struggling with food again.

It is simple to disguise a patient's identifying characteristics. The important point is that the case history illustrates a patient's recurrent dilemma in self-management, a defense mechanism in operation, or the clinician's attempt to be helpful. The therapist may quote his or her words used to give the patient solace, to put the situation in a new perspective, and ultimately to facilitate mastery of the deeply private recurrent struggle. The purpose of many psychotherapy case presentations is to demonstrate personal suffering and how it is relieved. Case histories contribute to the cultural maintenance of our skills.

#### ASKING FOR CONSENT TO PUBLISH CAN BE UNETHICAL

##### The Current Medical Standard for Obtaining Consent

Most commonly, the process of obtaining permission for purposes of research or a medical procedure involves a relatively brief discussion and a quick answer. The mental health professional will likely emulate the research standard: explain the risks, benefits, and alternatives, give the patient an opportunity to ask questions, have the patient sign a consent form, and have it witnessed. This meets current legal requirements. Governmental officials have recently articulated ethical problems with this form of consent for research.<sup>19,20</sup> The standard medical approach does not allow for in-

formed consent for the person who is in or has been in psychotherapy because it fails to examine the meaning of the request.

### The Clinician's Central Ethical Dilemma

When considering writing up a case for publication, the professional confronts this dilemma: in seeking written informed consent by having a patient in therapy read and approve the case report, the therapist may inadvertently directly injure the patient or ruin, derail, or prolong the patient's therapy. No one can be too sure who is vulnerable to injury. In publishing without consent, the therapist may eventually harm the patient by inducing an outraged, dismayed state of betrayal or humiliation. No one can be too sure who is likely to respond this way in the future and who will seek redress. The patient may ultimately lodge a complaint of unethical behavior with a licensing agency or professional organization, or may take legal action. Three perspectives—those of transference, countertransference, and practicality—illuminate this dilemma.

*Transference:* Altruism is sometimes said to motivate patients to grant permission for publication of their cases; they wish to help others by promoting medical knowledge. We suspect that the patient's feelings about being asked and feelings about the specific doctor who is asking play a major role in the granting of permission under these circumstances. Informed consent—or, as it is sometimes written, truly informed consent—may be impossible for psychotherapy patients because of transference.<sup>21</sup> In our attempt to be legally and ethically correct, we have to ignore what has been known for almost a full century about patients' hidden attitudes toward therapists and physicians.<sup>22</sup> Mental health professionals ought to be able to recognize that obtaining truly informed consent for publication of a psychotherapy case report is more complicated than obtaining consent in a medical setting. In the medical setting, altruism is a conventional, "look-no-further" explanation for permission. Yet some dynamic forces that may underlie patients' responses require closer examination. It is important to note that although these issues may be more apparent when considering patients who are in psychotherapy, these dynamics are present in any doctor-patient relationship.

A "yes" response to the therapist's request may reflect the patient's gratification at being chosen as a

subject. It may also be granted out of fear of the consequences of saying no. The patient may not understand the purpose of the report but may remain hesitant to acknowledge this. The patient may fear rejection, denial of treatment, or loss of favor if permission is denied. Alternatively, consent may be given out of gratitude to the professional. This may be countertherapeutic if it is immediately experienced by the patient as a manipulation, and it may result in the patient's leaving therapy. Or the request may be experienced only later on, when gratitude has faded, as a less-than-respectful exploitation.

For the patient who gives permission, the request may have an array of deeply satisfying meanings, such as "I am my doctor's favorite or most important patient." Later, however, these meanings may be transformed into an array of negative ones. Physicians are occasionally shocked at how angry a patient has become over what seems to be a minor aspect of their complex interactions over time. Much of the history of the psychotherapeutic relationship can be rewritten rather quickly in this way.

A "no" response may be seen as a healthy protection of one's privacy. However, it may also reflect distrust of the therapist—distrust that may be intensified by the request, making subsequent work with the patient more difficult. It could interrupt or end the doctor-patient relationship and make the patient more reluctant to seek care from another mental health professional.<sup>23</sup> The patient may also eventually regret a "no" response. Afterwards, an obsessive preoccupation with having thwarted the therapist may emerge. Over time, a "no" response might evolve into a "yes" response. By this time, however, having seen the earlier negative impact of the request, the therapist might decline to write about this patient.

A "let me think about it" response, which is the most reasonable one, seems to invite the therapist to engage in a detailed dialogue about the subject. Ideally, all initial responses should invite further discussion within the therapy. However, the discussion is at high risk for subtle coercion. The therapist wants permission, of course. Even logical, systematic inquiry in a neutral manner cannot disguise this fact. It cannot guarantee that the transference has not influenced the decision about permission. Even if the therapist does not use transference in the course of treatment, for example in behavior therapy, that does not justify ignoring this powerful hidden emotional process.

*Countertransference:* The patient and the therapist often experience the therapy in radically different ways. Much of what the doctor thinks and feels about the patient belongs solely to the professional realm. Society holds us responsible to manage these countertransference phenomena competently and silently. Our professional life, like that of our medical colleagues, involves nurturing our intellectual appreciation of what is unknown to the patient, all the while skillfully and sensitively ministering to the patient's needs and sensibilities. Our evolving hypotheses, changing perceptions, and intellectual musings—the forces that generate our case histories—are not to be revealed to the patient, because they may derail the work and may prove to be destructive. They are far removed from the concerns of the patient. Asking the patient to comprehend the pedagogical aspects of being a physician may in itself be an intrusive burden and render the consent invalid. Time in therapy is limited, and typically there is a great deal about the patient that needs to be skillfully processed.

Asking for permission crosses a professional boundary by inserting the doctor's professional agenda into the treatment.<sup>24</sup> The agenda consumes the patient's time and energy. It temporarily transforms the therapy into a discussion of the therapist's issue. The argument that this boundary breach can be worked through and can even prove helpful to the patient rests on two assumptions. The first is that the array of provoked feelings, meanings, and questions is not particularly intense. The second is that the psychotherapist is comfortable enough with his or her motivations to expend the effort to deal with the topic. But clinicians have to face the fact that publication has nothing to do with why the patient came for therapy. Publication is the product of the therapist's need; it is a boundary crossing.

In thinking about designing a research project to explore patient consent processes, the senior author (S.B.L.) created a brief therapy misadventure. A long-term patient who felt considerably helped in psychotherapy was asked about her view of the dilemma. The issue was presented in a neutral manner. Immediately, the patient said she was honored to be asked. In session, her response was that the doctor ought to be able to disguise the case and publish. She was sure it would be a respectful presentation. After the session, she couldn't stop thinking about it. She reported that she was gripped with an intense desire to be helpful to her therapist. As the hours of her deliberation went by, she felt disappointed that she was not chosen to be written

about, but also added that she would be mortified and would feel too paralyzed to object if she were. She concluded that she might do some further research on the subject and found that the prospect made her so excited and agitated that she could not sleep. The next day, she e-mailed a long answer that made it clear that the question had unleashed a disruptive emotional storm in her. The therapist felt that he had behaved inappropriately by inflicting his need on her precious therapy time. At the next visit, the storm was discussed in terms of the transference. She realized that a boundary had been crossed but insisted that she was primarily grateful that she was respected enough to be asked. Both the patient and the therapist were surprised by the intensity of her responses. After the therapist apologized, she said she was relieved not to have to think about the dilemma any more, adding, "I am thoroughly confused by what ought to be done."

*Practical Conundrums:* Three practical considerations about obtaining informed written consent quickly entangle the issue in labyrinthine complexities.

The first of these questions is when to seek permission to write about the patient. If it is after the manuscript is completed, so as to allow the patient to approve its contents, the effort of writing will have been in vain if the patient refuses. The therapist will have to be a saint not to resent the refusal. The patient will correctly worry about the effect of saying no. If the therapist obtains permission before the manuscript is started, the transference may be distorted by narcissistic pleasures and worries about what the therapist is writing. If the manuscript is not completed for any reason, this fact too will intrude upon the treatment process. If the therapist waits a year after therapy to seek consent to publish, it should not be because the writer can safely presume that the transference has abated. In the matter of therapist-patient sexual behavior, all mental health organizations have made it clear that a therapist cannot expect former patients' attitudes and feelings about their therapists to become fully resolved just because therapy has ended or an arbitrary number of years have passed.

Second is the uncertainty of who should pay for the time required to work through the informed-consent process. If the therapist does not charge because it is his or her agenda—as we think proper—psychiatry can generally expect a short informed consent process. If the therapist charges while the varied meanings of con-

sent are explored, this is likely to become a source of resentment.

Third, since it is likely that asking for written informed consent prior to a manuscript's acceptance for publication will stimulate intense emotions, exposing the patient to this affective upheaval is irresponsible considering that many submitted articles are rejected. If the manuscript is rejected, the patient has been subjected to this stress only to comply with editorial policy. No educational purpose has yet been served. In addition, both therapist and patient will likely have separate intense feelings about the rejection of the manuscript, leading to further need for discussion of publication issues. These discussions are further distraction from the patient's agenda; they are another iatrogenic burden to bear. Placing this burden on the patient, we posit, is unethical.

### OUR SUGGESTIONS

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We suggest that the tension between the right to privacy and the obligation to promote professional work be acknowledged and respected. It can be resolved on a case-by-case basis at three levels. First, the therapist is expected to make a careful judgment about the patient's vulnerability upon knowing that he or she is included in an article. Second, the therapist's colleagues can be asked to review the case report for anonymity. Finally, the journal editor should first look at the quality of the case report, its educational or heuristic value, and the degree of patient anonymity. If the manuscript is ethically compromised in any way, it should be returned with editorial direction for its improvement. The therapist-writer, not the patient, should bear the risk and the consequences of rejection. Editorial guidelines should insist that case reports be written with a focus on an aspect of professional life—diagnosis, treatment, outcome. The patient provides only the illustrative circumstances, and the case report generally should be written to reflect a passionate explication of individual or relationship psychology. This emphasis should also be quite apparent when reading the accepted manuscript. It is only *ethically* appropriate to ask for informed written consent after the manuscript has been accepted. However, this obviously puts the author at risk for patient refusal. This sequence still creates transference conundrums, but at this point the manuscript has been peer reviewed to maximize confidentiality and focus on

professional issues rather than the patient's private life per se. That should be more acceptable to the patient.

The alternative to this new solution is the continuation of the current pattern of assiduously reworking the case to attain anonymity without the necessity for informed consent. There are situations when this may be the prudent course. This course, however, rests on an assumption of professional nonmaleficence.

### The Question of Trust in Professional Goodness

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Society cannot tolerate blindly trusting the would-be author to appropriately balance patients' needs against professional opportunity. Physicians can be self-serving and amoral. Professional judgments may be poor when doctors are impaired by medical or psychiatric illness.<sup>25</sup> Ethics committees and institutional review boards exist to protect the rights of patients and research subjects. Nazi doctors' experiments, Tuskegee syphilis experiments, trading sex for medications, and other outrages remain in our collective professional minds.

The publication of a disguised case history without permission, however, is not comparable to these moral and ethical violations. Authors who do not believe that a particular patient's permission should be sought are not necessarily unethical: they weigh their obligations differently. In other ethical controversies, it is well recognized that reasonable people reach opposite conclusions.<sup>26,27</sup>

On the one hand, many psychiatric patients are too fragile, ashamed, private, or well known for the therapist to write about them. On the other hand, physicians need to read about difficult patients with poor ego defenses, chronic instability, paranoid psychopathology, or chaotic sexual lives because we need the perspectives of others to guide our difficult work. We believe psychiatry should continue to have trust in the professional's judgment and goodness rather than create a standard that will either backfire and hurt patients or severely limit professional opportunities to benefit from this pedagogical vehicle.

### Ethics Involve Balance

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Ethical case analysis involves weighing conflicting principles, understanding the facts of the case and the values at stake, and developing a reasoned argument to arrive at an ethical conclusion. The formal ethical prin-

ciples that guide clinical behavior are not absolute. They evolve with time. Prudent clinical decisions are made within a context of hierarchies that shift depending on the situation. An example is respect for patient autonomy: even though this is currently high up on the ladder of social value, it does not always stand inviolate at the pinnacle. Physicians are called upon to prudently balance this principle with their obligations of beneficence and nonmaleficence. Yesterday, a healthy person may have strongly stated that he never wishes to be intubated. Tomorrow, when septicemia makes him anoxic from respiratory fatigue, the doctor is not expected to allow the man, who may fully recover if temporarily intubated, to die. To do so would be to allow the principle of autonomy to run amok. Ethical principles are applied within a context that balances numerous factors.

Psychiatry needs to protect itself from ill-considered ethical and legal standards that impede day-to-day practice, research, and education. Psychiatry has joint

obligations to its current and future patients. We are now more concerned with legal protection than with respectful obligation to both patients and our profession. In stating that no case history will be published without the patient's written informed consent after reading the completed manuscript, the International Committee of Medical Journal Editors has not taken our specialty into consideration. We should not apply their new standard to psychiatry without further deliberation. The case history is too important to the lifelong education of mental health professionals, too indirectly beneficial to future patients, and too illustrative of the ethical balance of forces within individual physicians to be swept away by fiat. Perhaps a committee of psychiatric and social science journal editors, ethicists, and psychiatric educators ought to have a chance to offer their judgment.

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