Dan's TALKING POINTS Memo Ch. 3

Wilcoxon, Remley, and Gladding; Chapter 3 (v5.2)
For discussion on September 14, 2017

Promoting Ethical Practice:
Principles, Traditions, and Considerations

1. Berry (1982), and Herlihy and Corey (2006) try to distinguish between *ethical decisions* and *moral decisions* by stating, "Intentionality in ethical actions elevates practitioners' decisions beyond simple moral exercises for their satisfaction to the status of accountability for patient welfare (p. 43).

2. In matters of ethical decision-making in the biomedical world (which includes us), you will hear a great deal about the concepts of Beauchamp and Childress (2009). For the record, this is their list of five overriding ethical principles:

   Autonomy - All humans have a right to their independent thinking and their choices.
   Beneficence - We are principally bound to actively benefit another in a positive manner -- to help.
   Nonmaleficence - We must avoid causing harm to another.
   Justice - We treat everyone fairly and with an overriding sense of justice.
   Fidelity - We keep our promises, tell the truth, and are loyal in our service to others (p. 43).

3. The authors state that ethical practice is a balance of *risk* and *choice*; they suggest that through following ethical principles, risk and choice are minimized in favor of tradition and increased certainty (p. 43).

4. Which of the helping professions had the first code of ethics? When? (p. 43)

5. According to Van Hoose and Kottler (1985), what are the “three protections” provided by codes of ethics? (p. 44).

6. What are some of the *mandatory prohibitions* included an all helping professions' codes of ethics?

   Carefully read the inset on page 44; could this therapist be you?

   "A male therapist has been working for several months with a couple seeking a divorce. He finds the wife attractive and exciting. He is aware that she has similar feelings toward him and would like to become involved with him socially and sexually. Because of his desire to become intimate with her, he often finds it difficult to concentrate during therapy sessions."

Carefully read the inset on page 45; could this therapist be you?

> "A therapist encounters a patient who is experiencing a religious crisis while discussing her husband's pending and certain death. She indicates that she has always found strength in her faith and her religious affiliations. The therapist has no affiliations with religious groups, and she believes that a discussion about the patient's question of faith is irrelevant. Instead, she directs the session to considering the patient's plans for the future. The patient protests, but the therapist states that she has very little experience with the topic and believes that it will offer little benefit to focus on this matter."

7. What about the *mandatory prohibitions* found in California Association of Marriage and Family Therapists' code of ethics?

8. Ethical codes do not propose to “recommend specific behaviors in limited situations.” Why not? Wouldn’t his make life easier if they were more explicit? Do you understand the concept that more words equal less utility? What do Stude and McKelvey (1979) say about this on page 46?

9. While there are certainly formal disciplinary procedures for those who behave in contradiction to published ethical standards, is there any kind of "informal disciplinary action" that you might take against a colleague whom you KNOW is misbehaving? Careful with this one!

10. Know Kidder’s three bases for ethical decision-making: 1) end based, 2) rule based, or 3) care based. UNDERSTAND them! (p. 50)

11. I like the idea by Kidder on page 50 where he defines care-based thinking as application of The Golden Rule … Do unto others … Not a bad way to live, huh?

12. Read and get a feel for Kitchener’s (1986) four process model of ethical decision making: 1) interpreting a situation as requiring an ethical decision, 2) formulating an ethical course of action, 3) integrating personal and professional values, and 4) implementing an action plan (pp. 50-52). Frankly, I think this is what most of us do naturally when we are in "a situation” – in a way, this is a silly list of stuff we do naturally.

13. According to Welfel and Lipsitz (1984), about what percentage of mental health practitioners are insensitive to the ethical dimensions of their work? (p. 50)

14. Have a familiarity with the Keith-Spiegel and Koocher Model 8-step model of ethical decision-making. This model has lots of practical implications for the MFT (pp. 52-55) – Actually, just cruise through it. Another silly list of what we do naturally!

15. **Big discussion point:** Recognition that our first priority is to promote the welfare of the patient. What criteria should be used to determine whether there is benefit coming from our interaction? What if a patient thinks they are growing, but we don't? What about the patient who is using the relationship for companionship vs. therapeutic change? (p. 55)

16. Is "Due Care" (page 57) the same as "Scope of Competence?

17. What should be done when it is determined that a therapist is impaired? List a few of the more salient impairments? How about some less obvious impairments that may be equally detrimental? (p. 59)

18. **Confidentiality - Privileged Communication - Privacy.** Pages 60-62. Digest this stuff. It is the basis for what follows. This is complicated, but it MUST be understood for you to be a safe practitioner.

19. Know that the term "privilege" is a *legal distinction* that is a factor for us who practice in California. We will discuss.

20. Confidentiality is an "out of the courtroom" reference to our keeping material undisclosed. We say that we are observing the principle of confidentiality, but it is the patient who has control in the case of privilege. Confusing.

21. "Privacy" is an important construct that encompasses confidentiality and privilege; it seems to be used more frequently with reverence to HIPAA (Health Insurance Portability and Accountability Act of 1996) as it applies to the methods by which patient information is handled in the office and to communicate with outside payment sources or referral sources. There are lots of problems and considerable confusion around all of this. I'll have more to say about HIPAA in a few weeks (pp. 62-63).

22. **"Duty to Protect."** This will be a topic of ongoing discussion throughout the semester. At this juncture, one's "duty to protect" hinges on one's ability to predict violence. Wow, this is difficult. As a therapist, you are not required to be clairvoyant, but you are required to behave in a manner consistent with others in your profession when faced with similar circumstances. Corey et al., on page 64, has a set of procedures when assessing whether a patient poses a serous danger to others.

23. On page 64, the authors discuss a "duty to report" (e.g., child and elder abuse, etc.) and we'll work hard on "duty to protect" (e.g., Tarasoff). Just read this over and we'll follow-up later. Also, this area touches on "on-line therapy." More on this to follow, too.

24. “**Informed consent.”** What is the meaning and purpose of "informed consent"? Why is it an issue? How can "informed consent" save your bacon when faced with a malpractice lawsuit? What do you think about the therapeutic contract as presented on pages 65-66? What are the hazards of contracts?

25. In conjunction with documents for assuring "informed consent," the authors introduce the notion of "professional disclosure statements." What do you think about the items to address in a professional disclosure statement given on page 69?