A Survey of Psychiatry Residents' Informed Consent Practices

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Objective: A survey was used to investigate whether psychiatry residents obtained informed consent for treatment from 3 hypothetical patients.

Method: Clinical vignettes describing 3 patients with (1) major depressive disorder being prescribed medication, (2) borderline personality disorder starting psychotherapy, and (3) neurotic character traits starting psychotherapy were distributed to psychiatry residents at 7 New York City–area training programs. Necessary components of an informed consent discussion were defined a priori by means of a literature review and consultation with experts in informed consent. Residents' responses to questions about the vignettes were then examined to determine whether the residents would engage in an informed consent discussion with the hypothetical patients. The study was conducted from January to March 2005.

Results: 108 (49%) of 220 subjects reporting on a total of 324 vignettes returned the questionnaire. Responses to 8/324 vignettes met the minimal criteria established for an informed consent discussion. More residents reported they would initiate discussions with the depressed patient compared to the borderline and neurotic patients about diagnosis and prognosis, information about the recommended treatment, and side effects. A measure of what residents revealed about themselves to patients was also greater for the depressed patient compared to the borderline and neurotic patients. When the informed consent criteria were made less restrictive (requiring only that residents provide information in response to patients' questions rather than initiate the discussion), 173/324 vignette responses met the criteria.

Conclusion: Psychiatry residents did not initiate informed consent discussions with the hypothetical patients in this study, but they reported that they would provide appropriate information when asked by the patients. These results suggest that changing residents' passive approach to informed consent discussions might have a large impact.

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Historically in psychiatry, the doctrine of informed consent has been applied to research and invasive procedures such as electroconvulsive therapy, but psychiatrists increasingly are expected to obtain informed consent for treatment with medications and psychotherapy. Most states oblige clinicians to disclose enough information that a reasonable person may decide whether or not to accept the treatment in question.[1] Such information typically includes the diagnostic impression, information about the recommended treatment, the risks and benefits of the treatment, a discussion of alternate treatment options with their relevant risks and benefits, expected outcome of the problem with no treatment, and pertinent data about the clinician (e.g., licensure).[2,3]

Legal factors motivate many clinicians to obtain informed consent. For example, *Osheroff v. Chestnut Lodge* in the early 1980s influenced psychiatrists to disclose more information about available alternative treatments to avoid malpractice or negligence suits.[4,5] Despite this legal emphasis, ethical and moral principles offer equally compelling reasons for clinicians to obtain informed consent for their treatments. Protecting patients' autonomy by helping them understand and freely make decisions regarding their personal health care is a major foundation of the doctrine of informed consent.[6] Respect for persons requires the doctor to provide necessary information and encourage the patient to make a rational choice.[7] Other relevant principles are fidelity, which requires clinicians to respect the decisions of competent patients even if they are contrary to recommendations, and nonmalfeasance, since patients may be distressed or

harmed as a result of not actively participating in decisions about their care.[8]

Additionally, informed consent discussions may enhance clinical work by establishing trust, defining the nature of therapeutic work and therapist responsibilities, clarifying therapists' knowledge and values, and explaining techniques and procedures.[9] Patients are encouraged to become more active agents on their own behalf, and the responsibility for care is shifted from caregiver to both doctor and patient.[10] In fact, research suggests patients want information about the cost and duration of treatment, the credentials of the therapist, confidentiality, treatment alternatives, expected side effects, and outcome with no treatment.[11] Perhaps in recognition of these factors, the American Psychiatric Association,[12] American Psychological Association,[13] and American Psychoanalytic Association[14] have each set a professional standard to obtain informed consent for treatment.

Available evidence indicates that clinicians generally fall short of these recommendations. One study of psychotherapy showed great variation in the information conveyed to patients: therapists reported discussing the effectiveness of treatment with 42% of patients, risks of the treatment with 62%, and treatment alternatives with just 27%.[15] In another series, only 51% of psychotherapists reported conducting and documenting an informed consent discussion, with psychodynamic psychotherapists having the strongest negative opinions about informed consent.[16] Even in Colorado, where psychotherapists are required to provide written information about the treatment, a recent study found clinicians did not discuss alternate treatment approaches.[17] Data for psychopharmacologic treatment are mixed, but they also raise concerns about how informed consent is obtained. In one survey, 78% of psychiatrists prescribing antipsychotics reported informing patients about the risk of tardive dyskinesia,[18] but a later chart review showed documentation of informed consent discussions in only 25% of those cases.[19] Surveyed psychiatrists in another study believed disclosing rare but serious side effects was important, but very few told patients about the risk of neuroleptic malignant syndrome when prescribing typical antipsychotics.[20]

These studies suggest mental health professionals may not always obtain informed consent in clinical practice, but they share the methodological weakness of surveying clinicians' beliefs and opinions rather than evaluating actual disclosure practices. Recall bias and social desirability may confound these results, making a more direct method of assessing clinicians' practices important. In addition, no data are available on the informed consent practices of clinicians in training. Due to their uncertain knowledge and authority, lack of experience, and susceptibility to influence by supervisors, trainees may be even less likely to engage in adequate informed consent discussions.[21]

The central aim of this study was to investigate the informed consent practices of psychiatry residents by assessing their behavior with hypothetical patients in 3 vignettes. Our primary hypothesis was that psychiatry residents would not obtain informed consent for treatment with the vignette patients. We were also interested in whether residents learn to obtain informed consent during their training. Presuming they did, we hypothesized that informed consent would be obtained more frequently as year of residency training increased. Lastly, given a suggestion in the literature that clinicians have more difficulty obtaining informed consent for psychotherapy, we expected to observe differences in the residents' behavior during psychopharmacologic treatment compared to psychotherapy. We hypothesized that residents would obtain informed consent more often and be more self-disclosing with patients in psychopharmacologic treatment compared to psychotherapy.

METHOD

Sample

Subjects were recruited from the 7 largest New York City–area psychiatry residency training programs, which enrolled a total of 220 residents. Five of these programs are large academic medical centers, while 2 (comprising 39 of 220 residents) are community based programs. Most residents recruited for the study graduated from American medical schools, although 27 of 220 were international medical graduates. A letter was sent to the training directors at each site inviting them to participate. At luncheons subsequently provided by the study investigators, PGY II through IV residents were told about the study and recruited to participate. A waiver of written informed consent was granted by the New York State Psychiatric Institute Institutional Review Board, which approved this study (protocol #4990). Potential subjects were made aware of the risks and benefits of study participation by means of a cover letter. Participants anonymously filled out the study questionnaire, which was collected at the conclusion of the lunch. Blank questionnaires in self-addressed, stamped envelopes were left at each site, so residents not present at the lunch could participate in the study. The study was conducted from January to March 2005.

Survey Instrument

The questionnaire contained 3 vignettes whose format (but not content) resembled those in the DSM Casebook.[22] They described a patient with (1) a major depressive episode being prescribed medication, (2) borderline personality disorder starting psychotherapy, and (3) neurotic character traits but no Axis I diagnosis starting psychotherapy. The vignettes described an extended evaluation period and culminated in a treatment recommendation;

Appendix 1 shows a sample vignette. The same 6 questions were asked after each vignette, covering the following areas: (1) diagnosis and prognosis, (2) treatment options, (3) details of the recommended treatment, (4) side effects of treatment, (5) information regarding logistics of treatment, and (6) information about the clinician. Respondents were asked to limit themselves to the information contained in the vignettes, to accept the diagnostic formulations and proposed treatment plans as reasonable, and to respond based on what they would actually do in practice with the patients described.

Questions had multiple parts that between them covered all of the components of informed consent. Appendix 1 shows a sample question covering the area of diagnosis and prognosis. For each part, residents were instructed to check 1 of 3 possible answers: "Discuss," "Answer," or "No." They were not required to write in any answers. Directions explained that Discuss "means you would bring up the item with the patient spontaneously," Answer "means you would be comfortable talking about the item if the patient asked but would not bring it up yourself," and No "means you would not discuss the item with the patient whether or not they asked." For items respondents chose not to talk about, they were to select 1 of 4 possible reasons explaining their decision: (1) such a discussion is clinically incorrect or not applicable in this case, (2) such a discussion might adversely affect treatment of this patient, (3) such a discussion is unnecessary at this point in treatment, or (4) such a discussion likely took place prior to my interaction with the patient.

A preliminary version of the study questionnaire was piloted with the graduating class of psychiatry residents from one program (Columbia) who were remaining in the New York City area following graduation. This sample was chosen for the pilot study to select clinicians closest to the main study sample in terms of education and demographics and to facilitate follow-up personal interviews conducted by the principal investigator (B.R.R.). Pilot study subjects filled out the study questionnaire and provided written responses to additional questions: (1) "Was the phrasing of this question and its accompanying answer choices clear to you? If not, then which parts were unclear?" (2) "Was your answer to this question influenced by considerations not accounted for in the above vignette or question? If so, then what were these considerations?" and (3) "Did you have difficulty answering the above questions because another, better, answer was not listed? If so, then what was this answer?" These responses were then reviewed in person with each respondent to obtain comprehensive feedback on the study vignettes and address problems with the text or questions before they were administered to the study sample. All 8 participants in the pilot study felt their responses to the study vignettes accurately reflected their practices with actual patients.

Construct Development

Much care was taken to develop and operationalize a measure of informed consent disclosure to evaluate residents' responses to the survey in a standardized way. First, an extensive review of the literature was undertaken to determine the components of informed consent for treatment (a MEDLINE search was conducted using the keywords *informed consent* and *psychotherapy* or *pharmacotherapy*, relevant articles were reviewed, and the major relevant texts[2,3] were reviewed). Second, information generated from this review was used to develop a tentative measure. Since there was some disagreement between sources in what constituted an informed consent disclosure, we chose to create 2 constructs. The first was a bare minimum version of informed consent including ethically required elements on which all sources agreed, while the other constituted a desirable goal for informed consent disclosure that went beyond what was ethically required. The minimal standard, named "Adequate Informed Consent," included a statement of the problem, likely course of illness with and without treatment, treatment options, expected benefit of treatment, common and serious side effects, cost of treatment, and residents' supervision by senior clinicians. The more comprehensive standard, termed "Optimal Informed Consent," included over and above what was required for Adequate Informed Consent a more extensive discussion of different diagnostic possibilities and treatment options, expected duration of treatment, confidentiality issues, and more information about the clinician's qualifications. Next, we consulted with experts in informed consent, including a former chairman of the New York State Psychiatric Institute Institutional Review Board, to refine the standards. Finally, the Adequate and Optimal Informed Consent measures were again compared to descriptions in the literature to ensure their compatibility.

After the final revisions were made, these a priori–defined standards for disclosure were used to evaluate residents' responses to the vignette questions. To meet either standard, residents were required to check "Discuss" (i.e., report they would proactively bring up the topic with the vignette patients) for all of the items making up Adequate and Optimal Informed Consent.

Analysis

Standard descriptive statistical methods were used to analyze the data. Respondents were first classified as meeting or not meeting the preestablished criteria for Adequate and Optimal Informed Consent. This classification was made at the level of the individual disclosure topics assessed in each vignette (e.g., diagnosis and prognosis), each of the 3 study vignettes, and for the vignettes overall. The McNemar test of dependent proportions was used to determine whether there were significant differences between vignettes in residents' meeting the

Table 1. Percentages of Survey Responses Meeting Original and Revised[a] Informed Consent Criteria

	Major Depressive Disorder Vignette		Borderline Personality Vignette		Neurotic Traits Vignette	
Disclosure Category	Original	Revised	Original	Revised	Original	Revised
Overall vignette	5	71[b]	2	43	1	46
Diagnosis and prognosis	48[b]	94	24	93	21	90
Possibility of alternative treatments	68[c]	95	63[d]	95	51	94
Details of recommended treatment	51[b]	94	18	90	21	91
Information about side effects	67[b]	92[b]	22	61	23	65
Cost of treatment	65[c]	93	74	92	79	94
Appropriate self-disclosure	20	92[b]	21	82	20	83

[a]The original criteria required that respondents check "Discuss" (initiate discussion with patients); the less restrictive revised criteria also counted responses of "Answer" (answer in response to patients' questions) toward fulfillment of the criteria.
[b]$p < .05$ for comparison of major depressive disorder vignette with borderline personality and neurotic traits vignettes.
[c]$p < .05$ for comparison of major depressive disorder vignette with neurotic traits vignette.
[d]$p < .05$ for comparison of borderline personality and neurotic traits vignettes.

informed consent criteria. Three comparisons were made: depressed patient vignette versus borderline patient vignette, depressed patient vignette versus neurotic patient vignette, and borderline patient vignette versus neurotic patient vignette. To determine whether residents' responses differed by year of residency training, an omnibus χ^2 was conducted. We conducted follow-up tests by partitioning the overall χ^2 to determine the nature of any differences indicated by the overall test.

What residents reported they would disclose about themselves to the vignette patients was investigated by analyzing their responses to the survey question pertaining to self-disclosure. The number of items checked either Discuss or Answer for each vignette was summed, generating a total self-disclosure score for each resident on each vignette. A 1-way within-subjects analysis of variance was conducted to determine whether there were differences in self-disclosure across the 3 vignettes. Paired-samples t tests were then conducted to determine on which vignettes the residents differed. The Holm's sequential Bonferroni procedure was used to control for type I error inflation. For all frequencies, percentages were rounded to the nearest 1%.

RESULTS

Fulfillment of Informed Consent Criteria

One hundred eight of 220 subjects reporting on 324 vignettes returned the questionnaire, a 49% response rate. The sample comprised 27% PGY II residents, 42% PGY III, and 29% PGY IV. Six of the 108 respondents completed another residency prior to their psychiatry training. The frequencies of residents meeting the original and revised informed consent criteria described below for overall vignettes and each disclosure category are listed in the first line of Table 1. Overall, 8/324 vignettes (3%) met criteria for Adequate Informed Consent, and 3/324 (1%) met criteria for Optimal Informed Consent. Six residents accounted for all of the vignettes meeting Adequate Informed Consent criteria, and 1 resident's responses met criteria for all 3 vignettes. Given the small number of vignettes meeting criteria for the Optimal Informed Consent construct, it was dropped from the following analyses. There were no differences observed across residency years on responses to the overall vignettes or any of the disclosure categories. Since surveys were returned anonymously, it was not possible to test for differences between sites.

Differences Between Vignettes

Residents' responses to the individual disclosure topics assessed in each vignette appear in Table 2. Forty-eight percent of respondents met the Adequate Informed Consent criteria for diagnosis and prognosis with the depressed patient compared to 24% for the borderline patient ($p < .001$) and 21% for the neurotic patient ($p < .001$). Criteria regarding information about the recommended treatment were met with the depressed patient by 51% of residents compared to 18% for the borderline patient ($p < .001$) and 21% for the neurotic patient ($p < .001$). Also, more residents met the Adequate Informed Consent criteria with respect to treatment side effects for the depressed patient compared to the borderline patient (67% vs. 22%, $p < .001$) and the neurotic patient (67% vs. 23%, $p < .001$). Fifty-one percent of residents stated they would spontaneously discuss alternative treatments with the neurotic patient, which was significantly less than 68% for the depressed patient ($p < .01$) and 63% for the borderline patient ($p < .03$). Respondents reported they would spontaneously discuss the cost of treatment more often with the neurotic patient compared to the depressed patient (79% vs. 65%, $p < .005$) but not the borderline patient (79% vs. 74%, NS). The depressed, borderline, and neurotic patients were provided appropriate information about the clinicians at equally low rates (20%, 21%, 20%, respectively).

The mean self-disclosure sums computed were 7.8 (SD 2.3) for the depressed patient, 6.7 (SD 2.5) for the borderline patient, and 6.8 (SD 2.7) for the neurotic patient. The self-disclosure sum for the depressed patient vignette was

Table 2. Residents' Responses to Informed Consent Survey Items

Item	% of Residents Selecting					
	Major Depressive Disorder Vignette		Borderline Personality Vignette		Neurotic Traits Vignette	
	Discuss	Answer	Discuss	Answer	Discuss	Answer
What, if anything, would you tell the patient about his problems?						
Explain your view of patient's problems without using diagnostic terms or jargon	92	97	92	96	94	97
Explain patient's problems in specific psychological or biological terms	37	80	28	60	13	50
Give DSM diagnosis	61	91	16	59	16	67
Explain possibility of alternative diagnoses accounting for patient's problems	51	93	40	93	32	89
Explain incidence and prevalence of patient's problems	45	94	18	90	9	79
Estimate likely time course of patient's problems	65	94	33	88	29	89
Explain likely outcomes of the current situation without treatment	64	96	48	96	42	94
Having recommended this treatment, what, if anything, would you tell the patient about other ways of addressing his problems?						
Option to treat with medications (or different medication)	72	97	63	95	51	94
Option to treat with psychotherapy (or different psychotherapy)	87	98	64	93	33	77
Option to treat with combined psychotherapy and psychopharmacology	97	99	79	97	36	82
Option to treat in different settings: resident clinic with you, private office with attending psychiatrist, free clinic	29	89	34	87	36	89
Options to treat based on insurance coverage and financial costs of recommended treatment	35	88	41	88	36	82
What, if anything, would you tell the patient about how the treatment might help his problems?						
Explain it may help with chief complaint	97	97	77	96	85	97
Explain it may help underlying physiologic or psychological pathology	38	96	86	98	47	80
Explain response rate to treatment in similar patients	52	98	31	93	30	92
Explain which symptoms are likely to respond	70	98	51	95	40	93
Explain typical time course of response to treatment	96	99	47	90	46	91
Explain possible options should patient not respond to treatment	48	94	28	88	29	92
Explain expected overall duration of treatment	60	98	41	92	44	92
What, if anything, would you tell the patient about the treatment's possible side effects?						
Explain all side effects	18	76	9	51	9	55
Explain common side effects	96	97	38	83	44	80
Explain rare but serious side effects	67	92	24	62	23	65
What, if anything, would you say to the patient about details of treatment with you?						
Clinic hours	65	97	79	95	79	96
Cost of treatment	65	93	74	92	79	93
Frequency of meetings	98	99	95	97	95	98
Policy for missed sessions	66	94	84	94	79	94
Confidentiality	75	97	82	96	79	97
Emergency coverage	60	94	76	96	63	96
How chart records are kept	9	82	17	85	22	85
Expectation that patient report on what is on his mind, symptoms, and the effects of medication	76	97	86	93	81	90
What, if anything, would you tell the patient about yourself?[a]						
Your hometown	2	31	1	15	2	22
Your sexual preference	0	5	0	2	1	4
Your age	2	37	3	23	1	26
Your educational background	5	88	4	79	3	79
Your stage of psychiatric training	26	95	24	92	26	94
Your licensure information	5	91	6	87	3	88
Your career interests	3	37	2	26	1	29
Your board certification	4	94	3	87	2	86
Your supervision under senior clinician	37	94	37	84	34	83
Your marital status	1	15	0	7	1	8
Your children	1	7	0	4	1	7
Your duration of clinic rotation	40	88	52	83	45	81
Your experience with similar cases	13	86	8	73	6	65
Your religion	2	9	1	8	2	8

[a]The number of items checked "Discuss" or "Answer" for each vignette was summed to generate a total self-disclosure score for each vignette, and the mean overall sums were as follows: major depressive disorder, 7.8; borderline personality, 6.7; and neurotic traits, 6.8. For comparison of major depressive disorder vignette with borderline personality and neurotic traits vignettes, $p < .05$.

significantly greater than for the borderline patient vignette ($t = 5.1$, $df = 106$, $p < .0001$) and the neurotic patient vignette ($t = –0.68$, $df = 106$, $p < .0001$), while the sums for the borderline and neurotic patient vignettes did not significantly differ. Respondents reported they would share information about their educational background (88%, 79%, and 79% for the major depressive disorder, borderline, and neurotic vignettes, respectively), stage of training (95%, 92%, 94%), licensure (91%, 87%, 88%), board certification (94%, 87%, 86%), supervision under a senior clinician (94%, 84%, 83%), and experience with similar cases (86%, 73%, 65%), while avoiding mention of their sexual preferences (5%, 2%, 4%), marital status (15%, 7%, 8%), children (7%, 4%, 7%), and religion (9%, 8%, 8%). Whether residents stated they would discuss clinically inappropriate or irrelevant information with the vignette patients was also assessed. One percent reported they would suggest schizophrenia as a possible diagnosis for the depressed patient, 10% stated they would initiate a discussion of obsessive-compulsive disorder with the borderline patient, and 1% responded they would bring up delusional disorder with the neurotic patient.

Disclosure in Response to Patients' Questions About the Treatment

Further analyses were undertaken to investigate whether residents knew what should be disclosed to the patients in the vignettes but were insufficiently active in bringing up the information. The definition of Adequate Informed Consent was made less restrictive by counting an item toward the criteria if residents checked either Answer (i.e., they would answer in response to patients' questions) or Discuss (i.e., spontaneously bring up with patients). These revised criteria were met by 173/324 (53%) of the vignettes, and 36/108 residents (33%) met the revised criteria for all vignettes. Seventy-one percent of residents met the revised criteria for the depressed patient compared to 43% for the borderline patient ($p < .001$) and 46% for the neurotic patient ($p < .001$). Between-vignette differences in the residents' responses in this reanalysis occurred in 2 areas. More residents reported they would bring up or answer questions about treatment side effects with the depressed patient than the borderline patient (92% vs. 61%, $p < .001$) or the neurotic patient (92% vs. 65%, $p < .001$). They also stated that they would bring up or answer appropriate information about themselves more often with the depressed patient compared to the borderline patient (92% vs. 82%, $p < .03$) or the neurotic patient (92% vs. 83%, $p < .04$).

DISCUSSION

To our knowledge, this study is the first to investigate the informed consent practices of psychiatry residents. The major finding was that residents did not obtain informed consent from the hypothetical patients in this study. Only 8/324 vignettes met the minimal standard for informed consent. Contrary to our expectation, year of residency training did not affect how often informed consent was obtained from the vignette patients. It is unclear where those residents who did obtain informed consent from the vignette patients learned to do this.

Overall, residents did not obtain informed consent more frequently in the medication vignette compared to the psychotherapy vignettes. However, there were individual disclosure areas in which residents provided the patient in the psychopharmacologic vignette with significantly more information compared to the psychotherapy patients. These were the areas of diagnosis and prognosis, details of the recommended treatment, and side effects. The neurotic patient was spontaneously given less information about alternative treatments than patients in either of the other vignettes. Residents' overall self-disclosure was also significantly less with the psychotherapy patients compared to the depressed patient receiving medication, which suggests residents tend to be less disclosing with psychotherapy patients.

The minimal standard of informed consent used in this study required residents to proactively communicate relevant information to patients. The problem in the residents' responses was primarily not one of knowledge but of failure to initiate informed consent discussions. If patients asked questions, then by and large residents stated they would respond appropriately. When the data were reanalyzed and appropriate responses were counted as meeting criteria for informed consent, 173/324 vignettes met criteria for informed consent. Significantly more residents met the revised informed consent criteria for the medication patient compared to the psychotherapy patients; the lower rates for the psychotherapy vignettes were mainly due to residents' failure to discuss side effects of psychotherapy and provide appropriate information about themselves. Therefore, the failure to obtain informed consent from the vignette patients may have resulted from residents not understanding that informed consent is an active process. In other words, residents failed to appreciate that it is the physician's responsibility to initiate an informed consent discussion and ensure all components are completed.

The passive approach to informed consent discussions documented in this study has been found in other branches of medicine.[23] Several studies have shown that physicians in various specialties do not provide patients with sufficient information to make an informed decision.[24–27] One review of audiotaped doctor/patient encounters found that only 9% of clinical decisions met a complete definition of informed consent, while 20% met a "moral minimum" threshold.[28] In other studies, it has appeared that the more patients asked questions and indeed challenged the doctor's statements, the more likely the informed consent process would occur.[29]

Psychiatry residents, like other physicians, seem to know the content of informed consent discussions but have difficulty with the process. If the results of this study reflect residents' actual practices with patients, and residents do not effectively participate in the informed consent process, a direct educational solution would appear to be appropriate. Had residents proactively discussed what they were willing to answer in response to questions, many more would have met the preestablished informed consent criteria. Teaching residents about the informed consent process, through didactic classes or clinical examples, would seem be an intervention that could be studied to see if it is sufficiently effective. Indeed, this teaching should probably be done during the PGY I year. Since young physicians also learn by modeling themselves on teachers and supervisors, education about informed consent could be extended to faculty members as well.

This study has several methodological limitations, and conclusions should be considered with these limitations in mind. First, the informed consent practices of residents were examined using hypothetical patient encounters as a proxy for direct clinical observation. Responses to the vignette questions might be biased by issues of social desirability, meaning subjects might answer according to what they believe is correct rather than how they actually proceed with patients. Second, this study was conducted among New York City–area psychiatry residents, who may not be representative of psychiatry trainees. The study design also did not allow for determining whether residents' responses differed by program. Third, the response rate to the study questionnaire was approximately 50%, and residents who chose to participate may differ from those who declined.

Finally, this study reported only on psychiatric residents and contained no data on the informed consent practices of psychiatrists in clinical practice. Though other studies have suggested that graduate psychiatrists may be deficient in this area, to what degree adequate informed consent discussions occur in the community is unclear. One might wonder how psychiatrists learn to obtain informed consent if not during residency, and this is an area that compels further study.

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Appendix 1. Clinical Vignette and Sample Item for Major Depressive Disorder Patient

Clinical Vignette

The director of your psychopharmacology clinic performs a phone triage and then assigns to you Mr. L, a 43 year old man living with his wife and young son. At his intake appointment with you, Mr. L states he has experienced "the normal ups and downs of life" but has never before met with a mental health professional. A third grade teacher, Mr. L reports doing well until three months ago, when he was forced to assume new responsibilities at work and his wife asked him to start couples' therapy. He began to feel "sad and down" around that time, and he noticed that doing his usual good job at work seemed less pleasurable and important to him. Mr. L's social activities also diminished, and he started to isolate himself on weekends, though he felt guilty about not keeping in touch with his friends. He reports occasional crying episodes, which were previously rare for Mr. L, and he has felt tired during the day after having trouble falling asleep at night. Mr. L worries his wife will leave him if he is not "more fun to be around." Mr. L denies thoughts of death or suicide, and he reports no history of self-harm. Further questioning indicates that Mr. L has never experienced manic or psychotic symptoms, has minimal anxiety, and does not use alcohol or drugs.

After seeing Mr. L, you briefly discuss his case with your clinic supervisor. Though the differential remains broad, your impression is Major Depressive Disorder. In discussing treatment options, your supervisor suggests starting with an SSRI, since Mr. L has never before taken psychiatric medication and is likely to tolerate that treatment well. You agree and go back into the room to speak with the patient.

Sample Item From Questionnaire

1. What, if anything, would you tell Mr. L about his problems?

For those items you would **not** discuss or answer, please select the one most important reason of those listed below:

1. Such a discussion is clinically incorrect or not applicable in this case.
2. Such a discussion might adversely affect treatment of this patient.
3. Such a discussion is unnecessary at this point in treatment.
4. Such a discussion likely took place prior to my interaction with the patient.

	Discuss	Answer	No	Reason (1–4)
Explain your view of Mr. L's problems without using diagnostic terms or jargon (e.g., "your sad feelings have been getting in the way of enjoying life")		✓		
Explain Mr. L's problems in specific psychological (e.g., "your cognitive distortions cause you to feel depressed") or biological (e.g., "a relative lack of serotonin in your brain may affect your mood") terms	✓			
Give diagnosis of "Major Depressive Disorder"		✓		
Discuss the link between Major Depressive Disorder and schizophrenia in patients like Mr. L			✓	1
Explain possibility of alternative diagnoses accounting for Mr. L's problems	✓			
Explain incidence and prevalence of problems such as Mr. L's		✓		
Estimate likely time course of problems such as Mr. L's		✓		
Explain likely outcomes of the current situation without treatment	✓			