Ethical Behavior in Medical Settings

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Medical schools have recognized and endorsed integrative health care. As such, integrated care is becoming more common. Biofeedback practitioners already trained to work in medical settings and those willing to be so trained have a real opportunity to expand their base of services because self-regulation is an important part of integrated care and lifestyle change. Working in medical settings requires a broad base of knowledge and skill, including an understanding of both the formal and informal rules that govern activities in such settings. Having a mentor or supervisor who already possesses the requisite skills can be most useful in helping the practitioner acquire the needed knowledge and skills and to make a shift from focusing on pathology to one of promoting good physical and mental health. Issues of competence, informed consent, and confidentiality must also be addressed and often in ways not common in other settings.

Introduction

The focus on the term complementary and alternative medicine seems to be declining, and the use of the terms mind-body medicine and integrated (or integrative) medicine seems to be increasing as health care practitioners realize the importance of treating the whole person. A consortium for integrative medicine consisting of 42 medical schools defined integrative medicine as “the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing” (Riley, 2009, p. 10). Such a focus seems to provide a great opportunity for biofeedback practitioners, especially those skilled in working in medical settings.

For more than a decade, insurance reform, changes in health care delivery, managed care, and reimbursement policies have made it clear that health care professionals, e.g., psychologists, need to diversify beyond traditional practices that focus on pathology to focus on the promotion of physically and mentally healthy lifestyles (Bluestein & Cubic, 2009). Most professionals have not modified their practice activities, and most training programs do not prepare professionals to provide integrated care (Bluestein & Cubic, 2009). However, some training programs have focused on helping professionals to work collaboratively in medical settings (Belar & Deardorff, 1995). For example, clinical health psychology training programs prepare psychologists to address three areas of consultation more directly than do traditional psychology or psychiatry, including (a) treatments involving psychophysiological self-regulation and learning theory as applied to medical problems, (b) prediction of responses to medical-surgical treatments, and (c) the reduction of health and behavioral risks (Belar & Deardorff, 1995). Because lifestyle behaviors seem to account for about 50% of the instances of mortality related to cerebrovascular, cardiovascular, and similar serious diseases (McGinness & Foege, 1993; Seime, Clark, & Whiteside, 2003), it is important for health care to be collaborative, broadly based, and integrative. Physicians alone cannot be expected to deal directly with both the medical aspects and the lifestyle issues of patient care.

Lifestyle Issues

Lifestyle issues that need to be addressed are broad and include, but are not limited to, stress management, weight management, smoking cessation, increasing physical activity, nutrition, improving mood disorders (e.g., depression and anxiety), social support issues, and even personality variables (McGinness & Foege, 1993). To change lifestyle means to change the way one thinks, and to change the way one thinks means changing beliefs. As such, lifestyle changes occur via self-regulation or by taking control of one’s life. Competent and broadly trained and experienced biofeedback practitioners are in a unique position to provide some or maybe even most of the self-control services that are needed. However, being competent in biofeedback and other applied psychophysiological skills
Training and Competencies

The American Psychological Association (APA) provided a template for determining whether one is competent to provide services in a medical setting (Seime et al., 2003). A biofeedback practitioner who is or who wishes to work in such settings might access that template and use it to determine what other skills he or she might need to work successfully in medical settings. Of course, having the technical competencies such as good biofeedback skills is also necessary.

A medical setting is a unique environment governed by formalized rules (e.g., hospital bylaws and staff privileges) and informal rules (e.g., the physician is in charge; Seime et al., 2003). Many of the rules are not common knowledge to those who have not received training and/or supervised experience in medical settings (Seime et al., 2003). As such, to function effectively in medical settings, practitioners not so skilled need to make a concerted effort to gain both the knowledge and broad base of skills needed in such settings. A combination of reading, workshop attendance, taking of university courses (e.g., courses or practica in cognitive-behavior modification), and supervised experience can all be helpful in obtaining and/or enhancing the needed skills. Training in medical settings and their rules (formal and informal) by mentors so skilled cannot be overemphasized (Seime et al., 2003). A skilled mentor can help a practitioner to become socialized in the skills needed to function successfully in medical settings (Striefel, 2006a).

The skill and experience of the supervisor is critical in aiding other health professionals to master the culture of medical settings. Granello, Kindsvatter, Ganello, Underfer-Babalis, and Hartwig (2008) described a nice model for using peer consultation to enhance the skills of all supervisors at all levels of skill development. The model consists of group sharing of cases and discussion of services and skill enhancement because of the diversity of perspectives. More and more states are requiring that supervisors receive specific supervisory training; such a model can help supervisors become competent as supervisors, and they must be able to document that training (Granello et al., 2008). Peer consultation is also a good way to enhance clinical treatment skills and even the skill for working effectively in medical settings.

It is important to recognize and respect the fact that in medical settings, the physician is ultimately responsible not only for a patient’s care but also for making decisions that have implications for life and death. In addition, third-party payers have made primary care physicians the gatekeepers on determining what services a client will receive and to whom they will make referrals. As such, it is important to learn the rules and to follow them, including the informal aspects of collaborations (Seime et al., 2003), and to develop a cooperative and collaborative personal style for working with other health care professionals to further the best interests and needs of the patients served. Being in conflict with a patient’s physician is unlikely to be in the best interests of patients. In medical settings, those who receive health care services are always called patients and not clients.

Seime et al. (2003) and Belar and Deardorff (1995) stressed the importance of having a high tolerance for frustration (perhaps biofeedback practitioners will have to practice some of the skills they teach for managing their own stress and frustrations) and for being open, direct, active, energetic, and assertive. In medical settings, physicians expect a fast and almost immediate turn around when they seek a consultation from another health care professional, e.g., someone who offers biofeedback services. The practitioner needs to have the appropriate background, knowledge, interest, and clinical and interpersonal skills if she or he is to deal efficiently and effectively with the many complex patient care issues in a multilayered health care delivery system (Seime et al., 2003).

In a medical setting, a practitioner who also provides biofeedback services might be employed by the owners of the setting, might work under the supervision of a physician or other licensed health care professional, or more likely, he or she will provide consultation on a fee-per-service basis. Because the focus is often not on diagnosing pathologies but rather on promoting good physically and mentally healthy lifestyle changes, it can be difficult to bill for services and receive third-party reimbursement when there isn’t time to make a Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), or ICD-9 diagnosis (Seime et al., 2003). Of course, knowledgeable biofeedback practitioners will consult with others working in medical settings if an appropriate supervisor/mentor is not available to learn how to code and bill correctly and to be reimbursed using the behavioral codes (American Medical Association, 2009) and the Medicare “incident to” care guidelines (Gosfeld, 2001). In addition, it is helpful to learn how and when it is appropriate to have the billing submitted via the primary care physician. The bottom line is that practitioners are ethically and legally expected to know their areas of competence and the scope of practice allowed.
by their license and to practice therein (Striefel 2004b, 2006b).

**Confidentiality**

Confidentiality can be an issue of concern in medical settings, where a prevalent assumption is that it takes too much time and effort to obtain a signed release of information before sharing patient information. In fact, the Health Insurance Portability and Accountability Act (HIPAA) requirements were modified so that signed releases before sharing protected health information (PHI) were deemed unnecessary if the information dealt with patient assessment or treatment, billing, or other administrative issues. Provided the patient had been provided with a copy of a privacy notice, which outlined how PHI will be protected. HIPAA requirements are superseded if state law requirements are more stringent (APA, 2007). Many state laws, for example, the licensing laws for psychologists, include a requirement that licensees adhere to a specific ethics code included in the law. Many of those codes require a signed patient release of records form before confidential patient information is shared. Just violating the code of ethics of a professional association to which one belongs (e.g., that of the Association for Applied Psychophysiology and Biofeedback, 2003) can have negative consequences. Biofeedback practitioners are encouraged to strive for the highest level of ethical functioning, and that means obtaining a patient signed release of information before sharing confidential information. Understanding the rules, formal and informal, on how medical settings operate (e.g., if a physician requests information about a patient from another professional working with that patient, he or she is expected to provide the information in a timely manner, including immediately if it is a face-to-face request) would encourage a biofeedback practitioner to be proactive and to have developed and implemented a system for obtaining informed consent and signed releases of information for sharing PHI with physicians and other team members who are providing health care services to patients.

**Informed Consent**

Obtaining meaningful informed consent can be a complex process (Wise, 2008). It cannot be obtained via one-time-only written form but rather requires an ongoing process and verbal discussion to ensure that the patient has at least a reasonable understanding of what is being proposed before he or she gives consent (Barnett, 2007; Wise, 2008). Wise (2008) suggested that practitioners ask themselves what they would want to know if they or a loved one were contemplating receiving the proposed treatment intervention. Extra time, effort, and patience may be needed when obtaining informed consent in a medical setting (e.g., a hospital) if a patient is under stress, on medications, in pain, a minor, and/or confused by all that is or isn’t happening to him or her. Informed consent should include, at minimum, fees, billing, and collections; expected duration of treatment; potential risks and benefits of the proposed and the major alternative treatments; limits of confidentiality; and goals of treatment (Johnson-Greene, 2008; Striefel 2004a, 2004b). Informed consent also needs to explain the limits of what insurance will or will not cover (Striefel, Rosenthal, Whitehouse, & Schwartz, in press). Informed consent works best when individualized, when it occurs on an ongoing and flexible basis, and when questions are asked to ensure that the patient understands the information provided.

**References**


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