

Informed Consent – Part I

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The use of the phrase 'informed consent' has become much of a cliché. People perhaps use it without appreciating the meaning. I was recently at a meeting in Brussels, and the document we were reviewing spoke about 'withdrawing informed consent'. You do not, of course *withdraw* informed consent; you *withdraw* consent. *Informed consent* is a process. Conversely, at a meeting with the Data Protection commissioner, an insurance company, argued that they obtained 'consent' from a lady in order to look into her hospital file. She was subsequently refused settlement. Was the process of consent a truly informed process? Given the fact it was not explained to her that in the event that she suffered from a related condition she would not get the settlement, one cannot argue that a legal consent was obtained. I will refrain from commenting on how the hospital actually gave them the records of the patient.

There are five stages to the informed consent process. Although it seems complicated, doctors will usually go through them in their minds and it will only take a few moments to consider the stages. Informed consent presumes however the autonomy of the person giving the consent.

Autonomy is derived from the Greek *auto* (self), and *nomos* (control). It therefore speaks of self control. Just as a country exercises control over its territory, a person exercises control over his body. Nowadays, taking decisions 'for the good of the patient' without actually allowing the patient to participate in the process is not respecting the autonomy of the individual. A person who acts autonomously, acts according to his or her own free will (voluntariness); thus understanding what he or she is doing; and acts without any controlling influences. There are many examples one could bring to illustrate these, but of course it is obvious from the start that many categories of people cannot act autonomously (children, elderly with dementia, people who may be under the influence of drugs, those suffering from illness, or even stress). It is the responsibility of the physician to empower the person to see that he/she makes an autonomous choice. One must ask, 'Is this person making a voluntary choice? Has he understood what we are explaining? And are there any controlling influences?'. Controlling influences can be pressure from relatives or friends or perhaps the fear of the physician (people may fear that if they do not do what the doctor is saying, they will not get the full attention of the doctor, which may then abandon their cause).

1. Information

Having said that, we turn briefly to the five conditions. Information. What amount of information do I actually tell or give the patient? When prescribing an antibiotic, do I really have to explain all that is on the package leaflet? It is quite acceptable to follow two basic rules. The first

is to tell what a reasonable person would want to know. This is basically a transposition of the Golden Rule: *Do to others....* Therefore if I am going in for a thyroidectomy, I would want to know that there is a moderate risk of hoarseness as a complication. Someone going in for a prostatectomy has given his consent for that procedure and not for sterilization – which may be a complication. We cannot take for granted that because the gentleman is beyond his reproductive years, then he automatically does not need to function. I once saw a patient being told when waiting outside the operating room that it would be better to remove his testicle in order that his inguinal hernia repair has less chance of recurrence. That is definitely not the ideal circumstance to concede, no matter how much faith the patient has in the doctor.

The second rule is to follow a personalized standard. Some patients merely let the doctor do the decisions. In this case the doctor would still be wise to explain what he or she feels the patient should know. Conversely, some people, perhaps out of anxiety or perhaps because they find it difficult to decide, find that they need a lot of detail, which may even tax on the doctor's patience. Time spent here may make the difference between a fully satisfied patient and one who is not.

2. Understanding

Obvious as it may seem, do we actually make sure the patient has understood? Are we explaining what we have to say under the right conditions? Do we give news or explain outcomes in the hospital corridors; do we give advice on treatment when we have just imparted bad news? Do we allow

moments for people to digest what we have said? In a busy outpatient's department this is not all that easy. Only prudent doctors would put all else aside and focus on the being in front of them. Thankfully most are (prudent). Sometimes the environment we work in does not help people understand. Interruptions (telephone calls, nurses coming in and out of the office, etc) distract doctors, let alone patients. Patients may not yet be ready to take the news and may need time. Understanding really is a process studied considerably in social sciences and perhaps from the ethical point of view all we can ask is 'Have you actually ever read, and made an effort to understand and implement, a chapter from a psychology book, on understanding?'. How often have you seen colleagues on committees who make you wonder what effort they put in to understand patients – they seem to understand only after they would have taken up half the discussion time talking themselves, only to finally say what you or someone else has been saying all along. If only they make the effort to be quiet – and when they do so, actually *think* about what the person is saying rather than what they are going to say themselves. *Understanding...Hmmm!*

In the second part we will deal what constitutes a voluntary choice and competence. ☐

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