Informed Consent – Part II

by **Pierre Mallia** *MD MPhil PhD FRCGP*
Director, Centre for Bioethics, Medical School

In the first part we have discussed the first two stages to the Informed Consent Process. In this second part, we will deal with the last three stages, namely, what constitutes a voluntary choice, competence and consent.

3. Voluntariness

Are we making sure that people are making a voluntary choice? Are they being influenced by relatives or perhaps the situation? We are all influenced to a certain extent by the circumstances that we are in. If I have cancer I may make a so-called voluntary choice to have chemotherapy. But if I *really* had the choice, I would not have chemotherapy. It is the nature of my circumstance that made me make that decision. Without entering the philosophical debate on determinism and free will, it is obvious however that a free choice is not a random one. It follows a process of thinking and understanding. Thinking can only be done if I am given the information to evaluate. I can exercise my right *not to know*, but then I am compromising the information I have with which to think about my condition and make a choice.

However there are clear circumstances which compromise a voluntary choice. *Coercion*, the forcing of someone to make a choice, is the most obvious. People, especially the frail and/or dependent patient, such as an elderly person, may be forced to take medication or to make a decision regarding an operation or entering a home, by their children. A patient of mine decided to enter a home, against her own will, because one of her sons categorically repeated that he will never visit her if she lived with her daughter. He was at loggerhead with his sister's husband. A second way in which a voluntary choice is effected is *manipulation*. Do we try to make things look nicer than they actually are? Do we try to give a better picture or omit telling the patient some information which we are sure will make them change their minds. If we do we are paternalistic, period. This is not to say that we cannot exercise a *therapeutic privilege*, in extreme circumstances when we know that a particular piece of information is going to be harmful to the patient. Neither has it to do with being optimistic. These are in themselves virtuous acts. But being unduly optimistic may actually harm a person by forcing him or her to make a choice that they otherwise would not have made. Perhaps the person would prefer staying at home the last few months of his life instead of doubling the life-span but spending it in and out of hospital and treatment rooms. Manipulation is therefore the thwarting of news in a way that people understand something differently or understand what we want them to understand. Our political news channels are a clear example. You say something in public and one station makes it sound one way and another station makes it sound the exact opposite. *Il tono fa la musica.*

Negligence can even be considered when there is an act of omission – such as not practicing informed consent

4. Competence

This is by far the most important condition. Is the patient competent to make a choice? Obviously, as pointed out, children, demented people and psychotic patients, are all not competent to make a choice. But some older children can be considered competent to participate in their treatment. Certainly paediatricians are used not to give a particular medication because the child has expressed an aversion and moreover asked if he or she can do without it; or perhaps refuse altogether to take it.

Conversely a fever, or simply after just receiving bad news may render me incompetent for a while. Emergency situations are also a clear example of situations in which patients are not always competent. In this circumstance the physician must exercise the time-honoured virtue of prudence and act in order to save life. No one can have a case against someone who practiced the socially accepted ethos of his profession.

5. Consenting

Finally the actual act of giving consent (or refusing). Ideally this is done in writing but morally it is really not required. We witness countless patients signing consent forms which in a court of law will automatically be thrown out. A signature signifies nothing unless the above procedures have been followed and thought through. What is more important is actually making a note that one has been through the informed consent process; and, of course, patient satisfaction. The signing is a mere formality which is completely different from when we sign a business contract – although it should not be. Therefore if I sign a consent form without actually having understood, or without actually having been given the information, I may be competent to sign the document but indeed would not have acted autonomously and therefore that contract does not hold. It is the doctor's responsibility to see that the patient has understood and not merely that he 'told' the patient. Relying on other doctors (those junior to you, for example) may be risky, as at the end of the day it is the person performing the procedure who is responsible. Negligence can even be considered when there is an act of omission – such as not practicing informed consent.

Naturally being incompetent in one area of life need not render me incompetent in another. Therefore epilepsy, notwithstanding being a neurological condition, may render someone incompetent to drive a vehicle, but still able to participate in the treatment and therefore still competent. Whoever said our job was straight forward?

In the following article I will discuss Negligence and Malpractice and following that, we will attempt to debunk the myth of data protection, which *everybody suddenly is speaking about – as if it never existed.*