COMMENT

Comment on "Consent to treatment: practice vis-à-vis principle" by BK Bastia

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Dr Kumar Bastia's article (1) focuses on one of the important components of patient-physician interactions – ensuring that consent by a competent patient for therapy or surgical intervention is given voluntarily and after provision of relevant information that has been clearly understood by the patient. The author's aim, a salutary one, is to alert physicians to the basic elements of an informed consent that are often overlooked or misunderstood by medical practitioners, and several good points are made in this article. However, perhaps intentionally or not, the author seems to transform the informed consent into primarily a legal contract between a "consumer" and an individual (doctor) who "has to render service", and a tool of defence for physicians against malpractice suits. This approach runs the risk of reducing a critical component (the consent) of a fiduciary relationship grounded in the ethical duties of health care professionals towards the distressed who seek their help, to little more than a contract akin to one between a car owner and a mechanic.

In most societies law and ethics interact constantly, overlap at times, and frequently inform each other (2). Although the concept of an informed consent arose within the law, and is generally traced to the judgments in the Nuremberg trial of Nazi doctors after World War II, the underlying message is always an ethical one, namely, respect for the dignity of all persons and their right to make informed decisions about their bodies. It is with this background that the process of informed consent has come to be accepted as the plinth upon which ethical medical practice rests. Although a composite of the legal and the moral, it is the ethical ethos of the informed consent, rather than its legal aspects, that must remain central for health care professionals. It is important for health care professionals to understand that the ethical concept underpinning the informed consent is patient-centred, which then translates into legal protection against harm to patients. Informed consent is not physician-centred in the sense that, although it may help to protect physicians, it is to be understood primarily as an instrument to avoid lawsuits.

If the latter were true, and the author seems to believe so, then the meticulously detailed and documented informed consents that are the norm in the United States would have resulted in the lowest, rather than among the highest, numbers of litigation cases by patients against physicians and hospitals. Lawsuits are more likely to occur when there is a breakdown in communication and trust between patients and their treating physicians, and these can occur despite "legally" sound consents. This is, of course, in line with the author's own observation that "the ethics of trust between patient and doctor is gradually disappearing". It is also the author's (correct) belief that this is leading to an increasing number of malpractice law suits. It would seem to me then that, in order to tackle the problem systematically at its root, we must turn our attention as teachers and practitioners of medicine, to the reasons behind the increasing failing of health care professionals in their ethical duties towards patients, rather than assuming a defensive mode by only focusing on the "legal point of view" when it comes to the matter of informed consent.

The next point I would like to make is about a common misconception that an informed consent is the physical act of signing a piece of paper (with relevant information listed and appropriate signatures in place) by the patient after the physician has informed him/her of the details of the proposed procedure, risks/benefits, etc. Such a document is neither legally nor ethically sound. An informed consent is a *process* and not a "one-off" *event* of signatures on paper. It means a two-way dialogue (and not a one-way information flow from physician to patient) as often as needed and whenever possible (depending on the nature of the illness), a respectful exchange of views and concerns, and an ironing out of differences if any exist between the patient and the physician. The aim should be to help patients make a considered decision regarding their therapy. This decision, in some instances, may be a refusal on their part. (It is documentation of these patient-physician discussions in the medical chart, rather than a signed informed consent, that can provide the best "protection" for physicians in cases of litigation against them [3].) Above all, the process for an informed consent must rest on a respectful and compassionate relationship with a fellow human being made vulnerable by illness, and should not be understood in isolation from the rest of his/her health care plan (4).

The last point I will make is that many of us practise medicine in societies that differ in significant ways from those in which contemporary bioethics took shape, and we must remain sensitive to indigenous values and norms, family dynamics and local socio-economic realities. All these factors colour physician-patient interactions and relationships, sometimes to the benefit of patients and at others times to their detriment. It is beyond the scope of this commentary to explore the international variations in standards of practice related to

disclosure of information, the differing cultural understandings of what constitutes respect for persons and patient autonomy, or the role of families in medical decision making. However, these are areas receiving increasing attention by sociologists, bioethicists and physicians (5, 6), and should not be ignored.

In the final analysis, the complex nature of illnesses and therapies is such that there is no "cookbook" that can provide a single, generic recipe for taking valid informed consent. What are available are broad legal and ethical frameworks that work best in the hands of caring, compassionate and ethical health care professionals.

References

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