Problems of Informed Consent

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Age of Consent

- Standard problem of where to fix the age, and also charge of arbitrariness at using age as a marker for competence
- Recognition that any age might be a defeasible presumption of incompetence can bring its own problems:
- *Gillick* [1985]: 'the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed.' (Lord Scarman)
- Subsequent 'retreat': (a) parental consent not removed and could still trump even a mature minor's consent; (b) a mature minor's refusal of life saving or extending treatment was trumped by best interests (and especially value of life)
- How to determine incapacity if not by simple age? Important principle in UK Mental Capacity Act [2005]: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision' (1 [4])
- Any assessment of a person's capacity to consent should be made independently of an evaluation of the prudence of her choices.
- Yet surely one critical evidential support for incapacity is the imprudence of a decision in respect of some particular matter.
- And yet – in response – in respect of adults where there is a general presumption of competence, the imprudence of a particular decision is not allowed to serve as a reason to defeat that presumption.

Consent v. informed consent

- We might distinguish between consent *simpliciter* where there is a failure (*lack* of consent) if the person is completely ignorant that an action is being done to her. Someone does not even know that something is done
- And cases of *deficient* consent where there is a lack of relevant information: person (patient) knows that a medical procedure is being performed but does not know enough about that procedure to give full consent.
- What then is the clinician obligated to inform the patient?
  The plausible initial thought is that if the patient is not informed of something that would make a difference to the giving and withholding of consent then that information is material and relevant to the consent.

Obligation to inform

- What must the clinician tell the patient? Everything that is in this sense material and relevant.
- However, in the first place it is important to provide the right justification for any obligation to provide information.
- A clinician arguably has a duty to tell a patient the truth - although the doctrine of *therapeutic privilege* allows that in (admittedly very uncommon) situations a doctor might withhold diagnostic and prognostic information if she judged that disclosure posed very real and serious problems to the health of the patient (such as possible suicide).
- Not clear that obligation to provide information derives straightforwardly from obligation to secure informed consent. A doctor has a reason to do that which is a means to the obtaining of consent, namely to give the patient relevant information.
- However this reason does not amount to an obligation on the doctor's part to inform his patient. A doctor is obligated to do that which promotes the well-being of his patient and if he believes that a procedure does promote the patient's well-being then she ought to persuade the patient to have the operation, that is, give relevant information.
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Scope of obligation

- What must the doctor tell the patient? Whatever is material and relevant – i.e. would make a difference? But by which standards? Note that there are three possibilities
- Objective reasonable: whatever *any reasonable* person would need to know in order to make an informed decision;
- Subjective reasonable patient: whatever a reasonable person with this patient's beliefs and values would need to know, etc. (so imagine that this patient is particularly worried about some possible side effects)
- Reasonable doctor: whatever a reasonable doctor would tell a patient. *Bolam* [*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582]test: 'that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'

Chester v. Afshar [2004] UK HL 41

- Facts of case: A patient (Chester) is not warned about a small risk attendant on surgery (approx 1%) of cauda equina syndrome, which might result in serious disability. She consents to surgery and the risk eventuates, leaving her disabled. There was no evidence of medical negligence on the part of the surgeon (Afshar) in terms of the surgical procedure. Where some clinical negligence suits have rested upon the claim that *had* the patient been informed of certain risks he or she would not have given her consent to the intervention in question, the striking thing about *Chester v Afshar* is that Chester concedes that had she known of the risk she would have still consented to surgery, though perhaps not on that day, with that particular surgeon. Afshar's failure to inform is thus not directly causally relevant to the occurrence of the harm.

Negligent?

- House of Lords found Afshar to be negligent. Negligence requires both:
- Culpable failure or omission
- Attribution of harm as a result of the omission/failure
- Now, Afshar did not fail to do something any reasonable clinicians would have done (*Bolam* test) either in his consultation or surgery
- And the harm – the resulting disability – cannot be attributed to his failure since had he told her of the risk she would still have the operation albeit later.
- Fallacious causal reasoning: '[I]t is a distinctive feature of the present case that but for the surgeon's negligent failure to warn the claimant of the small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. It could therefore be said that the breach of the surgeon resulted in the very injury about which the claimant was entitled to be warned (Lord Steyn)
- The probability of the occurrence of the harm is the same whenever the operation is performed. It is false to claim that because it did occur at t_1 (when the operation did take place) its probability at the later hypothetical time t_2 is reduced.
- Yet Afshar *wronged* Chester

‘Dignitary harm’

- Failure to inform did not vitiate the consent inasmuch as what is needed for informed consent is only that which would make a difference
- Afshar did not act paternalistically inasmuch as he did not withhold information on the grounds that he thought such withholding was good for Chester in the face of her own and different judgment.
- He did – arrogance? Laziness? – deny her the chance fully to deliberate on the matter and to that end disrespected her as a deliberating agent.
- Imagine I move a chess piece of yours for you. I act paternalistically if I believe you would make a different (and in my view worse) move. But if I move your chess piece as I know you would anyway I still deprive you of something that is rightfully yours – the opportunity to make *your move yourself*.
- Afshar deprived Chester or making her own mind up herself – by and for herself.

Information and Understanding

- Patients have not only to be provided with relevant information but be in a position to *understand* that information. Raises two issues:
- Is the clinician obligated not only to provide relevant information but to ensure that it is understood? What does that require and what is it reasonable to demand of a clinician?
- How do we assess the relevant capacity of the patient? What is required in order to understand information?

Referential opacity

- Consent is not to a procedure or treatment as such; it is to a proposition that involves a particular description. And familiar problem from philosophy of language. I may know that something is the case under one description but not know that thing under another.
- Example: in the Alder Hey case parents complained about the use by the hospital of the organs of their deceased babies. The clinicians claimed that the parents had consented to the posthumous removal, storage and use of what was referred to as ‘tissue’. However the clinicians understand this term broadly to encompass organs (hearts, kidneys etc.) whereas the patients understood ‘tissue’ more narrowly and to exclude organs.

Value of autonomy

- *Kantian*: Kantians deny that Kant himself is a proper source of an answer to the question of why autonomy (as a source of consent) is valuable. What they understand as autonomy — namely the exercise of practical reason in conformity with the moral law — merits respect but it is some distance removed from what is meant by most of those who now use the term autonomy.
- Kantian autonomy may give you a duty (of doctor) not to deceive and not to coerce, but nothing like the doctrine of informed consent.
- Personal independence in leading my life as I judge best provides consequentialist justification
- But these are subject to 'on balance' and 'as a rule' constraints: it need not always be wrong to overrule an autonomous decision or consent

Relational autonomy

- Individuals are indeed in important relationships to others; how they understand themselves, how they are defined, involves reference to these relationships. Individuals are indeed embedded in such relationships
- The normative power to consent is possessed and exercised by individuals and not by sets of related individuals.

Autonomy v bodily self-ownership

- The wrongness of – for example – taking a simple painless and harmless mouth swab is best understood as an invasion of another's body and not as a violation of autonomy. The former does not reduce to the latter.
- For the latter construed as the power to make critical life choices or to lead a life as a whole as one chooses cannot explain what is wrong with the unconsented mouth swab.
- Two attempts to explain the wrong of bodily trespass in terms of 'personal sovereignty':
- (A) Arthur Ripstein ('Beyond the harm principle'): 'Use and injury exhaust the space of possible violations of sovereignty'.
- But a harmless bodily trespass such as a mouth swab need not be injurious nor motivated by the end of use by another. It may be wrong *just* because it is a trespass.
- (B) Joel Feinberg : personal sovereignty and choice is where and how to 'move my body through public space'.
- However the wrong of bodily trespass is not a simple correlate of a right to move one's own body through space.
- Moreover not all personal choice *is* about moving one's body through public space (Consider the freedom of thought and conscience).