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The Alchemy of Informed Consent[1]

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Carl Schneider's extraordinarily nuanced and sensitive study of autonomy[2] is a needed and welcome elaboration of the myriad empirical reasons why the sacred bioethical cow have given sour milk and rancid butter over the years. The case he makes for why patients are resistant to assuming the burdens of their own medical decision-making is compelling, both in its psychological sophistication and in its exposure of the off-putting and discouraging characteristics of medical bureaucracy and physician habits. And his proposal for a return to the rules of civil intercourse on the part of physicians are most welcome and not to be disputed. If widely implemented, they should substantially improve the atmosphere of relations between patients and physicians.

So, what, if anything, is to be said about his diagnoses and prescriptions, other than "Right on!?"

Schneider's book is, from one perspective, curiously incomplete. The wishes and interests of patients are detailed in all their rich variety. The benefits and disbenefits of the new organizations of medicine are characterized honestly and fairly. But, the plaints of physicians about patient suspicion and squeamishness are brushed off, relatively speaking, as the natural outcome of those forces that impinge on the patient. To be fair and balanced, docs deserve a better representation in this court of bioethics.

In the rush to counter principlist tendencies in bioethics with situationally sensitive characterizations of the plights of patients, the full range of reasons for the principles of bioethics as regards the duties of patients in the context of medical decision-making and of the moral needs of physicians is not fully explored. Schneider devotes less than a page to the latter subjects, and any full reconsideration of the relations between physicians and patients has, if it is to hope for success, to address this dimension of the issues with equal sensitivity.

The space is not adequate, even if the author were, for my providing such a complete set of considerations. Rather, I hope to establish that there is a legitimate set of further observations involved in patient responsibility to be considered by bioethics from the point of view of physicians, and to indicate just what some of

those issues are. In what follows, I give an argument that appears to support something like mandatory autonomy. I am not sure whether I personally would endorse it. Rather, I intend it as a foil to stimulate further exploration of the issues raised in Schneider's work.

1. *Physicians have a duty not to commit battery on their patients.* This truism, part of the rationale for such rules as the requirement of informed consent for treatment, has long been recognized from the patient's point of view. That is, since an unconsented touching is a battery under the law, apart from exceptional, emergency situations where consent is presumed physicians need their patients' consent in order to ply their craft. Absent such consent, surgery becomes stabbing, chemotherapy becomes poisoning, and urological examinations become sexual assaults. Nor is the defense of good intentions a sufficient excusing factor. The consent of the patient is recognized in the law as essential, and the provision of unwanted medical care is not excused by the benevolent intentions of the provider.

2. *Therefore, physicians have a right not to commit a battery on their patients.* Although sounding odd, this follows directly from the duty mentioned in the first observation, together with the general moral principle that "ought implies can." Any individual having a duty to do something has a right to do it, in that such a right at least involves a right against others who might place obstacles in the way of satisfying that duty. For example, if a divorced father has a duty to visit with his or her child regularly, he has a right that the child be available for such visitations. Sometimes such rights imply obligations on the part of others not merely not to interfere but actually to provide material elements necessary to doing one's duty. If I have a duty to repay you the $500 I borrowed, and I have sufficient funds in my bank account, I have a right to extract that money necessary to pay off my loan, and that right is one against my bank to assist in my withdrawal.

3. *What keeps a physician's touching of a patient from being a battery is the patient's consent.* We would no doubt want to qualify this claim for children and other persons lacking capacity, but the arrangements made in such cases are designed to have appropriate (not just any) decision-makers act on behalf of those incapable of competent self-determination. Generally, it is the consent of the patient that keeps a physician's touching from crossing the line of battery and assault.

4. *Therefore, physicians have a right to the consent of their patients to the acts that constitute the physicians' treatment.* This is not an absolute right to consent; physicians are not some special class of individuals who practice by divine right. Rather, the practice of medicine is a privilege extended by the patient, and the extension of such privilege is normally through the consent of the patient or the patient's representative or guardian. In the case of emergency treatment, where the patient's life hangs in the balance and no advance directive is evident, consent is presumed for such time as the patient's life is in the balance and no due representative of the patient can be consulted.

5. *Therefore, patients have a duty to give consent to the acts that constitute their physicians' treatments.* I do not mean this duty to be construed as absolute. Cruzan has taught us that, in the public morality of this society, a patient may refuse

treatment, even if it is life-sustaining, such refusal being finally determinative of the responsibilities and rights of involved physicians. Rather, when patients seek treatment by physicians, it is the consent of those patients to whatever treatment is provided that gives physicians what they need in order to avoid battering or assaulting their patients in providing that treatment.

We are at a critical juncture in the argument. For, it might seem that a patient can give a blanket consent to whatever the physician thinks best, and thereby shift the material burden of deciding on a treatment onto the physician. (Schneider contemplates such a practice and regards it rather benignly, noting that it is a common expression of patients' wishes and acknowledging that physicians meet such a stance with mixed feelings, but offering no principled argument against allowing such a shift.)

Let us assume that it makes sense to say that a patient has consented to a treatment regimen, using language like "Whatever you think best, doctor," even when the patient doesn't know what the doctor does think best in the situation. What, if anything, is authorized by such an act of speech?

I can envision three possible responses. (1) The patient might be said to have *authorized anything the physician thinks best.* In that case, nothing the physician does and "thinks best" would constitute a battery: the physician might sterilize the patient in thinking it best the patient not have any more children, or the physician might remove a healthy kidney in thinking it best another patient receive a transplanted organ. Or, (2) the patient might be said to have *authorized any standard medical procedure typically employed for patients with the particular problems this patient has.* Under such a conception (which I suspect Schneider would countenance under his notion of "Guidelines"), a naive or incautious Jehovah's witness would have unknowingly authorized a transfusion, and one who believes in certain versions of bodily resurrection might unknowingly consent to amputation and cremation of the amputated limb. Or, (3) the patient who attempts to consent without knowledge *hasn't really consented to anything at all.*

The consequences of (1) and (2) are unacceptable. (1) is wholly unacceptable on the face of it; (2) is unacceptable in a society characterized by an enormous diversity of beliefs about bodily matters as a rule of procedure when physician and patient do not come into the medical situation with fully consonant values and beliefs. That leaves us with (3). And the consequence of (3) is this:

6. *Patients who seek to give consent that is not knowing consent fail in their duty to their physicians: consent must be informed.*

For a long time I thought that the upshot of this was a kind of negotiation that needed to go on between the patient who was reluctant to make substantive decisions about his or her care and the physician who undertook treatment of that patient. One might still argue that physicians, while they have the theoretical right to insist on their patient's informed consent as a condition of treatment, routinely can and often should excuse patients from such an obligation. All I have shown, it can be objected, is that patients have no *right* to waive informed consent and remain blissfully ignorant; physicians may, and out of decency probably should, extend the *privilege*

to give blanket, uninformed consent out of respect for their squeamishness or their sense of being overwhelmed by their condition. After all, isn't the treatment situation somewhat analogous to a contract? Each party brings his or her terms to the table, and if a set of those terms are found to be acceptable to everyone, the bargain is struck. And if a part of that bargain is the "do whatever you think best, Doctor" attitude of the patient, and the physician is willing to assume the burden, where's the harm?

It has occurred to me, however, that physicians have another source of obligations besides the wishes of and agreements with their patients. Every physician takes, upon admission to the profession, the Hippocratic Oath. While some elements have fallen by the wayside in recent decades, one has remained central: Above All, Do No Harm. As medicine is now recognized in what is effectively the Social Contract, it is still largely a self-regulating profession that enjoys the privileges of monopoly and high status in exchange for adhering to the standards it has set itself and publicly proclaims.

It is an interesting historical fact that the informed consent doctrine emerged as medicine moved from a relatively passive art in which achieving a correct diagnosis of the patient's condition and prognosis of the patient's likely medical future was the goal, to an admixture of art and science in which the causes of ill health are dealt with aggressively. The Hippocratic injunction, more fully "to help, or at least to do no harm," has perhaps never been more apt than in this time of chemotherapy, cardio-pulmonary resuscitation, surgery, radiotherapy, and gene therapy.

What is it that keeps these invasions of our persons, our bodies, our minds, our germ cells and somatic cells, from being harms? They indeed are harms if performed by enemy soldiers, criminals, terrorists. They are harms even if performed by medical personnel if done so without our knowledge and consent, direct or through a proxy. It is the knowledgeable consent, the assent, the agreement of the patient to such invasions that transforms them from harms into treatments, and that converts the resultant scars, deformities, and functional losses from injuries into unfortunate consequences. This, if you will, is the alchemy of informed consent.

So, the final element in the case for informed consent being a patient's duty to the physician is in place. Informed consent to treatment is needed by the physician and surgeon, needed as a crucial element in the preservation of the physician's oath. The practice of modern medicine can avoid harm only with the informed, knowledgeable, freely given consent of the patient. Hence the final principle:

7. *Physicians need informed consent if their practice is to remain consistent with the Hippocratic Oath. That need is not satisfied if either patients or physicians waive their respective rights as regards informed consent. Hence, physicians have an absolute duty to obtain informed consent to invasive procedures ; patients have a duty, consistent with their capacities, either to give informed consent or to refuse treatment. They may not morally opt for blanket consent*

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In correspondence, Carl Schneider has raised with me the fundamental question he raises in his book, that of the practicality of principlist ethics. "How capable are patients of meeting the standards you set for them? How capable are doctors (etc.) of helping them do so in any satisfactory way?" Behind his questions is a seemingly irrefutable argument against my position, an argument that turns on the dictum, "Ought implies Can." If my requirements of patients and physicians are not capable of being met, that is, if neither "Can" meet my requirements, then neither "Ought " to meet them: the requirements are hollow and do not express duties at all. Is there any way to view such duty-claims other than in a way that they fall to the limitations of humans imbedded in their lives and struggles?

Ironically, Schneider has provided a direction in which to think about these difficulties. He suggests nearly a dozen courtesies that physicians would do well to adopt as measures that would ease the experiences of their patients and foster a better, less confrontational atmosphere in which the pursuit of healing can better occur. My suggestion is that Schneider's task is incomplete until a similar list of "courtesies" is commended to the patient and the patient's family. Such a list would be a step in the direction of countering bioethics' position that informed consent is (only) a right of the patient against the physician. The suspicions besetting medicine call for a recognition that the obligations of the physician-patient relationship are not one-sided, but that physicians have rights and patients responsibilities too, so that they may come together in recognition of duties owed to one another.

I suppose that my "requirements" should be taken as descriptive of the ideal. Do any physicians never do harm? I suspect even pathologists cannot evade the charge. Ought they to do no harm? To say that they ought may not imply that they can, but rather that they should strive mightily to avoid harming their patients. Should patients be expected to meet these standards? Even if they are not able, there is something more noble about a patient who recognizes that to ask another to undertake the task of healing is to ask a great deal, and who struggles, despite relative ignorance, fear, pain, and despair, to give the physician the forgiveness of informed consent, as compared with the patient who treats the physician as a servo-mechanism and simply commands, "Physician, heal myself!"

Notes

1. Portions of this paper are based on the author's "Informed Consent: Patient's Right or Patient's Duty? *J Med Phil* 10 (1985): 183-197.

2. Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (New York: Oxford University Press, 1998.