Moral quality entails a high standard of informed consent

The moral quality of health care is reflected by the degree to which it incorporates the right of patients to exercise their autonomy. The clinical duty of care to respect this right differentiates human from veterinary medicine. Animals cannot plan for, and make autonomous choices about, the future because they lack the uniquely human attributes of being able to formulate aims, and beliefs about how to achieve them. This is one of the reasons why respect for these attributes is tantamount to respect for human dignity itself.

Generally, people think that others have a moral duty not to force or otherwise manipulate them into actions which they would not choose for themselves. In other words we think that we have a right to expect others to respect our autonomy—that we have a legitimate moral claim on them to do so. We think that we are due this respect, because of our own unique human attributes. Thus we have no consistent option but to respect the autonomy of others with the same attributes. And as all competent humans also possess these same attributes then it follows that we must respect their autonomy as well.

The moral duty of clinicians to respect the autonomy of their competent patients is a special case of this general argument. This duty translates into the more specific moral right of such patients to agree to or refuse medical treatment on the basis of information about it. To suggest otherwise would be to equate patients with slaves to whom clinicians could do anything they liked. Thus the duty to respect the right to informed consent reduces to the duty not to coerce competent patients. Further, clinicians must do their best to ensure that patients from whom they wish to gain consent are competent to provide it. Although incompetent patients deserve a high standard of care and protection, it makes no sense to ask them to help to plan their medical destiny when they are incapable of doing so. And finally, sufficient information must be provided to competent patients about their condition, proposed treatments, possible alternatives, side effects, and hazards. Only information of this kind will ensure that competent patients have the potential for educated choice.

Apart from helping to ensure the moral quality of clinical practice, informed consent is also important for its pragmatic success. If patients think that clinicians will ignore their views about appropriate care and acceptable risks then irrevocable damage to the clinical relation may result. Even if patients are forced by the circumstances of the acuteness of their illnesses to receive treatment, they may be reticent to be completely honest about details of their clinical history or cooperative in other ways which can impact on the success of their treatment. When the need for treatment is not acute but elective, a relation of trust becomes essential. Without it, patients will almost certainly not conform to treatment and after care—if they agree to treatment at all.

There is nothing particularly original in these observations. All of the regulatory institutions of medicine stress the importance of the duty to provide patients with sufficient information to make informed judgements about treatment. The same applies for the organisations which provide professional insurance for clinicians—for example:

- The General Medical Council: “Successful relationships between doctors and patients depend on trust. To establish and maintain trust you must (among other things): give patients the information they ask for or need about their condition, its treatment and prognosis (and)...respect the right of patients to be fully involved in decisions about their care.”
- The British Medical Association: “As a prerequisite for choosing treatment, patients have the right to receive information from doctors and to discuss the benefits and risks of appropriate treatment options.”
- The Medical Defence Union: “The competent adult patient has a fundamental right to give, or withhold, consent to examination, investigation or treatment...Doctors, dentists, nurses and other healthcare professionals have a duty to explain to the patient, in non-technical language, the nature, purpose and material risks of the proposed procedure.”

And so it goes on.

Because of such arguments and professional policies, it would seem that informed consent would constitute a prominent dimension of clinical practice in the United Kingdom. Yet there is good reason to think that this is not always so and that to this extent the moral quality of related health care is poor. For example, many of the complaints made by patients about their clinical care do not concern treatment itself but rather the poor communication of information provided or the unwillingness to communicate it altogether. The same picture even holds for informed consent in clinical research, where, as the patient may be incurring unknown risks and may not benefit from treatment, there is an even stronger moral obligation to obtain their educated agreement before proceeding. Most patients certainly seem to want to make therapeutic choices after having been given relevant information and the chance to ask questions about it.
There are many reasons for this sad state of affairs. Until recently, clinicians in the United Kingdom have received little if any formal training in ethics or in communication skills. As a result they have not been aware of the extent of their moral and professional obligations and have lacked the practical abilities to put these into practice.13 Equally, young doctors are often unacceptably asked to obtain consent from patients about procedures with which they may not be that familiar.14 Under such circumstances, it is hardly surprising that they may be tempted to cut corners. The situation is especially dire in areas where there is a high percentage of patients who do not speak English as their first language, if they understand it at all. On top of the preceding problems, scarce resources may mean that the availability of translators and advocates is limited, negatively impacting on the quality of whatever consent for treatment is obtained.15

Unfortunately, the law about informed consent in the United Kingdom makes matters even worse. Although it is true that patients have a general right to information, in law the right is so qualified that it hardly can be said to exist. On the one hand, doctors risk a claim for battery if they touch a patient without giving them information about what they propose to do and why. Yet they only have to provide such information “in broad terms”, leaving open what this might mean in practice.16 On the other hand, although a claim of negligence may be incurred if appropriate information about risks of treatment is not provided, the legal standard of disclosure is also weak because it is determined with reference to any “responsible body of professional opinion”, no matter how unrepresentative.17 Thus, for example, in the United Kingdom, clinicians have no legal obligation to disclose the kind and degree of information about risks which it might be argued that any reasonable person would wish to have before agreeing to be treated.

If all of this were not enough, the Department of Health has issued a model form for obtaining informed consent from patients which is widely used in hospitals throughout the United Kingdom.18 It too actively encourages clinicians to be overly economical with information. For example, little space is provided to outline the information which has been communicated to patients. Indeed, there is really only enough room on the form to write in the name of the proposed treatment! Further, the form provides patients with little guidance about the rights which they do have about consent to treatment. Finally, clinicians using the form are not given adequate advice about the moral and legal boundaries of their professional responsibilities. For example, clinicians should only provide treatments for competent patients who have lost consciousness if their life is at stake or they are subject to serious and permanent disability: treatment which is “necessary” in this strict sense. Many, however, do not realise this, sometimes with disastrous consequences.19

Against this rather dismal background, this issue of *Quality in Health Care* contains an interesting survey of opinion about informed consent from both patients and clinicians.20 This survey was part of a study on the usefulness of a pamphlet published by the Royal College of Surgeons intended to educate patients about the Department of Health consent form and some of their moral and legal rights in relation to it. The survey confirms the findings of many other investigations. On the one hand, patients generally want to know what clinicians propose to do to them, what and with what probable consequences. On the other hand, many clinicians underestimate the desire of patients for information and have a correspondingly low level of interest in the consent process itself.

Despite its merits, one arguable weakness in the study is its uncritical approach to the Department’s consent form. Perhaps understandably no attempt is made to criticise either the form or the pamphlet designed by the Royal College to introduce and explain it. Indeed, being so uncritical, the study gives the unfortunate impression of agreeing with the approach of the government to obtaining consent. Nevertheless, the study shows that patients find it helpful to have some, albeit inadequate, information about their rights when giving consent.

Ironically, we have to return to the Royal College of Surgeons for better news. It has just published *The Surgeon’s Duty of Care: Guidance for Surgeons on Ethical and Legal Issues*. This explicitly endorses a higher standard of disclosure of information than the Department of Health proforma or the College’s own pamphlet designed to explain it. Many of the conclusions of this new publication can be read as an implicit condemnation of the current policy vacuum from the Department about informed consent. For example, it advocates the standard of the “reasonable person” to clinicians in deciding what type and how much information to communicate, making the point that “surgeons should always act toward patients in ways in which they would wish other surgeons to treat them, their families, and friends.”21

In the absence of morally acceptable guidance from the Department of Health about informed consent, it is hardly surprising that some hospitals in the United Kingdom are independently developing their own improved policies and associated consent forms—for example, at the Royal Hospitals Trust in East London. The government and the judiciary should follow suit before they are even more embarrassingly left morally behind.

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