

Virtual Mentor

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FROM THE EDITOR

The Less-Told Stories of Informed Consent

So much is written about informed consent—from how students and residents are taught to “consent” a patient (ugh) to the challenging of patients’ decision-making capability should they refuse recommended treatment. Often missing from these war(d) stories is a discussion of when in the course of ongoing patient care consent to treatment should be renegotiated. When a patient comes to the clinic or office, one assumes that he or she agrees to be asked questions about health history and to be examined. At what point in the care of that patient, though, is consent needed for a specific test or treatment intervention? And if special consent *is* required, for a lumbar puncture, say, must it be written, or will an oral consent, a nod of the head, or just the absence of a refusal suffice?

In this issue of *Virtual Mentor*, we examine the border between implicit, assumed consent and the place where explicit patient consent must be secured. We also examine two separate but equally important questions: how much information satisfies the legal and ethical stipulations that consent be “informed” and how convinced are we that the consent patients offer truly represents their understanding and acceptance of the diagnosis and treatment options the physician has presented?

Each of the four clinical cases explores a situation in which a physician confronts a serious consent question. Would a walk-in patient at a free clinic bolt if a doctor told him of the reporting requirements that go along with his HIV test? Or can the doctor withhold that information, for the patient’s good or the good of a third party—namely, the patient’s life partner? A second case places a physician in an emergency department when an intoxicated patient with head trauma refuses to cooperate with tests or scans. When is it ethical to override such a patient’s refusal of a head scan? Again, this is a serious ethical problem for the physician, with possible liability exposure as well. As a complement to this case, the clinical pearl details the classification and medical evaluation for traumatic brain injury.

The third case involves a teen whose cancer has returned. Treatment options that have toxic side effects and represent the patient’s best chance for cure are tough enough to explain to an adult, and mature minors merit special consideration. Can the teenager refuse treatment? Should the doctor downplay the effects of a therapy in an effort to convince the teen to begin treatment? Finally, recognizing that most physicians face the physical exam encounter daily, our fourth case explores the line between assumed and explicit consent during sensitive aspects of the routine physical.

Teaching about informed consent is a key to improving the quality of patient consent. This month's medical education article looks at that subject closely. How do subtle differences in the way difficult choices are framed influence the likelihood that consent will be given—or refused? Competence to consent to treatment is not always self-evident. Paul Appelbaum's classic article on that topic is the target of our journal discussion. Law has developed around consent controversies and has helped define the doctor's task of explaining treatment options to patients. As the health law article explains, the classic case of *Canterbury v. Spence* based its guidelines for the information patients should receive on "reasonable person" and "reasonable physician" standards—what would a reasonable person want to know? What would a reasonable physician consider "material" to the patient's decision?

Sometimes those who most need protection cannot consent for themselves to medical treatment or research. Wards of the state are a prime example of this sort of vulnerable population, and our policy forum article examines the importance of appointing effective guardians to watch out for these minors' rights.

The medicine and society column takes on the real question at the heart of many of these boundary cases of informed consent at work: Does the informed consent process—as currently practiced in the U.S.—truly elicit patient preferences, or does it merely allow patients to select which of the physician-determined options is most acceptable (or least unacceptable) to them?

Finally, we'd like to thank Ankit Shah, MD, JD, for suggesting the month's topic and working on the issue's case development and article outline for us.

Sincerely,

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