

# Informed consent (ethics)

Each patient must be made to understand that with every measure that concerns him, with every diagnostic or therapeutic intervention, this should be done not only with his knowledge, but also with his consent. This fact is self-evident. In our recent and current circumstances, this was not and is not the case. Many people have the anxious and depressing experience of being in a medical facility where "no one was talking to them" because the doctor or nurse did not see fit to tell them what was wrong with them and what was going to happen to them. Not only ``requesting consent, *but also simple ``informing* is considered superfluous. It is sadly grotesque that many doctors have had this experience when they themselves became patients, but still treated their patients in the same way. This distortion of the professional role and often of the physician's personality itself is caused by the ``bureaucratic model (*see chapter 7, 8), which is reproduced in this way.*

Failure to comply with this rule means ``disrespecting the principle of patient autonomy. *It is contrary to both ethical considerations (ignoring the essential purpose of the other) and purely medical considerations (impossibility of the patient's cooperation with treatment). The depersonalized patient then reacts with resignation. Any unpopularity of doctors has its main source right here.*

## Doctor-Patient Relationship

If the doctor-patient relationship is to correspond to the ``partnership model, *it must be a ``dialogue.* If the patient is to be a partner, he cannot be a "mere object", but a "co-author" of all decisions concerning his treatment, or at least he must "agree" with them. He can certainly give up his share in the decisions "voluntarily and authorize the doctor" himself. This decision is acceptable if it is truly voluntary. The doctor should not maneuver the patient into it (e.g. by suggesting uncertainty and helplessness).

The necessary condition (*conditio sine qua non*) of every serious doctor's decision is therefore the patient's *consent.* In order to be qualified, competent, the patient must be *properly instructed.* That's why we talk about *'informed consent.*

## Patient Competence to Consent

What does the patient need to know in order for his consent to be considered competent?

He should understand the nature of his illness (including the prognosis) and its treatment. He should know the therapeutic procedures that come into consideration and their risks (R/B = risk/benefit ratio), if this is significant, also their costs (C/B = cost/benefit ratio), and of course also the degree of their burden including hardship (pain, etc.). It depends on the pedagogic and psychological (psychotherapeutic) abilities of the doctor, who should choose such a method of communication so that its content is intellectually and emotionally accessible to the patient. If the doctor has adopted a style of dealing with patients that corresponds to a partner relationship (if, with his attitude, he educates them to an appropriate attitude), he will not have particular difficulties with this serious message. However, a doctor-bureaucrat or a doctor-expert, accustomed to depersonalizing his patients, can hardly avoid them, while they have long since resigned themselves to open communication as a partner.

## Verbal Consent

In simple situations, such a message can be one-time (perhaps even in a few sentences in the dental chair), in more complex ones it will require several "educational lessons". The doctor *verifies that the patient has properly understood.* He does not style himself into the role of a coldly matter-of-fact neutral, but rather remains himself (and thereby shows his participation), recommends, or does not recommend, and gives clear reasons for both. He will strongly draw attention to the binding nature of those procedures that should not be interrupted (eg antibiotic peels). When he has made sure that the patient understands and that he is thinking responsibly, he asks him for a decision or to agree to his proposal. *Mutatis mutandis* (= if we change what needs to be changed) this also applies to the parents of a minor child. Let's remember the patient's right to change a decision once made (if it is technically possible).

## Patient and physician access to informed consent

There is no need to hide that the principle of informed consent presupposes a certain minimum of psychological integrity of both the patient and the doctor. In our current conditions, marked by forty years of state nursing dirigisme and the evils of socialist health care, let us count on our patients with a higher degree of passivity and dependence, with an insufficient level of medical education, i.e. with a reluctance to think independently and co-decide about their illness and its treatment. Often, against our will, we will be forced to take a paternalistic attitude towards the satisfaction of our less engaged patients, who will be happy to empower us even to make important medical decisions without asking for their justification. Let this situation be an incentive for us to patiently educate them to greater independence: despite their lack of interest, let us inform them and ask for their consent. In Western democracies 20 to 30 years ago, the principle of informed consent was asserted against the inertia of patients and some medical circles. Today it is commonplace there, mostly in the USA. At the same time, it was not always an altruistic motive that led her to life, but - a self-defense perspective, to which legal practice made the

doctor. The legal model, widespread especially in the USA, also includes the fact that dissatisfied patients go to court. This was consistently based on the contractual nature of the doctor-patient relationship and insisted on the patient's informed consent.

## Minor Actions/Emergencies

For completely routine procedures (measurement of temperature, blood pressure, anesthetic injection), we do not require the patient's explicit "yes" after they have been announced, as we expect it to be said with probability equal to certainty. We're talking about **expected consent here. - In urgent situations requiring quick life-saving procedures, when the patient is often unconscious, we do not waste time finding consent, because we assume with probability equal to certainty that we would receive it. We are talking about implied consent.**

## Incompetent patient

We cannot rely on informed consent where it is inherently impossible, i.e. with children and the mentally severely disabled (see chapter 8/C). The legislation refers us to their legal representatives, it does not bind us to anything in this regard. However, respect for the dignity of their person is. Using all of our psychotherapeutic skill, we should bring the meaning of our actions to them in a reasonable way (and not act like veterinarians).

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