

# Consent to treatment

## Trust matters as much as information

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The legal and moral status of the concept of consent are examined. The notion of informed consent as the sole basis for acceptable treatment is found to raise moral difficulties and to have potentially damaging side-effects on the relationship between doctors and patients. It is argued that developing trust between doctor and patient is crucial to obtaining valid consent.

### Legal status of consent

The practice of medicine depends on consent: but what constitutes valid consent and how to obtain it, continues to pose problems for psychiatrists and other doctors (Jones, 1995; Mitchell, 1995; Burns & Harris, 1996; Delaney *et al.*, 1996). For consent to be valid it must be real, that is it cannot be mere acquiescence or submission under any form of coercion or duress (British Medical Association, 1992). There is general agreement that providing information in a form acceptable to the patient should be part of the process of obtaining valid consent and current guidance from the General Medical Council in Britain emphasises the need to keep the patient informed, although it does not mention consent explicitly (GMC, 1995). English law accords doctors a privileged position in allowing them to apply clinical judgement in determining the quantity of information to be disclosed to patients when consent is sought. However, this view has been criticised for failing to respect the bodily integrity and autonomy of the patient. Recently, a consensus has developed, with the support of English case law (BMA, 1992) and of the British Government's health department (Department of Health, 1993, 1996), that has been summed up as, "Consent is only consent if truly informed" (Burns & Harris, 1996). Are these the final words on the issue of consent?

### Moral status

This remarkable consensus among philosophers, jurists and government officials to base a system of consent on 'truly informed' judge-

ments arises from respect for the principle of autonomy of persons (Glover, 1990). However, the official adoption of this view, and some of its legal support, may stem also from the fact that quantity and content of information provided to a patient are relatively easy to record and audit. There are, however, reasons for believing that less emphasis should be placed on the central role of information in obtaining valid consent.

Firstly, and most simply, a patient may give valid consent to a procedure (examination or treatment) while declining information which is freely offered (BMA and Law Society, 1995). In these circumstances, lack of informed consent should not be allowed to delay or deny treatment which is both necessary and desired. Indeed, to require that a patient consider the information that is offered could be seen as lacking respect for their autonomy. The darker side of this situation is that it represents a projection of our own anxiety: we need the patient to share responsibility for their treatment by sharing the information that guides it. This is clearly unnecessary since they share responsibility for any actions they consent to, informed or not.

Secondly, in many clinical situations where consent is sought there may be doubts about the patient's capacity to comprehend relevant information and so become 'truly informed', (Jones, 1995; Burns & Harris, 1996). This imposes upon both doctor and patient the need to apply complex cognitive tests to assess competence (BMA and Law Society, 1995). These tests may prove burdensome in themselves and it is doubtful if they should be applied without the patient's consent to undergo them. This leads to an absurd infinite regress: competence to give consent depends on tests, but consent to undergo the tests depends on competence!

Thirdly, if valid consent may only be given following information about specific procedures, then the patient may find that their rights are not so well protected as they might expect. This paradox arises because of potential conflicts with other rights that can be said to arise from the principle of autonomy, such as the right to express advance statements (living wills; BMA, 1995). The situation is relatively simple regarding

advance directives, which are specific instructions refusing some or all future treatment. Provided the patient was competent at the time they were made they carry legal force (Dyer, 1996) and, unless they expose others to harm or conflict with legislation (such as the Mental Health Act), they must be complied with regardless of the patient's ability to comprehend contemporaneous information (BMA, 1995). A more complex situation arises if the patient wishes to make general statements expressing their values or preferences in relation to some future, hypothetical set of events. Such advance statements are not legally binding, but it would be absurd if doctors rejected them simply because they were not based on information given at the time of the proposed treatment (BMA, 1992, 1995).

Finally, over-emphasis on the provision of information has potentially deleterious effects on the doctor-patient relationship. There is a risk of encouraging a shift towards a more adversarial style, where consultation becomes confrontation, and both doctor and patient are deflected from equally important aspects of their contact. There is evidence already that while GPs are providing their patients with more extensive explanations they are doing so for defensive rather than clinical or altruistic reasons (Summerton, 1995, 1996).

### Consent requires trust

What, then, should be done to ensure that valid consent is sought and obtained? Clearly, information is only half the story. Patients are unlikely to have confidence in the information they are given unless they have confidence in the system providing it, and that confidence is a function of the patient's trust in the doctor. Since trust will diminish if the information that goes with it is scanty, unreliable or grudging, it is clear that valid consent depends reciprocally and crucially on both information and trust.

Recognising that valid consent requires trust should not be thought of as an easy option for psychiatrists and other doctors. Consent based on trust does not conflict with a patient's autonomy, with their rights to be provided with or to decline information, nor to make advance directives. Indeed, developing trust entails full cognisance of the patient's rights and of the doctor's responsibilities, including the recognition that doctors have other important duties to their patients than solely respecting their autonomy (Glover, 1990; Mitchell, 1995; Oyebode, 1996).

### Conclusion

Although improving trust cannot remove all the difficulties of obtaining valid consent (Delaney *et al.*, 1996) it may, in some clinical situations (Burns & Harris, 1996) reduce the need for complex cognitive assessment since trust in the doctor may be inferred from the patient's prior behaviour and expressions. Seeking to rehabilitate trust is not a return to a previous paternalistic doctor-knows-best system in which the patient is kept in the dark. On the contrary, it encourages open discussion and the fullest cooperation between doctor and patient while allowing for those who cannot or will not comprehend information to be treated as respected persons.

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