

Informed Consent: Over- and Under-interpretation

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Introduction

Informed consent is the expression of an individual's autonomy or self-rule. To be autonomous one has to be competent and acting freely. Ethicists make a distinction between a "thin" and a "thick" concept of autonomy.

The thin concept of autonomy refers to "a competent person, in possession of the relevant facts making a free decision about what to do with his or her life".¹ While, the thick concept of autonomy refers to persons possessing the capacity to act on the basis of normative reasons. In other words, we are autonomous when we act according to relevant normative considerations. In this perspective we refrain from an action because we have good reasons not to and act accordingly, and vice-versa.²

Case studies

Beauchamp lists six requirements for an informed consent's validity:³

1. Disclosure of information (i.e. explanation and recommendation of the planned intervention, and its consequences)
2. Full understanding
3. Voluntariness of the consent to follow or not the proposed plan
4. Competency (i.e. an adult fully conscious and fully rational)
5. Clearly expressed decision to follow the proposed plan or to reject it, and
6. Authorisation in favour of a chosen plan.

This is, in brief, defines the health professional's duty concerning the process of informed consent. In daily clinical practice, however, there is an existent risk to give more importance to the completion of a piece of paper (the informed consent form, or even the "consent to operation" as used in a number of South African public institutions). In such forms, the *risks*, *complications*, or *consequences* are often hardly addressed. The following case studies (based on true-life cases in a rural setting) illustrate how informed consent can be over or under-interpreted. In one case, the patient was clearly incompetent and in the other case, the consent was obviously obtained under duress thus negating the fundamental tenets of informed consent.

Case study 1*

Mrs X, gravida 5, para 4, a severe mentally challenged woman aged 42, was brought to the labour ward by her mother-in-law. On admission, the mother-in-law, who was the patient's legal guardian, told the midwife that if a caesarean section was indicated, the doctor could go ahead with it. Moreover, she said, the doctor should take the opportunity to sterilise the patient. The evolution of labour indicated a strong evidence of cephalo-pelvic disproportion and a caesarean section was indicated. Although on the informed consent form, the mother-in-law had duly signed for both procedures, the

midwife insisted that the patient had to apply her right thumb fingerprint on the document.

Case study 2

Mrs Y, a 27-year-old mother of four was seen at the termination of pregnancy (TOP) clinic. The social history revealed that she was unmarried and her current partner was unemployed. After further inquiry, it emerged that this was the fourth time in a period of two years that she had requested TOP. In view of the context, she was counselled and advised to have a bilateral tubal ligation (BTL) with the TOP. She agreed to both procedures and was given an admission date. An interview was organised with the social worker and clinical psychologist. The ward doctor suggested an interview with the partner, but this did not materialise. At this visit, the patient signed a consent form for the BTL.

A few weeks later when admitted for both procedures, she declined the BTL. She said, "her partner would not allow it". None-the-less the following day she was sent to the operating theatre with her original completed and signed consent form. The doctor in charge, who was fully aware of the events and had consulted his colleagues, declined to proceed with the BTL on the grounds that the consent was likely not valid.

Discussion

Case study 1 is a case where the autonomy of the patient was clearly

deficient and, therefore, having obtained the informed consent of the guardian was sufficient to proceed with the Caesarean Section and BTL. However, there was no reason whatsoever to add the patient's thumb print to the document. This is a good example of *over-interpretation* of the requirements of informed consent.

Case study 2 appears more problematic. It is not uncommon for patients who want TOP having what health professionals would consider "completed their family" to "bargain" in order to obtain a TOP. However, on admission when the guarantee that the TOP will be implemented, the consent for BTL is usually withdrawn. To exert pressure is incompatible with the requirements of an informed consent. In this case, it may well be informed but not the result of a free will.

In the context of a society where "communalism" prevails, one has to be watchful and aware of the fact that life-decisions are not taken solely on the basis of individual autonomy.⁴ In the context of reproductive decisions, even in societies where autonomy is the most valued principle of decision-making, it is desirable that the decision to limit the number of offspring be shared and agreed mutually. The fact remains, in the settings where many of us work many false beliefs about sterilisation prevail particularly rising from the male-dominant culture, e.g. that having sex with a sterilised woman is not sexually satisfying to a man. However, should such false perceptions allow us to override patient's autonomy? This would be seen as morally reprehensive paternalism. On the other hand, it could be argued that women have the constitutional right to make the decision they want about their body. But this illustrates the possible conflict between women's rights and the norms of a male dominated society.

As health professionals working in such settings we are placed in a situation where we are obliged to give due consideration to the principles of *autonomy* and *informed consent* while knowing that many women are not in a position to negotiate sex and reproduction. Patriarchalism and autonomy are not good bedfellows. This is well recognised in the myriad of ethical issues concerning female genital mutilation. We can only hope that women's reproductive rights and decisions in South Africa (as well as in other male dominated societies) will gain at least the same attention. ✎

References

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* An extreme example of this occurred in a rural hospital in the 1990's. A doctor had a patient in urgent need of a Caesarian Section and she had signed the form. However, the nurses refused to send her to theatre unless her husband signed the consent form. The husband was found in a near-by shebeen (tavern) inebriated. Nonetheless, he signed. The nurses were happy, the norms of the culture were maintained, and the C-Section was performed.