Why is informed consent important?

Rebecca Roache, Associate Editor

Bok, by contrast, agrees with Eyal that there are problems with the trust-promotion argument. She holds that the first premise of the argument—that trust in medical practice is necessary for ensuring effective use of medicine—is too strong: many patients provide consent despite being, to some extent, distrustful. Bok agrees with the second premise that it is 'usually wrong to jeopardise that trust'. She argues that the reason it is wrong to jeopardise patients’ trust in the medical system (and to jeopardise trust in general) is that trust is a prerequisite of cooperation, and hence an important social good. Violating informed consent requirements is wrong, in Bok’s view, because it diminishes the ‘fragile social resource’ of trust, not merely because it reduces effective use of medicine.

Eyal’s response (see page 447) focuses mainly on Tännö, to whom he sensitively responds that whilst—in the cases discussed by Tännö, at least—hedonistic utilitarian considerations give us the right answers to questions about when informed consent should be obtained and respected, they do not go far enough in accounting for commonsense beliefs about informed consent. For example, Eyal argues that, pace Tännö, utilitarian principles do not require us to treat psychotic patients without their informed consent in order to promote trust among the ‘many’ who are not psychotic. Eyal notes that, since the vast majority of people are not psychotic (nor likely to become so) it is implausible to hold that the trust of the non-psychotic is likely to be affected by the way in which the psychotic are treated.

IS INFORMED CONSENT ONLY INSTRUMENTALLY VALUABLE?

This is an enlightening and important debate, especially since lack of trust in medical research and practice can have worrying consequences, as Eyal and Bok both note. Eyal employs some ingenious and subtle manoeuvres in rejecting the trust-promotion argument, but there is an additional, fundamental problem with the argument that is worthy of mention here.

As noted above, the trust-promotion argument is consequentialist in that it takes informed consent to be valuable
because it promotes trust, which in turn promotes effective use of medicine. Informed consent, then, is valuable ultimately because it is instrumental in ensuring that people use medicine effectively. This, however, is not a satisfactory account of why informed consent is important in medicine. To see this, consider that other factors could also plausibly be instrumental in ensuring that people use medicine effectively, yet their instrumental value is not sufficient to accord them the sort of central role in medicine that informed consent enjoys. For example, empirical evidence demonstrates that providing patients with financial incentives is an effective way of getting them to use medicine effectively.\(^1\)\(^2\) If—as advocates of the trust-promotion argument hold—the importance of informed consent consists in its role in getting people to use medicine effectively, then (ceteris paribus) other practices that achieve the same end should be viewed as similarly important. Paying patients to use the medical system is one such practice. We can imagine other promising candidates for such practices, too: providing comfortable seats in surgery waiting rooms, affordable parking facilities, media propaganda to exaggerate the reliability of the medical system, ensuring that medical staff are physically attractive, celebrity endorsements, brain-washing, and so on. I suspect that few would wish to claim that such practices are as central to medicine as informed consent; indeed, some of them are highly undesirable.

As such, informed consent must be important for reasons other than its instrumental value in promoting effective use of medicine, so the trust-promotion argument does not fully account for the importance of informed consent. It would be natural, given this conclusion, to turn to non-consequentialist considerations to explain the importance of informed consent in medicine. For example, a virtue ethics approach could provide insight here: the idea that respecting informed consent requirements is among the virtues we expect our medical staff to cultivate is prima facie appealing.

**DECISION-MAKING IN MEDICINE**

A further six articles in the current issue address various other aspects of decision-making. Two of these articles relate to groups of patients generally taken to lack decision-making capacity: children and psychiatric patients. Rosalind McDougall and Lauren Notini review cases in the medical ethics literature in which health professionals have overridden parents’ wishes about their children’s medical treatment, and identify the ethical principles cited in justification of these decisions (see page 448). Rahime Aydin Er and Mine Sehiralti note the importance and difficulty of making accurate assessments of decision-making competence in psychiatry (see page 453). They compare assessments by medical staff, relatives, and a designated assessment tool, and conclude with some recommendations for improvements in practice.

A further three articles consider decisions about end-of-life care. Yi-Chen Su outlines some concerns about a recent revision to Taiwanese law that allows physicians to act as sole decision-makers to promote the best interests of incompetent, terminally ill patients in cases where the patient expressed no preferences about end-of-life care while still competent, and where no family members are available to provide surrogate decision-making (see page 484). Su notes that the law provides insufficient guidance about patients’ best interests and about what procedures medical staff should follow in such cases. He suggests some procedural safeguards to ensure that the law is ethically implemented. Next, Kenneth Chambaere, Ilse Loodts, Luc Deliens, and Joachim Cohen survey Belgian decisions to forgo end-of-life artificial nutrition and/or hydration, and find that such decisions generally proceed without discussion with the patient, contrary to existing legislation (see page 501). The authors emphasise the need for medical staff, patients, and their relatives to discuss end-of-life treatment options well in advance of the end of life. In another Belgian survey, Jef Deyaert, Kenneth Chambaere, Joachim Cohen, Marc Roelands, and Luc Deliens note that some end-of-life treatments are potentially life-shortening, and that it is often vague or otherwise unclear how a given treatment is best conceived (as, for example, euthanasia versus palliative) (see page 505). The authors used a questionnaire to discover how physicians involved in end-of-life care labelled the treatments they administered to their patients, and discovered that whilst the way in which physicians conceive euthanasia is relatively clear cut, their conception of palliative or terminal sedation is more ambiguous.

Finally, Gert Olthuis, Carlo Leget, and Mieke Grypdonck argue that shared decision-making can be burdensome to patients, and that education is needed to help medical staff understand the experience of the patient, and apply this understanding in providing improved care (see page 493).\(^3\)

**REFERENCES**


\(^3\)I am grateful to Kenneth Boyd for some useful feedback.
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