Informed consent: Broadening the focus

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In Australia, the landmark case of Rogers v Whitaker (1992) 175 CLR 479 clarified the law relating to the duty of health professionals to provide information to patients. In responding to these developments in the law, the Australian physiotherapy profession has sought to define and articulate the scope of this legal duty as it relates to physiotherapists and to specific physiotherapy treatments, in particular cervical manipulation (Mann and Refshauge 2001). The response has been to focus on the duty discussed by the courts rather than on the emerging underlying issues of shared decision-making and patient empowerment.

The profession’s adoption of a defensive position could be described as the donning of a legal “flak jacket” (Jones 2001). That is, by practising within the protective armoury of evidence-based clinical efficacy and appropriate educational qualifications, physiotherapists perceive they will be better equipped to deal with any legal threat and patients will also be in safer hands.

Whilst there is clear merit in this approach for both patient safety and quality clinical practice, it is a disappointingly narrow perspective from which to form the basis of information disclosure practices in the clinical encounter. The “flak jacket” response does not assist clinicians to negotiate decisions which incorporate the patient’s wishes or understanding in relation to a proposed treatment. If adopted, it places a defensive and minimalist approach to what can and should occur in discharge of the legal and ethical obligations of information disclosure within physiotherapy practice. In short, such an approach effectively ignores the ethical basis underlying the provision of information by distancing the action of information disclosure and informed consent from the moral theory of respect for a patient’s autonomy and ability to make an autonomous and informed decision.

There are three broad explanations that may account for a physiotherapist or other health practitioner providing information to a patient for the purpose of gaining their informed consent to treatment. The first explanation may be because it is recognised by the practitioner as part of his or her ethical duty to respect a patient’s autonomy and/or act in the best interests of the patient. The second explanation may be because the practitioner is aware of the inherent clinical value of giving patients information and obtaining their informed consent to the proposed treatment, for the purposes of compliance, co-operation or adherence to the treatment regimen. Third, the act of providing information and obtaining consent may be motivated by knowledge of the law, which demands that information be provided such that the patient is in a position to make an informed decision. In the latter context, obtaining informed consent is viewed as a legal obligation, which must be fulfilled, or a ‘hurdle’ rather than, and separate from, objectives of improved and enhanced patient outcomes, consistent with the traditional goals of health care practice.

From an historical ethical perspective, the amount of information a health care practitioner provided to a patient was related and subsumed into the goals of health care, formulated in terms of beneficence, which, in turn, was narrowly interpreted, understood and defined by the practitioner’s professional opinion (Cox White and Zimbelman 1998). Concomitant with this ethos, ethical justification of information provision would have been sufficient if a physiotherapist thought that certain information would be beneficial to the therapeutic outcome in terms of patient adherence, compliance and understanding. “Gaining the patient’s confidence and cooperation” is a mantra etched in the memory of undergraduate physiotherapy students of the Seventies and Eighties. It is a mantra that sought to serve the purpose of achieving both the established ethical and clinical goals of treatment.

In the last three decades, in the bioethical literature, the notion of information provision and informed consent has been framed in the emerging language of patient rights, patient empowerment and patient self-determination. The definition of informed consent from this contemporary ethical perspective is the autonomous authorisation of a patient for a proposed procedure (Beauchamp and Childress 1994). The requirement of a physiotherapist who provides information to a patient, based on these ethical ideals, involves the provision of information which offers meaningful and relevant choices. Information is required to be both intellectually and emotionally comprehensible to the patient. It should, in addition, be provided without any other controlling or coercive influences, allowing the patient freedom or autonomy of choice.

Traditionally, the law governing the clinical encounter has had a more narrow focus with the concepts of informed consent and patient autonomy. It has been centred upon respect for a patient’s autonomy and autonomous choice in the context of how the ability to choose, and the exercise of that choice, impacts on issues of liability for subsequent preventable injury to a patient (Faden and Beauchamp...
1986). From this perspective, legal disclosure requirements are influenced by legal theories of liability and practitioner responsibility, which delineate an obligation to make disclosures rather than the broader ethical and clinical meaning that information disclosure may have (Kerridge and Mitchell 1994).

The desire to prevent breach of duty is reflected in the physiotherapy literature, which has similarly sought to delineate practitioner responsibility relating to effective clinical screening and information provision requirements when a treatment has a recognised associated risk such as that relating to cervical manipulation. Subsequent research has focused on professional compliance with the published guidelines.

In 2000, the APA pre-manipulative testing protocol (originally established in 1988) was reviewed, on the basis of the findings of a survey conducted by the Manipulative Physiotherapists Association of Australia (Magarey et al 2000a) and current research outcomes. According to the survey, compliance with the protocol of screening and gaining informed consent was poor (Magarey et al 2000a). Many of the respondent manipulative therapists thought the protocol of objectively screening patients was cumbersome and (despite the legal necessity to do so if the “flak jacket” was to have a real prospect of providing protection) many members failed to comply.

Intra-professional discussion which followed the publication of the revised guidelines (Magarey et al 2000b) has focused on the capacity of physiotherapists to make sound clinical judgments where treatment carries some risk, based on educational qualifications and the application of adequate screening procedures. In 2001, a commentary on the APA guidelines in this journal acknowledged uncertainties confronting the clinician seeking to reliably predict risk factors in patients prior to manipulation (AJP Forum 2001). Concerns expressed included the use of screening tests that have inherent reliability, validity (and safety) limitations (Dunne 2001), the difficulty of identifying with accuracy the real risk of manipulation (including the various methods of application) (Reid and Hing 2001), and the relative risk of mobilisation treatment without manipulation (Schneider 2002). There was also concern expressed as to the effect on legal liability of following or not following the APA guidelines (Mann and Refshauge 2001). More recently, there has been further discussion as to what constitutes suitable qualifications to practise manipulation, with some authors suggesting that educational requirements should be specialised and restrictive to maximise safety and care for patients (Refshauge et al 2002).

The discussion of these issues of informed consent prior to cervical manipulation on the basis of patient safety, professional compliance and evidence-based clinical practice has taken place in the context of developments in the law and a perception that the profession should take steps to guard against exposure to legal action. Whilst this response is a professionally responsible one, it is also one that fits the third explanation of information provision above, that is, one which can be analysed in terms of guiding rules and social obligations (Beauchamp and Childress 1994), or as a legal ‘hurdle’ to be overcome, in itself somewhat marginal to the true goals of physiotherapy practice and narrow rather than broad in its focus.

The response need not and should not be so narrow. Recognition of the broader objectives of enhanced treatment outcomes fostered by a recognition of patient autonomy and right to informed decision making is consistent with discharge of more narrowly based legal obligations.

Several authors have devised guidelines and models of communicative practice for medical practitioners in an attempt to forge meaningful links between the ethical theory of respect for a patient’s autonomy and the practical action of providing information to patients and obtaining their informed consent. For example, Katz (1984) emphasised a model based on conversation and encouraged physicians to see informed consent as a genuinely mutual and participatory process similar to a conversation, whereby practitioners are willing to both confront and change their views of themselves as the sole authority and of their patients as unable to competently make medical decisions. A commitment to a conversation model would mean that physiotherapists would have to acknowledge their uncertainties and lack of evidence-based knowledge, and shortfalls and limitations of screening procedures and the like, which is a part of all health care practice, when disclosing information and gaining patients’ consent. Brody (1999) uses the strengths of the conversation model developed by Katz (1984) and operationalises them in his transparency model. The transparency standard does not key to adherence to a list of risks and benefits that a hypothetical reasonable patient would want to know, or to existing standards of other practitioners but rather, according to this model, disclosure standards and content are “adequate when the physician’s basic thinking has been rendered transparent to the patient” (p. 97). Transparency of communication means that the physiotherapist would need to share his or her thinking with the patient, encourage questions, discover how participatory the patient wishes to be and facilitate that level of participation. Wear (1998) believes the informed consent debate should be placed within the context of the realities, needs and opportunities of the physician/patient encounter, and should be aligned with the goals of the treatment encounter. In Wear’s view, information disclosure and informed consent are central to the goals of an effective treatment encounter, rather than a marginal legal requirement.

Taking this broader, transparent approach necessarily involves a clear explanation to the patient of the risks and benefits of what is proposed and is likely to go a considerable way toward discharge of information provision obligations which the law demands. Combining this approach with the conversational model means that the consent is likely to be meaningfully achieved at a level and on a basis suited to the patient’s individual needs.
Writing for physiotherapists, Coy (1989) suggested that the implication of informed consent or information disclosure to a patient, which is based on the moral principle of autonomy, is that provision of information to a patient and obtaining his or her consent is required not only for potentially risky procedures, but also for procedures that are generally perceived to be less risky or low risk. Coy states: “When informed consent is based on the importance of protecting or enhancing autonomy, it is required because of the potential infringement on autonomy, regardless of whether a potential for harm exists” (p. 829).

Adopting a broader approach to obligations of information disclosure and informed consent is likely to improve patient/therapist relationships and facilitate other treatment outcomes such as: identification of both patient and therapist treatment goals; identification and enhanced responsiveness to patients’ misconceptions, fears and false hopes; a decrease in the burden of responsibility on therapists to assume control for the complete cure of patients’ problems and enhancement and empowerment of patients’ abilities to use self-management strategies.

Whilst the physiotherapy profession is to be commended for its professional response to the legal issue of informed consent, it must also be brave enough to remove its defensive armour and to incorporate and embrace the broader ethical meanings of information disclosure and informed consent in clinical practice. Effective procurement of a patient’s informed consent is merely one aspect of a meaningful and effective clinical encounter where sound communication skills and techniques are employed between therapist and patient.

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References


