Dilemmas regarding the informed consent in the informative model of the doctor-patient relationship

George Cristian Curcă*

Abstract: The author presents a case in which the patient refused the continuation of medical care in a surgical emergency and which evolved dramatically, leading to the patient’s death. The doctor’s options against the patient’s refusal are analyzed both in terms of patient autonomy and the beneficence of medical care. The discussion includes a comparison between the paternalistic model and the informative model of the doctor-patient relationship, as well as the moral and legal values of informed consent. It is argued that patient autonomy, as a fundamental expression of individuality, with its unambiguous character, may conflict with the expectations society itself projects on medical care; it may also conflict with professional independence as a value of the same autonomy, but this time seen from the perspective of the physician. Informed consent is supported by legal provisions which do not provide an optimal solution, free of conflict, in cases such as the one hereby presented. The legal liability of the physicians is a possibility: but even more, their moral burden in cases where the “best interest of the patient” means his death is a certainty.

Key Words: informative model, paternalistic model, relationship models, informed consent, human dignity.

E very patient is entitled to respect: this respect has both moral and legal support.

When discussing about respect towards the patient, several topics must be addressed, such as respect for the uniqueness of the human being, respect for the intrinsic value of a person, respect for human dignity, respect for the autonomy of the person, respect for the sick person as a vulnerable one, respect for the sick person as a citizen from his/her civil rights perspective. The priority of the topics and the order of their approach in medical practice and in an ethics speech can be a subject of debate, but certainly is less relevant than the analysis of the topics themselves.

While lacking any intention to conduct a thorough research of the topics, one can see that the respect for the human beings comes from their uniqueness, a fact that was philosophically certified by Immanuel Kant. All humans have “an intrinsic worth or value, acting as a philosophic value, i.e., dignity, becoming an intrinsic property” which makes them valuable “in itself” or “for its own sake” and “above all price” and that may be regarded as an end or end-in-itself (Imm. Kant cited by Ivo de Gennaro, 2012[1]). Indirect references regarding the uniqueness of the human beings can also be found in the Universal Declaration of Human Rights “Recognition of the inherent dignity... of all members of the human family is the foundation of freedom, justice, and peace in the world” [2]. However, uniqueness of humanity must be discriminated from human dignity and not just encapsulated in this concept [3].

The intrinsic value of the human beings derives from the value of their spirituality and rationality over the extrinsic (instrumental) value of their biology (as living beings), the need for recognition and respect for human dignity, the need to consider and practice equal rights for every person: “All human beings are born free and equal
The respect for human dignity is shaped by the intrinsic value of the human being and is a concept that requires special attention. It is supported, among others, by Pope John Paul II when he debates the dignity of the human being in an objective sense based on the universality of the human nature enriched with free will and also in a subjective sense if we take into consideration that creatively he may constitute the individual self [3]. "Dignity signify that a being has an innate right to be valued"[4]. Human dignity is the quality of being worthy [5] or as one's self worth and irrespective worth of distinction. "Humanity itself is a dignity"[6].

Respect for the dignity of the human being has been a premise of medical care in the normative documents of medical practice since the Hippocratic Oath, which is the first document of medical ethics: "I will keep them from harm and injustice. ... Whatever houses I may visit, I will come for the benefit of the sick"[7]. The respect for human dignity is then taken over into the Geneve Declaration, 1948, "I solemnly pledge to consecrate my life to the service of humanity...I will maintain the utmost respect for human life" and finally found in almost any national medical code of ethics: "Every professional activity, of any kind or form will be conducted with strict respect of human dignity as a fundamental value of the medical professional body". Article 3, Code of medical Ethics of Romanian College of Physicians, 2012 [8]. Respect for human dignity is the basis of respect for the person who is a patient or a subject of scientific research, a patient being often placed in both positions [9].

The respect for autonomy is a core concept of bioethics. Autonomy is a triple folded concept, philosophically, biologically and legally.

Autonomy is first nominated as a philosophical principle of morality within Kantian arguments in the third formulation of the categorical imperative of his Groundwork of the Metaphysic of Morals, 1785, where the Principle of Autonomy "the principle of every human will as a will universally legislating through all its maxims" (4:432) conduct the reader to the Formula of Autonomy: at the heart of Kant’s moral theory is the standing that rational humans are autonomous not just simply because they are free and they act freely from influences [10] but also because they have the capacity to be legislators of moral laws and by this giving moral laws to all including to themselves: therefore humans acts as laws makers in as much as law subjects but in the same time sovereign administrators of a lawful world where all are human beings are autonomous and free.

Autonomy is then sustained as an inner biological concept that reinforces its philosophical meaning with a biological support: autonomy of the patient implies voluntariness of decision, understanding of information and critically, the capacity of decision [11] all three as functions within the psychic capacity of that person.

With a biological support the philosophical meaning is refined to the statute of a moral principle, i.e. a bioethical principle, among all others principles as beneficence, non-maleficence, autonomy and justice: the search for morality becomes a necessary application of all these moral principles altogether [11].

Finally autonomy is built as a legal concept which sustains human self-determination as a free agent entitled to have equal rights and which manifests himself within its legal capacity nominated as legal competence connected to his civil rights expression. Everyone interfering with an autonomous person has a negative duty not to interfere in his expression as much as a positive duty to protect this free will of expression.

Every patient who is ill and asking for medical care is a vulnerable person and thus entitled to protection and respect [11]: the vulnerability of the patient along with the trust that he may address to the doctor determines empathy and confidenciality as an offer of acknowledgment.

The human dignity asks for respect, additionally the human rights ask for respect. Beneficence and respect for person conduct the doctor’s duties generating morally and legally bounds in the doctor-patient relationship: benefits/risks balance is one of these duties the doctor share responsibility.

Finally but not least, the respect for the patient as a citizen asking for health care, who is entitled to civil rights and expresses himself as an autonomous agent in the limit of the legal framework of society and without interfering with other person’s rights.

This presentation was meant to launch the topics of respect for the patient as a person and of respect for the dignity of the patient; it will follow a further analytical application from the perspective of informed consent as the direct expression of the doctor-patient relationship [12].

CASE PRESENTATION

An adult patient without known diseases or any registered next of kin comes in with severe abdominal pain, defensive position with the shoulders down, and
sudden vomiting. The surgeon on duty performs the required laboratory analyses and a surgical examination; he confirms the acute abdomen diagnosis: he considers it is a case of acute appendicitis, requiring emergency surgery.

The physician has a general discussion with the patient regarding the symptoms and assesses that the patient is autonomous.

Since surgery looks like the only valid therapeutic option, he decides to inform the patient as soon as possible of the diagnosis and his professional recommendation; he asks if the patient wants this. The patient confirms his intention to know details regarding his health: the doctor informs the patient of the nature, purpose, benefits, risks, postoperative evolution.

The patient listens to the doctor's presentation with an apparent calm; after the doctor makes his professional recommendation regarding the necessity of surgery, the patient stops him, states his refusal of surgery, and asks to leave the hospital. The patient does not talk much about himself, and does not justify his decision.

The attending physician knows how to perform the surgery, he is competent, he has the means to do it, and also a successful experience with this type of surgery. The doctor tries to find out the reason for the refusal, but the patient does not give any explanations, insists to be discharged and asks to be left alone. The doctor tries to change the patient's mind by insisting on the surgical recommendation, the necessity of the intervention and the risks; the doctor asks if the patient has a different plan, a different intention, if he wants to have another exam, to go to another hospital or ask for a second opinion: the doctor underlines the urgency of the situation and the recommendation to accept the intervention as soon as possible. The patient continues to refuse and requests to be discharged.

What is better, morally speaking, for the doctor to do? What is legal for him to do? We consider that there are 3 options:

1. To consider that the patient is autonomous. To accept the patient’s request and let him be discharged as he has demanded.

The doctor believes that you cannot hold in the hospital and even less operate on an autonomous patient against his will (the right to freedom prevails over the right to life, although both rights have the same value as fundamental rights). The patient's autonomy prevails over the beneficence of medical care, the right to freedom and the right to self-determination prevail over the right to health, medical care and life. The doctor feels that he is caught in a conflict between the rights of the patient who expresses them by asking to be left alone, and the expression of legal competence and professional duty to act as per his medical knowledge and skills to the benefit of his patient: on one hand there is the patient with the rights he autonomously exercises; on the other, there is the physician with professional independence, but also legal and moral obligations.

Going against his better judgment, the physician accepts the patient's decision and approves the discharge upon request; the doctor considers that he is within an informative model of the doctor-patient relationship in which the patient's autonomy prevails over the beneficent medical care; that the patient's decision is based on his own values; that the patient is his own decision-maker; that the patient decides on his medical care and the doctor is just a consultant; the physician does not have the professional independence to continue the medical care he considers himself to be competent and responsible for (frustration, conflict, professional failure).

2. To consider that the patient has no autonomy because (1) he takes a decision that is not beneficial to him and which does not support his best interests as it endangers his life and (2) does not present the critical content of his decision, namely the reasons that make him refuse a medical act which actually addresses a surgical emergency.

The doctor is frustrated because he cannot perform his professional role with the competency he possesses: his expertise and training seem to be useless now. The professional independence is in conflict with the patient's right to self-determination.

The doctor is concerned in terms of the beneficence of medical care but also from a legal perspective; if the patient suffers complications or death occurs, the doctor may be considered to be in breach of his duty to provide medical care or may even be accused of abandoning the patient in a medical-surgical emergency situation; this could put him in a potentially litigious position ("The health of my patient will be my first consideration", Geneve Declaration, 1948).

The doctor thinks that he cannot accept to discharge from the hospital, from his jurisdiction and from his duty to care for, a patient who came to him requesting medical care, for which he has the necessary means and knowledge, for which he has the necessary competence and expertise, especially since the patient does not present the reasons for which he refuses the medical assistance he himself requested.

The doctor decides to refer to this patient as a person devoid of autonomy and therefore vulnerable, and he himself will take the necessary life-saving decisions instead of the patient.

The doctor leads a paternalistic doctor-patient relationship; he motivates his decision on the fact that this is a surgical emergency and the communication was severed without any explanations from the patient.

In the paternalistic doctor-patient relationship he has with this patient, the doctor understands that he is the decision-maker, he is the patient's legal representative,
he is the one who decides on medical care, and he implements his own values; the doctor is professionally independent and considers himself competent and responsible (professional accomplishment).

3. To search for another option: consult with another colleague, consult with a professional superior, consult with a psychologist to evaluate the patient, try to support his professional recommendation towards the patient with the advice of a colleague with more experience or even the head of the clinic, someone who could communicate the optimal professional recommendation with more professional authority to the patient, etc.

The case brings into question the issue of autonomy regarding the informed consent and the patient-physician relationship; it also raises some relevant questions about autonomy, as it is obvious that if the patient assesses himself as autonomous, then one must respect his decision; if not, then the doctor has the obligation to seek support for his decision (the patient's next of kin and/ or peers) or to act taking into consideration solely his own decision as long as the patient's life is in danger:

1. In order to objectively evaluate a patient's decision-making ability, is it necessary for the patient to communicate his decision to the doctor? Possible conflict between free will and constraints: the doctor has the obligation to inform and verify the understanding ability (transmission and reception of information) and he is entitled to know the decision his information led to (knowing the patient's decision).

2. In order to objectively evaluate a patient's decision-making ability, is it necessary to present to the doctor the critical content of the decision, which should include the motivation thereof and the deliberative mechanism through which the doctor would have the proof that the patient seeks to promote and to protect his best interest? Possible conflict between free will and constraints, between self-determination and autonomy on one hand and responsibility on the other: the doctor has the professional responsibility and the obligation to protect a person who is vulnerable and lacks autonomy; but for that, the doctor needs to know if the person is autonomous, and the autonomy analysis cannot be performed without knowing whether critically the patient has the decision-making capacity.

3. What is the best interest of a patient? Usually it is considered to be the patient's wish, which actually means the maximum measure of his subjectivity. Possible conflict between patient autonomy and physician autonomy, between the right to self-determination and the right to perform professionally on the basis of professional independence.

If the patient expresses a wish within his autonomy, how can it become a moral and legal duty, a moral and legal obligation for the doctor, who is in turn autonomous?

4. What are the discriminative values of the patient that can be considered or "accepted" as supportive of protecting his best interest, and thus of a rational, enlightened decision? Possible conflict between patient values which are sine die subjective and the values of the physician which are not subjective, such as his professional duty in relation to the patient's health and medical assistance towards the society.

"The right to refuse medical treatment is basic and fundamental. ... Its exercise requires no one's approval. ... The controlling decision belongs to a competent informed patient. ... It is not a medical decision for her physicians to make. It is a moral and philosophical decision that, being a competent adult, is [the patient's] alone" [13].

The legal text cited above is a quote from the famous Bouve v. Superior Court [13] case, and it expresses the right to refuse medical treatment within exercising the legal capacity of an autonomous person and the civil rights of a citizen (which is called legal capacity or legal competence) and which is seen to be an inalienable right to self-determination, incorporating undeniable legal values.

From this perspective the case we presented has just one juridical, legal solution, that is, the first option, where the patient is autonomous even if he does not effectively communicate his decision or the critical content thereof; the doctor does not have the moral and legal right to go forward with a treatment the patient did not consent to; in the case of an autonomous patient, autonomy prevails over beneficent medical care. There is the possibility of a legal dilemma between the civil rights of a competent person and the physician's duty of medical care: the solution for the legal dilemma would be to have the duty cease against refusal (to authorize) of medical care and to respect the competent person's autonomy.

Beyond these important questions, the case we presented contains several ethical and legal dilemmas.

From the doctor's perspective there are ethical dilemmas between beneficence/ autonomy, benefits/ risks, between the doctor's and the patient's autonomy, between the patient's autonomy and the doctor's professional independence, what is in the best interest of the patient (for the patient to make the decision – even if he chooses to die - or to live – even if another person makes this decision), about the nature of the respect for the patient (respect for his dignity, respect for the uniqueness of human beings), etc.

There are legal dilemmas as well between the right to life/ the right to freedom, the right to self-
determination/ the right to medical care, the possibility of a conflict of interest (between the self-interest of the physician not to become legally actionable and be accused of failing to provide emergency medical assistance and the interest of the patient to decide himself how to achieve what he considers to be his best interest), which is the extent to which one can limit exercising autonomy and how far it can legally go, etc.

Continuing with the presentation of the case, the doctor is split among the 3 options, while being unsure of the patient’s autonomy. He hesitates to make a decision when dealing with the patient’s refusal to continue with medical care and to authorize the surgical intervention. He chooses for the moment option 3 in the order they were presented and tells the patient that he has to discuss this situation with the head physician. The patient accepts.

The doctor goes to the head physician and asks for an emergency meeting to present his case. While the two talk, approximately 60 minutes after the patient came to the hospital, there is an announcement in the ward that the patient went into cardiac arrest. Emergency cardiopulmonary resuscitation is performed, which leads to the resumption of respiratory and cardiac functions, but the patient remains comatose that day. Next day at noon a second cardiac arrest is repeated, and this time it is fatal. The patient is pronounced dead.

The doctor hesitated and created a time interval before carrying out the discharge formalities for the patient or, on the contrary, deciding to perform the surgery as for a patient who lacks autonomy and the support of the next of kin, who could take the decisions in his place. The patient’s cardiopulmonary arrest has no direct connection with the doctor’s hesitation as this is not a common complication of acute appendicitis. It is likely the patient was a carrier of an unknown or undiagnosed heart condition. But the hesitation created the situation for an acute cardiopulmonary arrest to take place, and temporarily placed the patient in a room awaiting a medical decision.

Let’s try to analyze the situations in which the doctor would not have expressed any hesitation:

1. The doctor believes the patient is autonomous, he accepts his patient’s refusal and discharges him; the medical records specify in writing that the patient is discharged too soon and against medical opinion; the patient is asked to sign in order to take responsibility for this decision.

The patient will have the cardiac arrest (as it has happened) after it was decided to be discharged and that can place him in the following two situations:

a) still in the hospital on his way out of the hospital, elevator, etc.;

b) after leaving the hospital on his way to go home (maybe still in the hospital courtyard) or shortly after reaching his home.

In these situations we can ask these questions with a moral value:

I. Is the outcome (death) in accordance with the social values that the medical act defends? Is it according to the level of expectations the society has from doctors? The society expects the following, in this order: professional responsibility, professional independence, professional competence, fair and indiscriminate professional performance, availability [14]. The society expects the doctors to do their duty at work by competently exercising the expertise they acquired through the efforts and contribution of the society as well.

II. Is the outcome consistent with academic values? Is this what school teaches us to do? Do we learn to abandon the patient or, in the interest of his health, to follow up even on a minimal chance of survival?

We get the knowledge to prevent, treat and protect the patient’s health, and to show respect for life. Knowledge allows building one’s own experience and competence which in turn compel us to manage a case in relation to beneficence and our own responsibility.

III. Is the outcome in accordance with the values of the professional body? Is this what it is supported by the professional and ethical codes of conduct as norms of morality (of doing good) in professional practice?

Ethical norms focus on beneficence before anything, including in the benefits/ risks assessment and in the prioritization of benefits in curative medicine and of risks in research; if there is no benefit or if the risks exceeded the benefits, then the rule is to do no harm. The Hippocratic Oath, the Declaration of Geneva (WMA), the Nuremberg Declaration, the Declaration of Helsinki (WMA), the national ethical codes etc., all attest to the beneficence principle and prioritize non-maleficence as long as risks are higher than benefits.

IV. Is the outcome in line with personal values? The doctors choose to practice the medical profession in order to act, to intervene, to assist, to help, or to abandon, not to act? What is the professional accomplishment of a doctor who loses his patients without giving the medical care he knows he can give at his level of competence and expertise?

V. Is there any difference in terms of moral responsibility between a patient who died in the hospital elevator or after being discharged from the hospital or the one who might die on his way home? Can the doctor feel morally reassured? Can we consider we proved how competent we are? Can we consider ourselves professionally fulfilled?

2. The doctor believes the patient lacks autonomy, does not accept the patient’s refusal, and does not comply with the patient’s request to be discharged; on the contrary,
he exercises his authority as legal representative (as long as he can't find the next of kin) and decides to have the emergency surgery, sedating the patient if necessary.

The patient has the cardiac arrest (as it has happened) and that can place him in the following two situations:

a) on the operating table;
b) in the post-op ward.

The patient's death occurred in the middle of a medical action in which with a definite indication and a favorable prognosis the doctor acted with competence and beneficence to protect and promote the health and life of his patient.

If the previous situation led to questions of a moral value, this situation lends itself especially to questions of a legal value:

I. Did the patient lack autonomy so that it was within the legal framework to initiate a surgical intervention without consent (without authorization)? Questionable.

II. Does the doctor have the freedom to act in the patient's interest to the limit of the informed consent in a medical and surgical emergency (or even beyond the informed consent if the patient's life in danger - the doctrine of extension)? Yes.

III. Is the doctor legally actionable in this case? Possibly yes if the patient was autonomous.

IV. Was the doctor wrong in trying to save the patient's life? If the patient lacks autonomy, no.

V. Is the hospital or the medical unit legally liable in such cases? Possibly yes.

The questions contain legal values, and so do the answers. In the previous case the questions contain mostly moral values, and so do the answers. How does in this case the legality issue turn into a predominantly morality issue? By failing to perform the duty of care.

Paradoxically the lack of care creates mostly moral issues and fewer legal problems, whereas medical care at the limit of consent or without a clear authorization of the medical act creates mostly legal problems and fewer moral issues.

If we can agree with the statement above, we cannot however agree with its significance and meaning or with either of the meanings expressed due to the fact that the moral values of the medical act are always present.

The case we presented brings up a conflict between legal and moral values, between professional and individual values, between autonomy and beneficent medical care. We can now ask these questions with moral value, valid for any of the situations in which the patient was before he died:

a) Does respect for human dignity (for the value of the human being, the value of the patient) implicitly involves respect for life? Not implicitly but also.

b) Conversely, does respect for life implicitly involves respect for human dignity? Implicitly, it would be desirable, it is moral, and it is legal.

c) Is it possible, within medical practice, to have dissociations between respect for life (as instrumental value) and respect for human dignity (as intrinsic value)? It is possible, but it is unfavorable to the medical act, it is dishonorable, it is an error.

d) What about respect for human dignity without respect for life? Theoretically it should not be possible. It may be possible, however, if it is considered that human dignity is related to the value of the human person, and the human person is not present or is no longer present (the value of the human person vs. the value of the human being).

e) In the case above, when the patient refused medical care and was left without any medical care following his death, was there respect for human dignity, for the uniqueness of the human being? This is a difficult question, and the right answer or answers should have no connection with professional independence or autonomy, as human dignity and the uniqueness of the human being are fundamental values of both the medical act and of the society as a whole in the framework of a good and legal performance; they must be respected a priori.

f) What seems to be more important for a physician in his practice, respect for human dignity or respect for human life? I think a doctor should not make a choice. No one should have to make a choice. The two do not dissociate (moral path), for dissociation leads to the use of the instrumental value of life without recognizing the uniqueness of its manifestation within that human being (and I would prefer not to use the phrase "within the human person").

g) What if the doctor could choose between the right to life and the right to freedom? Would it be about his professional choice in relation to others? Undeniably the right to life for the accomplishment of which he became a doctor arises from his duty to care and from public duty. Would it be about his professional choice in relation to his patient? It is my opinion that in this case as well the right to life prevails (“The health of my patient will be my first consideration”, Geneve Declaration, 1948; actually if the health of the patient is a duty implicitly has a duty to protect life, because health exists only in relation with life itself). Would it be about his choice in relation to his patient? The doctor could not display a choice which is not professionally related to his patient.

The legal liability of the physician may be a reality in the cases where the patient's autonomy is manifested against medical advice leading to beneficent and curative medical practice, and post-factum questions can arise about the reality of said autonomy, about whether the
conditions to deprive the patient of medical emergency care were met. Conceptualizing autonomy cannot cover for atypical cases in which a careful analysis of moral values can sometimes be enlightening.

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References
Corrigendum: Sexual dimorphism of crania in a Romanian population: Discriminant function analysis approach for sex estimation

Mihai Marinescu, Viorel Panaitescu, Mariana Rosu, Nicoleta Maru, Antoaneta Punga

Due to a regrettable error while preparing the manuscript (prior to submission) of the article “Sexual dimorphism of crania in a Romanian population: Discriminant function analysis approach for sex estimation” published in Vol. 22 Issue 1 March 2014 of Rom J Leg Med, the corresponding author inadvertently omitted the Acknowledgements section. The article should have read:

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