

Medical Paternalism and Patient Autonomy

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Medical practitioners are beginning to realise that conflict between medical paternalism and patient autonomy would arise if they continue to uphold this dualism as distinct in all circumstances of medical practice. Information about an intended medical procedure or clinical research involving humans needs to be comprehensively transmitted so that the client can make a rational decision to consent. The rationale behind the doctrine of informed consent is primarily to uphold patient autonomy and self-determination without coercion.

This issue of the MJM carries an article on ‘Informed Legal Consent: A socio-legal study’ which dissects the subject of informed consent purely from a legal stand referring to numerous cases involving decisions relating to consent. Reference is made to recent developments where the ‘court decides and not the medical man’ on the adequacy of information disclosed to patients.

The doctor–patient relationship It is clear that doctor's autonomy acceptably has to give way to the patient's autonomy in medical treatment in the current climate. Apart from disclosing information about the procedure or research he is duty bound to clarify potential risks, likely outcomes, and possible physical and emotional effects, no matter how remote they are, including alternatives and costs involved. The ‘competency to consent’ has also to be factored in before informed consent is taken. The case of ‘Fitzpatrick and Aida White’, Ireland, reminds practitioners of timeliness in providing adequate information especially that related to risks and dangers of the procedure. The patient's complaint was that ‘the warning was given only on the day of the operation rendering him unable to make a rational decision’¹. Author brands this phenomenon as

paternalism by omission, observing that choice divorced from information is no choice at all.

The ‘prudent man test’ When medical paternalism is stronger than patient autonomy the ‘prudent man (patient) test’ is employed by the courts. In the often-repeated case of *Sideway vs. Board of Governors Bethlem Royal Hospital and Maudsley Hospital*² the court upheld clinical judgement regarding disclosure of information about the procedure. Medical practitioners will continue to be wary of several court decisions where rationalization by the medical practitioner at the time of decision making may not be totally acceptable. We are reminded about *F v R* in Australia where a failed tubal sterilization made the court decide there were concerns ‘that if left to medical practitioners, they may adopt unreasonable practices’³. One will be vigilant that medical practitioners have to conform to a ‘standard of reasonable care’ demanded by law.

The concluding remarks in the latter court ‘that medical judgement is relevant but not conclusive in determining adequacy of disclosure’ is yet another reminder as to how doctors should be trained during undergraduate and postgraduate years. Practitioners are now aware that the ‘prudent man (patient) test’ (*Rogers vs. Whitaker* 1993; 4 Med LR 79 (HC)) appears to overshadow the ‘doctor knows best’ (*Sideway vs. BOG Bethlem*) principle⁴.

Clinical Training Clinical training needs to incorporate the elements of communication skills, which become much more difficult in multicultural multiracial Malaysia where patients may have different levels of understanding and language may remain a barrier to information given especially where procedures are complex and involve advanced

technology. Reference is made to some of such procedures appearing in this issue of the MJM. Courts refer to ‘material risk’ inherent in a treatment but medical practitioners need to be aligned to the definition of ‘material risk’ as defined in a court of law hearing the circumstances of the case! Codification alone, however, would not cure what author calls paternalism by omission: clinicians can still withhold discussion of guideline-endorsed alternatives.

Informed consent would continue to be tested as technological advances in the medical fraternity moves in leaps and bounds with the courts referring to previous and personal judgement and interpretation based on evidence provided for guidance.

The 21st century sees the essential need for a new health care paradigm where one-to-one patient relation is blurred by involvement of multiple providers (nurse counsellors, anaesthetists, house officers and specialists) necessitating coordination and multiple consent taking often with the use of electronic records⁵. Would informed consent taken by the operating surgeon sufficiently meet all that has to be transmitted by the attending anaesthesiologist? Reference is made to an article in this issue on Endonasal endoscopic transsphenoidal surgery for pituitary adenoma. It is imperative that medical practitioners be competent in communicating adequate information in complex and technical subjects in such circumstances.

The changing scenario The origins of informed consent can be traced to Plato (law IV) where ‘foreseen problem’ is mentioned with ‘conditioning of the relationship between physician and patient by moral values and deontology’ is mentioned⁶. Other articles included in this issue of MJM are ‘Haemopoietic stem cell transplantation and occlusion of internal iliac artery pseudoaneurysm using amplatzer vascular plug’. Some of these are

pioneering work that would benefit the population in the long run and should be encouraged if well-constructed practice guidelines permit such intervention.

Controversies can arise in pioneering work in medicine where cost-benefit and success of the procedure are considered. Some complex procedures can be potentially 'tested' in a court of law should the outcome be less than favourable! The requirement for doctors to keep pace with rapid and exponential evolution of treatment approaches requires a parallel development of expertise to cover all the aspects of the procedure which may not be an easy task.

The court's decision in medical litigation often is related to 'incident by incident' which probably puts the risk of ambiguity arising from clinical care on the attending doctor when rational decisions are made in specific clinical situations. Crafting an adequately worded informed consent is a disconcerting exercise as one tries to include all inherent risks, benefits and alternatives to the therapy suggested in a short time frame for decision making, an often-seen practice in the clinical setting. Surgeons have been plying the trade with some reservation as technological skills in operative surgery and new operative technology have benefits which impact on cost and economics like laparoscopic surgery but involve small but real risks of even mortality⁷.

Capacity to consent The capacity to consent by a competent patient is yet another area of contention that medical practitioners need to be mindful of. Reproductive medicine and assisted conception introduces numerous moral and ethical issues relating to both societal acceptance and legal interpretation. The peculiar position of the fetus and the commonly accepted philosophy that it is not a 'separate individual' and the 'health of the mother

should prevail over that of the fetus' can be an area for discussion as far as informed consent is concerned.

Societal approval of common law especially informed consent is again not clear especially when the family functions as a single unit and 'family autonomy' is higher than the person's autonomy. Family units in some groups of society would want to play a pivotal role in decision making when risks of treatment involving their family member are explained. Asians have been found to slower in trusting statements by doctors. Organ transplantation from brain dead was not accepted in Japan till 1997 and in Korea till 20008.

The need for a core curriculum in medical education The subject of informed consent reflects on a larger picture where medical ethics and professionalism, medical law and patient safety should be integral parts of the medical curriculum with consolidation of the foundations of understanding of concepts during internship and postgraduate education so that patient's rights are guarded and ethical practice is in place. The outcome-based medical curriculum in many medical schools has incorporated the teaching of these domains by threading them through the curriculum so as to make the subject relevant. The Division of Ethics of Science and Technology (UNESCO) have developed an innovative syllabus 'Bioethics Core Curriculum' which is a useful resource for the teaching of medical ethics⁹.

The current issue on informed consent transcends across medical research and bioengineering and practical aspects of safe and ethical practice that the medical

practitioner should uphold especially in maintaining patient autonomy. Medical paternalism may have its place in few circumstances but the current move is to involve the patient in decision making. Health care professionals play pivotal roles as conventional health care givers, researchers, and policymakers. Apart from procedural medicine and clinical research they would also have to consider distributive justice as they take on these differing roles. While enjoyment of the 'highest attainable standard of health' is a fundamental right of every human (as defined by WHO) disparities in distribution of justice can inevitably occur. Consent to a procedure is only relevant if access to health care is uniformly available. Conflicts arise with basic definitions of libertarian, utilitarian and egalitarian concepts among health care professionals who are also advisers and managers. It is ironical when a doctor has to decide on who gets care when resources become depleted and the general argument is that patient's self-determination must supersede doctor's autonomy!

CONCLUSION Bioethics and informed consent have been explored in depth in the later part of the 20th century. The Bolam's Principle may no longer be solely applicable in all court decisions. The reduction in person-to-person connection which was traditional to the profession is more complex as many parties are often involved in the procedure or research. The issue of trust is paramount in any kind of contract between the patient and the health provider. There are misgivings in trying to practice defensive medicine and

using electronic consent taking which may defeat the purpose of ‘disclosing information’ in a language the patient understands. ‘Family autonomy’ has moved from being surreal to a reality in some societies. Clearly the subject of informed consent is much more complex than what is often referred to and the value of medical paternalism may be valid in some circumstances!

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