Priscilla Alderson and Christopher Goodey, 1998, **Theories of consent**, *British Medical Journal*, 317: 1313-1315

Consent is understood differently by various disciplines and professions, and also in various theoretical models.[i] We review the advantages and limitations of theories about real consent, constructed consent, functionalist, and critical consent, and postmodern choice. This article shows how analysing theories can clarify practical knowledge about advantages and problems in obtaining consent, to assist everyday practice and research

Real consent

Positivism works in clear factual concepts defined through dichotomies: informed/ignorant, competent/incompetent, free choice/coercion. Medicine, psychology, analytical philosophy[ii] [iii] and law[iv] [v] tend to assume positivist concepts of consent. Appropriate information for informed consent, including percentage risks, is treated almost as a "thing" which doctors give to patients. It is assessed by checking how patients recall and recount standard details.

Positivist surveys dominate research about consent, though they mainly measure information given. The essence of consent, patients' thoughts, feelings and values as they evaluate information and make and express their decision is far harder to observe or record, and too subjective and elusive to count as hard data. Problems in real consent are attributed to patients' and doctors' limited knowledge and communication skills, and are addressed by efforts to improve knowledge and skill. Social pressures, and great anxiety and distress are assumed to inhibit patients' ability to make independent, rational choices, and so should be reduced or avoided if possible.

Positivist respect for informed consent brings important benefits. It encourages health professionals to be accountable, and to know and explain clearly what they plan to do, and why. Basic information standards are agreed (see boxes 1-4), and are achieved partly through research, audit and professional education which also improve health care. Respect for patients' consent/refusal expresses precious ideals of respect for their physical and mental integrity. It defends them from unwanted interventions, and from deception or coercion during treatment and research. Yet positivist theories set such high standards that many people are classified as too ignorant, dependent or emotional to be competent. In an all-or-nothing approach, consent is seldom discussed in relation to good practice with supposed "incompetents".[vi] Sharp dichotomies are unhelpful when assessing borderline cases, though these are in greatest need of helpful theories of consent and competence. Real consent is unrealistic for many ordinary people, so that clinicians and researchers feel cynical, irritated or despondent about consent.

Constructed consent

From a range of social construction theories we review a few ways of understanding consent. Modern ideas of consent only began in the late seventeenth century and are used in varying and contradictory ways, sometimes by the same person unwittingly using differently theories. The two main components of modern consent are *understanding* and *voluntariness*. These

originate from seventeenth century religious belief that the *intellect* and the *will* are the two things that make us human. Thus theories of consent are based on personal and social beliefs about human nature. Consent is integral to modern democracy, also born at that time, as the idea that we have enough understanding and will to withdraw consent from inadequate rulers. Theologians argued then about whether the intellect or the will was more important for obtaining redemption, and about the exact relationship between them. Consent was seen largely an act of the will.

Some modern interpretations of consent emphasise patient understanding and, once that is programmed, voluntariness is simply a mouse which clicks OK. Yet decisions may involve a process of voluntariness or unwillingness, with complex desires and resistances. Desires and feelings can confuse understanding but also enrich it. Initially, patients often want to reject dangerous, unpleasant treatments. Before they can willingly consent, they have to journey from fear of the treatment into greater fear of the untreated condition, with growing trust in their health carers. Parents consenting to their baby's heart surgery, for example, are bewildered but also informed by their moral emotions of fear, anguish, empathy, hope and courage. If they were as emotionless as real consent theories expect, they could not really understand or consent. Theories of how people construct their identity by telling and retelling accounts of their lives, such as while moving from fear towards hope, can explore experiences which elude standardised surveys. Through lengthy research interviews, ordinary people show how profoundly they understand and reframe concepts of altruism or autonomy, responsibility and risk.

Professional assessments of adequate information and competence to consent can similarly be seen as varying social constructs, not universal standards. Some doctors consider that young children are competent to consent, others say that patients can "never" adequately understand.6 Positivism tends to see patient's abilities as fixed personal attributes. Social construction sees them partly as responses in relationships, influenced by the professionals' abilities to explain, respect and support. Patients initially assumed to be incompetent may then be helped to attain understanding and resolve which they and their health carers regard as competent. They may decide about certain aspects of treatment, and share or refer other decisions; being able to decide differs from wanting to be the responsible decider.

In real consent, all influences tend to be seen as potentially coercive pressures, and autonomy as free-floating individualism. Social construction shows how, without numerous social and personal influences, we would have neither choices nor the ability to choose between them. A 14-year-old boy with cystic fibrosis (CF), whose brother had died of CF, was asked if he really wanted to have the recommended heart lung transplant. He answered, "My mother would be so sad if I did not have it". Relationships can enrich as well as restrict the autonomy to consent.

By holding in tension individual agents and social structures, and interactions between them, construction theories provide a framework for case studies of

consent as process rather than event. These range from individuals' narratives to studies of surgical units. They show how patients may be influenced by their family and friends, memories, the media, and hospital staff who all make up a coherent or confusing jigsaw of knowledge. The type of unit and of treatment, whether elective or emergency, how complex and risky, and the time, space and resources available, all influence individuals' responses. Detailed studies can show the extra complications in daily practice in each clinical speciality, and also possible ways of addressing them.

One problem in social construction theories is that of becoming so absorbed in variety and complexity that the essential kernel in "real" consent (boxes 1-4, and respect for individual integrity) is lost. All researchers potentially face difficulties in justifying their selection of theories, questions and data, their interpretations, and the validity and generalisability of their work. These difficulties are especially obvious and central in case study research. Because it collects vast amounts of data, a further problem is its unpopularity with clinicians who prefer clear, easily applied research conclusions.

Functionalist consent

This is a polite ceremony, a token of respect that is hardly necessary because benign, expert doctors contribute to the smooth functioning of society; refusal and non-compliance are irrational. Consent is, however, a convenient means of transferring responsibility for risk from the clinician or researcher to the informed patient, thus enabling treatment and research to proceed without serious risk of costly litigation. English courts usually support the doctors in disputes about consent,[vii] and psychiatrists can advise in cases of seemingly irrational refusal of minors.[viii] To some extent, most people are partly functionalists, in needing to be members of a coherent society with some consensus on stable, useful knowledge. Although many doctors would not explicitly support extreme functionalism, in busy wards, clinics and surgeries consent tends to be treated as a simple or tedious formality.

Critical theory

The opposite view sees consent as a necessary protection for patients against useless, harmful and unwanted interventions, an occasion when doctors have to be accountable, and an essential constraint onthe most powerful profession.[ix] Informed consent is not regarded as simply one-way medical information-giving, but as an exchange of knowledge between doctor and patient so that together they can make more informed decisions.

Postmodern choice

In postmodern societies, people generally have moved from being producers in factories, farms or mines, to being consumers whose highest value is choice. Theories of critical and real consent, mindful of the serious political and legal history of rights, respect for personal integrity and, if necessary, defence against atrocity,12 appear to shrivel into the choice of trivial pick 'n mix options. Significantly, the British government's *Patients Charter* does not give legal entitlements but quality checklists, treating citizens as consumers. Postmodernism analyses various forms of consumption,[x] amply illustrated by health care

examples. The identity seeker looks for a face-lift, a sex change or a designer baby. Even people having mundane treatment, who do or do not make it their main topic of conversation, thereby shape their identity. The Which? consumer studies expert advice and calculates the best buy treatment. Political consumers campaign for ethical care and fair rationing; green consumers are keen on keeping fit and on alternatives to products derived from animal experiments. Consumers as explorers go in for the exotic, maybe experimental treatments or New Age ones. Hedonists consume for pleasure, glamour and attention, and feature in BUPA advertisements and health farms.

All this may seem a travesty of real consent and serious medicine. Yet postmodernism contributes important insights. Social and economic forces ensure that everyone in wealthy societies is a consumer. We expect to be offered choices - of groceries, shoes, radio channels or holidays - and do not suddenly change on becoming ill or injured. Doctors are among the leading purveyors of choices from before the cradle to the grave: prenatal screening; childbirth analgesia; growth treatments; prostate surgery or watchful waiting; organ transplant or acceptance of death. Much treatment is not for serious disease, but for convenience, such as to hasten recovery from minor illness. Even consent to major surgery, like hysterectomy or spinal fusion, may be influenced more by personal preferences than by clinical judgement. Doctors also expand notions of choice into areas once thought to be immutable, for example by altering bodies through surgery, minds through drugs, and promising to alter identities through gene therapy. There are curious contradictions between seemingly momentous or trivial choices. Are termination for fetal abnormality, or prescribing Ritalin to a difficult child, sensible routines? Or are they part of great transformations in our understandings of human nature, relationships and obligations? Although appearing to expand choice, do they close other options and ways of living and relating, and impose a tyranny of choice? Choice can be more onerous when people are uncertain how to choose among values and rules for choice making.

Choosing among theories

Consent is a strong concept in being so versatile and durable, but is vulnerable to conflicting interpretations and rejection as a worthless ideal. Real and critical consent remind practitioners and researchers about standards which protect them and their patients; these are at times too high to achieve but endure as standards to aim for. Functionalist consent reflects common medical practice if not medical values. Social construction shows how consent is a process, perceived, experienced and shaped through interactions between individuals and their social contexts. Postmodernism provides revealing descriptions of current contradictions and confusions in consent, which is usually assumed to epitomise rational and moral certainties. Consent is too complex to be understood fully in any one theoretical model.

Box 1. *Informed consent involves knowing about:*[xi]
the nature and purpose of the intervention
intended effects, and side effects
risks, harms and hoped-for benefits
any reasonable alternatives

Box 2. *Voluntary consent involves*:[xii]
freedom from "force, fraud, deceit, duress, overreaching or other ulterior form of constraint or coercion"
knowing about the right to refuse or withdraw, without prejudicing further health care,
the right to ask questions
and to negotiate aspects of treatment
coerced perhaps by disease, but not by other people.

Box 3. *Consent to research involves knowing about:*
the research purpose, questions, aims and methods
relevant terms like "randomise"
the treatment, if any, which the research investigates
benefits, risks, harms or costs to research subjects
hoped-for benefits to other groups such as future patients
confidentiality, indemnity, sponsors, ethics approval
the research team and a named contact.
(Some of these details can be explained in leaflets
and discussed with those who ask about them.)

Box 4. *Competent consent involves the person,*
being able to make and stand by an informed, freely made decision.
Adults can decide as they please, but a minor,
in the opinion of the treating doctor,[xiii]
must have "sufficient understanding and intelligence
to understand fully what is proposed"
be "capable of making a reasonable assessment of the advantages
and disadvantages of the proposed treatment"
and have "sufficient discretion ... to make
a wise choice in his or her own interests".[1xiv]

References

i. Alderson P. Theories in health practice and research. *BMJ* 1998

ii. Faden R, Childress T. *A history and theory of informed consent* . New York: Oxford University Press, 1986.

iii. Gillon R. *Philosophical medical ethics.* Chichester: John Wiley, 1994.

iv. Kennedy I. *Treat me right*. Oxford: Clarendon, 1988.

v. Montgomery J. *Health care law*. Oxford: Oxford University Press, 1997.

vi. Alderson P, Montgomery J. *Health care choices: making decisions with children.* London: Institute for Public Policy Research, 1996.

vii. *Bolam v Friern Hospital Management Committee* [1957]; *Sidaway v Governors of the Royal Bethlem Hospital and others* [1984].

viii. *In re R* [1991]; *in re W* [1992].

ix. Oliver M. Theories of disability in health practice and research. *BMJ*, 1998

x. Yiannis G, Lang T. *The unmanageable consumer: contemporary consumption and its fragmentations*. London: Sage, 1995.

xi. Declaration of Helsinki. *The world medical association handbook of* declarations. Ferney Voltaire: WMA, 1989.

xii. *Nuremberg Code*. 1947.

xiii. Age of Legal Capacity (Scotland) Act, 1991, section 2(4).

xiv. *Gillick v West Norfolk & Wisbech AHA* [1985].