

## Editorial : The Patient as a Client: Issues Pertaining to Consent

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On November 13, 1995, a three-member bench of the Supreme Court of India delivered a historic 65 page verdict that held, essentially, that service rendered to a patient by a medical practitioner by way of consultation, diagnosis and treatment, both medical and surgical, falls within the ambit of 'service' as defined under the Consumer Protection Act.

From the terms of the judgement, the patient is a consumer of services; consequently, he has the right to be aware of what he is 'purchasing', and all the ramifications thereof. But, are medical practitioners conforming to this legal and moral ethic of professional care? Apparently not, to judge from the findings of Murthy and Bharati (in this issue, pp 121-126).

Murthy and Bharati reported that patients were inadequately educated about the nature, cause, complications and prognosis of their illness, about the side effects and complications of the treatment prescribed, about the availability of alternate treatments, about the investigations ordered, about financial costs etc. While the results of a single study cannot be generalized across the country, they certainly underscore the need for similar investigations to be conducted at other centres.

Why is such patient education important? There are many reasons. The patient has a legal and moral right to know what is being done to his body, and to participate in decision-making processes. A well-informed patient is more likely to be compliant, cooperative, and participative in the therapeutic process than a poorly-informed patient [1]. The provision of proper informed consent will protect the legal interests of the clinician.

These considerations prompt the question, "What is an appropriate model for patient education?" There are no statutory guidelines by way of answer; however, at least in the field of psychiatry, an official body, the Indian Psychiatric Society, is attempting to frame a position statement on the subject. In any framework, certain important issues need to be kept in mind.

The patient and / or a key relative should be aware of the diagnosis and the implications thereof. A brief explanation of the nature of the illness and of the manner in which the drug therapy is believed to act will justify the need for the prescription and will form the essential structure for a compliant attitude. A basic explanation should be provided about the need for the recommended intervention (investigation or treatment), the likely benefits from the intervention, the likely short-term and long-term adverse effects, financial costs, and the merits and demerits of alternative interventions. Information that is conveyed should be unbiased; practitioners may consciously or unconsciously supply information that, either in content or in the manner of conveyance, supports their advice.

In providing information, the clinician should consider the patient's education, cultural background, mood state, level of preparedness etc. This is because in the Indian setting, to judge from the opinion of medical practitioners, patients may have a difficulty in understanding information, and may have problems with the concept of informed consent [2]. Information may need to be distributed over several sessions, and may require repetition. Provision of written or audiovisual information, wherever available, is a useful resource [3], [4]. Certain of these issues have been discussed in greater detail elsewhere [5].

Empirical research is needed to identify what patients and their relatives want to know, how best this information may be provided to them, how much they can understand, how much they recall, and the manner and extent to which they are

influenced by the information. While little research of such nature has been conducted in this country, Murthy et al [6] reported that, contrary to clinicians' opinions [2], Indian patients are able to ask relevant questions and make clear choices provided that sufficient information is provided to them; their sample was however over-represented in literacy and urban residence. A question that begs answer is, are Indian patients, especially less literate and rurally-resident ones, more likely to prefer to be guided by their clinician's opinion?

Issues of potential legal importance require clarification; these include the matter of who should provide consent, the circumstances in which written consent is necessary, the legality of 'blanket' consent forms, etc. It is also necessary to frame guidelines for patient education and the obtaining of informed consent in routine clinical care, in research situation, and in situations in which invasive (e.g. surgery), potentially controversial (e.g. electroconvulsive therapy) or potentially life-threatening (e.g. clozapine therapy) interventions are recommended. by way of example of efforts towards the resolution of certain of these issues, Martin and Glancy [7] have proposed a 15-item questionnaire to evaluate competency to consent to electroconvulsive therapy. The questionnaire clarifies, amongst other matters, the patient's understanding of the nature of his illness, his understanding of the interventions proposed, his concept about the doctor's motivations, his awareness about alternate interventions, etc.

Contrary to traditional practice, medical practitioners do not have the right to aver "I know best; it is unnecessary for the patient or the relatives to be part of the decision-making processes; they should have trust in me, not ask questions." An exhibition of such traits of medial divinity is morally and legally inexcusable [5]. Clinicians need to keep in mind the position of the Council on Medical Service [8]: care of high quality should seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process.

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