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## INFORMED CONSENT: PATIENT'S RIGHT OR PATIENT'S DUTY?

**ABSTRACT.** The rule that a patient should give a free, fully-informed consent to any therapeutic intervention is traditionally thought to express merely a right of the patient against the physician, and a duty of the physician towards the patient. On this view, the patient may waive that right with impunity, a fact sometimes expressed in the notion of a right not to know. This paper argues that the rule also expresses a duty of the patient towards the physician and a right of the physician against the patient. The argument turns, first, on the truism that a physician has no obligation to commit a battery, or unauthorized touching, and, second, on the thesis that a patient necessarily cannot consent to something that is unknown to him. The conclusion is drawn that a patient is not free to receive treatment voluntarily without knowledgeably authorizing it.

### INTRODUCTION

Discussions of the physician/patient relationship have for several years centered on the rights of patients and the duties of physicians. Chief among the rights ascribed to patients has been that of informed consent to therapy or treatment. Physicians and other health care professionals have been charged with the duty to ensure that the patient's consent to therapy is freely given and informed according to appropriate standards (American Hospital Association, 1973).

It is widely acknowledged that this doctrine of informed consent has two historical sources: (1) standards for medical practice deriving from malpractice and court-ordered treatment case law, and (2) standards for research and treatment deriving from the Nuremberg Code and the International Medical Association's Declaration of Helsinki. By so fostering the interpretation of informed consent as the patient's right, biomedical ethics and case law alike have

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developed an analysis of informed consent that expresses its elements and presuppositions exclusively in terms of the needs and state of the person who gives it. The current rule marks a major departure from the tradition in which the bond of trust between patient and physician, a desired characteristic of their relationship, was the prime protector of the patient's interests.

Thus, a typical analysis (Beauchamp and Childress, 1979, pp. 66ff) identifies (1) competence, (2) voluntariness, (3) the disclosure of information about the diagnosis, proposed therapy and its risks, and alternative therapies and their risks and benefits, and (4) comprehension of such information as the four elements of a valid informed consent, understood in terms of what a reasonable patient would need and use in order to exercise his or her right effectively.

This 'rights approach' encourages the view that a patient may legitimately withhold consent (even to life-saving treatment), may consent but waive the right to understand the information that is disclosed, and may even waive the right to have disclosed any of the relevant information about the diagnosis, the proposed treatment and its possible risks, and alternatives to the proposed treatment. (For, a right normally carries with it a liberty to exercise that right or to refrain from exercising it. Hence, if a patient has (only) a right to information, he is at liberty, it would seem, unilaterally to choose not to exercise the right and to forego acquiring the information.) The typical blanket consent form presented to a patient to sign upon admission encourages the patient passively to waive, rather than vigorously to exercise these rights, and many physicians feel morally bound to 'protect' patients from the stress of a serious diagnosis or of knowledge of the risks involved in a therapy. Thus, while there has been a strong theme in the literature of medical ethics about the importance of informed consent, couching it solely in terms of the patient's right permits paternalistic attitudes to continue in physicians and the permissive corollary of infantile attitudes to persist in patients.

We have even now reached the point where Beauchamp and Childress, two prominent bioethicists, have announced,

if a deeply committed Jehovah's Witness were to inform a doctor that he wishes to have everything possible done for him, but does not want to know if transfusions or similar procedures would be employed, it is hard to imagine a moral argument to the conclusion that he must be told (Beauchamp and Childress, 1979, p. 79).

Beauchamp and Childress notwithstanding, I want to give an argument that, if successful, radically enriches the informed consent requirement. I want to show that there is a moral duty on the part of the patient to give an informed consent as a precondition of therapy, that that duty is owed to those who will conduct the therapy, and that the patient thus cannot unilaterally waive any part of the informed consent requirement. (While I shall be explicitly concerned only with the relationship between patient and physician, much of what I say should also hold for relations between patients and other health care professionals as well.)

I proceed by arguing for four propositions. They are, in order of consideration:

- (1) A patient has a duty to consent to treatment;
- (2) A patient has a duty to know to what treatment s/he is consenting;
- (3) A patient has a duty to know the precedented consequences (risks and benefits) that a reasonable person would want to know, which are attendant on the treatment to which s/he is consenting;
- (4) A patient has a duty to know the medical alternatives to the treatment to which s/he is consenting, including their precedented attendant risks and benefits which a reasonable person would want to know.

## II. THE DUTY TO CONSENT TO TREATMENT

The argument for proposition (1) runs as follows:

- (1a) A physician has a right not to commit a battery in providing treatment to a patient or client.
- (1b) Therefore, a patient has a (*prima facie*) duty to do that which relieves the physician of the burden of committing a battery while providing treatment.
- (1c) A battery is an unauthorized touching of the body.
- (1d) Therefore a patient has a (*prima facie*) duty to authorize the touching which is involved in his/her treatment by a physician or surgeon.
- (1e) Consent to the treatment to be given constitutes authorization of the touching which is involved in that treatment.
- (1) Therefore, a patient has a (*prima facie*) duty to consent to treatment.

There are several points to be made about this argument.

First, the rather odd notion of a right not to commit a battery is a simple consequence of the duty not to commit a battery. If one has a duty to do something, one clearly has a right to do it (where 'duty' and 'right' are understood as of the same type – e.g., moral duty and moral right). These claims will be elaborated more fully below.

There is an objection to be considered here. It proceeds as follows. 'X has a right to do Y' means 'X is at liberty to do Y and X is at liberty not to do Y'. Further, 'X has a duty to do Y' might be taken to mean in part 'X is not at liberty not to do Y'. Hence, the joint assertion of a right and a duty concurrent in the same individual with respect to the same act would yield a contradiction. For, 'X has a right to do Y' implies 'X is at liberty not to do Y', and 'X has a duty to do Y' implies 'X is not at liberty not to do Y'.

It is not my purpose here to provide an analysis of the concepts of rights and duties that would show the correct alternative to the foregoing, mistaken analysis. But a simple example should serve to convince that it is not correct as a general analysis that would refute my first argument. Consider Smith. Smith is divorced, having first sired a daughter. Smith has a right to visit his daughter after the divorce, on the grounds of his being her father; this right is against both the ex-wife and the daughter. But it is quite plausible to argue that Smith has a duty to visit his daughter, correlated with a right of hers (less clearly correlated with a right of her mother). Hence, Smith has both a duty and a right to visit his daughter; the daughter has both a right and a duty to visit with her father. This perfectly ordinary example, which I should think we would all accept, shows that the analysis of rights and duties which entails that assertions of their concurrence imply contradictions, cannot be generally correct. Hence, there is no such general difficulty with the notion of a duty not to commit a battery being accompanied by a right not to commit a battery.

Second, the patient's duty to consent is a *prima facie* duty, in that there clearly are cases in which other considerations would override it. For example, a patient who is comatose or unconscious is unable to consent; a patient who is retarded or mentally ill may be unable to consent competently or to understand the medical aspects of the case; similar comments hold for a young child. Hence, there are conditions which excuse the patient from this duty. However, that does not in any way imply that the physician's right not to commit a battery is *prima facie*; it indicates rather that authorization

will have to come from some other legitimate source – either a proxy of the patient (e.g., a spouse or parent or guardian) or from the courts.

Third, this argument should not be taken as supporting the view favored by a few individuals (such as Tendler, 1972), who argue that a patient has no right to refuse treatment necessary to preserve his or her life, and that in such circumstances there is thus no mere right, but a duty to give consent. That duty would be unconditional, whereas I am after a duty simply conditional on one's requesting of a physician treatment appropriate for one's medical aim of getting well, becoming healed, having a damaged body part repaired, having a chronic dysfunction managed, and so forth. Whether one has a duty to pursue those ends, and if so, whether by the means most likely to secure them, are separate questions I shall not address here.

Fourth, it might be objected that there may well be an irreducible dependence on the law in the argument, and that it is thus not a moral argument at all. For example, would the duty to consent exist in a society which did not recognize the provision of any medical or surgical procedure as a battery if not authorized? If not, it would seem to follow that (1c) is specific only to certain legal systems. I am inclined, however, to think that the principle that one has a right not to be touched without one's authorization is a moral principle which is derivable from the moral principles of autonomy and privacy, and that battery is thus a moral as well as (in this society) a legal offense.

Finally, it may be useful to apply an analysis of rights developed by the legal thinker Hohfeld (1919) to be sure that the inference of (1b) from (1a) in the argument for (1) is valid. Hohfeld distinguished between claim-rights and liberty-rights. A claim-right is a right that another provide one with some specific benefit or service. The correlative of a liberty-right is not an obligation, but a 'no-right', that is, the absence of any legitimate demand that what one has a liberty-right to do not be done. Thus, if a physician's right not to commit a battery is simply a liberty-right, the patient merely has no right that the physician commit a battery. The way that a physician would exercise such a liberty-right, however, would be simply not to practice except when to do so involves no battery. It sounds like the best one can get with this analysis is a prudential admonition to patients to give valid consents if they want physicians to practice on them.

But the situation is more complex than that. Often the professional

relationship between physician and patient preexists the specific treatment situation, and it is not uncommon to speak of the relationship as already involving contractual obligations on the part of the latter to treat, rather than simply to choose not to practice, in the face of serious illness or need (as opposed, perhaps, to a request for a strictly elective procedure). Similar obligations exist in emergency situations, situations involving involuntary commitment, military medicine, and so forth. In these situations, the patient has a claim-right to treatment usually based on either preexisting contractual obligations between patient, employer and physician, or on statutory or institutional duties (as in the case of physicians on duty in emergency rooms to provide treatment (Beauchamp and Childress, 1979, pp. 142–143)). Even where a preexisting contractual obligation or relation with a patient is not involved, a physician may be obligated to treat. The American Medical Association's 1971 edition of its *Code of Ethics*, while acknowledging the physician's discretion in entering this relation, adds that "in an emergency, however, he should render service to the best of his ability (Section 5) . . . . He should . . . respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service" (American Medical Association, 1971). Hence, there seems to be a strong case for the view that a physician may usually not be at liberty to decline to practice. If so, then even if one regards the right involved in (1a) as a liberty-right, with the patient's correlated state being a no-right that the physician commit a battery, the patient would be *prima facie* obligated to give consent as a consequence of the physician's liberty-right not to commit a battery and the patient's claim-right to treatment.

All this can be put more simply, though less precisely, by saying that the situation created by a patient's request to a physician for assistance in any more than a strictly elective situation is one in which the physician has a duty to treat added to his or her duty not to commit a battery. In that situation, the physician has a claim-right to the patient's consent.

### III. THE DUTY TO KNOW WHAT ONE CONSENTS TO

So far the results may seem trivial. For is not this duty to consent equivalent to the right to consent which the standard analysis recognizes, in that both will apply when either does, and neither will apply in cases of emergency, incompetence, extreme emotion, and

so forth? Perhaps there is such a congruence, an equivalence of a material sort. But the next step will show the deeper divergences in this view of the informed consent doctrine.

First, I must introduce a distinction between two types of relations. Some relational expressions, like 'to the left of', preserve the truth values of the sentences in which they occur when different expressions referring to the same things are substituted for their terms. If 'Jones sits to the left of Smith' is true, and 'Smith is the man who was elected' is true, it follows that 'Jones sits to the left of the man who was elected' is also true – this by virtue of the relational expression 'to the left of' having the property of preserving truth value when different terms equivalent in reference are exchanged.

By contrast, some relational expressions do not have this property of 'referential transparency'; they do not guarantee preservation of the truth values of the sentences in which they occur when different expressions with the same reference are substituted. 'Wonders whether' is such a relational expression. 'George wonders whether Jones sits to the left of Smith', together with 'Smith is the man who was elected', does not entail that 'George wonders whether Jones sits to the left of the man who was elected', because George may know nothing of the election or its outcome.

Let us call such expressions 'referentially opaque'. Then a necessary condition for such inferences as involve these sorts of relational expressions together with certain non-trivial identities, is that the subject know the identity. I will call this necessary condition PI, for easy reference.

The argument for (2) now turns on showing that 'consents to' is referentially opaque like 'wonders whether'; and that, in turn, hangs on the following reductio:

- (2a) Assume that 'consents to' is not referentially opaque.
- (2b) If so, then inferences of the form 'If  $S$  consents to  $x$  and  $x = y$ , then  $S$  consents to  $y$ ' are all valid.
- (2c) Let  $x$  = whatever the doctor thinks best, and  $y$  = the doctor thinks it best that he sterilize  $S$  during  $S$ 's appendectomy.
- (2d) Under that interpretation of the schema, ' $S$  consents to whatever the doctor thinks best' and 'The doctor thinks it best that he sterilize  $S$  during her appendectomy' entails ' $S$  consents to being sterilized during her appendectomy'.
- (2e) But this is obviously absurd.
- (2f) Therefore, 'consents to' is referentially opaque.

- (2g) Therefore, for inferences of the form mentioned in (2b) to be valid, we must presuppose that the subject know what treatment s/he is consenting to. (from (2f) and PI)
- (2) Therefore, the patient has a duty to know what treatment s/he is consenting to. (from (2g) and (1))

If one is not satisfied as to the obviousness of the absurdity referred to in (2e), it might be useful to consider what 'consenting to' consists in.

First, note that an event conception of consent, together with the notion that consent to a procedure is sufficient to authorize it, entails that one cannot withdraw consent to a procedure once one gives it. But this is absurd. Giving consent is not analogous to signing a contract, in that it does not have the status of a binding agreement that a contract does. While consent may date from some verbal or written expression, since consent requires continuous assent, one should regard it as a kind of disposition of the subject; the subject who consents is disposed to act in characteristic ways under appropriate circumstances. Clearly, on such an analysis, since the patient in our interpretation of the schema is not disposed to do any of the things towards which one who has consented to a sterilization is disposed – whatever they may be – but may well react under the appropriate circumstances as one who has not so consented would react, any result of an analysis which implies that, despite the lack of appropriate dispositions, the subject has consented, is strong grounds for rejecting that analysis.

Second, one may well ask, what has our subject *S* consented to in uttering words to the effect that she consents to whatever the doctor thinks best? Well, one might put my point by saying that, in the absence of knowing what the doctor thinks best, in consenting to that, she consents to nothing! Her consent, on my view, fails to authorize any action by the surgeon. The utterance may indicate a disposition to accept what the doctor does, provided that the results are not 'unexpected' or in violent conflict with the patient's values. The surgeon, however, has no good indication of that if the patient does not know what she is consenting to, since he may well be wrong about what the patient does expect or value. He is, in accepting an expression like 'Do whatever you think best' as a valid consent, banking on a retrospective acceptance by the patient of what he has done. But he does not have a valid consent; the patient must know what s/he is consenting to.

It may be instructive to regard expressions of the form 'I consent to  $x$ ' as performatives, following distinctions developed by Austin (1961, pp. 220–239) and Hart (1963, pp. 145–166). Certain conditions must obtain for a performative utterance to succeed: a transfer of ownership with a sentence such as 'this is yours' requires an appropriate situation, in which the speaker has ownership of the referent of the word 'this', is speaking to an individual or entity capable of owning such property (e.g., not to a wall or a dog), and so forth. A minister who utters those fateful words, "I now pronounce you husband and wife", succeeds in performing a valid marriage only if the bride and groom have reached majority or have parental consent, only if (in some jurisdictions such as Ontario) the bride is not retarded, only if a blood test and license have been obtained, *et cetera*. A friend who utters the words "I apologize" succeeds in making an apology only if he is heard, only if the hearer is the true object of the previous or prospective slight in question, and so on. 'I consent to  $x$ ' may also be (the schema for) a performative. If so, then my argument aims at showing that for it to constitute a valid or successful act of consenting, the utterer (or one signing the consent form) must know what it is that s/he is consenting to; and a physician who accepts as valid a blanket consent referring only to "what, in the opinion of my physicians, is necessary and proper medical or surgical treatment" may not, if the patient is unknowledgeable, have obtained the performance of a valid consent that will release him or her from the moral burden of performing a battery, or from other burdens that will be discussed shortly.

#### IV. THE DUTY TO KNOW PRECEDENTED RISKS AND BENEFITS

The argument for (2) turned on the claim that a necessary condition of the validity of the inference pattern in (2b) is that the patient know what therapy s/he is consenting to. Is this presupposition's satisfaction sufficient for the validity of instances of that pattern and of the consents which result? If it is, then the requirement that attendant risks and benefits be disclosed is at most a right of the patient, and the patient who does not want to know inherent dangers of the treatment or possible benefits expressed in terms, say, of odds of survival with the treatment, may waive disclosure of such information consistent with his/her duty of informed consent.

In order to test this, let us take a second look at what consent

does for the health care provider. It removes a certain moral and legal burden, that of inflicting unwanted touching. This removal of the burden of battery matters in a society such as ours which values health because it is of sufficient importance to our individual and collective well-being to have a supply of health care providers sufficient for our health care needs, and it is unlikely there would be an adequate supply if unnecessary burdens were placed or left on those individuals – quite apart from the ethical issue of fairness.

But then it becomes important to relieve such providers not only of the burden of committing battery when providing therapeutic services, but also of the burden of responsibility for unavoidable, harmful consequences. That is a direct consequence of one interpretation of the principle of non-maleficence, which holds that a health care provider has a moral duty not to harm a patient. The patient, again, would seem to have a duty to do what will relieve his or her physicians of that burden, and what does provide such relief is the acceptance by the patient of the possible negative consequences of the (competently-performed) therapeutic procedure. A voluntary and knowledgeable acceptance of a risk of undesirable consequences renders their occurrence no longer a harm, but rather like an unfortunate turn of events (unlike harms resulting from incompetence or careless practice, to which the patient does not consent).

We must be careful, though, and not require too much. Some consequences are fully predictable, some only with varying degrees of probability, a few virtually unprecedented. If we say that accepting all the consequences of the (properly conducted) treatment entails knowing all the consequences, and that relieving the physician of the burden of inflicting the consequences requires accepting all of them, then we have a requirement that cannot be met in any case where the actual consequences include unprecedented ones. I prefer, rather, to hold that the therapist bears the moral burden only of precedent, resultant harms. Hence, it is possible to relieve the therapist of precedent, unavoidable consequences for which the patient is at risk in consenting to the treatment. With the restriction to precedent consequences, we may recognize a duty in the patient to relieve the therapist of the burden of unavoidable negative consequences.

But could that duty be performed without such risks being disclosed? On the one hand, some physicians prefer not to disclose risks unless the patient seeks such disclosure; so that it is evident

that they are able and willing to bear the burdens of nondisclosure and of subsequent precedented negative consequences with stoic fortitude. Under our analysis, that is their right: if we hold that there is a right of the health care professional to have the patient accept the risks, that does not imply that the health care professional may not waive that right in certain instances and thereby nullify the patient's coordinated duty. Indeed, the physician may well elect to waive this right if the patient waives his or her right to know such matters. Where the traditional relationship of trust by both parties still obtains, the absence of explicit consentings and informings may well reflect such mutual waivers.

But should not a physician be able to say to a patient, "Look, I understand that you want me to do all the deciding, but I'm unwilling to substitute my judgment for yours since there are significant risks to this therapy. Unless you can knowingly accept those risks, I am unwilling to subject you to them"? It seems to me that a health care professional has a perfect right to take such a position (one would hope not so bluntly), and that the patient, like it or not, has a duty to learn those risks and consent to treatment, if s/he will, in possession of that knowledge.

#### V. THE DUTY TO KNOW ALTERNATIVE MEDICAL THERAPIES AND THEIR ATTENDANT PRECEDENTED RISKS AND BENEFITS

A similar argument can be given for this duty as for the previous one. If a patient wishes simply to leave the selection among alternatives up to the physician, must the physician accept the patient's waiver? It seems highly dubious to say that the health care professional must bear this burden, although s/he may elect to do so. Put another way, the patient has a duty to relieve the health care professional from the burden of a subsequent defense of his/her decision among alternatives with different expected outcomes and consequences, and this would seem to require that the patient at least preview the alternatives and concur in the physician's choice.

If one still thinks it possible for the patient to concur in the choice without knowing the alternatives, it is worth considering a situation in which a physician chooses a therapeutic procedure which, say, has among the available therapies maximal disfigurement but a slightly higher long-term survival rate. A patient who chooses not to actively participate in the review of alternatives, say, to radical

mastectomy but simply to trust in her physician's judgment, may have consented to the procedure in full and awful knowledge of the probabilities of cure, recurrence, disfigurement, and the like. Yet, if she learns after the procedure that a lumpectomy, in combination with radiation therapy, has an only slightly lower survival rate, the surgeon may well have to bear her anger at the disfigurement, accepted in ignorance of the alternatives.

Our intuitions are that this is unfair to the surgeon, for it was the patient's willful ignorance of the alternatives until after the procedure that led to the dissatisfaction and has placed on the physician the burden of ingratitude for a job well done. Yet, on the view that the patient has only a moral right to know alternative treatments, it is a consequence of no moral significance of the patient's election not to exercise that right. If we want to retain our sense that ingratitude or dissatisfaction with a well-executed medical procedure that one has authorized is reprehensible, the view that the patient has a duty to know the alternatives and the attendant precedented risks and benefits, as well as to concur in the choice of therapy, becomes highly attractive.

## VI. SOME OBJECTIONS

Several objections to the foregoing analysis can be advanced; I want to deal with three of them, two closely related.

First, it might seem that too much education of the patient would be required for the patient to be able to dispatch this duty to give an informed consent. But this is a problem not peculiar to my proposed conception of the informed consent requirement, but a problem for the rights conception as well. A patient who cannot understand the information being disclosed by a physician may be incompetent, by virtue of ignorance, to exercise the right of informed consent. Such a person would also be incompetent to act in accordance with the duty of informed consent as well. Hence, the problem of patient ignorance and the need to educate patients (or to secure consent from a proxy) cuts against the duty to give informed consent no more than against the right to give informed consent.

Second, this conception of the duty to give informed consent seems to require the patient to know every detail of what is to be done in a procedure, since s/he is to consent to every detail. Hence, if consent is to be possible, only one who has the level of knowledge

of the procedure equivalent to that of the proposing physician or other health care professional will be able to give it. On the other hand, if we acknowledge that a weaker requirement is appropriate, it seems difficult to distinguish between the kinds of knowledge that a patient has when she consents to, say, a mastectomy, and when she consents to whatever the doctor thinks best.

The answer to this can be provided in two ways. One might impose the same standard of information involved in the rights conception: what a reasonable person would want to know, or needs to know to make a responsible decision. This would determine in a rough fashion a body of knowledge smaller than what the surgeon or physician needs to know in order competently to perform the procedure, but more than that needed by the trusting patient who is willing to give *carte blanche* consent. The second way is to note the difference between the concept 'mastectomy' and concepts such as 'whatever Doctor X thinks best'. The former has definite, intersubjective content for those who understand the term in such a manner as to be able to use it correctly; the latter is scarcely more than a referring expression, without cognitive content beyond that involved in picking out certain (undisclosed) states of the physician's mind. Consent to whatever Doctor X thinks best is hollow, since nothing substantive is authorized by such an utterance; whereas, consent to a mastectomy, where the term is understood by the user, authorizes the procedure which follows from the concept. Because the concept has both a use in ordinary language and in the more technical language of physicians and surgeons, the patient can employ it to authorize more than s/he knows in detail, since the general features of the procedure (the surgical removal of breast tissue, the repositioning of a skin graft, etc.) are known and consented to explicitly, with the details of those procedures consented to by implication. While patient education may be necessary to give an informed consent, an M.D. is not requisite.

Finally, let us return to the case of the Jehovah's Witness cited by Beauchamp and Childress. I have attempted to give an argument that would, if applied to this case, have the consequence that the Jehovah's Witness patient has an obligation to the physician whom he has asked to do everything possible to save his life, to consent to what is being done to him, even if that includes being given a transfusion of (someone else's) blood. If the physician wishes to relieve the patient of this duty, it is perfectly consistent with my considerations that he or she do so. But such an act would be clearly supererogatory;

the patient has no right that he not be told, for that would be a right that the physician bear the burden of having performed an unauthorized and unconsented to procedure on the patient; and, as I have argued, no physician has such a duty.

#### VII. SUMMARY

By encouraging the view that informed consent is only the patient's right and not the patient's responsibility as well, bioethicists have too closely followed the lead of the courts and have encouraged this type of all-too-common disappointment with the results of competently performed procedures; this, in turn, has contributed both to the malpractice volume and the more general climate of public dissatisfaction with medicine. That volume and that climate are taking their toll in the attitudes physicians bring to their work, with physicians and surgeons influenced in their acceptance of cases and selection of therapies by whether they think the patient will be dissatisfied with the results (Guinther, 1978).

Asking another to assume the task of restoring one's health, repairing one's broken body, trying to save one's life, is asking a lot. We have in our society elected to emphasize too exclusively the health care professional's responsibility for the choice of therapy and its results, to the exclusion of any sense of responsibility in the patient. I do not want to deny the progress that has been made in emphasizing patient rights; indeed, one of my ulterior motives in this paper is to get physicians to see that it is in their interests as well to seek their patients' informed consent. But it is time for the pendulum to swing back to a more balanced view of the physician/patient relationship, each with both rights and responsibilities to the other.

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