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THE WHITE HOUSE

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To the Medical Society of the County of Niagara,  
New York:

It has come to my attention that the Medical Society of the County of Niagara has been providing free medical care to the unemployed. Congressman John J. LaFalce informs me that your health care coalition will provide needed care for 500 people.

I am grateful for this voluntary contribution of your skills to aid your fellow citizens who are in need. Your action demonstrates that the private sector can help solve community problems in many areas, including health, housing, and education. Through such initiative, we can preserve a balance between private and public responsibility. By working together, government and the private sector can accomplish far more than either could working alone.

Please convey my thanks and best wishes to everyone who has participated in or supported this important program.

Ronald Reagan

# Is There Time For Informed Consent?

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Physicians commonly perceive the requirement of the patient's informed consent as posing grave difficulties. Many general facts about patients seem to support this view. I want to explore this dilemma and to suggest that there are ways of economically approximating the limits of a fully informed patient as a condition of an ethical intervention.

## Obstacles to Informed Consent

Obtaining informed consent is made difficult both by demands on the physician's time and by factors characteristic of patients dealing with disease processes. The patient who is ill, apprehensive, upset, and in pain is a patient who will require extra time and effort to achieve any significant change in his or her knowledge state. Patients generally retain only about 40 percent of what they have been told, and when the process of informing is coupled with a communication of a diagnosis such as cancer or some other potentially fatal condition, the amount of information which registers typically drops to between 10 and 15 percent.

Thus, a physician attempting to communicate the details of diagnosis, proposed treatment, and predictable possible side effects encounters a patient likely to hear only a portion of what he is told. If the requirement is that the patient must understand all of the relevant factual material which a rational person would want to know in making a decision whether or not to undergo a therapy, and the patient

will not remember 60 to 90 percent of what he is told in a given communication, it looks as though the informed consent requirement cannot regularly be met given the short time the physician spends in informing the patient.

It is a simple-minded response to suggest that the physician, therefore, ought to spend more time with the patient. For the compensation of the physician is based on the service performed, not on time spent. To collect revenues sufficient to cover overhead and provide a decent compensation for his or her services, a physician has to carry a certain volume of patients and must bill them at a standard rate—irrespective of the fact that one patient may require extensive discussion and reassurance, while another patient requires a lesser amount of discussion and reassurance. A physician who takes the informed consent requirement conscientiously is one who will predictably encounter decreasing revenues, because he or she will be able to deal effectively with smaller numbers of patients than appropriate levels of compensation require.

The dilemma arises, then, when the physician tries to meet the positive requirement for a rational, voluntary, informed consent through acts of verbal communication with the patient. The time frame is expensively impractical, yet the requirements of ethics are insistent. Is there a way out of this dilemma?

## Alternative Means of Informing Patients

One of the demographic facts about the patient population in this country, which it is easy sometimes for physicians to overlook, is that the general education level of patients has markedly increased in the past 50 years. The capacity to understand relatively sophisticated explanations has increased. Moreover, a variety of communications in the media permit continued development of understanding of physiological processes. Thus, it is increasingly reasonable for physicians to presume a significant level of sophistication in their patients that would permit reliance on the patient to acquire information and understanding through a guided, non-personal process.

Package inserts, film strips, video and audio tapes, printed material, and special instructional personnel all make possible repetition of presentation of material until a level of understanding is achieved sufficient to permit a patient to reach a well-reasoned decision. Such instructional aids can be tailored to the level of educational sophistication of the patient.

The other point that is frequently overlooked in contemplating the relative merits of personal communication versus that of an instructional aid (not at all exclusive) is that the instructional aid provides an objective record of the information

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presented to the patient. Mere reference in the patient's record to that aid's presentation could constitute powerful evidence both that the patient was informed and of the content of that information. Finally, a taped record of a patient explaining back to a physician what it is that he or she understands will be done is excellent reassurance that the consent was well-informed.

Hence, I believe that taking the informed consent requirement seriously (and striving to meet that requirement through processes of informing, educating and testing the patient) is both practicable and morally required. It is practicable because the investment in reusable educational materials is relatively small. It is moral-

ly required because the principle of respect for persons that calls for reinforcing and maintaining the autonomy of the patient where possible, implies that we should make every effort toward preserving that individual's sense of control—particularly at a time when illness, disease, and injury work against it.

**Editor's Note:** This is the second in a series of articles. Richard T. Hull is an Associate Professor of Philosophy and as Assistant Professor of Medicine at the State University of New York at Buffalo. He teaches freshman and junior medical students and undergraduate and graduate nursing students and participates in grand rounds and staff conferences in area hospitals. ■