Office Hours: **Patient Autonomy**

Hi everyone! Thanks for the thoughtful questions and requests to hear more. A lot of the discussion this week had to do with the ER discussion prompt. So we will here say a few things about two of the most common questions raised.

»»» First, many of you wondered what **true consent** might look like in an emergency setting.

In an emergency setting, when someone is critically injured or in need of rapid medical care, the conditions for obtaining informed consent for treatment are far from ideal. Even when patients are conscious and appear competent to choose, health care providers still have little time in which to share full information, check patient understanding of that information, and verify that the patient is truly competent to choose (not to mention free from the influence of others). Too often, even this is not the case: patients may be unconscious, delirious, in shock, or otherwise incapacitated by their injuries.

What, then, are health care providers to do?

Bioethicists distinguish between several kinds of consent. In **ideal**conditions, a patient gives genuinely informed consent to some medical treatment or intervention. But in **non-ideal** conditions, health care workers often rely on what is called **hypothetical** or **presumed** consent.

Hypothetical consent appeals to what a competent, fully-informed, free patient *would* choose in a given health care situation. For instance, a young woman rushed unconscious to the emergency room after a bike accident who needs an immediate surgery to save her life cannot consent to that surgery because she is unconscious—but in most cases health care providers *presume* that if she were conscious and compentent, she *would*consent, and so they proceed with the surgery. **Hypothetical consent** is contrasted with **actual** consent: when a patient cannot actually consent to treatment, providers rely on this form of presumed consent to guide and justify their choices.

As you might imagine, it's important that health care workers do everything in their power to obtain actual, fully-informed consent from patients. Most bioethicists believe that relying on hypothetical consent is justified only when actual consent is impossible, and that this hypothetical consent is immediately nullified by conscious, deliberate refusal of treatment.

So how can providers tell whether it's **ethically appropriate** to rely on hypothetical consent in the particular situation they face?

In the end, as so many of you pointed out in your comments on this week's discussion prompt (Consent in the ER), these judgments can be incredibly difficult to make. Bioethicists typically think of the ethical appropriateness of relying on presumed or hypothetical consent as a sliding scale: the higher the stakes for the patient, or the more urgent it is that a decision be made quickly, the more justified a provider will be in relying on hypothetical consent. The lower the stakes, or the more time that can safely be taken before a decision is made, the less appropriate it is to rely on hypothetical consent and the greater the ethical importance of trying to obtain true informed consent.

»»» As very many of you pointed out, however, **financial issues**also become relevant against a backdrop of privatized medicine. Does it change the equation if what a doctor wants to do will have a severe financial impact on the resisting patient?

First, these are great sorts of questions to raise: the best case studies are ones that are detailed and textured, and so while we want to talk about autonomy and informed consent, we shouldn't pretend that these discussions happen in a vacuum.

Having said that, let's return to our case of the emergency room patient: now suppose that the case is occuring in a **privatized medical system**, in which the patient will be responsible for his or her own hospital bills. Does this detail change our judgment concerning whether the doctor ought to allow the patient to leave?

This issue is raised by the case of Ms. Burton, which you can find here. In this case, the attending physician admits a 38 year old woman who was drinking alone at a bar when she fell and hit her head. Ms. Burton has a headache, and is irritable and impatient, which are all signs of acute brain injury. However, they are also signs of having bumped one's head and been restrained against one's will! If she has a brain injury, then her words and actions are symptoms, and she is not capable of giving genuine consent, so consent should be presumed; if she doesn't have a brain injury, then her words and actions still make perfect sense, and amount to genuine refusal of care. This is a familiar dilemma from this week's discussion; what the case of Ms. Burton adds is that she explicitly tells the doctor that she cannot afford the recommended CT scan.

What does this fact add to the problem?

Well, it adds an additional, legitimate concern, for sure. However, it does not change the basic **structure** of the problem. If Ms. Burton is of sound mind, then the doctor clearly ought not to perform a costly medical procedure; but if she is not, then the invocation of finances doesn't change whether the doctor ought to **presume** her consent.

Do read the case of Ms. Burton and the doctor's commentary—it's a thoughtful, nuanced exploration of all of the relevant issues. And you may be surprised at the conclusion the doctor comes to (and the little twist he drops in at the end!). Whether the doctor's evaluation is correct or not, what we hope it makes clear is that these cases are very difficult, and that locating them within a setting of expensive medical care may, far from ending the discussion, further complicate it.

Keep the great questions coming. We'll see you next week!