"Ethical Dimensions of Informed Consent": A Psychiatric Perspective

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In "Ethical Dimensions of Informed Consent," the ACOG Committee on Ethics addresses the tensions between the extremes of traditional paternalistic coercion and modern psychological abandonment, between the lures of oversimplification and the paralyzing dangers of complexity. Questions of consent in obstetrics and gynecology are made especially poignant by the psychologically loaded implications of the procedures consented to or refused, and their closeness to powerful, universal, and mysterious human drives and values. Consent is also complicated by the inadequacy of information about the outcome of many of the interventions proposed. Nevertheless, as the Committee on Ethics explains so well, informed consent represents a legal, ethical, and clinical imperative. This commentary by a psychiatrist will deal with some of the psychosocial realities impinging on informed consent, and offer clinical suggestions.

Under the guise of informed consent, emotional processes and decisions may masquerade as or be reduced to cognitive ones. Consulting psychiatrists frequently discover that a clear, but unexplored, psychological dilemma is at the root of what seems to be an ethical impasse. For example, the patient who is refusing a lifesaving procedure on grounds of "autonomy" is not aware of, or cannot acknowledge, an overwhelming terror arising from an unresolved past experience. The clinicians cannot grasp the psychological meaning of a religious proscription against a particular intervention (blood transfusion). Resolution of the psychological conflict solves the ethical conflict.

Questions of informed consent in obstetrics and gynecology involve medical/surgical interventions performed on the reproductive organs of women. Discussion of informed consent in this context must take into account women’s psychology, as it pertains both to their reproductive organs and capacities and to their management of medical information, women’s traditional and evolving role in society, and the history of women’s treatment in the medical setting. Women’s reproductive organs tend to be experienced by them and by medical professionals as messy, dirty, troublesome—with the trouble ranging from inconvenient (menstruation) to life-threatening (ovarian malignancies). There has been a corresponding tendency in Western medicine to look
to female reproductive organs as a cause of any perceived female dysfunction ("hysteria"), and to organ excision as a remedy for women's ills. At the same time, women are defined by their reproductive organs and seen as reproductive vessels.

Each of these sociomedical perceptions can distort the process of informed consent. Physicians may underestimate the psychological centrality of genital preservation, especially if reproductive functions are seen to have been fulfilled: "You already have your family." They may overlook the needs and rights of the pregnant woman who uses illicit substances or acquires human immunodeficiency virus because of the physicians' preoccupation with the potential effects on the fetus. Insensitivities in either direction undermine the patient's trust in the doctor, which is essential for effective communication and thus for informed consent. The current realities of training in obstetrics and gynecology allow little or no time to acquire knowledge about psychology, communication skills, or ethics. Doctors in training have little but their instincts and prejudices to draw upon.

In this health care setting, preoccupied with the learning and provision of technical skills, the real state of knowledge—or ignorance—about the long-term physical and psychological effects of those techniques are often overlooked. This cognitive sloppiness also affects the provision of information, and the public's faith in the profession. We know virtually nothing about either the medical or the psychosocial long-term effects of new reproductive technologies. Will the children conceived and gestated in artificially altered hormonal environments be able to reproduce normally? How will they assimilate the knowledge of their unusual origins?

Even where there is scientific information about medical outcomes, it is extremely difficult for an individual patient or her physician to predict how she will feel about a decision in the future. Human motivation and situation are fluid. Sterilization is a frequent example. Even when there is information about long-term satisfaction and regret, the patient and her clinician must decide how to weigh them in comparison with her current wants and needs. The time gap is smaller, but the challenge no less acute, in the case of labor. Can a patient who is not, and/or has never been, in the throes of labor make an informed decision about pain management in labor? Can a patient in labor make an informed decision about the risks and benefits of various forms of pain management in labor?

Another complication is the fact that the perceived necessity for informed consent is governed largely by unexamined tradition. Surgical procedures are seen to require consent, but episiotomy, whose beneficial effects have yet to be scientifically demonstrated, has generally been performed without specific consent. Despite the fact that some pharmacologic interventions entail more risk than some surgical procedures, the numbers and types of medications requiring formal consent have been very limited. The public, which has read about the effects of diethylstilbestrol, questions whether procedures currently considered benign will prove to be so.

In contrast to the dubious members of the public are the many patients who refuse or are unable to process information and make decisions about their medical care. The requirement for informed consent overlooks an innate human need to put one's care in the hands of the healer, and the impact of illness and anxiety on the capacity to make informed decisions. Though no one but the patient can know what a medical procedure will mean to her, patients often ask or demand that the doctor make the decision. The medical profession trained generations of patients to do so. Few patients actually refuse recommended care.

The clinician does not have the luxury of prolonged reflection or procrastination about these fascinating ethical dilemmas. However, tradition,
clinical experience, and personal prejudice are not adequate substitutes. One must help the patient to assess her own history, values, coping style, resources, and plans, and to bring them to bear on her own, autonomous decision. She can be encouraged to imagine the scenarios that will result from the various options with which she is presented. When her indecision is paralyzing, or psychiatric symptoms interfere with her function or well-being, the primary physician can explain that the psychiatric member of the team is often helpful in these situations, and, while making it clear that the primary doctor–patient relationship will continue, arrange a referral to a mental health professional.