

The Role of Unconscious Conflict in Informed Consent

Ben Zeichner, MD

Informed consent refers to the requirement that a patient be apprised of the nature and risk of any medical procedure before his/her physician can claim exemption from liability for damages to him/her. If a patient has not given a voluntary informed consent, a medical procedure is deemed to be unauthorized and recovery for damages may result. Under conditions of emotional or intellectual limitation, or of medical emergency, the central problem of informed consent becomes that of assessing the degree to which individual well-being is furthered by individual autonomy as opposed to medical paternalism.¹

Efforts to formulate a comprehensive legal doctrine of informed consent inevitably have certain assumptions about the role of information and rationality in the exercise of free choice. The operational legal system assumes that normal adults primarily rely upon a logical approach to decision making. In other words, that data are collected, compared, instances recalled, and analyses undertaken of risk versus benefits with physician assistance, ultimately leading to conclusions about various treatment alternatives upon which a patient's decision is based. Naturally such an accomplishment requires a collaborative physician/patient relationship and some discussion beyond mere written consent. What little research on this subject exists is far from conclusive but seems to dispute this view of rationality and lend support to ideas of a less logical basis of decision making.² Even in those instances in which efforts are made to ensure a sympathetic, communicative environment, the nature of human thought process and emotion, some of which is universal and some of which belongs to either individual character or acute stress reactions, will heavily influence patients' decisions.³

Law and psychoanalysis both value personal autonomy. Law attempts to secure it by eliminating social injustices and psychoanalysis by overcoming the instinctual domination of rational thought. Common aims are pursued differently. The law regards a social context, the analyst regards an internal equilibrium of psychologic forces. The law's unease with the subjective question of a patient's personal comprehension has led to the prevalence of the Canterbury Standard⁴ of consent based upon what a "reasonable person"

Dr. Zeichner is a clinical associate professor at Georgetown University School of Medicine, Washington, DC, a faculty member at the Baltimore DC Institute for Psychoanalysis, on the staff of Forensic Psychiatric Services of DC, and a member of the DC Mental Health Commission.

would find relevant to informed voluntary decision making. The California Supreme Court in *Cobbs v. Grant*⁵ discussed its distrust of subjective standards of materiality as follows:

"... it would be surprising if the patient-plaintiff did not claim that had he been informed of the danger he would have declined treatment

Thus an objective test is preferable: i.e. what would a prudent person in the patient's position have decided if adequately informed of all significant perils."⁵

Nonetheless questions of individual, subjective experience insistently recur when assessing materiality, voluntariness, recollection, and understanding.

Problems of Materiality

Information presented to patients must be material to the making of a decision. What, therefore are the cognitive and emotional aspects of materiality that promote and determine decisions? It is often overlooked that proposed procedures are deemed useful or not by decisions previously made by the medical community according to rules of science by which practitioners set great store. Yet, the bases for these scientific conclusions are often unknown by practitioners themselves.

It is somewhat surprising to learn that only 20 percent of current medical procedures are deemed safe and effective by a recent U.S. Office of Technology Assessment study.⁶ The basis of scientific theory is itself a combination of intuition and formality, subject to many emotional biases which are often forgotten.

For example, connections are made in which A is linked to B because of an investigator's idea of resemblance. Researchers have a natural tendency to arrive at concepts of probability and causal connection based upon the ease with which occurrences of comparable kind are perceived and tabulated. Familiar to many researchers is the concept of "adjustment anchoring" in which data are adjusted to fit familiar values and categories of traditional understanding.⁷ Examples such as the medical advocacy of circumcision or routine tonsillectomy are well known and illustrate medical reasoning in the support of customary practices which have not been shown to promote better health.

The validity of medical research is not easy to assess. In an attempt to study this issue, Fletcher and Fletcher⁷ reviewed research designs of 600 randomly chosen medical studies from 1916 through 1976 as reported in medical journals. They found the 1976 studies to be weaker and less precise than earlier studies. The uncertainties of what we know of the natural history of disease are nowhere better illustrated than in the now famous pre-World War II Tuskegee syphilis experiments, in which 85 percent of

untreated controls lived normal lives, 70 percent of which showed no syphilis on autopsy.⁷ One may conclude that, even today with better odds, only a small percentage of ill patients will really be known to benefit from recommended treatment.

The conscientious physician is thus faced with the dilemma of offering material of uncertain relevance to persons in great distress. How he/she does this will depend upon his/her own sense of reality, security, toleration of uncertainty, and ability to sustain a flexible sensitive attitude in situations where his/her own scientific certainty may not be much greater than that of his/her patient.

In this regard, the law may well ask how much a reasonable person should be told in order to make a reasonable decision. How much scientific bias should remain unspoken to reassure doctor and patient alike? Some physicians may deal with disclosure problems by an authoritarian stance, attempting to thus identify with powerful revered figures and deny their own sense of helplessness; others may become preoccupied with obsessive detail, or withdraw prematurely from the decision-making process, or become curt and irritable, rupturing the patient/physician relationship as a means of defensive avoidance.

Problems of Comprehension and Recollection

The manner of presentation of medically important material is known to influence the decision that patients make and to influence what they remember. In a study at the Peter Bent Brigham Hospital, McNeill and Paulker⁷ presented data for patient consent decisions to 838 outpatient subjects, explaining X-ray versus chemotherapy alternatives for lung cancer treatment. When morbidity figures regarding the negative features of each were presented, 40 percent chose X-ray treatment over chemotherapy. When, instead, the benefits of each were given, only 18 percent chose X-ray. A study assessing the retention of material in 100 patients signing voluntary admission forms to a mental hospital demonstrated that only eight knew and recalled the information a short time afterward.⁸ Outpatient schizophrenics asked to describe the drugs benefiting them best could do so in 90 percent of the cases, yet only 40 percent could name any side effects and only 1 percent could name more than one side effect. This is not limited to mental patients. A study in the *New England Journal of Medicine* of 200 female cancer patients showed that one day after disclosure, only 50 percent knew the nature and purpose of chemotherapy versus radiotherapy and only 5 percent could identify one possible complication.^{7,9} It seems likely that emotional factors, anxiety, distortion, and denial substantially influence understanding and recollection.

Psychoanalytic Perspectives

Psychoanalytic theory considers certain basic mental functions such as memory, language, and the capacity for abstract thought to be relatively nonconflicted capacities of the human mind, unless drawn into emotional conflicts by unfortunate developments. One can easily imagine how stresses of uncertainty, physical illness, and dependence upon physicians may substantially weaken these autonomous capacities in most patients. Such a state of affairs calls into question the concept of the "reasonable man," and introduces psychologic complexity into the idea of an objective standard of necessary and sufficient information.

What elements of autonomy and comprehension are necessary to achieve the voluntary informed consent that both law and medicine desire? It seems from what is described above that the mere presentation of risk and benefit data are insufficient and that individual voluntariness and comprehension may fluctuate greatly. Psychoanalytic theory suggests that when confronted with inescapable conflictual situations of great stress, people revert to earlier modes of thinking and feeling, becoming less intellectually autonomous, less reasonable, and more vulnerable to coercion. Even indirect forms of coercion such as hospital routine, staff requests, and impatience can then loom large and may influence consent decisions based upon desires to please or other stress-provoked immaturities not serving one's best interests.

Unconscious Issues

Psychoanalysis has much to say about the relationship of a person to his/her caretaker who is the natural object of needs and desires. The psychoanalytic schools of "object relations" base their theories of psychologic development and treatment upon an examination of such relationships. Kernberg,¹⁰ a proponent of this view, points out that early organization of the human personality involves a mental internalization of one's interaction with a nurturing environment, from which one develops images of oneself, of others, the nature of personal interactions, and their emotional components. Mental mechanisms, such as denial of danger or identification with a parental caretaker, reflect these early relationships which may be reactivated when one fears harm.¹⁰

Examples of the tendency to sacrifice rationality and autonomy for the comfort of imagined childhood security and nurturance are found in the results of Roth and Winslade's Informed Consent Project.¹¹ In this study patients were divided into different groups using different methods to obtain consent for medical research. These included the use of trained informants, video tapes, consent forms, and post-consent interviews. At each step of the consent discussion, despite what they were told of the research process,

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most subjects assumed that their physician was treating them with a primary goal of improving their health. Many ignored the word "research," both written and verbal, and many interpreted it to mean intensive diagnostic study. One must wonder what medical consent means, what degree of consent is possible, and of what "materiality" consists under such psychological circumstances.

Many unconscious conflicts contribute to difficulties in obtaining an informed consent. Conflicts over helplessness, dependency, and physical danger impact upon the perception of one's body image. This is especially so when fantasies of anticipated physical changes relate to functions highly prized or overvalued because of their roles in relationships with early life figures. A patient in his late 30s, unmarried and with little prospect of becoming so, developed a life-threatening cancer that required immediate surgical treatment. His chief concerns were those relating to his future potency and fertility, which could be impaired by the necessary surgery. Consequently, he postponed treatment for more than one month while collecting semen for storage. This man's choice of priorities had much to do with his feelings toward his surgeon whom he saw as protective competent, omniscient, and aloof like the overeducated father with whom he had been in phallic competition.

Another patient, a young woman, desperately wished for a child to fulfill her father's seductiveness and to compensate her for her mother's poor nurturance. She developed early morning nausea and stomach pains, for which she sought assistance from young handsome gastroenterologists. Each in turn raised her hopes for relief, obtained signed consent forms for endoscopic examination, and ultimately disappointed her, as she dismissed him and turned to her next physician.

In these two cases medical explanation was offered, consent discussion took place, and valid consent was obtained; yet, the patient's rational understanding was subordinated to older aims intended for earlier life figures. Ideas of bodily changes, long sought reparations, and triumphs, took precedence over current realistic health concerns and understanding.

As do his/her patients, so does the physician himself/herself struggle against fears of helplessness and mortality. When assailed by cries for protection against danger and oblivion, he/she may seek refuge in a paternalistic role, desiring the false comfort offered by grandiosity rather than addressing more honestly the clinical needs of a difficult case.

A distinguished psychoanalyst suggests in his book, *Talking to Patients*,¹² that . . .

"The assumption of this unique personal authority is needed it seems, to make sure that doctors while doing their extraordinary work are not handicapped by thinking of themselves as ordinary persons. Ordinary people do ordinary things.

Only extraordinary people do extraordinary things . . . it is exceedingly dangerous in my opinion, to do anything to destroy the doctor's sense of his special, even unique attitude toward patient care, his sense of himself as an exception, someone who has been given the tremendous responsibility of doing to other human beings things that no one else is permitted to do."¹²

This justification for a defensive grandiosity would seem to confirm the idea that doctor and patient alike struggle against common unconscious fears, sometimes at the cost of losing touch with the clear-sightedness required for difficult clinical decisions. At such times a patient's intuition that his doctor's urgency for consent exceeds the bounds of clinical judgment may be well founded and lead to a consent based primarily upon needs for mutual reassurances between doctor and patient.

Of course one cannot ask courts to guarantee that every person will always do the best for himself/herself and to offer recovery if he/she does not. Yet perhaps by understanding the different levels of decision making, one may at least gain some appreciation of a patient's capacity for meaningful comprehension and consent.

Levels of Decision Making

Inasmuch as the foregoing discussion deals with levels of rationality and psychologic maturity, from which patients may regress under stress, it seems reasonable to consider types of decisions from the same perspective. Consent decisions reflect one's level of psychologic autonomy at the time the decision is made.

Decision making can be understood as a spectrum of mental activity proceeding from a passive dependent level of simple assent to levels of greater autonomy and maturity. On this first, lowest level, that of simple assent or refusal, higher intellectual functions largely give way to wishes for nurturance and protection by trusted authoritarian figures. At this level the doctor/patient relationship primarily allays the conflicts and anxiety of the patient. The intellectual functions of the doctor supplant those impaired functions of the patient, who, because of immature character or stress, has reverted to an infantile position. Information offered the patient remains largely unquestioned. Ambiguity is rejected in favor of physician suggestion. Voluntariness consists of understanding the doctor's goodwill, patience, and willingness to postpone nonemergent treatments. A well-known example of such a level of assent is the patient who wishes to put himself/herself totally into his/her physician's "hands" and has little interest in explanations beyond those detailing his/her course of treatment.

Higher levels of decision autonomy involve the ability to establish more investment in the intellectual aspects of a decision; to realize that an issue is more complex than assent or refusal; that responsibility for a decision

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and some evaluation of medical issues is one's own responsibility; and that needs for fantasy gratification must be relinquished to focus upon reality with a physician or other professional collaborator. Roth *et al.*¹³ give an example of a woman who demonstrated minimal capacities at this second level of decision making. They describe a nonpsychotic but chronically schizophrenic 44-year-old woman who refused amputation of her frostbitten toes despite her awareness that there was some risk of infection without surgery. She stated, "You want to take my toes off; I want to keep them." She agreed to return if things worsened and did so one month later when she suffered autoamputation of the toes, without infection.

Where capacities for more advanced thought exist and are not unduly compromised by anxiety and regression, one may deal with hypothetical issues or medical presumptions in order to arrive at a position of conviction that will contribute to a decisive act and the ability to live with it afterward. If this point is reached, contemplation of legal action against the doctor would be unlikely without valid cause.

The ultimate level of decision would be one in which emotions and feelings toward oneself, toward beloved others, toward treatment figures, and society can be appreciated and contribute as legitimate factors to the contemplation of either medical or in some cases, of legal decisions. At this point, fears of helplessness, separation, and bodily damage, with their accompanying fantasies, would recede under the influences of reality considerations and considerations for others beyond the self. Insight and judgment would be at their best and the idea of the mature "reasonable" man embodied in the Canterbury decision would be most closely approached.

Conclusions

The idea of informed consent embodied in the law's quest for fairness deals essentially with issues of external and internal autonomy, coercion, independence, and their relationships to one's capacity to use both information and assistance in the service of pursuing vital life goals under adverse conditions.

Claims for damages generally address themselves to the issue of informed consent when other bases of malpractice action are weak, suggesting that a perception of misunderstanding and breach of trust play major parts in the informed consent issue. It is difficult to imagine that fully informed consent can be achieved merely by the formal presentation of medical data or the signing of a written form.

A conscientious practitioner will, in obtaining informed consent, make some effort to respond to the emotional need of his/her patient or client by

seeking a dialogue appropriate to his/her level of mental function. In those cases where problems of competency, communication, or mental illness appear to predominate, psychiatric consultation may be useful. A greater understanding of the levels of human thought and decision should prove to be helpful in addressing both intellectual and emotional aspects of informed consent.

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