

## The Weather Report Model of Informed Consent: Problems in Preserving Patient Voluntariness†

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Just as Sergeant Friday used to tell those he questioned on *Dragnet*, "Just the facts ma'am. We just want the facts," increasingly doctors are being told by the courts and by legal, ethical and social commentators, that their role in medical decision-making is limited to providing the facts.<sup>1,2,3</sup> Advice giving is not warranted. Thus Freidson says:

[T]he professions' role in a free society should be limited to contributing the technical information men need to make their own decisions on the basis of their own values.<sup>4</sup>

Commentators who hold this view make a sharp distinction between facts and values. Facts are important for the doctor to provide the patient. Without facts the patient cannot make a rational decision about treatment. However, the appropriate values are a private matter. Disclosing to the patient values and opinions are illegitimate pressures. Such disclosures are none of the doctor's business. This is the position that I would like to call "the weather report model of informed consent."

The weather report model depicts the professional informing the patient as analogous to the weather report that one can receive by dialing a special telephone number. It specifies a detached almost mechanical person presenting information to the patient. The presenter is not to show his or her opinions, only to present the facts. The frequent use of forms rather than more informal personal communication to convey information is partially a reflection of this model.<sup>5</sup> The proponents of this model are worried about the freedom of the patient to choose. They note, quite correctly, that the immense authority that the society invests in medical professionals makes it difficult for patients to go against the professionals' expressed wishes.

The weather report model specifies several things about appropriate behavior on the part of the professional. To begin with, the professional is to present all the reasonable treatment alternatives to the patient and

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explain the risks and benefits of each. In presenting these risks and benefits the professional is to refrain from two specific types of actions. First, he must not put any pressures of any kind on the patient. While this model recognizes that *there are numerous pressures on the patient from other sources, the professional is supposed to refrain from augmenting these with his own*. Second, the professional is expected to refrain from value judgments of any kind. His information is exclusively technical. The values involved in the decision are intended to be exclusively those of the patient whose role in the decision-making process is to apply his own values to the facts presented by the professional. Just as the weather report does not tell us whether or not to go on a picnic and only the chances of rain, the professional is only supposed to tell us the risks and benefits. If I want to go on a picnic in spite of a 60% chance of rain, that is my business.

This paper seeks to use data from an ethnographic study of decision-making procedures in a psychiatric facility to throw light on the viability of this view of doctor-patient relationships.

### **Methods and Setting**

The data on which this paper depends consists of observations by two observers of the diagnosis and evaluation process on 71 different patients seen in a diagnosis, referral and admission unit of a university-based psychiatric hospital. The hospital contained both a series of outpatient clinics and a number of inpatient wards with a total of approximately 100 beds. Two observers watched the diagnosis and evaluation process. One had responsibility to observe all the interactions in which the staff interacted with or discussed the patient. The other spent all of her time with the patients, observing interviews, discussions with family and interviewing and chatting informally with the patient.

Extensive field notes were dictated each day on all observations. For 48 of the 71 patients the interactions between patient and hospital staff were recorded almost verbatim by the patient observer using speed writing.<sup>6</sup>

This paper will present some descriptive statistics on the decision patterns. These must be understood only as descriptive of the patients we observed. The organization of the diagnostic and evaluation unit precluded taking a random sample and we had to settle for what is euphemistically called "an opportunity sample." While we know of no serious biases in the selection, the sample cannot be rigorously generalized.

#### *External Pressures and Their Uses*

Although hospital staff occasionally argued vehemently with the potential patient about his or her decision, the most substantial pressures on the patient seemed to be from external sources. Thus, in 23% of the cases we saw, the family brought the patient to the hospital in spite of the patient's objection. Even when the patient did not object to

coming to the hospital the family was often present (35% of all cases). In 6% of the cases the family was consulted by the patient by telephone. Thus, almost two-thirds of the cases had substantial and visible family involvement in the decision-making.

In most of these cases the pressure was relatively subtle. An example is the man in his late thirties who was brought in by his brothers. Their relationship was friendly and there were no arguments, but one brother, when asked "What is the main reason your brother is here?" responded, "We finally convinced him that there is something wrong with him and that he needs treatment." However, in 16% of the cases we judged the pressure to be much less subtle. In these cases the family argued vehemently with the patient and/or staff about the decision. However, it is worth noting that this did not always involve trying to get the patient into the hospital; sometimes the family tried to keep the patient out.

The police and the legal system were also a source of pressure. Fourteen percent of the cases involved the police bringing in the patient against his will, and in another two cases they accompanied a non-objecting patient. Likewise, several patients were admitted to the hospital "voluntarily" after court hearings or at the suggestion of juvenile court personnel. In two cases the patient was accompanied by a non-hospital mental health professional, and in both cases they exerted strong pressure on the decision.

At this point one might well object that these pressures are outside the control of the professionals whose job it was to present the information. To continue the analogy, the weatherman cannot be held responsible for the pressures placed on the individual by his family members about whether or not to go on a picnic even if the weather forecast is the substance of the family discussion.

However, the matter is not so simple. For these "external" pressures are often the foci of the pressures that the staff brings to bear on the patient. Consider, for example, the 63-year-old woman, brought in by her nephew, who had been acting bizarrely and fighting with her sister in whose house she lived. When it was suggested that she be admitted, the following exchange took place:

Patient: Oh, don't let me be admitted here.

Staff: Why not?

Patient: Well, I've got plenty of things to do and places to go . . .

Staff: Well, we think you ought to come in and so does your nephew.

Patient: No, I don't want to be here. Why would he think that? He wouldn't want me to come in here . . .

Staff: I understand you are not getting along with your sister.

Another case we observed involved a patient referred by the criminal

court for evaluation following an ambiguous incident in which the patient claimed that he had fallen against a woman in the street and the woman claimed that he tried to molest her. When the patient resisted suggestions that he consider treatment, the interviewing psychiatrist suggested that since the court took the possibility of psychiatric problems seriously enough to refer him perhaps the patient should consider it more seriously. In another case the clinician told a patient who was having a lot of trouble deciding whether or not to admit herself that there was only one bed available in the hospital and that it would be taken pretty soon if she did not take it herself. In all these cases the staff person can be seen as using the external pressures to try to persuade the patient that he or she needs treatment. Likewise, the staff also frequently reminded patients of their family responsibilities and the desires of their families when trying to persuade the patient that it was not necessary to be admitted and that outpatient treatment would do.

A similar type of problem is raised by the recent case of *Marcus v. Liebman*<sup>7</sup> in which the patient sued her psychiatrist for false imprisonment. After voluntarily admitting herself, Ms. Marcus signed a paper to leave against medical advice. The doctor subsequently informed her that if she did not rescind her request to leave she could (or "would," depending on whose testimony is believed) be committed to a state hospital. The court ruled that such a statement by the psychiatrist was a "threat" and could be the grounds for a finding that the patient had been falsely imprisoned. Note that this finding was made in spite of the fact that the psychiatrist only stated a "fact." He did not even express an intention of his own to commit her. The court apparently found that "facts" may be "threats." Since presumably this was a relevant or "material" fact, apparently the court found that not all "material" facts should be presented to the patient. It is also important to note that the court did not deny that the psychiatrist had the right to try to commit the patient.

From one point of view, all of the examples above, both from our field notes and from the Appellate Court of Illinois, consist in simply presenting the risks of various treatment or non-treatment options. They are facts about the consequences of treatment. However, it is also clear that such a process increases the pressures on the patient and lends the professional's authority to the pressures. The problem is that what are factual consequences of treatment and what are pressures — radically opposed categories in the weather report model of informed consent — cannot be clearly distinguished in practice. Thus the weather report model produces conflicting interpretations of what the professional should do.

The staff we observed did not behave like a weather reporter. They advocated what they thought best both by presenting facts favorable to their position and by other means. However, it is interesting to speculate about what would have happened if they had acted like a

weather reporter. Would this have improved or undercut the quality of the patient's decision? What would a completely "free" and "voluntary" decision without any pressures on the patient look like?

*An Unpressured, Unjudged, Decision*

Fortunately we did have an opportunity to observe one decision in which there were neither staff pressures nor family pressures on the patient to decide one way or another, and in which the staff was largely indifferent to the outcome. This involved a consent to release demographic and other information to a county agency which was keeping track of the use of mental health facilities. The hospital policy was that routine reporting of such information would violate the patients' privacy, and it gave the patients the right to forbid the forwarding of the information. Although how the problem was presented to the patient varied depending upon which nurse or doctor was involved, most often the patient was told that it was completely the patient's decision whether or not to allow the information release and that the hospital was "indifferent." Since families did not even know about the decision unless a family member was present, there were rarely any pressures on the patient from either family or staff. This then seems to be a perfect example of what otherwise almost never happened during our study, a decision which was completely free from external pressures, and about which there were no staff judgments. The staff usually played its role as weatherman and no other pressures were significant. Although we saw only nine examples of this decision (staff personnel typically forgot to obtain this consent), how the patient managed the decision is of particular interest to the theory of informed consent.

To begin with, three of the patients seemed to have decided purely on the basis of a mild suggestion from the professional gathering the consent. Thus when told, "The county likes us to send information about the patient but we think that is unfair . . . and you can write that you don't want this sent," the patient responded, "What do you want me to write?" Likewise, when told, "The county likes us to send information about people who consent, do you mind?" another patient readily agreed. In the three cases where the patients were given moderately explicit directions on what to do, the decision seemed to be quite simple.

On the other hand, consider the case of Mrs. A., a moderately depressed young woman with an intact ego, who persuaded the staff to hospitalize her even though they felt she could be managed on an outpatient basis. The observer's notes are worth quoting:

Clinician: Now one more thing. We send the county information about the patients for statistics. If you don't want us to, you have the right to refuse to permit us to send any information about you. Write here OK or not.

The patient didn't seem to understand.

Clinician: If you don't want to you can say 'No.' It is up to you.

The patient hesitated.

Patient: I don't see any reason why I wouldn't want the county to know.

Clinician: If you don't want to, you can write that there.

Patient: I don't understand.

Clinician: What don't you understand?

Patient: You want me to choose whether you will send this information to the county?

Clinician: Yes

Patient: Will that benefit the hospital?

Clinician: Don't worry about the hospital. I don't want to influence you. This is your own decision . . .

The patient eventually refused to release the information and a few minutes later said to the patient observer:

Did you see me? I was so confused about the thing about the county. I thought 'Now if I don't let them release the information will they make me an involuntary patient or is it that if you want a job with them they won't have records on it.' I was getting so confused . . .

Lacking any specialized knowledge of the purposes and dangers of record keeping systems, this patient got confused. Other patients showed similar confusion, whether they were psychotic or not. One patient decided that releasing the information might help her get the county to pay for her treatment since being indigent she was very worried about paying for treatment. Another patient somewhat bewilderedly asked the clinician if releasing the information would interfere with her getting a county job later. When the clinician responded that she didn't want to influence the patient, the patient's spouse suggested that the county might hold it against her future job application if she did not release the information and that maybe it would interfere with other future financial benefits. The patient released the information.

Ms. B showed a similar confusion:

Clinician: The County collects information on cases we get, but if you don't want us to send any information on your case you can just write that here.

Ms. B.: What do you mean? What's that for?

Clinician: (Looking puzzled herself) I don't know. I think it's for statistical reasons.

Ms. B.: Well, I don't see any reason why not. We're not on

welfare or anything.

Clinician: Well, you can write here 'I don't want information to be sent.'

Ms. B.: I don't see any reason why they shouldn't know. I mean we've been trying to get food stamps. We've applied for aid and maybe if they knew about this then I would get it.

Later Ms. B. told our observer: "I've never been on Welfare and if they do send them the information it could be that if I wanted to get separated from my husband that I'd need some kind of assistance from the county."

Still another patient consulted his lawyer, who was present, after failing to get any guidance from the clinician.

The weather report model of informed consent suggests that the professional must not involve his values in the patient's decision. The release of information provides an ideal situation to study the consequences of such a policy because the professional involved frequently had no commitment to either the idea that the information should be kept confidential or that the county should receive the information. Typically they followed the weather report policy of saying nothing except "if you do A, B will happen." Two things must be noted about the workings of this policy.

First, the patients found this policy confusing. They did not seem to find this information adequate. Explicit statements of not understanding and efforts to gain further orientation were frequent. Moreover, the value basis on which eventual decisions were made ended up bearing little or no resemblance to the values that the choice was supposed to involve and little rational relationship to the actual use for which the information was intended.

The problem thus seems to be that when the professional fails to try to provide the patient with value orientation, the patient may be left without any basis for the decision at all. The decisions that patients must make when entering a psychiatric hospital are often highly specialized ones. While the nature of county record systems and their purposes are well-known to professionals who routinely deal with them, they are often a mystery to the patient. While from a professional point of view we may regard the preservation of the patient's privacy as an important Constitutional issue, and the bureaucracy's need for information an important practical matter, the patient may never have considered either. The weather report model of informed consent, in this case at least, seems to be a recipe for confusion, not a procedure for freeing the patient from constraint.

The second problem that this example poses for the weather report model of informed consent concerns the staff's behavior. It is rather easy to see that the staff provided the patient with minimal information.

Part of the difficulty with the consent could have been resolved by a dispassionate description of the effects that the choice would have on privacy and governmental efficiency. This would, of course, imply that these were the relevant values but it was not out of deference to the weather report model that the staff did not provide this information. Rather the staff viewed this consent in the same light that the official hospital policy did, with indifference. Precisely because they were indifferent to the outcome and willing to let the patient choose free of pressure and staff judgment, they also were uninterested in aiding the decision-making process. While the weather report theorist may say that professionals *should not* be indifferent to the decision-making process because they are indifferent to the outcome of the decision, the theorist will find such a moral policy hard to enforce. Like most of us, professionals at the hospital we studied assumed that if the outcome of the decision was unimportant, the process of that decision was unimportant as well.

## Conclusion

### *The Need for Advice*

The weather report model of informed consent seems to have two basic difficulties. First, the distinction between the presentation of information and the application of pressure cannot be sustained. Staff routinely used facts about the risks and benefits of a proposed treatment as a mechanism to pressure the patients into making the decision the staff thought appropriate. While it may be possible to prevent doctors and other medical personnel from pressuring patients about what decision to make, this cannot be done by trying to restrict the staff to presenting only facts about the patient's illness. This may be especially true in psychiatry where difficulties with others which cause families and friends to pressure the patient into treatment are seen as symptoms of the patient's problem.

The second problem with the weather report model concerns the distinction between facts and values. In a highly differentiated society decisions cannot usually be made without the advice and counsel of specialists. It is important to emphasize that such information must go beyond just what will happen. Unless the patient is provided with some explanation of the values involved, the decision we have been discussing will make no sense to the patient. The patient must have his "self interest" explained to him and this involves the staff person going way beyond the weather report model. Evaluations of what are the important points of the decision cannot be left up to the patient alone because he does not have the specialized evaluative knowledge. The professional must do more than tell the risks and benefits, he must clarify the value standards against which these are evaluated. While it is true that one of the reasons patients failed to understand the particular decision that we discussed was that they were not given enough



information, the information that they lacked was precisely the value context. Further value-free descriptions of what was to be done with the information would not have helped.

What this data leads us to is a rejection of the idea of informed consent by the prevailing formula which I have called the weather report model. We cannot insist on "nothing but the facts" and expect this to produce a rational, autonomous decision. We cannot completely divorce facts from values. The doctor must be free to give advice about the meaning of the alternatives.

Moreover, it seems that efforts to keep medical personnel from expressing their opinions are doomed to failure. These opinions can and will be expressed simply by the facts that are presented and how they are presented. We seem to be better advised to simply allow the doctor to give advice and simply try to see that pressures are minimized and alternatives presented.

This is not a call for an abandonment of the doctrine of informed consent. Patients, and all human beings, have the right to know what will happen to them, and the right to prevent what they find objectionable. But the doctrine of informed consent cannot be pushed too far. We cannot use the law as a mechanism to turn the doctor or staff person into a machine, devoid of beliefs, opinions or a desire to influence the patient's choice. Likewise, we cannot expect patients to understand all of the issues about which they must make a choice.

At its best, the doctrine of informed consent promotes an open human dialogue between doctor and patient. This involves more than facts generated by a machine-like doctor. It involves a complex interchange of facts, values, opinions, emotions and advice.

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6. Unlike a number of other papers we have reported from the larger study, this paper includes the findings from 23 cases of a preliminary study designed to test our methods. The modifications in our methods made between pretest and the data gathering were not relevant to the validity or reliability of the data for our purposes here. For further description of the methods of the study, see Ashley M, Sestak RM, Roth LH: Legislating human rights: Informed consent and the Pennsylvania Mental Health Procedures Act. *Bull Am Acad Psychiat Law* (this issue)
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