"Misinformed" Consent

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The doctrine of informed consent presupposes a contractual relationship between a professionally knowledgeable and informing physician and a rational if presumably less knowledgeable patient. Within this traditional paradigm, the physician (in this case the psychiatrist) is expected to inform the less knowledgeable patient about the consequences of a procedure and the possible side effects of a particular medication.

There has been considerable question about the degree of disclosure required. One approach is:

> The general rule has been to disclose even the smallest probability of extremely dire results, such as death or paralysis, as well as minor side effects or complications that are to be more commonly expected.[1]

In general, a more flexible, "reasonable patient" standard is advocated:

> The physician must disclose what an average, reasonable patient would want to know before the patient makes a decision whether to undergo or forego treatment.[2]

Both of these positions may ascribe to the patient a lack of information that is not the case with unexpected consequences resulting, as illustrated by the following case:

> Jun K., a 35 year old Nisei male, had multiple hospitalizations for Schizophrenia, Paranoid Type. He was followed on an outpatient basis without incident using chlorpromazine and supportive psychotherapy. He had a long history of paranoid ideation and was guarded about his feelings. He would occasionally discuss the possibility of having children but dismissed it because of the marginal nature of his wife's adjustment and his own. After three years of treatment, he casually mentioned that the main reason he had not attempted to have children was his conviction that the medication he had taken and was still taking would have caused any

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children to have birth defects. He had never raised this concern previously.

What is the psychiatrist's responsibility, if any, for this patient's idiosyncratic course of action? Jun K. had given his consent to the use of chlorpromazine. This medication was of the utmost importance if he were to maintain his outpatient status. The psychiatrist had discussed at great length with the patient the various possible side effects of chlorpromazine. The patient had never raised with the physician his concern about this specific aspect of his drug usage. The literature makes no mention of any possible teratogenic effect from using chlorpromazine (except for a general caution about its use with pregnant women). The patient's course of action reflected his suspicions and misinformation; misinformation whose source was never pinpointed but seemed to express his generalized suspicion of "the establishment." Jun K. held the psychiatrist responsible for his inaction towards having a family, although he did concede that his inaction also reflected his own ambivalence towards having children. To what extent must the psychiatrist deal with possible misinformation in his concern to obtain informed consent?

Recent Federal regulations governing medical research stipulate that informed consent includes "the description of any attendant discomforts and risks to be reasonably expected."[1] The goal is to increase the patient's awareness of the possible consequences of either undergoing a procedure or using a drug. The doctrine of informed consent attempts to foster the development of cooperative relationships in which physicians and patients rationally act together to determine what course of treatment, if any, should be pursued.

The relationship of the schizophrenic patient and the psychiatrist may not readily follow this paradigm of rational decision-making. A major cause of recidivism and rehospitalization is that outpatients simply stop taking their medicaion. Psychiatrists work with many persons who find it difficult to communicate their basic concerns. The patient's continued use of medication may be discouraged by an explanation of all possible side effects which a guarded and defensive individual might misinterpret. Might the courts hold psychiatrists responsible for the consequences of a patient's not taking his medication because side effects were explained in an overly frightening manner?[3] There has been judicial recognition of the psychiatrist's dilemma:

> The therapeutic privilege is not intended to permit the physician to withhold information that he or she believes will cause the patient to refuse treatment; its purpose is to allow the physician to withhold information that will so upset the patient that rational decision-making will be precluded. Here, too, no hard and fast rule can be announced that all psychiatric patients will be upset by the

disclosure of information to them about the risks of treatment, thus providing the psychiatrist with license to withhold all information. Rather, the applicability of the therapeutic privilege must be dealt with on a case-by-case basis.[2]

Thus, the psychiatrist must constantly steer a course between the Scylla or diffuse underexplanation and the Charybdis of overly dramatic overexplication.

As the case of Jun K. demonstrates, the patient is often a misinformed or partially informed individual who has been repeatedly exposed to media sources that express skepticism of physicians and medication. Frequent side effects are projected onto the use of any medication not administered by a "holistically" oriented physician. Psychiatrists and psychotropic agents are not immune from this suspicion. The recent scrutiny and the limitations accorded the use of inpatient medication reflect this judicial skepticism.[4] The courts have circumscribed the "rational" and the "medically emergent" aspects of consent so that:

> Judicial reliance on the rationality of the patient's consent is being increasingly displaced by the patient's right to assert his or her individual needs in terms of the "contract" concept between patient and physician. As an example, the courts have allowed that the patient has the right in his contract to give "valid but ignorant" consent where the patient desires not to be informed of any aspect of treatment.[1]

It is in this context that the question of "misinformed" consent is raised. A suspicious and guarded patient concealed his fantasies about medication from the treating physician. He significantly inhibited himself because of his "information." Despite his guardedness and lack of questioning, it can be appropriately inferred that Jun K. gave informed consent. Nonetheless, the problem remains.

There is a remedy for the type of problem posed by Jun K.'s case. As we thoroughly outline the possible side effects (both expectable and remote) we should continue with the therapeutic task and ask patients if they have any thoughts or feelings about what the medication will do for them or to them. Exploration of the patient's fantasies and any attendant popular misconceptions helps to demystify psychotropic medication. Drugs will then become a less awesome and more realistic part of the psychotherapeutic transaction. Any loss in placebo effect will be compensated for by the growth of a less adversarial and more cooperative relationship between psychiatrists and their patients.

References

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