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# *A History and Theory of Informed Consent*

by Thomas Beauchamp and Ruth Faden

(New York: Oxford University Press), 1986. xv + 392 pp. \$29.95, Hardback.

Beauchamp and Faden have provided a much-needed study of the history in America of the development and theory of informed consent, and this is a book that is well worth reading. It provided much valuable information about the development of informed consent, and it tries to account for it in contemporary legal and ethical theory. The authors argue that informed consent is relatively new in medical history, only developing significantly after the atrocities of World War II. They note that it developed as a device to protect patients from physicians and researchers who sought to manipulate patients for research or experimental reasons without providing any benefit to the patients. Since then it has developed to encompass those who participate in psychological experimentation as well.

The book first illustrates the moral foundations of informed consent, and the authors ground informed consent on the moral principles of autonomy, beneficence and justice. The legal principles of liability, full disclosure and causation are seen as the legal foundations of informed consent. They note that the legal doctrine of informed consent not only requires that informed consent be obtained, but that information be disclosed. It is interesting that this positive duty is incumbent on physicians, for many argue that the law cannot compel physicians to take any positive actions. In light of this claim, if the law can compel physicians to undertake positive actions such as providing information, it would seem that it could also compel them to provide routine, customary care and routine patient maintenance.

Beauchamp and Faden then provide a history of the doctrine of informed consent, and this section appears somewhat disappointing because it appears to be historically and ethnocentrically limited. There is virtually no mention of the development of this doctrine in antiquity, the middle ages and the early modern period. The authors did little investigation of the thought of medieval or early modern moralists, and one wonders if this was done because it was feared that it would compromise their claims that informed consent should promote pure contentless autonomy in decision-making.

The sections describing the emergence of informed consent in America are helpful, but they seem to be rather narrow in scope. The doctrine of informed consent has developed in other countries where there are other perspectives on it and yet nothing was mentioned of those developments. The chapter discussing the evolution of the U.S. federal policies on informed consent doctrine suggests that this doctrine developed primarily to promote the autonomy of the patient, while in fact it evolved to prevent individuals from suffering psychological or physical harm as a result of research or experimentation.

The authors describe the development of the requirement for informed consent in psychological research, and much information is given regarding contemporary controversies about the ability of individuals to give informed consent is provided. And the controversy between ethicists, psychiatrists and researchers over the ability of patients to give informed consent is concisely presented, well-explained and insightfully criticized.

The most interesting section of this work is that dealing with the theory of informed consent. Beauchamp and Faden develop a rather complete and well-developed theory of human action, and they analyze closely the conditions required for informed consent. They suggest that informed consent in sense<sup>1</sup> as an autonomous authorization is not always and everywhere possible, but informed consent in sense<sup>2</sup> as effective consent is possible in most circumstances. They argue that informed consent is possible when there is "substantial understanding" of the relevant material, and this is a reasonable claim.

They hold that disclosure requirements should demand that health care professionals reveal to patients the benefits which accrue to a treatment, the expected risks, the optional

treatments available and the freedom of the patient to reject the treatment. They admit that it is sometimes difficult to properly communicate with the patient, but they claim that the best way of assuring that the pertinent information has been received is by confirming that it has been communicated to the patient.

They discuss the problem of manipulation, coercion and persuasion of patients. Manipulation occurs when physicians only provide patients with certain forms of information, but withhold other forms of information so that the patient can only make one decision. This is generally considered to be objectionable, but in circumstances where there is sound reason to believe that the patient will make an immoral choice, the withholding of information which would justify such a choice would not seem to be immoral. This is pejoratively called "paternalism", but it is not clear how this differs from responsible professional use of information to protect a patient from immoral and harmful choices.

The authors strongly object to coercion of patients. They seem to define coercion as forcing a patient by means of a threat to consent to a procedure that is in itself immoral. In contrast to coercion, manipulation would seem to be the use, not of force or threat, but information, to bring the patient to a morally good decision. Persuasion, on the other hand, would seem to be the use of arguments or reasons to bring the patient to consent to a morally good action. It would seem that physicians should be morally free to try to persuade patients to consent to morally good decisions and to employ medical information to prevent a patient from making an unethical choice. These distinctions are not fully seen by the authors, and they voice, without adequate justification, objections to all of them.

The authors suggest that informed consent exists to promote the requirements of justice, autonomy and beneficence. Yet when their theory is closely analyzed, it becomes clear that they see this doctrine exists primarily to promote the pure contentless autonomy of the patient. This is made evident for they do not discuss at any length the conditions under which an informed and competent consent can be overridden and treatment applied. The authors provide almost no discussion of the role that informed consent plays in making morally good health care choices possible. If concentration camp patients consented to their torture and malicious experimentation, that would not make those actions morally acceptable and good. Informed consent is in the service of morally good choices, and not merely in the service of the formal and contentless autonomy of the patient.

We must be careful that we do not lose this perspective, for many who are promoting euthanasia by omission of morally required care and treatment are arguing that the wishes of the patient, irrespective of their content, must be given full authority. Medical decisions made by patients with full and complete consent and information can still be immoral, and there is a moral obligation incumbent on the physician to do what is possible to protect the patient from those decisions.

It is unfortunate that the authors do not note how respect for the requirements of informed consent promotes medical practice. The patient-physician relationship should not be one that is dominated by either the physician or the patient, but should be a covenantal relationship between the two. In this relationship, the patient should strive to promote not just his or her own health, but also the development of medical practice and the fulfillment of the objectives of healing. This would mean that the patient must not stand in the way of the health care professional who is seeking to fulfill his or her ordinary, common and routine healing or nursing responsibilities. On the other hand, the physician is to respect the right of the patient to refuse any and all procedures that are purely experimental or not of any clinical benefit. Even further, the patient is to be free to refuse any medical treatment that is judged to be too physically painful, clinically useless or so burdensome financially that relevant ordinary financial obligations could not be met. The requirements of fully informed consent protect patients from unjust harm, but they also protect health care providers who attempt to be fully responsible healing professionals. What is needed at the present time are laws to protect physicians who attempt to provide emergency care or aspects of routine patient maintenance.

Twenty years ago, the popular model of the physician was that of Dr. Kildare, who boldly rushed in to do everything possible to save the last ounce of life. Now the popular image is that of a patient boldly fending off medical treatments which are unwanted, for whatever idiosyncratic reason the patient might have. It is time to find a median between these two extremes and recognize that both the patient and physician must be involved in these decisions, which are the most important in any patient's life. What is needed now is a legal and moral theory of informed consent which protects both the rights of patients to accept and refuse treatment and the right of health care professionals to provide it in accord with their professional responsibilities. Unfortunately, while Beauchamp and Faden provide much useful information about informed consent, they have not been able to provide a foundation for the sort of theory of informed consent that can achieve this objective.

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## *Ethical Issues in Family Medicine*

by Ronald J. Christie and C. Barry Hoffmaster

*Oxford University Press, New York, 1986, 190 pp.*

*Ethical Issues in Family Medicine* was a difficult book to review. It is an important book because it attempts to deal with ethical issues in family practice. I am sympathetic to many of the ideas which emphasize the importance of family practice and the importance of understanding the need for a comprehensive knowledge of each patient, including that patient's relationship to the family unit and its concern, particularly about the individual as a *person* with a major emphasis on emotional factors.

This provocative presentation of a unique theory on ethics in family practice by Christie (a family practitioner now deceased) and Hoffmaster (a member of the philosophy department) apparently rose out of their work together in the family practice program at Western Ontario University in London, Canada. The volume is provocative, in part, because it is unconventional. They find themselves dealing with the current dilemma of establishing a balance between patient autonomy and professional paternalism. They appropriately reject both as absolutes and attempt to arrive at some middle ground. Their answer seems to be to remove moral dilemmas from the area of decision-making (appropriate to a consideration of both autonomy and paternalism) and shift it into a moral grounds in which the family physician becomes virtually the *moral guardian* of both the individual and the family unit. They appropriately point out that the idea of total autonomy in the medical model is a fallacy because, even as a physician informs a patient about his condition, he is necessarily being formative and also conveying almost certainly some type of emotional support. A good physician, as physician, should be doing both.

In the book, the authors give a series of almost too brief clinical vignettes on various topics. They then list the various options for each case report and then begin their ethical discussion. The methodology is appropriate and sometimes helpful but it is, at other times,