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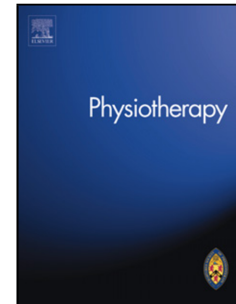

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Informed consent in physiotherapy practice: it is not what is said but how it is said

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Abstract

This paper discusses the concept of informed consent in the context of contemporary biomedical ethics. A change in UK law regarding what information should be provided to patients has brought to the fore the role of physiotherapists in the process of gaining informed consent. It is important that physiotherapists are aware of how this change in the law will affect their practice.

For an individual to consent, they need to have both the capacity and freedom to exercise rational thought. These concepts are challenged in contemporary biomedical ethics. An individual's ability to make rational decisions has been increasingly questioned by empirical evidence from behavioural psychology. In addition, the concept of freedom in contemporary neoliberal societies has also been critically examined. Liberal paternalism has been advocated by some as a means of helping patients to make better decisions about their care. Actualised as a 'nudge', liberal paternalism has been influential in a number of health policies, and has

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recently been discussed as a means of gaining consent from patients for assessments and treatments.

Physiotherapists engage directly with patients and, through this engagement, construct a therapeutic environment that aims to build mutual trust. This paper questions the legitimacy of informed consent, and presents the argument that, through communicative actions, physiotherapists nudge patients into consenting to assessments and treatments.

Contribution of the paper

This paper:

- highlights a change in UK law with regards to gaining patient consent;
- explores the concept of informed consent in relation to contemporary physiotherapy practice; and
- introduces liberal paternalism and nudge theory to physiotherapy practice.

Keywords: Ethics; Informed consent; Liberal paternalism

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<A>Physiotherapeutic practice

Informed consent with regards to treatment is at the centre of the patient–therapist relationship. Regulatory and professional guidance outline the importance of gaining informed consent, and provide clear guidance on what information physiotherapists should provide in order for patients to make informed decisions about the treatments they receive [1,2]. Until 2015, the decision-making processes of healthcare professionals, including the process of gaining informed consent, were assessed in line with the Bolam test [3]. Application of the Bolam test means that the decisions of healthcare professionals are assessed against that of a 'reasonable body of medical opinion'; this included what information to provide in gaining informed consent. A ruling by the Supreme Court in March 2015 [4] now places emphasis on what a reasonable person in the patients' position wants to know, as opposed to what the healthcare professional thinks they should know. The case of Montgomery v Lanarkshire Health Board has resulted in a change in the law regarding what information should be provided to patients in the process of gaining informed consent; healthcare professionals now have a duty to take 'reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments' [4]. For clarity, the term 'material risk' is defined in law 'as either a risk to which a reasonable person in the patient's position would be likely to attach significance or a risk that a doctor knows – or should reasonably know – would probably be deemed of significance by this particular patient' [5]. This change in the law in the UK has been hailed as a positive move towards patient empowerment and patient-centred practice [6–8]. Guidance in response to the change in law has been provided by the Chartered Society of Physiotherapy (CSP), and is detailed in a recent information paper on consent and physiotherapeutic practice [9]. This article will not discuss the recommendations provided by CSP or analyse the legal stance taken by the Supreme Court. Rather, it will explore the ideal of informed consent in contemporary

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physiotherapeutic practice by drawing on literature from behavioural psychology, medicine and nursing. This article will begin by providing an overview of the ethical foundations of informed consent as an enactment of the principle of respect for autonomy; both deontological (actions based on a moral duty) and utilitarian (actions based on achieving a moral outcome) interpretations of autonomy will be considered. The article will then move on to reviewing the fundamental elements of informed consent, namely the ability and freedom to make rational decisions, arguing that neither are truly achievable. Finally, the article will briefly introduce the theory of liberal paternalism and the concept of nudge as a possible means of conceptualising contemporary ethical physiotherapeutic practice with regards to gaining consent.

<A>Informed consent and autonomy

Gaining patient consent for assessment and treatment is the physical enactment of the professional value of respect for the patient's autonomy [10]. Taking this into consideration, it is somewhat surprising that it has received relatively little attention in the physiotherapeutic literature [11]. Autonomy is closely linked to the notion of agency (individual action), both concepts denoting images of selfhood, choice and freedom [12]. Two pre-requisites of autonomy have been identified [13]. The first is rational thought. Autonomy is not simply doing what one wants, but rather doing what one has decided to do, the latter implying some reasoning. The second requirement of autonomous action is liberty (i.e. freedom from external influences) [14].

Within most western healthcare contexts, the principle of autonomy is often given precedence over beneficence (to do good), this being a reflection perhaps of the neoliberal philosophies that currently shape contemporary western societies [15]. The ideals of rational choice and individualistic agency have been challenged by a number of authors and, partly as a response

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to the evolution of these concepts, so has the contemporary understanding of the concept of autonomy [10,15].

Philosophically, autonomy has its roots in deontological and utilitarian ethics, detailed primarily in the works of Immanuel Kant (1724–1804) and Jeremy Bentham (1748–1832).

Deontological ethics was developed by the German philosopher Immanuel Kant. Kant's metaphysical interpretation of morality is based on the foundation of humans having the capacity to reason. Kant formulated a 'supreme moral law' within which humans, through their capacity to reason, had an 'absolute moral value' [13]. Kant's overall interpretation of ethics was that, as in the laws of the physical world, there are laws of ethical behaviour, and thus humans have a duty to act in accordance within these laws, hence deontological or duty bound moral action.

Kant regarded humans to be 'ends in themselves' [16, p. 4], meaning that people should not be treated as a means of achieving something else. One of the most recognisable interpretations of this element of Kant's supreme moral law is 'do unto others as you would have done to you'. This principle of universality asserts that one would not want to be forced into an action against one's will, and thus should not force others. A further important element of Kant's interpretation of ethics is that everyone has a duty towards their own 'perfection' (self-betterment) [16, p. 9], and this is regarded as an end, and as this is one's own end, which is a duty, it must be the end of others. Kant is clear that humans have a duty to help others achieve their ends, but cannot determine what the ends of others are (i.e. what they have defined for themselves as perfection). Finally, Kant makes a distinction between autonomy and heteronomy. For an individual to be autonomous, they must make a decision based upon reasoned 'universally valid moral principles' [14, p. 351]; if an individual's decisions were based upon anything other than their own reasoning (e.g. their emotions or as a result of manipulation by others), they would be acting hetronomously [16].

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The second ethical theory to be outlined with regards to autonomy is utilitarianism. Utilitarian theory states that actions are either morally right or wrong based upon the consequences of those actions [14]. In addition, consequences are judged by how much they contribute to the overall happiness of those affected. The philosopher and social activist John Mill (1806–1873) argued that in order for individuals to be truly happy, they must have liberty, and therefore autonomy is a pre-requisite to an individual's overall happiness. This could be seen as promoting, at its worst, anarchy with regards to human choice. Mill did, however, write in a condition that 'respect for autonomy governs absolutely provided that this does not harm others' [13, p. 64]. Placing this qualification in contemporary interpretations of utilitarian ethics means harm to both self and others. The liberalist interpretation of this being that in order to lead a good life, every competent adult be provided with a sphere of self-determination or, more precisely, freedom of choice [17].

Both classical deontological and utilitarian interpretations of autonomy legitimise, theoretically, the assumption that for individuals to be autonomous, they must have the ability and freedom to make their own decisions. Contemporary interpretations of autonomy in the context of bio-ethics maintain the importance of rational thought and liberty as being pre-requisites to autonomous action. They recognise, however, the temporal and contextual nature of these two concepts but rarely question them [14]. The change in legislation for gaining patient consent highlights the responsibilities of physiotherapists to ensure that each particular patient is fully informed as to how the treatment would affect them; this action arguably requires the physiotherapist to interpret the patient's need(s) and could therefore be interpreted as morally paternalistic. The new legal ruling is seen as a positive move towards enhancing patient autonomy; however, there is mounting evidence that the foundations of autonomy are open to debate, and brings to the fore the moral position of physiotherapists as healthcare professionals in the process of gaining consent.

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<A>The ideals of rational thought and liberty

There is both theoretical and empirical evidence that questions this foundation of autonomy [18]. Normative theories (e.g. rational choice theory) [19] of decision making propose that in order for an individual to make a rational decision, the following assumptions are made: the individual is fully aware of all the key elements related to the decision, including the positive and negative outcomes and their probabilities; they have a fixed set of preferences; they are able to make decisions quickly; and they are not persuaded by emotion [20]. In clinical practice, physiotherapists are expected to create an environment that facilitates these elements of rational thought [1,2]. However, it can be argued that, due to limitations of resources such as time, physiotherapists rarely, if ever, gain informed consent that reflects all the elements identified. The idealised concept of informed consent as a result of rational thought is therefore, at its best, aspirational and, when viewed in light of the emerging understanding of human decision making, unrealistic.

Recognising that individuals rarely have all the information needed at their fingertips, a concrete set of preferences and emotional neutrality when making decisions, Simon [21] formulated the concept of bounded rationality. Having its foundations in behavioural economics, bounded rationality recognises that humans tend to make satisfactory as opposed to optimal decisions [22,23]. Empirical evidence from behavioural psychological studies has shown that humans are over reliant on their intuitive heuristic decision-making capacities at the expense of more effortful and time-consuming processes of reasoning [24–26]. This over reliance on heuristics (rules of thumb) and biases means that the ideal of rational thought is rarely achieved [27]. This will come as no surprise to readers who are familiar with the literature on clinical reasoning in health professions [28].

The second element of autonomous action is liberty. It has been argued that liberty means not being prevented from doing what one desires to do [29]. Using this definition, however, it could

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be argued that the fewer desires one has, the freer they can be. However, this point is challenged because not having the desire to act does not mean that one is free to act [30]; likewise, just because someone can act does not mean that they want to. Freedom is not directly related to desire, but it is related to choice; therefore, liberty as a concept is concerned with the ability of individuals to choose [31]. Freedom, therefore, is being free from external influence, through either coercion or manipulation, in making a decision. There is an issue here, however, as the ability to make a decision relies on having access to information, which means engaging with the social world; as such, freedom from external influences is impossible.

<A>Persuasion, coercion and manipulation

Concerning influence, the act of decision making can be seen on a spectrum of interactions with others. At one pole is persuasion; an individual's decisions are made based upon the 'merit of reason'. Such decisions should be consensual, in that the decision made is the willing agreement of all involved based upon deliberation [32]. The aim of physiotherapists is to gain informed consent by providing their patients with all the information needed to make an informed decision. This includes the potential benefits, harms and alternatives. At the opposite pole is coercion, where a person's decisions are reached because of force or threat. Between the two poles is manipulation [14]. The case against coercion appears clear; healthcare professionals would not want to force or threaten patients into making a decision. However, the distance between the two poles of persuasion and coercion can be vast and is covered by the single concept of manipulation, which concerns any action that is not deemed to be persuasive or coercive.

Manipulation occurs when the capacity for rational thought is bypassed, and includes actions such as withholding information, presenting information in a certain way, gesturing and tone of voice [33]. The ideal that information contributing to a decision made by patients is value

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neutral is naïve. As Cohen [10, p. 7] has suggested, 'there is virtually no substantive communication without manipulation in some trivial sense'; as such, all interactions (with patients) involve some form of manipulation. In this sense, almost all decisions are as a result of heteronomy not autonomy. As Devisch [15, p. 91] has argued, 'when it comes down to human existence, autonomy and heteronomy are intertwined, more than they are merely opposites. Heteronomy is not the dark side of autonomy, and thus something that we should try and eliminate whatever it takes, but rather what constitutes autonomy'. Such a view, however, does not align with the individualism expressed in neoliberal societies, and is not reflected in the change in the law with regards to informed consent to medical assessment and treatment.

Taking into consideration the arguments about both the ability and freedom of humans to make rational decisions, it would appear that the ideal of autonomy is, in contemporary society, unattainable. This does not mean, however, that physiotherapists can forgo their moral responsibilities towards their patients. Physiotherapists have a professional and moral duty [1,2] to gain informed consent from their patients, and thus should help patients to make decisions, but should physiotherapists also help patients to make the right decisions? Both actions could arguably be seen as manipulative [10].

As well as having a moral obligation to respect an individual's autonomy, physiotherapists also have a duty of care. As professionals, physiotherapists have both legal and social responsibilities to ensure that their patients receive their 'best' care possible, which may mean taking a paternalistic role [34].

<A>Liberal paternalism and nudge

The confrontation between patient autonomy and beneficence in the form of paternalism is a significant concern for contemporary healthcare ethics [10]. How can healthcare professionals

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support autonomy while at the same time influencing patients to make the right sorts of decisions? An answer to this seemingly contradictory stance has been provided in the form of liberal paternalism (theoretically) and nudge (practically).

Developed by the behavioural economists Sunstein and Thaler [35], liberal paternalism is a theoretical stance that proposes to maintain freedom of choice (liberalism) while, at the same time, influencing people to make choices that will benefit them and/or society. The latter is achieved by providing information in a way that will appeal to patients' intuitive heuristic decision-making capacities. This process has been termed by Sunstein and Thaler as a 'nudge' [35]. Nudges operate through what is termed 'choice architecture', which refers to the way that information is presented to people. A nudge has been defined as 'any aspect of the choice architecture that alters peoples' behaviour in a predictable way without forbidding any options or significantly changing their economic incentives' [35, p. 8]. Drawing upon the behavioural and psychological evidence, scientists are more aware of how people will respond to certain stimuli and, as a result, the types of decisions that individuals make can be predicted. As Blumenthal-Barby and Burroughs [33] point out, generally, humans respond positively to incentives; rarely deviate from default options; and are heavily influenced when information is personalised, when it appeals to their egos, and when it is given by someone trusted and respected. As an example, consider the use of goal setting in physiotherapeutic practice. Here, a patient's preferences, likes and dislikes are utilised in order for them to find a particular form of therapeutic intervention more acceptable than if the intervention was presented in a value-neutral form. Through goal setting, are physiotherapists not tapping into elements of choice architecture in order to manipulate the patient into adopting their therapeutic recommendations?

Nudges come in a variety of forms and occupy the whole spectrum of what could be considered manipulation. At one end, there are seemingly soft nudges, such as the placing of a picture of

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a fly in urinals as a target designed, it is reported, as a means of cutting down on cleaning bills [35, p. 91], or perhaps the use of antismoking posters in the physiotherapy waiting room. At the other end of the spectrum are harder nudges such as restricting surgery until a patient has lost weight [36]. Morally, both occupy the position of manipulation and take advantage of the same inherent cognitive short cuts that humans employ when making decisions.

Both theoretically and practically, nudges have been hugely influential with regards to health promotion [33]. An example can be found in the recent change in policy regarding organ donation in Wales, where almost everyone is automatically an organ donor unless they choose to opt out [37]. The use of nudges in one-to-one interactions and, in particular, the gaining of informed consent has only recently been highlighted. Cohen [10] makes the claim that it would be unethical not to nudge patients into giving informed consent, this being partly based upon the discussions regarding both freedom and rational thought. The use of nudges in therapeutic interactions generally, and the gaining of informed consent specifically, has also been advocated by Agarwal *et al.* [38, p. 5] who accuse doctors of 'shying away from the concept of manipulation' when they should accept that, although they have a duty to respect autonomy, they also have a duty of care which may require them to manipulate patients in order for them to make better decisions regarding their health.

<A>Conclusion

The use of nudges in gaining informed consent has been criticised [39] and defended [10], and has brought to the fore the issues of medical paternalism and patient autonomy. This is now more pertinent in light of the change in legislation regarding informed consent [4]. Claims that the new legislation will end medical paternalism, although valid, require further examination as it would appear that the 'nudge' is an inherent part of clinical practice.

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So where does this leave physiotherapists? Two issues come to mind. Firstly, with regards to gaining consent, Sokol [5], writing in the *BMJ*, offers this advice: in the process of gaining consent, medical professionals should ask themselves, does the patient know the risks to the treatment being proposed and any alternative treatments and risks? What would a reasonable person want to know? What would this patient want to know? This is practical advice and is supported by the guidance provided by CSP [9]. Secondly, at a more general level, it can be argued that, as well as providing a strong evidence base for the profession, physiotherapists should be addressing the ethical underpinnings of their work. In a post-truth age, there is a risk that patients (and professionals) may question the utility of evidence-based practice. Perhaps physiotherapists should consider what Levy [32] has described as 'nudges to reason', where the aim is to present information in such a way as to enable patients to make 'good' decisions.

Ethical approval: Not required

Conflict of interest: None declared.

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