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Informed consent in rural settings: An Eastern Kentucky case study

The standard model of informed consent in the United States has a two-fold justification. Firstly, any medical procedures done without consent constitute a form of trespassing. Informed consent represents an act of permission giving. Secondly and more importantly, informed consent minimizes the directive role of the physician. According to this second justification, a physician is but a health care advocate (analogous to a legal advocate) whose duty is to provide allegedly value-free information so that the patient can pursue a course of treatment of her choosing. Thus, the treatment respects and maximizes her autonomy. In this respect, the patient is acting in a manner that she would have if she possessed the proper medical knowledge.

This two-fold picture of informed consent—permission giving and decision directing—dominates most hospitals' policies. The purpose of my paper is to challenge both the philosophical motivation for this view and its practical implementation. To wit, my current research on rural health care in Eastern Kentucky shows that this model when instituted in hospitals with underprivileged patients often morphs into a mere bureaucratic hurdle lacking any ethical justification. Patients sign informed consent forms not because they believe or wish to exercise their autonomy; rather, they see it as a necessity in order to obtain health care. The current literature on rural medical ethics has focused solely on the lack of access to quality care and proper ethical consultants. No one has challenged the more fundamental question of whether the standard model of informed consent is appropriate for patients with significantly different needs and background. My paper aims to formulate an alternative model that is more sensitive to diverse demographics while remaining true to the ethical motivations behind the need for informed consent.