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Informed consent to medical intervention: the figure and role of a doctor

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Informed consent reflects a patient's right to decide whether to receive or refuse medical intervention. Ideally, the patient receives all the necessary information from a physician and, consciously, allows the treatment or refuses it. However, in routine practice, a doctor may influence the patient's decision: both because of professional knowledge, and because of the very fact that a patient seeks medical help. It follows from this that voluntary basis of a patient's consent can hardly be absolute, since a doctor often influences his decision to a greater or lesser degree. The article proposes criteria for assessing the admissibility of doctor's influence on a patient when deciding whether to sign informed consent to medical intervention or to refuse it, using the example of cardiac surgery.

Keywords: informed consent, bioethics, medical law, autonomy, doctor's power, discursive power, doctor-patient communication, health care delivery.

Relationships and Activities: none.

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The concept of voluntary informed consent (VIC) to health care and medical intervention is at the heart of the ethical and legal side of working with a patient. The signing of VIC, from the ethics point of view, is an affirmation of respect for the dignity of the individual, the prohibition of any inhuman treatment. From the legal point of view, VIC ensures the legal purity of health service provision, giving a patient an understanding of what he will face, and for a doctor and medical institution — verifying this understanding. Legal practice shows that correct VIC is a tool to protect the interests of the institution and medical workers. However, it is important to understand that behind the formal, legal and ethical aspects lies a psychological or communicative problem, which goes back to a more complex idea of the patient as a person. In terms of *informing*, VIC is included in the so-called narrative of the disease — the patient's idea of his condition and the fact of interaction with the health care system [1]. Clinical practice raises questions about whether a patient can fully consciously sign a consent and be *truly* informed. Thereby, paternalism in the doctor-patient relationship is abolished. Practical cardiology and, in particular, cardiac surgery have their own specifics, which means it also has features of communication with patients, their perception of those questions that require an answer from an ethical and legal point of view.

In accordance with the Constitution of the Russian Federation and universally recognized international norms, people are equal, have free will and the right to personal inviolability (Article 22). It follows from this that the doctor, despite his superior knowledge and understanding of patient conditions, has no right to dispose of his body. Even if the very fact of health service provision presupposes the doctor dominant, this does not mean objectification — transformation of a client or patient into an object. Therefore, medical intervention is possible only with the consent of a patient. This is closely related to human *dignity*, the right to protection of which is described in Article 21 of the Constitution of the Russian Federation. It is in this article that there is a direct prohibition on conducting medical experiments without VIC.

Requirements for patient consent to intervention

In order to meet the requirements from the aforementioned personal rights, consent to medical intervention must be voluntary. After all, "consent" given under pressure (for example, under pressure from a doctor authority) or under indirect coercion (for example, emotionally colored description of disease development) is not, in fact, consent. It is difficult to call the expression of will, since it reflects not will of a person, but the will of the one who exerts pressure. But in order to be able to give truly voluntary consent, a patient without medical knowledge must receive information from a doctor necessary for making a decision [2]. Therefore, medical legislation calls the patient consent necessary for the intervention informed and voluntary. Specifying the requirements for VIC, Article 20 of the Federal Law On Fundamentals of Healthcare of Citizens in the Russian Federation establishes that a consent must be received using information from health worker about the goals, methods of health provision, the associated risk, consequences and expected outcomes. Each aspect should be considered separately.

Preliminary. Preliminary of consent means that a patient must make and express decision *before* the intervention. Potentially questionable here are cases when previously unknown pathologies are detected during the intervention: it is clear that a patient could not give consent to eliminate such pathologies, because did not know about them. In elective cardiac surgery, such cases are rather an exception, because a thorough examination is carried out before such operations. However, if we talk about the surgery of defects, aneurysms and tumors, and even more so in emergency surgery, the scope of the intervention may turn out to be more extensive. In this regard, when fixing the fact of giving a patient informed voluntary consent to cardiac surgery, it is necessary to explain the procedure for doctors' actions when previously unknown pathologies are detected or, in general, the need to change the scope and tactics of intervention. At the same time, from a medical point of view, such a change can be both part of the initial treatment strategy and the result of a change in strategy due to new data.

Voluntariness. Voluntariness implies the absence of pressure on a patient when deciding whether to consent or refuse medical intervention. This aspect is described in the Oviedo Convention [3] as follows: "the person shall not be subjected to unreasonable pressure or influence. To an individual who is in a vulnerable position, even the slightest pressure can be enough to make them feel they are being forced into giving consent against their will" and "pressure involves influencing an individual to agree to something they would not agree to under normal (non-pressure) circumstances".

Of course, the above formulations are rather formal: any patient is in a vulnerable position due to his illness and lack of medical knowledge. The doctor motivates a patient, suggesting ways of treatment. In healthcare practice, this cannot be avoided. A more correct criterion for distinguishing between impermissible and permissible influences is the presence or absence of a direct connection of

a patient's illness with the doctor's motivation and arguments given in favor of the intervention. The weaker the connection between these arguments and illness, the more unfounded the pressure may be. If, for example, a doctor truthfully tells a patient that if the operation is refused, the disease will threaten life, then there is a direct connection. If a doctor is motivated not by concern for a patient's health, but, for example, by his own career, and even more so by finances, then there is clearly no direct connection. If a doctor is concerned about the health of a doubting patient and tries to convince, for example, by appealing to the patient's responsibility to his relatives (for example, "because of illness you will not be able to help your elderly parents"), then such a case could be considered as borderline and leave its qualifications to the courts. But in this case, it is noteworthy that the doctor's point of view is based on knowledge and experience but not on the patient's experience of life. Therefore, the balance between these types of pressure is not easy to maintain, and this requires a high level of communicative competence [4].

Informedness. In cardiac surgery, the aspect of consent informedness is problematic, because it is difficult for a patient without medical knowledge to have a vision of cardiovascular processes, the consequences of influencing it or refusing to intervene. A patient will not *directly* experience the beneficial result of the intervention, while, for example, the words of an otorhinolaryngologist that "the nose will be blocked" or "the ear will stop hurting" give a patient the opportunity to sensually assess the benefits of intervention and compare it with the risks. Even the anticipated result in the form of stopping angina attacks or getting rid of shortness of breath is an indirect clinical result of surgeon actions, and for which, in fact, a patient agrees. Informing in cardiac surgery occurs at the theoretical level. It is far from always that a doctor can use concepts that do not require additional clarification. And if so, then a patient is forced in many respects to take on trust and to submit to doctor's professional authority when deciding whether to agree or disagree with the intervention. As can be seen, in cardiac surgery, the concept of VIC Infor-medness is closely related to the concept of voluntariness. This imposes a duty on a doctor to pay more attention to the availability of explanations and the patient's perception of the information received.

To record the fact of giving consent, it is signed by a patient or, in certain cases, by a legal representative. Here it should be borne in mind that cardiovascular patients may have cognitive or affective disorders. In general, the somatic status creates the basis for psychosocial function [5]. Therefore, a thorough fixation of receiving VIC is especially important in view of possible legal proceedings, since can serve as evidence used in the future to resolve disputes.

Thus, based on the key regulatory legal acts, based on ethical imperatives, a number of questions arise about the concept and procedure for giving VIC. The key ones are as follows: 1) influence on the patient's decision and the communicative role of a medical worker who obtains consent; 2) amount of information and understanding by a patient of actual situation; 3) psychosomatic status of a patient related to the situation of care and information about disease [6]. Answering these questions, one should turn to the concept of *doctor's power* [7].

Doctor power as a factor in medical intervention

Clinical medicine combines biomedical practice with interaction between two following subjects: a doctor and a patient. In order to understand the logic of the legal aspects of VIC, it is worth establishing th e relationship of subjects that provoke a specific (legal) need to record the interaction between a doctor and a patient. If we present a relationship model in the form of a case with details that can be decoded, then in addition to the legal aspects of VIC, the prospect of related problems will arise.

Both a doctor and a patient are people, individuals: social, legal, ethical subjects. Doctor-patient communication is in a special context and carries the characteristics of helping professions*. Considering the figure of a doctor from the legal point of view, it is obvious that a doctor is endowed with professional duties, belongs to the medical community and is responsible for his activities according to Federal Law. There is a formal understanding *that* a doctor can do and what he should not allow in professional practice. Nevertheless, the personality of a doctor has its own philosophy and motives, an individual attitude to the profession and patients' specifics within a particular disease group. So that a doctor-personality and doctor-professional do not contradict each other in the context of medicine, there are deontological and legal standards.

Since it is impossible to program behavior in advance, the standardizing of interactions (formulation of legal rules) will be dynamic and multifactorial even if legal restrictions on actions are concretized and sanctions are articulated. The development of human sciences serves as a catalyst for experiments with various interdisciplinary concepts

* The profession of a doctor as a concept has an ethical trait of virtue, while the nature of this component can be considered separately from a psychological point of view, for example, within the framework of the phenomenon of pathological care.

of doctor-patient interaction, where the legal aspect serves as a line in the sand, and where it serves as a trigger for the bureaucratic process, compliance with which, in turn, makes it possible to distance from situations dangerous from the legal point of view and their consequences. Thus, the receipt by a doctor of medical worker status nominally neutralizes the very possibility of a criminal motive or intent, but at the same time endows a doctor with an inalienable professional privilege — discursive power [8]. The *natural* doctor-patient relationship at its core an inherent feature that distinguishes it from other types of social ties, including commercialized, which determines the rate of their interaction. This feature is *vital needs* from a patient. A patient, not having competence in cardiac surgery, deliberately delegates decision-making to a doctor, while remaining a person, an ethical and legal entity, like a doctor.

Thus, an essential problem is felt in the relationship model — *discursive power of a doctor borders on the patient's subjectivity*. In some situations, a patient loses subjectivity for physiological reasons. And this problem is solved by the concept of a legal representative and a patient centeredness, which incorporates legal and bioethical aspects, providing for situations of force majeure and the impossibility of making a decision by a patient as a person. The dignity and duty of a doctor is implied a priori in relation to the patient's care. This social-medical-legal model is the implementation of the patient's tacit need for qualified care. One way or another, a patient does not compete with a doctor, but interacts with him within a medical culture that has been forming for more than one thousand years.

VIC in the above context is a *consequence of the patient's request* (patient's right to qualified health care), the implementation of decision already made by a patient and the formal result of visiting a doctor — recording this fact. VIC also serves as a horizontal bureaucratic standard — a kind of recording a doctor-patient interaction to protect against sanctions.

Conclusion

The potentially insoluble complexity of the doctor-patient relationship, requiring in practice fairly unambiguous decisions and legal assessment, can be mitigated by a building of communication around the fact of health care. This is especially important in modern medicine, when scientific analysis of the "side" effects of non-medical actions or psychosomatic effects of communication is possible. When receiving a VIC, before an intervention, in particular, cardiac surgery, it is imperative to discuss options for action if previously unknown pathologies are detected. The motivation and arguments of a doctor should be as closely related to the disease as possible. In this case, special attention should be paid to the patient's understanding of the doctor's explanations, and the generalized task of interaction should be the formation of a constructive attitude of a patient to the disease situation. Consent or refusal must be carefully recorded.

Relationships and Activities: none.

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