

Pain: Ethics, Culture, and Informed Consent to Relief

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As medical technology becomes more sophisticated, the ability to manipulate nature and manage disease forces the dilemma of when *can* becomes *ought*. Indeed, most bioethical discourse is framed in terms of balancing the values and interests *and* the benefits and burdens that inform principled decisions about how, when, and whether interventions should occur. Yet, despite advances in science and technology, one caregiver mandate remains as constant and compelling as it was for the earliest shaman—the relief of pain. Even when cure is impossible, the physician’s duty of care includes palliation. Moreover, the centrality of this obligation is both unquestioned and universal, transcending time and cultural boundaries.

Although universally acknowledged, pain is a complex phenomenon for both the patient and the caregiver, influenced as much by personal values and cultural traditions as by physiological injury and disease. The multiplicity of factors that influence the perception and expression of pain take on special importance in the health care setting, where pain becomes an interpersonal experience between the sufferer and the reliever. How pain is signified by the patient and understood by the provider determines in large measure how it is valued and, ultimately, how it is treated.

If the perception of and response to pain are to be understood in a useful way, they must be examined in the context of culture, gender, imbalances of power, morality, and myth. This paper will not address the anthropological dimensions of pain—how patients of different cultural and ethnic backgrounds experience and express pain.¹ Rather, we focus on professional attitudes toward pain management, and we suggest there is a moral imperative for re-

lieving pain that transcends (1) the expressed wish to be treated, and (2) the informed consent process. Even though informed consent has become the lens for viewing the doctor-patient relationship, it is not a singularly useful model in the treatment of pain. We argue that the ethical duty of beneficence is sufficient justification for providers to relieve the pain of those in their care absent rejection of analgesia by a capacitated patient.

Accordingly, this discussion will be framed by the following questions:

- What is the philosophical significance of pain and how is it reflected in the physician’s obligation to relieve pain?
- Do ethnicity, gender, age, and race make a significant difference in how people perceive, experience, and react to pain?
- Do the differing values placed on the expression and relief of pain affect the interaction between patients and providers, or the effectiveness of care giving?
- How are the ethical principles of autonomy and beneficence implicated in the pain experience?
- How is the process of informed consent changed by incorporating issues of pain?

The moral imperative to relieve pain

Pain, suffering, and choice

During the past thirty years, the ethic of medical care in the United States has changed radically. The traditional paradigm was largely paternalistic—the doctor would decide what was medically appropriate and present it to the patient, not for consent, but for assent. Today, the governing ethic is anti-paternalistic. Bioethicists, philosophical and

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legal scholars, physicians, and judges all have made a powerful case for patient autonomy and have objected to paternalistic medicine on the grounds that it supplants patient values and preferences with those of the provider.

Given personal idiosyncrasies, frequent denial of reality, and greater or lesser dependence on others for strength and direction, autonomy becomes very complex. Because it focuses primarily on self-determination and liberty, with less attention to the needs for support, autonomy alone cannot provide a sufficiently rich doctrine to inform the doctor-patient relationship. In defining the moral framework for this relationship, we must consider other values.

Principled analyses of the doctor-patient relationship suggest that it is the dual obligation of physicians to respect and promote the autonomy of their patients *and* to protect and enhance their well-being. This obligation of beneficence requires physicians to do good and prevent harm, the list of goods typically including prolongation of life, restoration of function, and relief of pain and suffering.² Whether something is counted as a good or a harm depends on the specific circumstances, the patient's values, and some shared notions of suffering and well-being.

Despite its subjective quality, the experience of pain is both real and reverberating. As one writer describes it,

Pain is dehumanizing. The severer the pain, the more it overshadows the patient's intelligence. All she or he can think about is pain: there is no past pain-free memory, no pain-free future, only the pain-filled present. Pain destroys autonomy: the patient is afraid to make the slightest movement. All choices are focused on either relieving the present pain or preventing greater future pain, and for this, one will sell one's soul. Pain is humiliating: it destroys all sense of self-esteem accompanied by feelings of helplessness in the grip of pain, dependency on drugs, and being a burden to others. In its extreme, pain destroys the soul itself and all will to live.³

The lay, medical, and bioethics literatures tend to equate pain and suffering, and most people assume that the greater the pain, the greater the suffering. However, as Dr. Eric Cassell⁴ points out, pain and suffering are, in fact, distinct phenomena. He gives as an example childbirth: although the pain can be extreme, many women regard the experience as joyous and life-enhancing.⁵ Conversely, some people may suffer greatly even when they are not in great (physical) pain, perhaps in anticipation of pain.

When pain and suffering *are* closely related, Cassell claims, it is for one or more of the following reasons: the pain is overwhelming; the patient does not believe the pain can be controlled; the source of the pain is unknown; or the pain is apparently without end. Suffering is preeminently a threat to the personhood of patients—a threat not

merely to their lives, but also to “their integrity as persons.”⁶ Only when one's continued existence is threatened in this way can the experience of pain properly be said to cause suffering. Thus, when patients are told their pain cannot be managed, diminished, or controlled, they frequently experience suffering because they believe their personal intactness is jeopardized. In some instances, emotional isolation adds to patients' suffering, as when the physician suggests that the pain is only imagined.⁷

Common parlance often distinguishes among physical, spiritual, or emotional pain, that is, between pain that is physiological or psychological in origin. But, whether we speak of different kinds of pain or of pain and suffering, the relief of physical pain is regarded as a primary moral goal of medicine because of its intimate connection with patient well-being.

As a threshold matter then, it is necessary to understand this relationship between pain and well-being, and why the obligation to serve patient well-being encompasses the obligation to relieve pain. “No one wants to be in pain,” is a rather careless way of expressing a commonly shared assumption. It is important to distinguish between (1) wanting to live a life that is free of pain, and (2) wanting to be relieved of the pain one is currently experiencing. Given a choice between living pain-free and living with some admixture of pain and pleasure, it would not seem wise to choose the former. A life without pain would be rather shallow and uninteresting, and would leave one vulnerable to the injury and disease that pain often signals.

The obligation of physicians to relieve pain is what moral philosophers call a *prima facie* or conditional obligation, something physicians ought to do unless some other duty or moral consideration takes precedence. One such consideration is the refusal of a decisionally capacitated patient to have her pain relieved. Pain control may be welcomed by some who are capable of choosing, while others may view it as yet another instance of unwarranted physician paternalism. For example, if a patient with the capacity to make health care decisions says she wants the pain to continue because for her it has redemptive meaning, then the obligation to relieve pain is overridden. The patient is saying that, although in pain, she is not suffering or that the suffering is chosen and accepted.

A more common reason for electing to experience pain is the choice of cognition and affective response over relief. Many patients refuse higher doses or more potent pain medication because they do not want chemically to compromise their intellectual and emotional awareness. For these individuals, the choice is a deliberate and delicate value-based balance between relief of pain and erosion of personality.

But suppose a patient is incapacitated and clearly in pain. Should efforts always be made to provide relief? Does the incapacity automatically abrogate choice? Although

honoring the wishes of a capable individual shows respect for the person, withholding relief from one who cannot decide or communicate is a form of abandonment, indefensible for caregivers. Compassion, then, is the basis of a moral presumption favoring pain relief. It will always tip the balance in favor of pain relief if the patient can no longer choose or if the patient's intent is in question. Pain is not always devalued, but it is something we need a compelling reason not to treat. The most humane approach, and the one to which caring physicians are disposed, is to relieve pain until evidence of patient refusal is forthcoming.

The response of caregivers to patients' pain behaviors

Just as patients' attitudes about and responses to pain are affected by their personal and cultural values,⁸ so are those of their caregivers.⁹ For example, physicians' clinical judgments about pain are influenced by group-based factors, including age, gender, race, and ethnicity,¹⁰ as well as physical appearance, with the more attractive patients perceived as experiencing less pain than those who are physically unattractive.¹¹

The effect of age and gender stereotyping on how patients are medicated for pain was studied by Karen Calderone.¹² Because physicians and nurses saw women as more emotionally labile and prone to exaggerating pain complaints, they were given analgesia less frequently and sedatives more frequently than male patients. These gender distinctions were not related to the patients' sensory perceptions, only to their overt expressions of pain, with women seen as more expressive. Both men and women under sixty-one years of age received more frequent pain medication than their elders; younger men were medicated most frequently and older women least frequently.¹³

A 1993 study by Knox Todd et al.¹⁴ of patients treated for long-bone fractures at the UCLA Emergency Medicine Center found that Hispanics were twice as likely as non-Hispanic whites to receive no medication for pain. Todd et al. explain the distinction as (1) culturally influenced expressions of pain, and (2) the failure of health care professionals to recognize the presence of pain in patients whose cultural backgrounds differ from their own. The study suggests that the difference in how doctors managed the two groups may occur either when pain is assessed or when analgesia is ordered. A subsequent study of the same population found that, although physicians did not assess pain differently in the two groups, their estimates of pain in both were consistently lower than those of the patients themselves.¹⁵ The ethnically based inequity in pain treatment was found again in the follow-up study, with Hispanics receiving analgesia less often than non-Hispanic whites. Nevertheless, Todd et al. reject the notion that cultural bias among physicians aware of similar pain in two patient groups could account for their undertreating one group.¹⁶

The balance of power between provider and patient is yet another theme in the pain management interaction. So long as therapeutic control is vested in the caregiver, the patient remains the passive victim of pain. In examining the "regularly and systematically inadequate" treatment of severe pain in hospitalized patients, Dr. Marcia Angell¹⁷ asserts that the standard "prn" (administer as needed¹⁸) regimen makes patients powerless supplicants, forcing them to endure pain until the next scheduled opportunity to ask for medication. Even then, she concedes, the request might be inhibited by the patient's "desire to please the medical staff and not be a nuisance."¹⁹ The result is an adversarial, rather than a therapeutic, relationship. Dr. Angell suggests a more flexible regimen, which prevents rather than treats pain and better balances the treatment benefits and risks.

Caregivers' responses to their patients' pain are also shaped by their understanding—often misunderstanding—of pain and the agents for its relief. Numerous studies have demonstrated that inadequate professional education and the susceptibility of health care providers to misconceptions and unfounded fears about opioid addiction and related regulation undermine effective analgesia.²⁰ These misconceptions are also shared by the lay public. A 1993 survey²¹ found that 92 percent of Americans accept pain as an inevitable part of life, with most having either experienced severe pain or observed it in someone close to them. Even so, most Americans were found to reject what they believe to be effective medicinal pain relief because they fear overreliance and/or addiction. These fears, plus concerns about legal liability, are reflected in the stringent laws regulating drug prescription and the suspicion of health care providers who see patient requests for pain relief as drug-seeking behavior related to addiction. The unsurprising result is the routine undermedication of even terminally ill patients.²²

These interesting and counterintuitive findings may have their roots in beliefs that are not peculiarly American, but common to Western cultures generally. Commenting on the Agency for Health Care Policy and Research practice guidelines on pain,²³ Patricia Crowley²⁴ asserts that the current health care standard of treating acute pain retroactively rather than preventively stems from two well established myths of Western culture: (1) enduring pain is a character-building, moral-enhancing endeavor, and (2) patients who receive pain medication will become addicted to the drugs.

Pain, suffering, and death

An article by Dr. Timothy Quill²⁵ presents the obligation of health care providers to help terminally or severely ill patients achieve a "good death." He focuses on the needless suffering of those whose experiences have left them terrified of a bad (painful, prolonged, lonely) death. He argues that it is the provider's duty to relieve pain, suffer-

ing, terror, and fear of abandonment. Dr. Quill notes that, given data that 50 to 100 percent of pain can be effectively relieved, dying patients must be reassured and then provided effective pain control while being helped to remain as alert as possible.

An oft-quoted article by Dr. Sidney Wanzer et al.²⁶ about the care of hopelessly ill patients examines an array of accepted treatment policies, their implementation and deficiencies, including pain management. Dr. Wanzer et al. assert that not only should patients be treated aggressively with pain medication, as much and as often as necessary, but they must also be reassured early in the terminal disease process that they will not be allowed to suffer.²⁷

Physician-assisted suicide, a subject of growing concern within the lay, medical, and legal communities, also has implications for any discussion of pain attitudes, behavior, and management. A substantial body of evidence indicates that many if not most people who request assistance in ending their lives are really seeking their doctors' help in ending their pain,²⁸ and that what patients fear more than the prospect of death is the prospect of life with unrelieved pain. The clear implication is that severe and unremitting pain may make even death seem preferable, and that such a request may in fact signal the need for more aggressive palliation rather than assisted suicide.²⁹

Decision making, informed consent, and pain

Autonomy, beneficence, and consent to pain relief

The ethical principles that classically inform a bioethical analysis are *autonomy* (respecting the privacy and self-determination of the individual), *beneficence* (providing benefits and balancing risks or burdens against those benefits), *nonmaleficence* (avoiding harm), and *justice* (fairly distributing the risk, burdens, and benefits).³⁰ Pain and its relief implicate especially autonomy and beneficence, and discussions of pain management and informed consent highlight the tension between the two principles.

Autonomy underlies decision making that gives priority to the values and wishes of the individual when they are not legitimately restricted by the rights of others. It is only when the individual's wishes are obscure, inaccessible, or overridden by competing principles that the judgment of others is substituted. This concept of the individual and independent self is accorded near reverence in Western cultures.³¹ Indeed, commentators challenge the attempt of American bioethics to define its concepts and frame its discourse in terms so unbiased and culturally neutral as to create the impression of universality. In fact, its principles reflect mainly Western values³² and it is asserted that patient autonomy is almost exclusively a product of the Western preoccupation with individuality and self-control.³³

The principle of beneficence underlies obligations to

benefit others and the ways in which these obligations are fulfilled. These behaviors include actions that defend, prevent harm, and rescue those in danger. Beneficence is the principle with arguably the greatest resonance for caregivers, whose mission is to provide patients with therapeutic benefit and shelter from harm. These notions of nurturing and protecting reach fullest expression in caring for those who are the most vulnerable, conferring a special responsibility on those who care for the very young, the very old, those who are suffering, and those who are incapable of looking after themselves.

In the health care setting, autonomy is reflected most prominently in the doctrine of informed consent. This paradigm of self-determination is the process of knowledgeable and expressed choice whereby a decisionally capacitated individual, who has been apprised of the risks and benefits of a proposed treatment, grants explicit permission for or rejects a particular intervention.³⁴ It is by now well established theory, although not always well established practice,³⁵ that the contemporaneous or prior expression of treatment wishes by a capacitated individual controls the health care decision.³⁶ The doctrine of informed consent represents the legal embodiment of the right to self-determination in health care.³⁷ In addition, it guides the process of medical decision making by defining the parameters of the patient-physician dialogue.

The roots of informed consent

The ethical and legal roots of informed consent provide the basis for its power. The notion of informed consent was initially grounded in the law of assault and battery, holding that any unconsented-to touching constituted an unlawful act.³⁸ The subsequent trend toward negligence rather than battery reflected judicial dissatisfaction with the artificial notion that consent either did or did not happen.³⁹ The doctrine of negligence permits a nuanced examination of whether the discussion reflected the risks and benefits that were material to this patient. Although modern law treats failure to disclose as an action in negligence, the patient's right to make knowledgeable health care decisions has expanded the focus to make the informed consent process act as a protection of privacy and autonomy,⁴⁰ rather than as a barrier to negligent failure of a "duty to warn."⁴¹ Finally, in the current climate of malpractice, cost containment, and managed care, informed consent has become a defensive weapon of risk management.

Courts hearing negligence cases based on absence of informed consent tend to rely on an objective reasonable person standard, which assumes that the reasonable person is one holding Western values and favoring Western-defined approaches to medical decision making.⁴² In contrast, a subjective standard requires physicians to disclose information relevant to the particular patient and judges

whether *that* individual would have reached the same decision absent disclosure. Ultimately, a subjective standard evokes a richer notion of informed consent by considering the diverse ways and the different contexts in which patients and physicians communicate and make decisions. Although courts have not adopted a pure subjective standard,⁴³ recent statute and case law have considered the importance of patients' particular values in making medical decisions and suggest a trend toward a more patient-centered notion of informed consent.⁴⁴

During the past thirty years since the explosion of the various rights movements, the ethical principle of autonomy has become the major support for individual empowerment and self-determination. In virtually every social sphere, the aim has been to level the playing field by eliminating power imbalances caused by race, gender, class, and education.⁴⁵ In the health care setting, the twin notions of patient as partner in medical decision making and patient as informed health care consumer reflect patient autonomy as the controlling principle. Simultaneously, malpractice litigation involving informed consent placed the wishes of the patient, rather than the conventions of physician practice, at the core of possible liability for negligent disclosure. In time, patients came to see informed consent as their offensive security against physician overreaching, while doctors perceived it as their defensive protection against charges of malpractice—the medical equivalent of a prenuptial agreement. The unfortunate result is an adversarial rather than therapeutic climate, with informed consent as the weapon of choice.

Because of its ethical and legal supports, informed consent is now broadly accepted as indispensable to patient rights, the violation of which essentially invalidates the legal and ethical propriety of medical treatment. However, autonomy itself is a doctrine that may be imposed on individuals whose values support a more communally experienced ethic. The elevation of patient autonomy to its preeminent position has increased the potency of explicit patient permission to the point where it effectively trumps all other avenues for determining and implementing what is in the patient's best interests. Exalting the patient's right to exercise autonomy has correspondingly restricted the doctor's discretion and opportunities for therapeutic intervention. Ironically, the pursuit of greater patient power has actually devalued the physician's duty of beneficence. The obsession with autonomy has led to a fetish of informed consent that substitutes delivery of consumer-chosen health *care* for the provision of patient-oriented health *caring*.

Barriers to a universal and inflexible informed consent requirement

Although the principle of autonomy, manifested through knowledgeable consent, is routinely required for therapeutic

interventions, we argue that, for at least two reasons, informed consent should not be invoked in decisions about pain management. Substantial evidence confirms that the key elements in the pain experience (the perception and expression of pain; the relief-seeking behavior and response to it; and the capacity or willingness to assume decisional responsibility) are highly complex and dependent on numerous variables. The informed consent doctrine depends entirely on the elevation and expression of self-determination. Under these conditions, requiring that pain management rely exclusively on or be constrained by an affirmative act of patient consent threatens to undermine the very foundations of the caregiver duty of beneficence.

Legally valid informed consent can only be provided by a decisionally capable⁴⁶ individual. The presence or absence of decisional capacity is evaluated according to the specific decision under consideration, with a higher level of capacity generally required for those decisions carrying greater risks.⁴⁷ If a person clearly has the capacity to understand and process his situation, reference values, consider the consequences, and make his wishes known, then his decision should control and his consent is required.⁴⁸

This analysis does not apply to the formerly capable and communicative individual. Often, when choices must be made, age or illness has destroyed the abilities of reasoning and expression. If this incapacitated individual, while still capable, had articulated treatment wishes prospectively through advance directives (by appointing a health care proxy agent, by executing a living will, or by leaving explicit oral instructions), those directions should be respected and implemented even though capacity has lapsed.

Likewise, people unable to grant informed consent either because they have lost capacity through age or infirmity and left no advance directives, or because they never were capacitated (such as newborns, children, and mentally retarded adults) are excluded from the requirement to provide consent. Their health care decisions must be made by surrogates using substituted judgment (based on what is known about the patient's values and preferences) or the best interest standard (based on the surrogate's evaluation of the patient's welfare). For these individuals, many of whom require pain control, the informed consent requirement is fulfilled by others acting on their behalf, although some notion of their assent may be important. In these situations, surrogate refusal of pain treatment is ethically problematic, especially if it is based on fear of addiction. Consider, for example, the young man who is dying of end-stage AIDS. He is wasted, obtunded, and writhing in pain. His mother, who cannot accept either his diagnosis or his prognosis, refuses to allow him to be given pain medication because she does not want him to become addicted. In this instance, the caregivers would have to overrule a mother's misplaced attempt to protect her son in order to do what is, in fact, in his best interests.

The second reason why informed consent cannot always frame health care determinations about pain is that individual autonomy is not the universal paradigm for decision making. The architecture of informed consent represents a legal attempt to find and secure the patient's voice in medical deliberations and to equalize the balance of power between patients and their physicians. It is also increasingly a risk management strategy to protect the institution from later liability by demonstrating that the risk of negative outcomes was known and accepted by the patient. The patient voice sought, however, echoes a notion of autonomy based on Western cultural values that favor the individual over the community, self-reliance over dependence, action over passivity, scientific rationality over spirituality, and forthrightness over harmony. This doctrine focuses on the right—often, it seems, the obligation—of the individual to make decisions concerning medical treatment. In addition, it advocates candor and assertiveness regarding the disclosure of medical prognosis, treatment options, and their risks and benefits. Finally, it promotes the active participation of the individual patient, rather than family, community, or other surrogates, in medical treatment decisions.

It is important to bear in mind that this preoccupation with patient autonomy does not apply universally. Western values often clash with world-views held by non-Western cultures that may place greater emphasis on spirituality, family and community, or authority and social stratification. These communitarian ethics may value less assertive decision-making processes and encourage deference to physician judgment. By mechanically applying narrow Western-defined doctrines of autonomy and informed consent, American law deprives non-Western cultures of their proper position of power and actually devalues the notion of autonomy.⁴⁹ The very meanings of health, illness, and healing are shaped by cultural values. Sensitivity to these distinctions encourages critical thinking about how they affect medical care discussions and decisions, as well as the experience and expression of illness, disability, and discomfort—issues that form the essential background for considerations of pain control.

Finally, it has been suggested that, when a person is in extreme pain, truly informed *consent* may not be possible. Caregivers have an ethical obligation to inform the capacitated patient about the salient effects and side-effects, benefits and risks of pain management options, especially those related to use of narcotics, to help the patient to reach an informed *decision* about treatment. But, despite the best efforts to provide relevant information and elicit the patient's values and wishes, severe pain may erode an individual's cognition and autonomy. A patient suffering such pain often can think of nothing except relief and will agree to anything that will provide it. For such patients, truly free and informed consent may be an illusion.⁵⁰

Exceptions to informed consent

Inevitably, the rigid express permission requirement has necessitated the invention of ways to get around it in order to provide patients with the care they need. These loopholes are embodied in three well established exceptions to the informed consent requirement: medical emergency, therapeutic privilege, and waiver.

In an emergency, the patient might be precluded from consenting because of unconsciousness or incapacity, and life-saving treatment delay or failure would result in harm so grave as to outweigh any potential harm of a proposed treatment.⁵¹ Under these critical conditions, courts agree that physicians may dispense with informed consent, so long as they conform to practices customary in such emergencies. Some courts even hold that in emergencies, consent is implied.⁵²

The second exception falls within therapeutic privilege, under which information may be withheld from the patient when, in the physician's judgment, disclosure of the information would itself be harmful to the patient.⁵³ Some commentators strongly criticize this exception, arguing that it risks destroying the theory of informed consent and signals a return to medical paternalism.⁵⁴

The third recognized exception, waiver,⁵⁵ provides either statutory⁵⁶ or judicial⁵⁷ support for patients to give up their right to receive and to act on medical information. The notion of waiver acknowledges that some patients lack the confidence to analyze risk data or prefer to depend on their physician's professional judgment; others simply prefer not to hear adverse information, or choose to depend on family judgment.⁵⁸ Patients may waive their right to receive relevant information, and they may also waive the right to make a specific decision or any decision at all.⁵⁹ As a result, the waiver mechanism accommodates diverse cultural values by respecting alternative approaches, such as family-centered decision making and deference to physician authority. Because the patient remains in control of the decision-making process by choosing when to allow others to make the actual treatment decision, the waiver also upholds the value of self-determination. In theory, then, the law allows patients who understand their right of waiver to relinquish their right to grant informed consent so long as the waiver is given with full information and without coercion.⁶⁰ In fact, in the health care setting, waiver is rarely used because risk management concerns require the patient's expressed consent to protect the institution from liability.

In addition to these customary exceptions, it has been necessary to create other varieties of nonexpressed consent to validate the notion that treatment has been authorized. Most relevant are *presumed consent*, derived from a general theory about the way rational people behave, and *implied consent*, inferred from the actions of a particular individual in a specific circumstance.⁶¹ The presumption underlying both exceptions appears to be that, because

people will invariably opt for treatment to restore health, individuals who are physically or cognitively incapacitated can also be presumed to prefer health and would consent to therapeutic intervention if they were able to do so. Thus freed from the need to obtain expressed informed consent, the physician's twin duties of beneficence and nonmaleficence trigger a default posture that supports treatment.

Informed consent and the management of pain

Predating the current emphasis on patient autonomy, the duty of beneficence has been a core value of the healing professions, incorporating the relief of pain as well as the promotion of healing. It has been claimed that relieving pain is a "moral duty, based on both beneficence and respect."⁶² And yet, despite this ethical mandate, it has been repeatedly demonstrated that caregivers routinely, often deliberately, undermedicate patients in pain.⁶³

Aside from the few exceptions noted, informed consent is required for most treatment interventions, especially those that are invasive or carry more than minimal risk. It is interesting, therefore, that pain control interventions are traditionally exempt from this requirement. As a matter of practice, physicians are expected to ask patients about drug allergies and inform them about the proper dosages and potential side-effects of prescribed pain medications, and pharmacists are required to enclose warning labels and information about synergistic effects; but there is no formal requirement that patients give informed consent for analgesia.⁶⁴ It is true that pain medication is routinely given on a prn basis, which requires patients to request the medication and thereby affirmatively signal their consent to receive it. Recently, patients have also been given the option of patient-controlled analgesia, whereby they actively participate in the decisions about and administration of their own pain medication, usually through a self-regulated intravenous pump.⁶⁵ Finally, it is certainly plausible that a patient who does not want pain medication at all and is able to communicate that preference would have that refusal honored. The crucial point here is that these circumstances apply only to patients who are decisionally capacitated or at least alert and articulate enough to determine and communicate whether they want pain relief.

The more challenging situation involves those patients who are decisionally incapacitated or unable to communicate, and who require surrogate decision-makers to authorize treatment interventions. Perhaps an individual has left an advance directive stating that, should he become incapacitated and be in pain, no analgesia is to be administered. Even in the absence of contemporaneous refusal or explicit advance instructions, enough may be known about him, about his values and beliefs, to determine that he is or was the sort of person who finds meaning in pain.

However, the duty to honor the refusal of analgesia

issued prospectively by a currently incapacitated patient is significantly weaker than the duty to honor the contemporaneous refusal of a capacitated patient. It has even been argued that the currently incapacitated patient may be so different from the formerly capacitated one that they are in effect two distinct people with different interests.⁶⁶ However, when there is no advance directive and inferences must be drawn about what the patient would want, not making an effort to relieve the patient's current pain is even more ethically problematic than proceeding without expressed instructions. It would be both irrational and inhumane to withhold relief because of inability to request it. Analgesia is routinely given when patients are *understood* to be in pain. Physicians and nurses, using their well developed skills of observation and clinical judgment, evaluate patients' body language, cardiac and respiratory function, facial expressions, emotional signals, and verbal and nonverbal cues, and do what they believe their patients would want done for them.

Applying the primacy of patient autonomy to the issue of pain management, one could argue for yet another exception to the informed consent requirement that would be applicable to an incapacitated patient in pain. It is generally acknowledged that, except for the rare instances when pain is believed to have some character-building or redemptive quality, people desire to be rid of the pain they are currently experiencing, even though some may choose to endure it as the only alternative to diminished consciousness. If *presumed consent* is that which can be expected of most people, then the incapacitated postoperative, terminally ill, or grievously wounded person can be presumed to consent to pain relief intervention. Likewise, if *implied consent* is that which can be inferred from an individual's conduct, then the incapacitated person writhing and moaning in pain certainly can be believed to consent to the administration of analgesia. It is a short step from there to the concept of an implied waiver by which an incapacitated patient in pain is understood to delegate decisional authority regarding analgesia. It could even be argued that an individual who seeks medical attention is, by definition, seeking relief of the presenting pain and/or implying consent to the relief of any pain resulting from treatment.

Although it is tempting to subscribe to these arguments and suggest that pain management requires no expressed informed consent because the patient is believed to have given presumed or implied consent, or waived consent altogether, we decline the opportunity to use such flimsy contrivances. Rather, we submit that providing relief from pain is central to the very notion of healing and, for that reason alone, it requires no exceptions or intellectual artifice for its validity. Indeed, we agree with the following sentiments regarding implied consent:

[I]t is quite obvious that implied consent is a legal

fiction. Clearly there is no consent in this [emergency medical] situation. Rather, the law gives physicians a *privilege* to provide treatment in emergencies, even in the absence of consent, in order to promote other important societal goals besides individual choice—namely, the preservation of life or the restoration of health.... [I]n such a situation a physician has an obligation to do what is best for the patient.⁶⁷

We do not accept the proposition that the caregiver's twin duties of respect for persons and beneficence are mutually exclusive in the realm of pain management or even necessarily conflicting. Rather, we argue that principled and compassionate caring embraces both the respect for and the protection of persons.⁶⁸ It has been claimed that beneficence can legitimately outweigh autonomy when it is clearly in the best interests of the patient and, especially, when the treatment interventions are consistent with the patient's own therapeutic goals.⁶⁹ We would go further and argue that the current obsession with patient autonomy risks courting a form of patient abandonment in which healers are prevented from healing, and those in pain are denied relief because expressed consent is lacking. To succumb to such reasoning demonstrates a lack of respect for patients and places caregivers in danger of sacrificing beneficence on the altar of autonomy.

The persuasive argument that the individual's diminishing cognitive capacity changes her needs and goals⁷⁰ carries the implicit notion that decisions, such as advance health care directives, made by a formerly capacitated person are not *necessarily* appropriate for the now incapacitated person, and caregivers should not be bound to honor these directives if they are clearly contrary to the patient's current best interests. The implications for pain management are compelling. The person who, never having experienced severe pain, says, "No matter what happens, I do not want pain medication," may feel very different about the need for analgesia when experiencing an attack of renal colic. The caregiver might well be justified in giving more weight to the individual's current relief-seeking behavior than any prior theoretical statements. Likewise, an incapacitated patient's signals of pain can and should speak as clearly as any articulated request for relief.⁷¹

Conclusion

Pain, although universally acknowledged, is experienced in ways that vary with ethnicity, gender, age, class, and condition. The implications for health care are obvious. If culture is a lens through which the world is perceived and understood, each refraction will depend on the particular prism employed. People bring their culturally determined values and behaviors to all consequential experiences, especially interpersonal encounters. The meaning pain holds

for sufferers and the person(s) attending them determines the intensity with which it is perceived and the response it calls forth. Substantial differences among patients, families, and caregivers in their perceptions of and reactions to pain can affect significantly the ways in which pain is expressed, the ways in which relief is requested, and how it is administered.

The importance of decision making is nowhere more striking than in the health care setting. Issues of control and choice, influenced by cultural background, current illness, and perceived obligations, are brought into sharp focus as people from different vantage points grapple with complex and emotion-laden dilemmas. The twin duties of autonomy and beneficence assume special significance in this context. Self-determination, valued most highly in Western cultures, is articulated in the doctrine of informed consent, required for almost every therapeutic intervention. Yet, the duty of beneficence, reflected in the caregiver mandate to relieve pain, can be seen to transcend boundaries of culture and even self-determination. Ultimately, compassion speaks in the most forceful and universal tongue to relieve pain.

References

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6. *Id.* at 36.

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8. See *supra* note 1.

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Valid or Biased?," *Social Science and Medicine*, 40 (1995): 537–43.

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13. See also a discussion of "learned inhibitors" to nurses' appropriate decision making regarding treatment of pain. M.A. Greipp, "Undermedication for Pain: An Ethical Model," *Advanced Nursing Science*, 15 (1992): 44–53; and B.R. Ferrell, "When Culture Clashes with Pain Control," *Nursing*, 25, no. 5 (1995): 90.

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16. Recognizing the impact of these factors, researchers have developed ethical approaches to cross-cultural encounters and decision making in the health care setting. See, for example, Jecker, Carrese, and Pearlman, *supra* note 1.

17. M. Angell, "The Quality of Mercy," *N. Engl. J. Med.*, 306 (1982): 98–99.

18. Abbreviation for the Latin *pro re na'ta*, "according as circumstances require." *Dorland's Illustrated Medical Dictionary* (Philadelphia: W.B. Saunders, 27th ed., 1985): at 1355.

19. See Angell, *supra* note 17, at 98. See also Gail Davis, suggesting that the patient should be an active participant in, rather than a recipient of, the pain management process. G.C. Davis, "The Meaning of Pain Management: A Concept Analysis," *Advanced Nursing Science*, 15 (1992): 77–86.

20. See, for example, F.X. Mananey Jr., "Proper Relief of Cancer Pain Is Worldwide Concern," *Journal of the National Cancer Institute*, 87 (1995): 481–83; Foley, *supra* note 15, at 13; K.M. Foley, "Pain and America's Culture of Death," *Wilson Quarterly*, Autumn (1994): 20–21; H. McIntosh, "Regulatory Barriers Take Some Blame for Pain Undertreatment," *Journal of the National Cancer Institute*, 83 (1991): 1202–04; D. Doyle, "Morphine: Myths, Morality and Economics," *Postgraduate Medicine Journal*, 67, Supp. 2 (1991): S70–S73; M. Zenz, "Morphine Myths: Sedation, Tolerance, Addiction," *Postgraduate Medicine Journal*, 67, Supp. 5 (1991): S100–S102; J. Porter and J. Jick, "Addiction Rare in Patients Treated with Narcotics," *N. Engl. J. Med.*, 302 (1980): 123; and R.K. Portenoy, "Opioid Therapy for Chronic Nonmalignant Pain: A Review of the Critical Issues," *Journal of Pain and Symptom Management*, 11 (1996): 203–17.

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22. See Rouse, *id.*

23. Agency for Health Care Policy and Research, *Clinical Practice Guidelines, Acute Pain Management: Operative or Medical Procedures and Trauma 2* (Rockville: Dept. of Health & Human Services, Pub. No. 92-0032, Feb. 1992).

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Journal of Contemporary Health Law and Policy, 10 (1993): 383–403.

25. T. Quill, “You Promised Me I Wouldn’t Die Like This!,” *Archives of Internal Medicine*, 155 (1995): 1250–54.

26. S.H. Wanzer et al., “The Physician’s Responsibility Toward Hopelessly Ill Patients, A Second Look,” *N. Engl. J. Med.*, 320 (1989): 844–49.

27. “The proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness.” *Id.* at 847.

28. See, for example, K.M. Foley, “Pain, Physician-Assisted Suicide and Euthanasia,” *Pain Forum*, 4 (1995): 163–78; T.E. Quill, “When All Else Fails,” *Pain Forum*, 4 (1995): 189–91; C.B. Berde et al., “Proper Palliative Care Should Reduce Requests for Euthanasia and Physician-Assisted Suicide,” *Pain Forum*, 4 (1995): 195–96; Foley, *supra* note 20; W. Breitbart, “Suicide Risk and Pain in Cancer and AIDS Patients,” in C.R. Chapman and K.M. Foley, eds., *Current and Emerging Issues in Cancer Pain: Research and Practice* (New York: Raven Press, 1993): 49; T.E. Quill, “Death and Dignity: A Case of Individualized Decision Making,” *N. Engl. J. Med.*, 324 (1991): 691–94; and Quill, *supra* note 25.

29. T.E. Quill, C.K. Cassel, and D.E. Meier, “Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide,” *N. Engl. J. Med.*, 327 (1992): 1380–83. William Breitbart asserts that “[p]ersistent pain and terminal illness are the most common reasons for euthanasia or physician-assisted suicide.” Breitbart, *supra* note 28, at 49 (citations omitted).

30. See generally T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 4th ed., 1994).

31. See, for example, H.S. Warren, “Unlimited Human Autonomy—A Cultural Bias?,” *N. Engl. J. Med.*, 336 (1997): 954–56.

32. See Jecker, Carrese, and Pearlman, *supra* note 1.

33. E.D. Pellegrino, “Patient and Physician Autonomy: Conflicting Rights and Obligations in the Patient-Physician Relationship,” *Journal of Contemporary Health Law and Policy*, 10 (1993): 47–86. Dr. Edmund Pellegrino also argues that this biased view of autonomy prevents care providers from recognizing that some patients may not want to make health care decisions and that beneficence and respect include adapting to multicultural considerations and not imposing an unwanted burden of autonomous decision making. See E.D. Pellegrino, “Prologue: Intersections of Western Biomedical Ethics and World Culture,” in E.D. Pellegrino et al., eds., *Transcultural Dimensions in Medical Ethics* (Frederick: University Publishing Group, 1985): at 13–19.

34. See Beauchamp and Childress, *supra* note 30, at 128.

35. See, for example, a study by Dr. Joan Tenon and Dr. Joanne Lynn recently asserted that, in spite of substantial publicity and educational efforts, very few people at the end of life have advance directives and, when they do exist, these prospective instructions have little effect on medical care. G. Kolata, “Documents Like Living Wills Are Rarely of Aid, Study Says,” *New York Times*, Apr. 8, 1997, at A12.

36. See, for example, *Mohr v. Williams*, 95 Minn. 261 (1905) (holding that “the free citizen’s first and greatest right, which underlies all others—the right to himself—” precludes even the most skillful medical or surgical intervention without patient consent); *Pratt v. Davis*, 224 Ill. 300 (1906) (holding that, unless there is an emergency or a circumstance where disclosure would be harmful to the patient, a capable individual must be consulted and must give consent before surgery can be performed); *Natanson v. Kline*, 86 Kan. 393 (1960) (upholding the

necessity for physicians to employ discretion in disclosure of information to patients); *Salgo v. Leland Stanford University Board of Trustees*, 154 Cal. App. 2d 560 (1970) (introducing the term “informed consent,” and holding that the physician is under an affirmative duty to disclose the risks, benefits, and alternatives to the proposed treatment intervention); *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (holding that the physician is obliged to provide sufficient information about a procedure’s risks so that a reasonable patient can make an informed decision); *Moore v. Regents of the University of California*, 51 Cal. 3d 120 (1990) (holding that informed consent requires physician disclosure of “personal interests unrelated to the patient’s health” but potentially affecting medical judgment); and *Arato v. Avedon*, 5 Cal. 4th 1172 (1993) (holding that the duty to obtain informed consent does not require a physician to disclose a patient’s statistical life expectancy).

37. Presently, each of the fifty states and the District of Columbia have legally recognized patient rights by adopting an informed consent doctrine.

In addition, the U.S. Congress has expressly legislated patients’ rights to individualized medical decision making. The Patient Self-Determination Act (PSDA) (42 U.S.C.A. § 1395cc(f) (1992)) advocates patients expressing their wishes about future treatment in the event they become incapacitated. PSDA requires all health care facilities funded by Medicare or Medicaid to inform patients on admission of their right to execute advance directives under the laws of the respective states. Although most people use these written instruments prospectively to *refuse* care, advance directives are value neutral and can be used to *request* care as well.

38. See, for example, 95 Minn. 261; and 224 Ill. 300. See also A. Kiev, “A History of Informed Consent Doctrine,” *Applied Clinical Trials*, 2 (1993): at 61; J. Katz, “Informed Consent: Ethical and Legal Issues,” in J.D. Arras and B. Steinbock, eds., *Ethical Issues in Modern Medicine* (Mountain View: Mayfield Publishing, 1995): at 88–91; President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*, at 18–20 (1982) (hereinafter *Making Health Care Decisions*). The question in a battery action is whether the physician informed the patient of the nature of the procedure and whether the patient consented to the intervention. Proponents of the battery theory argue that its purpose is to protect bodily integrity, thus linking informed consent to the principle of personal autonomy. See R. Faden and T. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986): at 26–27. Critics counter that the theory is useful only when a physician intentionally withholds information or acts beyond the scope of the patient’s consent. *Id.* at 29–30. Battery law is also criticized as limiting physicians to a single defense, that of having obtained explicit consent or, in an emergency situation, presumed consent. See Pellegrino, *supra* note 33, at 78. Others maintain that battery theory disadvantages the patient because many courts are reluctant to view physicians as acting in bad faith or in an antisocial manner. See, for example, Faden and Beauchamp, *id.* at 29–30, 127–28. Currently, Pennsylvania is the only state that characterizes the lack of informed consent as battery. See *Gray v. Grunnagle*, 223 A.2d 663 (1966), *on reh’g*, 228 A.2d 735 (1967) (finding that, based on a battery analysis, consent to treatment must be knowledgeable and informed). All jurisdictions, however, permit a battery approach when consent is absent or is determined to be absent for a particular procedure. F.A. Rosovsky,

Consent to Treatment: A Practical Guide (Boston: Little Brown, 2nd ed., 1990): at § 1.3.

39. In contrast to the battery analysis, the negligence theory of liability examines the defendant's unintended harmful act or failure to act. The elements required to establish negligence include the presence of a legal duty, the breach of that duty, measurable injury, a direct causal link between the breach and the injury, and a proximate causal relation between the act and the injury. Thus, to win the case, the patient must prove physical injury. See Rosovsky, *id.* at §1.3. Advocates of negligence theory applaud its allowing physicians to invoke many defenses and acknowledging that most physicians act in good faith. Opponents argue that negligence theory reduces the informed consent doctrine to a "failure to warn law," based more on professional liability and the expectations of the medical profession than on patient decision making and self-determination. See J. Katz, "Informed Consent: A Fairy Tale? Law's Vision," *University of Pittsburgh Law Review*, 39 (1977): at 139. Other commentators argue that the negligence theory's emphasis on proving physical harm ignores the rights-based aspects of informed consent. See R. Dworkin, "Medical Law and Ethics in the Post-Autonomy Age," *Indiana Law Journal*, 68 (1993): at 729 ("The loss of dignity, autonomy, free choice, and bodily integrity that is so exalted in the rhetoric of informed consent is worth nothing at judgment time.").

40. See, for example, *Canterbury*, 464 F.2d 772 (D.C. Cir), *cert. denied*, 409 U.S. 1064; and *Wilkinson v. Vesey*, 295 A.2d 6769 (R.I. 1972). See also Kiev, *supra* note 38, at 62.

41. *Making Health Care Decisions*, *supra* note 38, at 20.

42. See Beauchamp and Childress, *supra* note 30, at 147-48, 142. For an analysis of informed consent as upholding patient choice and a proposal for reframing the doctrine as a constitutional right to patient choice in medical decision making, see M.M. Shultz, "From Informed Consent to Patient Choice: A New Protected Interest," *Yale Law Journal*, 95 (1985): 219-99.

43. This judicial reluctance may reflect fears that the patient, in retrospect, will decide that the information not disclosed was material to the decision and that, with full disclosure, she/he would have declined treatment. See *Canterbury v. Spence*, 464 F.2d 772, 790-91 (D.C. Cir. 1972) ("It places the physician in jeopardy of the patient's hindsight and bitterness, thus an objective test is preferable....").

44. *Arato v. Avedon*, 858 P.2d 598, 606 (Cal. 1993) (finding that "the contexts and clinical settings in which physician and patient interact and exchange information material to therapeutic decisions are so multifarious, the informational needs and degree of dependency of individual patients so various, and the professional relationship itself such an intimate and irreducibly judgment-laden one that we believe it is unwise as a matter of law that a particular species of information be disclosed.").

45. Note the civil rights and feminist movements in general, with examples from education (the *de jure* and *de facto* integration of religious and ethnic minorities into educational institutions; the admission of women into formerly all-male schools); art (serious artistic criticism of the highly suggestive, and to some offensive, art; greater acceptance of homosexuality as an artistic subject and homosexuals as actors in drama); sports (the acceptance and success of athletes from ethnic minorities and alternative sexual orientation); professions (women and (religious and ethnic) minorities increasing their presence in medicine, law, and academic faculties). Note the parallel consumer movement awakening the buying public to its right to full disclosure as a prerequisite to informed purchasing.

46. Mental capacity or competence has been defined as "[s]uch a measure of intelligence, understanding, memory, and

judgment relative to the particular transaction (e.g., making of will or entering into contract) as will enable the person to understand the nature, terms, and effect of his or her act." *Black's Law Dictionary* (St. Paul: West, 6th ed., 1990): at 986. Although the terms *capacity* and *competence* are often used interchangeably, for bioethics purposes there are important distinctions that go beyond semantics. *Competence* is technically a legal designation made only by a court, whereas health care decisions are a matter of medical determination. Because the legal system is rarely involved in decision making in the clinical setting, it has become customary to refer to the patient's *capacity* to make health care decisions, and to refer to the decisionally *capacitated* or *capable* individual. See B. Lo, "Assessing Decision-Making Capacity," *Law, Medicine & Health Care*, 18 (1990): 196-97; see also Wanzer et al., *supra* note 26, at 845.

47. See Beauchamp and Childress, *supra* note 30, at 138-39.

48. According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, capacity to make health care decisions requires "(1) possession of a set of values and goals; (2) the ability to communicate and to understand information; and (3) the ability to reason and to deliberate about one's choices." *Making Health Care Decisions*, *supra* note 38, at 57 (footnote omitted).

49. For example, a study found that traditional Navajo culture includes the belief that reality, rather than being reflected in language, is shaped by language. Because great importance is placed on avoiding negative thoughts or speech, policies requiring discussion of end-of-life issues in compliance with PSDA become ethically problematic in the Navajo community. See Carrese and Rhodes, *supra* note 1. Likewise, attitudinal variations have been found toward disclosure of diagnosis and prognosis of terminal illness and end-of-life decision making among elderly subjects from different ethnic backgrounds. Although European Americans and African Americans preferred the patient autonomy model, Korean Americans and Mexican Americans preferred that family members deal with medical information and decision making. See Blackhall et al., *supra* note 1; and Murphy et al., *supra* note 1.

50. John D. Arras, interview with Ronald Kaplan, M.D., Department of Anesthesiology, Montefiore Medical Center, Bronx, N.Y. (1992).

51. See Beauchamp and Childress, *supra* note 30, at 147-48, 142. For an analysis of informed consent as upholding patient choice and a proposal for reframing the doctrine as a constitutional right to patient choice in medical decision making, see Shultz, *supra* note 42.

52. See B.R. Furrow et al., *Health Law* (St. Paul: West, 2nd ed., 1991): at 435.

53. See Kiev, *supra* note 38, at 104; and Beauchamp and Childress, *supra* note 30, at 150.

54. E. Patterson, "The Therapeutic Justification for Withholding Medical Information: What You Don't Know Can't Hurt You, or Can It?," *Nebraska Law Review*, 64 (1985): 721-71.

55. The U.S. Supreme Court defines *waiver* as the voluntary and intentional relinquishment of a known right. See *Miranda v. Arizona*, 384 U.S. 436, 475-76 (1966); and *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

56. See, for example, Alaska Stat. § 09-.55.556(b)(2) (Supp. 1989); Ark. Code Ann. § 16-114-206(b)(2)(c) (Michie 1987); Del. Code Ann. tit. 18, § 6852(b)(2) (Supp. 1994); N.H. Rev. Stat. Ann. § 507-C:2(II)(b)(3) (1983); Utah Code Ann. § 78-14-5(2)(c) (Supp. 1995); and Vt. Stat. Ann. tit. 12, §1909(c)(2) (Supp. 1990).

57. See, for example, *Arato*, 858 P.2d 598 Cal. (holding that a patient may validly waive the right to be informed); *Holt v.*

Nelson, 523 P.2d 211, 219 (1974) (holding that “a physician need not disclose the hazards of treatment when the patient has requested she not be told about the danger”); and *Cobbs v. Grant*, 502 P.2d, 112 (1972) (holding that “a medical doctor need not make disclosures of risks when the patient requests that he not be so informed”).

58. Lawrence Gostin proposes that the conflict between the patient autonomy-based informed consent doctrine and the family-centered model of caring may require legal reform to promote cultural diversity in health care decision making. He suggests a standard of disclosure based on patient values, including the right to decide *whether* to receive medical information. L.O. Gostin, “Informed Consent, Cultural Sensitivity and Respect for Persons,” *JAMA*, 274 (1995): 844–45.

59. See A. Meisel, “The ‘Exceptions’ to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking,” *Wisconsin Law Review*, (1979): 413–88. See also Carrese and Rhodes, *supra* note 1 (discussing the importance of respecting an individual’s culturally based need *not* to know and adopting a more communal style of decision making).

60. Some commentators frame patient waivers in terms of patient self-determination. See A. Meisel, “Entrapment, Informed Consent, and the Plea Bargain,” *Yale Law Journal*, 84 (1975): at 694. It has been suggested, however, that legal precedent and the litigious nature of contemporary medical practice require framing the issue as one of “informed” waiver, obligating physicians to alert patients to their right to waive, as well as to the consequences of forgoing knowledge of the medical risks and benefits. For a more complete discussion of informed waiver, see E. Gordon, “Multiculturalism in Medical Decision Making: The Notion of Informed Waiver,” *Fordham Urban Law Journal*, 23 (1996): 1321–62.

61. For a description of the several types of nonexpressed consent, see Beauchamp and Childress, *supra* note 30, at 128.

62. See B. Schoene-Seifert and J.F. Childress, “How Much Should the Cancer Patient Know and Decide?,” *CA—A Cancer Journal for Clinicians*, 36, no. 2 (1986): at 90.

63. See *supra* notes 20–29 and accompanying text.

64. It is important to distinguish between *anesthesia* (“loss of the ability to feel pain, caused by administration of a drug or by other medical interventions”), which requires informed con-

sent, and *analgesia* (“absence of sensibility to pain ... designating particularly the relief of pain without loss of consciousness”), which does not require informed consent. See *Dorland’s Illustrated Medical Dictionary*, *supra* note 18, at 79, 70.

65. It is interesting to note that patients using patient-controlled analgesia not only have a greater sense of control over their pain and its relief, they often use less analgesic medication. Telephone Interview, Dr. Carole W. Agin, Director, Pain Management Service, Dept. of Anesthesiology, Montefiore Medical Center, Bronx, N.Y. (1997).

66. See R. Dresser and J. Robertson, “Quality of Life and Non-Treatment Decisions for Incompetent Patients,” *Law, Medicine & Health Care*, 17 (1989): 234–44.

67. N.S. Abramson et al., “Consent: Informed, Implied, and Deferred,” *JAMA*, 256 (1986): at 1892 (footnote omitted) (emphasis in original).

68. “The principle of respect for persons incorporates at least two ethical tenets: first, that individuals should be treated as autonomous agents; and second, that persons with diminished autonomy (including minors) are entitled to protection.... [B]eneficence[] is the obligation to secure the well-being of persons by acting positively on their behalf and maximizing the benefits obtained.” S. Leikin, “The Role of Adolescents in Decisions Concerning Their Cancer Therapy,” *Cancer Supplement*, 71 (1993): at 3342.

69. See P. Levendusky and L. Pankratz, “Self-Control Techniques as an Alternative to Pain Medication,” *Journal of Abnormal Psychology*, 84 (1975): 165–68; see also P.A. Schulte and K. Ringen, “Notification of Workers at High Risk: An Emerging Public Health Problem,” *American Journal of Public Health*, 74 (1984): 485–91.

70. See *supra* note 67 and accompanying text; and R. Dresser and P.J. Whitehouse, “The Incompetent Patient on the Slippery Slope,” *Hastings Center Report*, 24, no. 4 (1994): 6–12.

71. See, for example, “Some patients are ‘barely conscious,’ ‘stuporous ... with negligible awareness of self, other, and the world.’ Their capacity for sentience gives such patients an interest in avoiding pain and other unpleasant physical sensations, which justifies the administration of pain-relieving medication and other palliative measures.” See Dresser and Whitehouse, *id.* at 10 (quoting N. Rango, “The Nursing Home Resident with Dementia,” *Annals of Internal Medicine*, 1026 (1985): 835–41).