In private practice, informed consent is interpreted as providing explanations rather than offering choices: a qualitative study

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Question: How do physiotherapists working in private practice understand and interpret the meaning and significance of informed consent in everyday clinical practice? Design: Qualitative study using semi-structured interviews. Participants: Seventeen physiotherapists purposefully recruited from metropolitan private practices where treatment was on a one-on-one basis. Results: Therapists defined informed consent as an implicit component of their routine clinical explanations, rather than a process of providing explicit patient choices. Therapists’ primary concern was to provide information that led to a (therapist-determined) beneficial therapeutic outcome, rather than to enhance autonomous patient choice. Explicit patient choice and explicit informed consent were defined as important only if patients requested information or therapists recognised risks associated with the treatment. Conclusion: Physiotherapists defined informed consent within a context of achieving therapeutic outcomes rather than a context of respect for patient autonomy and autonomous choice. Physiotherapy practice guidelines developed to ensure compliance with ethical and legal obligations may therefore be followed only if they fit with therapists’ understanding and interpretation of a desired therapeutic outcome. [Delany CM (2007) In private practice, informed consent is interpreted as providing explanations rather than offering choices: a qualitative study. Australian Journal of Physiotherapy 53: 171–177]

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Introduction

Informed consent has a history in law, ethical theory, and clinical practice (Faden and Beauchamp 1986, Appelbaum et al 1987, Beauchamp and Childress 1994). The moral principle of autonomy provides the ethical basis of informed consent (Faden and Beauchamp 1986) and from this basis providing information and obtaining informed consent should be formulated from the patient’s perspective, even where the treatment involves very little associated harm or risk (Beauchamp and Childress 1994, Coy 1989).

This research seeks an understanding of how physiotherapists understand and interpret the meaning and significance of informed consent.

In order to analyse physiotherapists’ rationales for obtaining informed consent, a comparative framework or model of analysis was developed from a review of the biomedical and physiotherapy ethics literature relating to informed consent (Delany 2005). The ‘iceberg’ model (Figure 1) consists of the ethical theory of autonomy in below-surface layers which support the obligation to obtain patients’ informed consent to treatment in above-surface layers. Below-surface layers comprise foundational moral theories in Layer 8 (Kant 1785, Mill 1875); ethical theories of autonomy in Layer 7 (Dworkin 1988, Young 1986); biomedical ethical principles in Layer 6 (Beauchamp and Childress 1994), and in Layer 5, ethics-based models of practice of informed consent (Lidz et al 1998, Brody 1989). Above-surface layers are more familiar to practitioners as they represent professional interpretation of the ethical theories. They comprise in Layer 4, legal obligations and guidelines (Skene 2004, Vines 1996, Kerridge and Mitchell 1994, Delany 1996, Elkin 2001); in Layer 3, physiotherapy-based ethics literature about informed consent (Delany 2005); in Layer 2, how physiotherapists understand and interpret informed consent; and at the tip of the iceberg, what physiotherapists are actually doing in practice (Magarey et al 2000, Grant and Trott 1991). Compliance with the above-surface layers that focus on what should be done in practice presumes that clinicians have an understanding of the expectations of the below-surface layers. However, few studies have examined this understanding and interpretation of ethical theory from a clinician’s perspective (Darvall et al 2001, Dharmananda 1992).

In the physiotherapy literature, discussion about informed consent concerns the validity of information given to patients (Refshauge et al 2002), and practitioners’ compliance with both legally-based guidelines and ethical obligations (Delany 1996, Magarey et al 2000, Grant and Trott 1991, APA 1988, Kerry 2002, Magarey et al 2004, Rivett et al 2006, Magarey et al 2004). Most of the debate has centred on Layers 3 and 4 of the iceberg model (see Figure 1) as a measure of what therapists ought to do in practice and whether they are complying with written guidelines.

By examining and analysing therapists’ understanding and interpretations of informed consent (Level 2 of the iceberg model), this research aimed to highlight how ethical theory and legal and professional guidelines for practice are synthesised and implemented by physiotherapists. The research aim is derived from recognition that therapists’
own values, knowledge, understanding, and interpretation inform and guide their communicative practices implicitly and explicitly within the physiotherapist/patient treatment encounter (Plaud 2001, Titchen and McGinley 2004, Thornquist 1994). The research question, therefore, is:

1. How do physiotherapists working in private practice understand and interpret the meaning and significance of informed consent in their everyday clinical practice?

Method

Design

The study used a qualitative grounded theory design (Strauss and Corbin 1990; Mellion and Tovin 2002). A grounded theory approach involves collecting data about phenomena or experiences. Analysis of this data then involves interpretation and synthesis of themes arising from within the data to formulate explanatory theories and concepts of a social phenomenon (Creswell 1998, Strauss and Corbin 1998). In this research, the phenomenon was therapists’ understanding and interpretation of informed consent.

Audiotaping individual physiotherapy treatments by private practitioners was followed by audiotaping semi-structured interviews with the practitioners. This paper reports the data obtained from the interviews. Semi-structured interviews occurred at the workplace of the physiotherapists at a time they specified. After transcription of each interview, summary notes and memos were written to record and capture the author’s overall impressions of the interview process (Hammersley and Atkinson 1998). Interview audiotapes were transcribed by a trained transcriber, and then read several times by the author whilst listening to the tape so that any transcription errors could be corrected and a more detailed understanding of the transcribed data could be obtained. Ethical approval was obtained from the University of Melbourne Human Research Ethics Committee and informed consent was obtained prior to participation in the research.

Participants

A purposive sample of 17 physiotherapists was recruited using a publicly-available list of private practices in Victoria, Australia. Therapists were asked to participate if they were representative (Patton 1990) of a metropolitan private practice, where treatment was on a one-on-one basis and patients chose to attend the practice. Therapists were chosen for heterogeneity of experience and postgraduate physiotherapy education (Table 1).

Data analysis

The overall sample size of 17 was determined according to the grounded theory concept of theoretical saturation (Glaser 2002), when conceptual explanations arising from analysis of the data were well developed, and importantly, no new themes emerged from ongoing data collection (Dey 1999).

In accordance with grounded theory methodology, analysis of the interview data involved a series of iterative (Edwards et al 2004) or repetitive analytic steps. The transcripts of the interviews were printed and pasted into large notebooks with wide margins allowing for notes next to each page of transcript. Each line of the data was numbered and was read, coded, and categorised according to its content.

In the first step (open coding), questions were asked of the data (Creswell 1998) such as: How do therapists describe informed consent? When do they think it is necessary? How do they relate it to other types of clinical communication? The next step (axial or theoretical coding), involved building analytic categories that reconceptualised the initial codes of

Figure 1. The ‘iceberg’ model of informed consent.
communication (Creswell 1998). More conceptually-based questions were asked of the data, such as: What do therapists’ explanations about informed consent take for granted? What ideals and assumptions underpin their description of informed consent? The third step (selective coding) (Glaser 2002) aimed to integrate the categories developed through axial coding by identifying core categories which were capable of explaining and unifying the data to form a coherent and explanatory theory (Charmaz 2000). During the analysis, no attempt was made to classify themes quantitatively according to participants’ gender, experience, or postgraduate qualification. In accordance with qualitative methods, the aim was to build a theoretical explanation that captured and accounted for how therapists viewed the obligation of obtaining patients’ informed consent. This qualitative knowledge base enables future quantitative studies and comparisons to be formulated.

The analysis and findings are presented as direct quotations, allowing for assessment of transferability rather than generalisability to other clinical situations (Appleton 1995). Each quotation is attributed to the particular therapist by number (Table 1). The quotations are representative of statements and ideas from other participants.

Results

Therapists defined informed consent in two main ways: first, and most commonly, as an implicit and everyday part of their usual clinical communication; and second, as a purposeful and explicit part of their communication when there was an element of risk or uncertainty associated with the treatment.

Informed consent as an implicit part of communication

Using this definition, therapists equated the provision of information leading to informed consent with their usual explanations of aims and proposals for treatment and as a way to improve patient compliance. How much explanation, its content, and timing, was a decision to be made by the treating therapists, on the basis of their assessment of their patients’ needs. Therapists’ definitions were tied closely to their concept of themselves as the provider of physiotherapy treatment:

- Informed consent means letting the patient know exactly what I am about to undertake (Participant 9)
- No, I don’t ask can I have your consent to … but I will explain to the patient what I want to do and why I want to do it and ask them ‘Is it OK if I proceed with that?’ (Participant 5)
- The best way to get a person’s consent just mainly in general or commonly used treatment is to say ‘I’m going to do this …’ and try to explain to them what’s the purpose of it. (Participant 14)

These quotes are examples of therapists’ views about informed consent enhancing patient compliance:

- I like to give patients enough knowledge so that they can participate actively and understand what’s going on and, hopefully when they are not with you they know what to do and what not to do. (Participant 12)
- I’m very big on getting to the heart of the problem and then explaining it very, very well because I think you get the most out of it then if they understand what’s going on. (Participant 9)

Therapists found it difficult to disentangle the act of obtaining a patient’s consent from their clinically focused, intuitive, and routine clinical communication:

- I don’t think the boundaries are set clear enough as to what informed consent is. When I stopped and thought about what informed consent is … it’s so sort of entwined in what we do that it’s not really a clear little subset on its own that you can say, ‘Well I have given this person informed consent’ about everything you do, from the time you walk in the door to the time you walk out. From the time of your assessment, through
your treatment then through your advice. It’s a part of everything that you do. (Participant 1)

Therapists assumed their explanations would provide sufficient opportunity for the patient to be satisfied and implicitly agree with treatment proposals. Patients’ consent was assessed as either tacit agreement or lack of disagreement rather than an explicit or separate part of the communication:

Informed consent means the patient understanding what you are doing so they understand why you are doing what you are doing and also that they’ve got the option to say no if they don’t feel comfortable with it basically. (Participant 12)

I’ll just let them know I’m going to do this and if they don’t have any objection or any query I will go ahead. (Participant 14)

The way we normally do it, that sort of implied consent, which is probably as close as we ever get to really having consent when you think about it, is that the patient agrees with what you have to say and away you go. You know, most things we take for granted that the patient has consented, umm (pause) and they don’t actively object. (Participant 12)

Therapists spoke of being not unwilling to involve patients in the treatment discourse, but their explanations in the interviews about the reason for the level of patient involvement was limited to the patient gaining greater understanding of what the therapist was doing and why, so that they could take on board the advice and expertise of the therapist. One reason for patients being given the role of agreeing and complying rather than contributing on a more equal level to clinical decision-making is that:

Knowledge is power and, because patients have not studied for four years, they can never be equal in this area of knowledge, so they can never be truly informed. (Participant 12)

The idea of patients having an equal or collaborative role in decision making or in choosing a particular treatment strategy did not emerge from therapists’ definitions and explanations of informed consent. As a consequence patient choice was not seen as a significant concept in most treatment circumstances. Therapists believed that patients expected them to make decisions, or would most likely be confused by too many choices:

I think you give them what you think they need … and so they don’t have a choice then … really, I think that the choice comes in with, when they leave, whether they were happy with you. And if they are, they come back. And if they weren’t it wasn’t what they wanted for their back and they go somewhere else. I think they either like the way you assessed and decided what they need or they don’t. I’m going to go to someone. (Participant 10)

Therapists spoke of tension between giving choices to their patients on the one hand, and their perceived role of providing a professional service on the other. Consequently, patient choice was an extra to be added to their clinical goals and framework of practice within a given treatment time:

If you’re spending a few minutes describing sort of treatment options and pros and cons of both then that is often a few minutes that you could have perhaps achieved a little bit more with a given patient. (Participant 16)

Where treatments were achieving a good outcome and there was evidence of progress, or where the therapist was satisfied with the treatment and sensed the same satisfaction or sense of familiarity and acceptance from the patient then therapists’ views of the need for and relevance of patient choice decreased correspondingly:

I guess because she had been improving quite well through the previous treatments I didn’t feel the need to then say ‘Are you happy with what’s going on, do you think we should try something else?’ So that I didn’t present that opportunity to her. (Participant 1)

Two further disincentives to offering choice to patients were that the patient might make the wrong (where wrong was formulated in terms of a physical benefit) choice or they may become confused by the choice:

He needs more guidance than him actively choosing which direction to go. So we hang on to him a little bit more probably, because sometimes his choice may not be the right one. (Participant 6)

But you can’t offer too many choices to the patient because if I say that one, that one and that one, they get confused when what they’re after is what’s the best. (Participant 9)

I just find that you can go overboard with trying to get consent for any sort of treatment that you do. The fact that the person has come here implies that they are seeking treatment and I find with informed consent particularly with regards to manipulation, you just have to be very careful. It’s the sort of thing that is likely to scare a patient much more so than reassure a patient. (Participant 8)

Informed consent as an explicit part of communication triggered by the patient

There were two main triggers that altered therapists’ ideas or perceptions of patient choice and led to a change in the amount of information they would give or the opportunity for patients’ contribution to the interaction. The first was patient-initiated and the second depended upon recognition by the therapist.

Therapists described how they would always change the amount and type of their explanations if a patient indicated some dissatisfaction with the treatment or diagnosis, or was assertive in requiring information about a particular type of treatment. They described waiting for the patient to indicate a particular concern, rather than giving options or choices proactively, especially if the patient had not indicated a need for anything different:

Often people will state if they’re not happy about some technique or procedure … and often they’ll state quite clearly from the start that ‘I don’t want any cracking’, and that you don’t do any cracking or that they’ve had a bad experience and that makes it quite clear. It doesn’t mean it won’t form part of your treatment, it just means you’ve got to make sure they understand
Interaction, therapists remodelled informed consent to their perception of their role as a professional. In defining the course of action was counter-intuitive to therapists, given patients choosing other than the therapist-recommended goals of treatment were to be achieved, then the idea of explanations, rather than offering choices. If the therapeutic process of informed consent is interpreted as providing information about the proposed treatment and focus more carefully on their explanation about the treatment. The following three quotes illustrate therapists’ reasons for making informed consent more explicit. The first concerns poor treatment progress; the second, a need for increased patient involvement; and the third where treatment is potentially confronting:

So the key times are early on and if things aren’t changing and I’ve seen the patient twice and listed nothing’s changed and then I’ll say ‘Well what do you think about it?’ (Participant 8)

I suppose the only time I need to get consent or agreement with patients is if they come in and I think the main thing they need is an exercise program and I have to really explain to them that that is what really is going to help them and they really have to apply themselves to that for the six or ten weeks or whatever and not to expect an improvement unless they do that. (Participant 10)

I think patients need more choices when particularly if the techniques used are more confronting for the patient. I would tend to give further description or definitely ensure that they are aware of what is planned. Although obviously they should be aware at all times but I think in areas such as dealing with parts of the body that are more exposed or that sort of thing, I tend to be a little more explicit with describing what’s going to be happening. (Participant 16)

**Discussion**

When I explain to the patient what’s wrong, I’ll explain what we are going to do and why so they understand how we are doing, especially if it’s going to be painful … I suppose I wouldn’t then often say to a patient ‘Do you want to try this one, do you want to try that one, do you want to try this one?’, so I’ll sort of suggest this is the way we’d normally go about it unless it’s an issue. (Participant 11)

This quote encapsulates the research findings, that the process of informed consent is interpreted as providing explanations, rather than offering choices. If the therapeutic goals of treatment were to be achieved, then the idea of patients choosing other than the therapist-recommended course of action was counter-intuitive to therapists, given their perception of their role as a professional. In defining informed consent as an ordinary or routine part of their interaction, therapists remodelled informed consent underpinned by autonomy to informed consent grounded in beneficence.

With reference to the iceberg framework, therapists’ understanding and definitions of the informed consent process did not include an explicit understanding or incorporation of the underlying ethical theory of autonomy as it has been described in the biomedical (Layers 6 and 7) or the physiotherapy literature (Layer 3). They were concerned more with patients’ best ‘therapeutic’ interests than with providing opportunities for them to express and exercise autonomy.

In the same way that patients’ adherence to treatment has been found to be influenced by their initial values and beliefs prior to involvement in therapeutic interventions (Veenhof et al 2006), this research suggests that physiotherapists rely on their own values and interpretations of professional practice to inform decisions about providing information to patients. This means that informed consent guidelines may be followed only if they fit with therapists’ understanding and interpretation of a desired therapeutic outcome.

An important question arising from these findings is whether it matters if physiotherapists in private practice settings focus more on beneficence than on autonomy in their clinical communication and treatment. Current guidelines suggest informed consent matters when there is a recognised and quantifiable risk associated with the treatment (Rivett et al 2006). More generally, the overall ethos of physiotherapy practice and communication is to provide a benefit in either physical function or ability to manage a physical problem (Stiller 2000, Cromie et al 2002). Therefore, both the specific informed consent guidelines and overall practice ethos are concerned with beneficent therapeutic outcomes.

However, health professionals in general (Fullinwider 1996), and physiotherapists as a specific example, have an ethical obligation to engage in moral deliberation beyond adherence to the dictates of their code of ethics (Portillo et al 2005, Delany 2005) and guidelines for practice. When obtaining patients’ informed consent, therapists need to understand not just how to implement the (iceberg above-surface) elements of informed consent, they should also have an understanding of and be able to articulate (iceberg below-surface) reasons and values that influence its practical implementation.

The 2020 vision of the Australian Physiotherapy Association states (APA 2005):

*Physiotherapists are patient-focused practitioners and the focus on active involvement of patients will increase. Physiotherapists will spend more quality time during consultations working with patients to ensure that they understand the benefits, risks, and alternatives to the proposed treatment.*

By this statement, the profession envisions for itself not only a level of professional maturity and autonomy underpinned by ongoing research into its effectiveness, but also a future where the involvement of the patient will be active rather than passive.

This study demonstrates that, in order to implement legal and ethical expectations to obtain patients’ informed consent and to incorporate the profession’s vision of practice, therapists may need to deepen their understanding of the underlying ethical or philosophical meaning of respect for autonomy as the supporting theory. They may also need to re-examine and reframe physiotherapy practice goals so that ideals of beneficence, assumptions about therapeutic roles, and principles of practice might be understood in light of the...
ethical meaning and clinical relevance of patient autonomy.

Qualitative studies of a small sample of physiotherapists cannot be generalised to a broader population (Shepard et al 1993). Although therapists participating in this research were chosen to represent a diversity of experience, practice, and views, this diversity strengthened the credibility of the thematic analysis rather than directly affecting generalisability. A further limitation is that physiotherapists’ beliefs as expressed in an interview may not represent what in fact occurs in practice. The limitations in terms of generalisability are offset by the recognised functions of qualitative research (Morse and Field 1995) to provide insights into practice and not just a description or measurement of practice. These insights provide opportunities to make sense of behaviours which are hard to measure, and a conceptual framework to guide further quantitative or qualitative research.

In conclusion, this research demonstrates that physiotherapists’ interpretation of the ethical obligation to obtain a patient’s informed consent to treatment is informed and underpinned by an overriding motivation to obtain a (therapist-determined) beneficial therapeutic outcome for the patient, rather than by a primary concern for respecting patient autonomy. This insight into therapists’ values and understanding provides a basis for ongoing research examining the values and belief of physiotherapy practitioners and factors affecting compliance with professional practice guidelines.

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**References**


Statement regarding registration of clinical trials from the Editorial Board of Australian Journal of Physiotherapy

This journal is moving towards requiring that clinical trials whose results are submitted for publication in Australian Journal of Physiotherapy are registered. From January 2008, all clinical trials submitted to the journal must have been registered prospectively in a publicly-accessible trials register. We will accept any register that satisfies the International Committee of Medical Journal Editors requirements. Authors must provide the name and address of the register and the trial registration number on submission.