

Informed Consent in Societies with Different Ethos of 'Selfhood'

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الموافقة المستنيرة في المجتمعات ذات الأخلاقيات المختلفة من 'الذات'

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IT HAS BEEN WELL ESTABLISHED THAT MANY illnesses, disabilities and distress are influenced by psychosocial factors.¹ These psychosocial factors are central to the predisposition, onset, course, and outcome of illnesses.² Thus, biopsychosocial factors are of major importance in designing intervention and management plans. According to Sirri *et al.*, "When patient behaviors differ from those expected or recommended by physicians, the greater this discrepancy, the less likely the course of the disease will be predicted solely by bio medical factors" (P. 74).³ However, social and cultural factors appear to be marginalised when applying informed consent in traditional societies around the world where factors underpinning cultural beliefs or practices and social behaviour might be different to what is often taught in medical schools.

In this issue of *SQUMJ*, Al-Balushi raised interesting points on the hegemony of modern medicine in the midst of a pluralistic world.⁴ Specifically, Al-Balushi has observed that in a traditional society, it is the male members of a family rather than the female patients themselves who took the lead on issues pertinent to the doctor-patient relationship. From a bioethical perspective, this conduct undermines the patient's inalienable right to personal autonomy. Such occurrence has been previously observed in many traditional societies.^{5–7}

This contradictory practice of bioethics in traditional societies owes its origin to how medical science has spread in different parts of the world without being culturally sensitive. Modern medicine, sometimes known as 'cosmopolitan medicine' or simply biomedicine, often tends to have its true identity hidden. When one examines the underlying bioethical outlook, one cannot escape observing that it is shrouded with a Western philosophical view. The Western bioethical approach is taken as an article of faith.⁸ Such a stance appears to have set forth what has been previously observed by Al-Balushi.⁴ It is well-known that Western medicine with its reliance on experimentation and empiricism has triumphed over

many epidemics that have caused the deaths of millions.⁹ The global impact of the development of antibiotics and vaccinations, without which the world would have looked very different than what it is today, can also not be ignored. On a superficial level, it appears that Western medicine has transcended geographical, cultural and linguistic groups. Therefore, it is safe to assume that Western medicine is accepted in all corners of the world. However, such acceptance appears to be limited to its curative ability and there is a concern regarding its applicability in medical policy, practice and professionalism. The universal applicability of Western bioethical approaches, including issues pertinent to confidentiality, determination of death, doctor-patient relationship and the topic of present scrutiny, informed consent.¹⁰

Informed consent refers to the process of obtaining the permission of a patient before proceeding with health-care intervention.¹⁰ In essence, informed consent requires the treatment team to enlighten the patient about the nature of the treatment, risks and benefits and alternative treatments, if any. Once informed, patients have the choice to agree or disagree with the suggested intervention. Informed consent is, therefore, a voluntary agreement. The principle of informed consent is based on the undeniable right to personal autonomy, self-determination, self-governance or 'self-mastery'.¹⁰

According to the *Internet Encyclopedia of Philosophy*, "autonomy is an individual's capacity for self-determination or self-governance".¹¹ This stems from Western philosophies such as those expounded by Kant.¹² The proponent of personal autonomy in bioethics has stated that it is the only way to safeguard us against mistakes of the past.¹⁰ This view was consolidated further in 2005 during the 33rd session of the General Conference of the United Nations Educational, Scientific and Cultural Organization when the Universal Declaration on Bioethics and Human Rights was adopted.¹³ There are many situations where informed consent is legally waived. For example, it is waived if the patient lacks decision-making capacity, has

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depressive symptoms, suicidal intent, in an emergency or in a life-threatening situation. In the absence of such circumstances, failure to obtain informed consent prior to medical intervention could lead to legal action. While informed consent has been developed with good intent, sometimes, when applied in non-Western societies, it may be deemed as being ethnocentric or simply insensitive to the 'norm' in traditional societies. This editorial examined some of the constraining factors including cross-cultural variations in the role of 'the sick', selfhood and the doctor-patient relationship.

Cross-Cultural Variations in the Sick Role

Blind enforcement of the Western view on self-mastery is opposed to what has been observed as the societal view of the sick role or illness behaviour. Sigerist observed that societies tend to assign a specific role or social status to 'sick' people.¹⁴ Parsons indicated that being sick entails that the afflicted person enter a new role.¹⁵ Accordingly, the sick person is not only marked by a physical ailment, but acquires a new social role that is intimately tied to his/her state of health. One of the main aspects of the sick person's new role is to be alleviated from their assigned pre-morbid role since his/her well-being has been compromised. Thus, a sick person is deemed incapable of taking care of themselves and as a result, the family 'takes over' the responsibility of their welfare.¹⁶ In most cases, the family willingly commits to take responsibility for the afflicted individual even if this would entail temporarily seizing his/her personal autonomy. These studies suggest that some communities around the world are likely to revoke the personal autonomy of the sick.¹⁴⁻¹⁶ Such societal practices would invariably be at odds with Western bioethics stance on self-mastery.

Cross-Cultural Variations in Selfhood

Some societies may not prescribe to the ethos of personal autonomy. In a collective society, such as Oman, individual identity is infused with the collective identity of the society; thus, from birth to death, an individual is ushered into the collective mindset. Selfhood, as defined in Western psychology, is generally not tailored to different socio-cultural values—such as that of a collective society.¹⁷ Therefore, it is not surprising that constant observation by the family infringes on personal autonomy of the afflicted family member. There are impressionistic and anecdotal reports that the family does not allow the patient to be informed of his/her diagnosis.¹⁶ Conseq-

uently, the family finds it incomprehensible that a health-care professional demands from the sick to decide for themselves and sign consent forms. When viewed through the lens of Western biomedical ethics, such an undertaking clearly denigrates the much cherished autonomy of the sick person.

Cross-Cultural Variations in the Doctor-Patient Relationship

The central tenet of informed consent is to promote shared decision-making.¹⁰ This ensures that the patients remain informed which in turn would permit them to play an active role in the intervention process and have the liberty to agree or disagree. Although shared decision-making may theoretically be desirable, in reality, patient expectations have been documented to vary across different societies. In some non-Western societies, the physician is perceived as *Hakim* or 'the wise'.¹⁸ The concept of *Hakim* suggests that doctors are the experts and, therefore, the patients are expected to surrender all their self-determination or self-governance. Hence, in such societies, the doctor-patient relationship befits Emanuel and Emanuel's paternalistic model.¹⁹ In this model, the doctor decides what is best based solely on medical information and the doctor's judgment, where he/she acts as a guardian and determines from his/her perspective what is best for the patient. There is an indication that Omanis tend to prefer a doctor who takes on this paternalistic role rather than a person who simply acts as a provider of technical expertise.²⁰ Within such a socio-cultural setting, it is not surprising that the patient may not want to indulge in any discussions on informed consent.

Conclusion

In order to ensure that current medical practice does not suffer from past mistakes, many bioethical principles have emerged to safeguard the doctor-patient relationship and intervention process. Existing bioethics owe their origins to Western philosophical principles of respect for persons, with a strong emphasis on individual autonomy. The centrality of individual autonomy has pervaded modern medical practice worldwide; yet their entrance into non-Western communities, as in the case of informed consent, appears to be out of sync with the local understanding of self-determination or self-governance in societies in transition. Therefore, cultural relativism and adaptability should be the goal when employing bioethical principles in traditional societies around the world, where such concepts of self-determination, self-governance or self-mastery are different.

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