THE OBJECTIVES OF this issue’s column are to define voluntary informed consent and review the minimal components required for its appropriate implementation in the allied health-care setting. You will find that the particular circumstances (e.g., the patient’s needs for the procedure) often direct the boundaries and breadth of the informed-consent process. To bridge the gap between principle and application, a scenario with discussion questions is provided to facilitate the application of this process in a work-related situation.

Informed consent is the process by which a fully informed athlete (herein used interchangeably with patient) can participate in intelligent choices about his or her health care. It originates from the legal and ethical right the patient has to direct what happens to his or her body and from the ethical duty of the health-care provider to involve the athlete in his or her own health care. Initially, the concept of informed consent was an ethical ideal that gradually worked its way into the law. As an ethical rule, this ideal tells us that it is wrong to perform any procedure or treatment on competent adults if they have not knowingly and freely consented. The legal foundations of informed consent are based on negligence and the concept of battery (unlawful touching).

The gap between the ideal and actual practice is often vast, especially in athletic training environments, where rushed and chaotic schedules often predominate. The process is multifaceted and is predicated on the provision of information to the patient, followed by a patient decision to undergo or not undergo the examination, treatment, or procedure. The details and extent of this process vary from state to state and are subject to ongoing judicial and professional review and debate.

An area of informed consent frequently debated is the balance between “best interests” and “autonomy.” There is a delicate relationship between personal well-being or best interests and self-determination or autonomy. Best interests of an individual are constituted by personal factors about which typically only the individual himself or herself can be the judge. At one end of the spectrum, patient preference is no guarantee that the option chosen does, indeed, serve the patient’s best interests. On the other end, personal involvement is no substitute for technical expertise. The argument for giving the patient a fundamental role in decision making rests on the theory that the patient is more likely to succeed if the goal is taken on through personal choice, as opposed to it being imposed by an outside party.

THE COMPONENTS OF INFORMED CONSENT

The most important goal of informed consent is that the patient have an opportunity to be an informed participant in his or her health-care decisions. It is generally accepted that complete informed consent includes the following components:

**Competency:** being legally capable of giving consent. This means that the individual must be of legal age and mentally competent to understand what is being done.

**Disclosure:** knowing the relevant and material risks to which one is consenting.

**Comprehension:** fully understanding the relevant and material risks to which one is consenting.

**Voluntary:** accepting the intervention without coercion or duress.

In order for an athlete’s consent to be valid, he or she must be considered competent to make the decision at hand, and the consent must be voluntary. It is easy for coercive situations to arise in athletics. The informed-consent process should be seen as an invitation to the patient to participate in his or her health-care decisions. Comprehension on the part of the patient is equally important as the information provided. Consequently, the discussion should be carried on in layperson’s terms, and the patient’s understanding should be assessed along the way.
A great deal of litigation has occurred over the disclosure requirements for the informed-consent process. This involves whether or not information was withheld from a patient or if the information was correctly and impartially communicated to the patient without outside interference. The task of determining whether or not sufficient information (including risks) has been provided to the patient to facilitate an “informed” decision is a difficult one. The disclosure of all known risks could potentially cause additional risks as a consequence of the disclosure.

Approaches to this challenge include using one of three criteria: the reasonable-clinician, the reasonable-patient, or the subjective criterion. The reasonable-clinician approach allows the health-care provider to determine what and how much information is appropriate to disclose. This standard is generally considered inconsistent with the goals of informed consent because the focus is on the health-care provider rather than on what the patient needs to know. The reasonable-patient criterion focuses on considering what a patient would need to know in order to understand the decision at hand. Finally, the subjective approach centers on what the patient needs to know and understand in order to make an informed decision. This standard is the most challenging to incorporate into practice, because it requires tailoring information to each patient. The best approach to the question of how much information is enough is one that both meets your professional obligation to provide the best care and respects the patient as a person with the right to a voice in decisions about his or her health care.

Another challenge in the informed-consent process is determining when it is appropriate to question a patient’s ability to participate in decision making. In most cases, it is clear whether or not patients are competent to make their own decisions. Occasionally, it is not so clear, for example, when athletes are under an unusual amount of stress and are experiencing pain, anxiety, fear, anger, or depression. Although the stress associated with an injury should not preclude one from participating in one’s own care, precautions should be taken to ensure that the athlete does have the capacity to make good decisions. There are several different standards of decision-making capacity. Generally you should assess the patient’s ability to understand his or her situation, understand the risks associated with the decision at hand, and communicate a decision based on that understanding. Refusal of treatment does not in itself mean the athlete is incompetent. Competent athletes have a right to refuse treatment. Treatment refusal might be a flag to pursue further the athlete’s beliefs and understanding about the decision, as well as your own.

If an athlete is determined to be incapacitated or incompetent to make health-care decisions, a surrogate decision maker must speak for him or her. There is a specific hierarchy of appropriate decision makers defined by state laws. If no appropriate surrogate decision maker is available, the athletic trainer is expected to act in the best interest of the athlete until a surrogate is found or appointed. An athlete’s consent should be “presumed” rather than obtained in emergency situations when the athlete is unconscious or incompetent and no surrogate decision maker is available. The athlete’s wishes and values might be quite different than the values of the athletic trainer. Although the principle of respect for persons obligates you to do your best to include the patient in the health-care decisions that affect his or her life and body, the principle of beneficence might require you to act on the patient’s behalf when his or her life is at stake.

It is important for athletic trainers to review their informed-consent process and revise it if necessary and as required by individual state law. The frequency with which these types of decisions need to be made on a daily basis should not go unmentioned. Consider the routine clinical encounter provided in the scenario that follows.

**Case Scenario**

A female cross-country athlete presents with nonlocalized medial shin pain, with an onset of approximately 1 week. The pain has become progressively worse over the past few days. The athlete has nearly doubled her mileage (from 35 to 66 miles per week) during this time frame. In addition, she has been using heat and aspirin since her pain started, both before and after workouts. The athlete has no prior history of lower extremity pathology and is in overall good general health. The athlete’s coach is demanding that a bone scan be performed. After consulting with the team physician, however, it is decided that the best course