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Philosophical Discussions and Cultural Understanding Within Informed Consent

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Medical professionals are held to a specific standard of informed consent when treating their patients. Doctors cannot perform a treatment on a patient who did not agree to it with full knowledge of what it is, how it is performed, and the complications that it could potentially cause. On the basis of qualitative interviews with healthcare professionals, traditional healers and patients, we assessed the approaches to addressing such differences using interpretative approaches. One area where the questions still arise with regards to informed consent is in regards to people of differing cultures. A large number of factors between people of different cultures can greatly alter how they view consent. Some people have strong dislike for certain medical procedures and other groups involve people in the decision making process that may be traditional. Still others have different views on who it is that should be informed of the patient's conditions. This addendum is intended to clarify and provide understanding of the responses and narratives based on the patients' interviews, and care providers' views of the role of culture and understanding within informed consent.

Keywords: informed consent, culture, customs, autonomy, legal consideration

Introduction

The data and information were obtained by interviews with the informants (doctors, nurse/other health workers, traditional healers and patients) most intimately involved in the process of consent to medical treatment. Generally, patients would like their doctors to be serious and tell them what is expected based on the treatment they undertake. For consent to be informed patients rely on the information provided by their doctor. Honesty and truthfulness are required to make the process of consent valid. I studied all the four groups attending healthcare facilities in two provinces in Papua New Guinea (PNG). I worked closely with the healthcare workers and community leaders to identify the participants to participate in the surveys following the participants' approval to participate.

This work used rigorous methods to identify them following their consent to participate and was also applied to participants who had difficulty to come in on time for the interview (Minei, Arafia, & Roldan, 2018; Minei, Kaipu, & Minei, 2020; Minei, 2023). The situation was common in Central Province (CP) where patients lived

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in their own local settings. In the National Capital District (NCD) the participants lived in urban areas. The research team vehicle (transport) was sent out to pick patients who have no transport or for some patients in CP the community headman brought them to the survey site or a healthcare worker would accompany them to attend the interview at the healthcare facility.

I included information provided by healthcare facility personnel to ensure wide coverage and capture the relevant information from the interviewees. I visited institutions and geographical settings which maximize the relevance of the review to different settings. To ensure the interviews and meetings were effective and time-efficient, we made sure to clarify the research structure and goal. I clarified what the study sought to learn and discover from the interviewee. Many interviewees were educated and assisted in educating their colleague respondents to understand the purpose of the study. We met our study goal by utilizing qualitative research approaches such as interviews directed at the healthcare professionals in the medical settings and the traditional healers in their local areas in order to understand the situations people of cultural difference experience when seeking medical advice, and to understand the information presented to such in order to obtain their sufficiently informed consent.

In this paper, we discuss the situation that establishes the issue or idea of informed consent (Minei et al., 2018). I start this discussion by examining the laws regarding informed consent and secondly, by mentioning the views within the medical settings regarding informed consent that may be of philosophical concern in the local areas, as well as the cultural considerations that may or may not presently be addressed by the current informed consent model (Minei et al., 2020). Finally, I conclude with a description of communities in PNG regarding particularly traditional customs of the people in the area and those institutions that handle their medical situation.

Laws and Legality Regarding Informed Consent

In PNG, custom is constitutionally recognized as a proof of the legal system that originates from the way of live of people (Minei et al., 2020). The customary laws comprise both the body of legal principles and concepts which have evolved from it over the past and, as for the English common law, they are rules and principles that were articulated by judges in England and later transported through the British Empire to Australia, then from Australia to PNG. PNG is working towards developing a common law of its own. The decisions of other common law jurisdictions such as England and Wales, New Zealand, Canada and the United States are not binding in PNG courts, but are useful only to the extent of the *ratio decidendi*[1], in other words, their motives for the decisions chosen to follow. It must be pointed out that pursuant to Schedule 2.2 of the Constitution, the principles and rules of common law and equity of England that formed immediately before Independence Day its principles and rules of common law and equity are applied and enforced as part of the customary law.[2] It consists of traditional rules, practices and norms and those common throughout the country that have been adopted by the courts and formally declared through judicial decisions are used as part of the developing common law of PNG.

The principle of autonomy is enshrined within the meaning of Section 35 under the PNG Constitution.[3] The expression “right to life” is of the widest amplitude and covers a wide variety of rights, including the right to live with human dignity and all that goes along with it, and any act which damages, injures, or interferes with the use of any limb or faculty of a person, either permanently or temporarily, is tortious unless justified by a court order.

[1] The reason for deciding.
[2] Customs Recognition Act, Chapter No. 19, Sections 2 & 3, GovPNG.
[3] Constitution, Section 35, “Right to Life”, GovPNG (1975).

However, the common law application of consent is not fully developed in PNG, although in a few unrelated cases PNG courts might have referred to this principle. In such situations, obviously one has to refer to the principles of the law of contract and the criminal law. The relationship between medical care professional and his or her patient is a contract by parties competent to contract giving rise to contractual obligations. Parties are generally competent in accordance with Criminal Code Act.[4]

In order to give valid consent to participate, participants must understand: that they are being asked for consent; how to exercise their right to give or refuse consent (e.g., by signing their name); and what they are being asked to consent to (e.g., this physician can insert a needle). Nevertheless, in making sure that consent was accepted before the procedure, and the explanation was given by the patient's doctor or by the healthcare worker with whom the patient has more than a passing familiarity, one of the outcomes would be that patients begin to appreciate that consent to treatment is in fact a "real" or "true" or "informed consent". There exists a vast discrepancy (Minei & Kaipu, 2020a) between what informed consent really is and as perceived by patients in PNG (Minei & Kaipu, 2020b). I explain how this might play out.

> A person only goes to a health post when s/he is sick to receive medical treatment. If they are not sick they do not go to the health facility. The idea of going there for regular check-ups or clinical reviews is still foreign when a person does not feel sick. (Minei et al., 2018, p. 406)

The step taken to go to the health facility may amount to the patient saying to the healthcare worker, find out what is wrong with me, and do what you can to get me well soon. "However, would by going to the health facility for help be tantamount to giving consent for healthcare worker to deal with his body? Thus, couldn't it be that informed consent need not be express in the context of PNG?" (Minei et al., Feb. 2023)

The current practice within PNG is that all healthcare professionals are held to a certain standard of practice under the Medical Registration Act[5] and National Health Administration Act[6] when treating their patients. These laws in PNG amplify to some extent Section 49 of the Constitution.[7] This provision states that every person has the right to reasonable privacy in respect of his private and family life, his communications with other persons, and his personal papers and effects, except to the extent that the exercise of that right is regulated or restricted by a law that complies with the Constitution, Section 38.[8] It is illegal when a healthcare professional in a healthcare facility performs a treatment or a procedure on a patient who did not agree to the treatment with full knowledge of what it is about, how it is performed, and major complications that it could potentially cause. Although no informed consent case has been considered through the judiciary in PNG, if informed consent is to be more than an empty formality and possibly a legal trap for an unwary medical practitioner (in developed countries) and researchers (globally), the rules governing consent forms must take cognizance of the structural, situational, and social factors that simultaneously impinge upon the dialogue between the physician and the patient (Maclean, 2006). The difference in perception and limited knowledge of the legal implications of signing or not signing consent forms indicates that consenting in its current form in PNG is not informed and should be reassessed in order to achieve patient autonomy (Minei, Araña, Roldan, & Kaipu, 2019).

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4 Criminal Code Act, GovPNG (1974).
5 Medical Registration Act Chapter 398, GovPNG.
6 National Health Administration Act, GovPNG (1977).
7 Constitution, Section 49, "Right to Privacy", GovPNG (1975).
8 Constitution, Section 38 (general qualifications on qualified rights (special rights of citizen)), GovPNG (1975).

Philosophical Discussions and Cultural Understanding Within Informed Consent

Throughout the course of this study, acquiring interview opportunities was a challenge. Medical professionals are busy people, as there are always new patients coming into their clinical examination room. Finding a time when to meet the potential interviewee available was difficult, and issue of sensitivity made it even more difficult to find a willing potential interviewee without undergoing a process of explanation. We interviewed doctors, nurses, other healthcare workers, and healers of various practices in the study areas and in addition to their institutions. Due to the sensitivity of the study, it did not seem feasible to interview patients directly. Interviewing patients who were undergoing treatments ran the risk of uncovering unwanted personal information, and interviewing patients who could be defined as being part of an at-risk community, such as those of a linguistic and cultural minority, ran the risk of putting them more at risk. Instead, through the interviews with healthcare workers, especially doctors, we were able to collect a great deal of information as much as we could in lieu of speaking to patients directly.

Medical Generalisation Regarding Informed Consent

I examined informed consent of the participant-respondents when interacting with the patients with differing customs. I interviewed the healthcare professionals and traditional healers to learn about their perspectives regarding informed patients namely those with cultural difference, and determined what the medical community described as an effective explanation of informed consent for a standard patient and how this explanation changed with people with customary differences. The interviews with doctors also focused on how patients and doctors treated each other as well as how the doctors interacted with patients with cultural differences. The other participants including nurses, other healthcare workers, and traditional healers who dealt with the different nuances of the informed consent process were interviewed as such as well. Each semi-structured interview included identical background questions as well as questions attempting to target the same general concepts regarding informed consent and other associated topics.

I studied the medical culture that has formed around the idea of informed consent in order to better understand the attitude medical officials possess towards the informed consent process. Within the medical community there is a prevalent concept of paternalistic care. The concept refers to a sort of behaviour that the doctor thinks he or she knows best and even if the patient rejects a certain treatment it is unacceptable that the patient should consent to the treatment. Many people would argue that patients have ultimate knowledge of what would bring them the most happiness, and this sort of behaviour is inexcusable. There are situations in which someone must make decision for the patient. For example, a child who does not like the pain of an injection shot would likely have his or her decision overruled by a parent or doctor. This is one situation where paternalistic behaviour is necessary. There may be cases where paternalistic behaviour is necessary but it is easily viewed as a denial of a patient's rights, even though it may be in the best interest of a patient's health (McKinstry, 1992).[9]

Criticisms of Informed Consent

While a patient is not capable of giving consent to a procedure, someone must assume whether the patient would consent or not. In PNG, it is a practice by patients that family members and spouse may give consent for and on behalf of the patient (Minei et al., 2020). The issue here is that such presumed consent assumes that the

[9] This concept refers to a sort of behaviour wherein "the paternalist" is aware that his or her actions maybe opposed by the patient if s/he knew about it. The paternalist expects that in the long run the patient will agree that that the action was correct.

individual does not have any special cultural, religious, or other requirements that would make them go against the norm. Similarly, implied consent only works if one knows the individual in question well enough to make that sort of judgement call. Valid consent is the only alternative proposed for informed consent (Culver & Gert, 1982).

In PNG, many local people believe in an idea of shared decision-making. It describes a mode of conduct in which patients, family relatives, and the doctor participate in the process of deciding what the best mode of treatment is for the patient (Minei & Kaipu, 2020b). Most importantly the parties must agree to a single decision; however, the parties do not necessarily think that this is the best treatment but agree that the treatment is viable. In emergencies where a patient may be unconscious or otherwise unable to give consent themselves, it can be quite easy for the medical community to accidentally assume consent that would not be given (Post, Blustein, Gordon, & Dubler, 1996). In general, the challenge with the idea of informed consent comes with the fact that the western ideal of medicine comes from western ideologies. The idea that one must be freely to choose what they do, has been the concept of informed consent when it was first brought up as an idea in court cases and in its key founding documents such as the Belmont report.[10] The idea of personal freedom is brought in through western ideology.

Role of Culture in Informed Consent

In PNG, consent is usually by a smile or by a shake of hands which is common among the indigenous people. It may or may not demonstrate that communication is satisfactory to the patient or the legal requirement of disclosure has occurred. Clearly, the participants need to understand the facts necessary to distinguish the act they are consenting to from some other act. Informed consent process is believed to be affected in areas where indigenous customs prevail and has a marked influence on the lives of the people (Minei et al., 2018). There are restrictions that inhibit participants from participating in health activities. Misunderstandings concerning the medical procedure have led to patients withdrawing from participating in maternal and child health (MCH) care services for immunization, family planning, antenatal and postnatal care, and nutrition. For example, in an informed consent case (unreported), a mother refused to attend the family planning clinic and refused immunization for her child because she was picked on by an angry nurse for her lack of understanding to participate in the clinic (Minei et al., 2018). The medical procedure which might have been essentially important to the individual health of her child was refused by the mother. The illustration in the MCH case highlights the issue concerning refusal of essential health care service and raises questions of why refusal occurred, and if informed consent was obtained. It also implied that a responsibility existed in the healthcare worker who ought to have explained fully and meaningfully what the health program is about and the participants' involvement. It is possible to consent without knowing why the treatment is given or the research is being conducted. A possible analogy is to give a valid consent to lend someone your car without knowing exactly why he needs to borrow it. Also, the healthcare professional or researcher may not know all the risks the treatment or study may entail in advance. One of the key issues when attempting to follow the ideal of informed consent with the local people is the fact that the local customs of the people and language should be understood to be able to convey the ideas of informed consent (Saldov, Kakai, McLaughlin, & Thomas, 1998); this means that a healthcare worker or a researcher needs to resort to awkward translations and phrasings.

[10] The Belmont Report ethical principles and guidelines for the protection of human subjects of research. The National Commission for the protection of human subjects of biomedical and behavioural research; April 18, 1997. Available from: http://www.ohsr.od.nih.gov/guidelines/belmont.html.

The aspect of religion in regards to cultural differences also cannot be ignored. Many religions take issue with several procedures that healthcare facilities typically perform when quick action is needed and consent may have to be obtained within the time frame needed to save the patient. Most notably is the case of Jehovah's Witnesses. This sect of Christianity believes quite strongly that a person's blood is heavily tied to who and what the said person is. They believe that any morally questionable behaviour could potentially be transmitted from one individual to the next through a blood transfusion. Doctors use blood transfusion frequently in times of emergency. When the patient cannot give consent because he or she is unconscious to do so, this issue is easily disregarded (Escobedo et al., 2007).

To appreciate, in particular the importance of consent process, it is ethically necessary to account for the misunderstandings in the consent process, for example in the preceding case, which started when the mother entered the care centre till she approved of her child to receive immunization. Other factors which have a role in the decision-making are factors such as unfamiliarity with the care centre or hospital environment, the stress of being ill or attending a medical clinic, and not yet knowing the details of their diagnosis and prognosis effectively could act as barriers impeding both comprehension and retention of information provided by the healthcare professional (Escobedo et al., 2007). Above all else, the patients' right to determine what investigations and treatment to undergo must be respected by the medical care professionals.

Medical and Cultural Situation Within the Study Areas

I analysed the perspectives of different healthcare professionals involved in the process of information delivery as well as the perspective of patients of differing cultural backgrounds in all regards of informed consent. Within the study areas themselves, there was a wide variety of different groups of people, especially in regards to cultural diversity. According to the study, majority of the people living in the areas at the time were from the Melanesian race. The other race was identified as from the Pacific Island natives and a few Asians and Europeans who lived in the study areas. There was an interesting trend that appeared within the percentage growth in population overall; the minorities (Asians) were growing quite rapidly. Ethically the study areas are varied. There is wide variety of the people from most parts of the world. In terms of religious affiliations in the study areas, while largely Christian they did include many faith groups. As the communities were diverse one would expect cultural disagreement within several different communities of the study areas; hence we decided to delve further into the issues of informed consent within the community. The sensitivity of the study required that we need to address the issue with great care. In many cultures autonomy does not raise as high of a concern, instead being replaced by other concerns; in PNG, valuing the family unit over the individual (for example, family's authorization to receive or refuse treatment for the patient, family planning for the wife refused by the spouse) (Joseph et al., 2008); the Japanese value more their family unit than an individual (for example right to know what goes on with the patient and receiving the test results of the patient) (Saldov et al., 1998); the Jehovah's Witnesses refuse life-saving treatment because their spiritual needs override their personal ones. These are examples of how the western ideas of informed consent do not translate perfectly across cultural boundaries (Hattori et al., 1991). The customary rules of the local (or indigenous) peoples deprive non-western cultures of their proper positions of power and actually devalue their notion of autonomy (Minei et al., 2020). Customs emerge from what people do, or more accurately from what people believe they ought to do, rather than from what a class of legal specialists consider they should do or believe (Minei et al., 2020). What people do and how it is transformed into a norm, that is, what people ought to do (Saldov et al., 1998), are an enigmatic process that

has never been fully understood (Bennett, 1991). To address these issues within a community would be a benefit to all in it. After having considered these issues and others, we developed a method for moving forward with our research.

The study was empirically designed and employed a mix of quantitative and qualitative, and descriptive cross sectional design in contemporary clinical practice settings. This approach was followed because the time between procuring informed consent and medical treatment is very short and patients are normally in hospital or clinic for a limited time. The descriptive approach allowed the healthcare professionals (doctors, nurses, and other healthcare workers) to describe their experience with the informed consent process as it happened, thereby bringing out the required real-time information. The traditional healers who live within the medical settings and familiar with the traditional customs of the people were included in this study. The patients were the means through which healthcare professionals, nurse/healthcare workers, and traditional healers interacted and they were key to understanding how informed consent unfolded in practice, and so participated in this study. We studied the situation in the study areas pertaining to informed consent, and elucidated the similarities or differences between the practice of informed consent within the context of an interdisciplinary legal analysis. More specifically, we examined the considerations that healthcare professionals and traditional healers take into account when dealing with patients with such cultural differences.

I commenced this study through identifying institutions where patients with cultural differences would seek medical attention. I identified the patients and patients of at-risk communities were the first step to seek relevant interview contacts and address.

Determination of Effectiveness of Current Informed Consent Delivery

It is imperative to understand the circumstances in which the patients live, the socio-economic standing of the community, and the indigenous culture. Cultural issues such as customs, languages, and other social factors impact on healthcare of the communities. One area where questions still arise with regards to healthcare decisions by the patients, is in regards to peoples of differing customs and languages. Some groups would involve people in the decision-making process to reach a medical decision, and other groups may dislike certain medical procedures. Certain groups of people have different views on what should be disclosed of the patient's condition.

This work provided the insights into the role that the law plays in day to day decision-making in the clinical settings. What it revealed was that the law did not figure foremost in the minds of patients or in the minds of doctors or professional nurses and healthcare workers (Chima, 2009), and in the mind of traditional healers who all care for the patients (Minei et al., 2020). Rather it works in the background, providing an unconscious architecture for the treatment relationship. It does not drive practice or decision-making which, quite rightly, is concerned more with care and the achievement of remission and long-term survival. In this sense the concepts of consent and the duties to provide information that are generated by the common law are negatively required, rather than how to maximize the best outcomes in the treatment relationship.

Law on medical decision-making holds that "simple" decision-making is insufficient; the choice must also be informed (Dalla-Vorgia, Lascaratos, Skiadas, & Garanis-Papadatos, 2001). Though people may not understand everything about a procedure, and they do have the right to make foolish choices, they still need to know what they are being foolish about, but they do not need to know and understand everything about all the possible impacts participation might have on their lives. However, in the preceding case, the healthcare worker did not commence the process to obtain the patient's informed consent to medical procedures when the mother

refused to participate in the family planning clinic and immunization for her child. Valid or invalid consent, the subject did not understand that the tests they were being exposed to were in fact the procedure to take even though it was troubling her that she did not understand something so important bothered her and the child. It is noted that much of the recent thinking on informed consent holds that it is not valid if it is not informed. From the legal perspective the emphasis is on what is disclosed to someone giving consent, not what the person understood, given that it is hard to "get a handle" on what was actually understood. There have been interesting cases in which the focus is on understanding because the subjects involved have questionable capacity to decide. There have been cases in which it was important to show that a person actually understood something critical (Shultz, 1985) (16), such as the fact that if s/he did not have a limb amputated, the result was death. If the person did not understand this, their consent was not valid.[11]

Obtaining consent involves informing the subject about his or her rights, purpose of the procedure, procedures to be undergone, and the potential risks and benefits of participation. When the participant understands the procedure to be undertaken, then the healthcare giver has communicated with the participant successfully and the participant makes an informed decision the decision reached and based on ethical standards completes the process for making an informed consent (Allmark et al., 2010). Clearly if patient participation is to be viable, then healthcare professionals have to view and treat the signing of consent forms as an important procedure or, in the preceding case or MCH case, the mother takes the child and enters the immunization room to receive vaccination. On the other hand, by placing so little emphasis on the consent form, healthcare professionals encourage the patients to view the consent form as merely a legal contract, and such a view reinforces the general perception held by patients that the "doctor knows best", and therefore the patients do not have to actively participate in the decisions on their healthcare needs. Thus, when the subject(s) participate willingly, the wish of the child or vulnerable person is protected and the mother's voluntary action reduces the risk of the child to infections and reduces the prevalence of the disease in the community. The procedure to informed consent educates the mother and ensures she understands the consent they have provided. The legal rights of the participant had not been waived and the healthcare professional may not be subject to liabilities in negligence.[12] The doctrine of informed consent adds a remedy for patients with injuries that result from undisclosed risks, even though they consented to treatment and are unable to show negligent diagnosis or treatment.[13] As expressed in this excerpt,

> Patient have the right to know about their health problem and any treatments the care provider suggests. This is called informed consent. If the patient does not get all the facts, she can't make a clear decision or give valid permission for treatment.
>
> The care provider (or doctor)'s duty, doctor must explain:
>
> - What patient's health problem is,
> - The main treatment and any other options,
> - The benefits, risks, and possible problems of each choice.
>
> After talking, the doctor may ask the patient to sign a consent form. Signing give legal permission to go ahead with the procedure. (Minei, 2023)

On record, PNG has no informed consent case that had passed through its judiciary. It is unclear in PNG about the laws and enforcement mechanisms in relation to informed consent to medical treatment. Informed

[11] Canterbury v Spencer (1972). 464 F.2d 772 (D.C. Cir. 1972).

[12] Patients have a legal right to be told any information that relates to their medical condition and their treatment. The signed consent form is considered a legal document. As a patient, it is her who must decide about her medical treatment, although it is important to consider the advice of the care provider.

[13] Natanson v Kline 186 Kan, 393 (1960) 350 P2d 1093.

consent is fundamental to ethical and legal medical practice; several issues of concern can compromise its effectiveness and the quality of patient care. There are many factors which may hinder the efforts to promote the regulatory mechanisms. Within certain social and economic positions in a society, the issues of patients being misinformed can be more or far less prevalent (McCabe et al., 2005). Some ideas may not translate well across language barriers or other ideas may seem more offensive within certain cultural boundaries. For example, language is an issue in securing informed consent, and is an obstacle to comprehension going beyond the obvious linguistic barriers. The intervention of an interpreter may help but different concepts of illness and issues of translation and cultural bias on the interpreter's part would compromise the extent to which information is understood. In other traditional settings where inhibiting customs are widespread, patients may refuse to make a medical decision for their healthcare needs. Another example, a patient may have religious or cultural beliefs or opinions which would affect his or her own personal decisions, and though they may not be supported by scientific evidence, they are still completely relevant to the patient's final decision, and so the information given should be relevant to that (Minei et al., 2020). The need for an important doctor-patient relationship and discussion is clear, as without an understanding of the patient's beliefs, a doctor may completely overlook relevant information and fail to achieve valid informed consent (Allmark et al., 2010). The notion of informed consent to medical treatment is a fundamental precept in law (Maclean, 2006). It recognizes autonomy and the right to personal inviolability.[14] One factor relevant to lack of a regulatory mechanism and enforcement is the inaction of the law enforcement bodies including the state and courts. Another related factor may be the varied socio-cultural aspects of the lives of people, the way the people live, interact with one another within their communities and with other people (Beauchamp & Childress, 1989; Minei et al., 2020). It is believed that traditional customs are essential to consider in developing tailored approaches to informed consent process. Case illustrations or examples used to verify situations arise from circumstances experienced and lessons from other jurisdictions. Nevertheless, given the above the current consent procedures seem inadequate in PNG. These issues highlight the importance of improving communication, patient education, cultural competency, and ethical practices within the informed consent process to ensure it is intended to protect patient autonomy and promote trust in the healthcare system.

The concept of shared decision-making has evolved from the foundational idea of informed consent, expanding the focus from simply obtaining patient permission to actively involving patients in the decision-making process and ensuring their values and preferences guide care choices.

Conclusion

Practices of Giving Consent (Doctor)

The American Medical Association's first code of ethics has warned that the physicians must avoid all things which have a tendency to discourage the patient and to depress his spirits.[15] These paternalistic viewpoints of the physician-patient relationship were replaced by a modern, patient-oriented approach that emphasized informed decision making by the patient. Nowadays physicians give care to every human being of adult years and sound mind and the patient has a right to determine what shall be done with his (or her) body. The view above is accepted and hence it forms the modern doctrine of informed consent.[16]

[14] Airedale National Health Service Trust v Bland, AC 789 All ER 82 (HL 1993).
[15] Schloendorff v Society of New York Hospital, 105 NE 92 (New York Court of Appeals 1914), p. 93.
[16] The relationship is one of the categories of relationships protected by the equitable remedy against breach of confidence. Most courts that have considered the question have held that a physician who violates the physician-patient privilege is liable to the patient

In the study (Minei, 2023), doctors were asked about their knowledge on giving consent to patients that agree to the medical treatment or undergo a procedure. The study checked on the knowledge, content of consent form, age of the patient who can give valid consent, and at which point in time to obtain informed consent. Majority of doctors (78.95%) in the study agreed that informed consent should be applied to all procedures, not to be applied only to patients with critical cases. There were doctors (10.53%) who answered that informed consent should not only be applied to critical cases but to all cases. In terms of the consent form, more than 84.21% agreed that patient's education, recording of consent (84.21%), and the patient and doctor's signatures should appear in the consent form (89.47%). Only about 38.89% cared to include their evaluation of competence in the form. The responses indicated levels of knowledge patients have regarding informed consent as well as granting this study the ability to identify where these answers were coming from in terms of the circumstances and influences each patient was subject to.

In terms of which point in time to get the informed consent majority of doctors answered in the ward or clinic (94.44%). Some doctors answered, in the operating room (44.44%) especially if the case is an emergency one. Some doctors suggested, at the admission counter for straightforward cases (38.89%). Doctors were also asked about the necessity of getting informed consent from patients. Only one doctor disagreed to this statement. The response from the doctors further indicated that they lacked general knowledge of understanding informed consent and it further points to lack of practice in obtaining consent.

Generally, many patients would respect the doctor, wait to see the doctor and majority would leave the doctor to decide what is best for them (Minei, Arana, Kaipu, & Minei, 2020). The shift in doctor-patient relationship seems inevitable in hindsight in PNG (Minei et al., 2020).

Practices of Receiving Consent (Patient)

In PNG there are unreported cases regarding disagreements between patients and healthcare professionals over the provision of their healthcare needs in treatment although there are no reports to verify the extent in the community.

In other jurisdictions[17], the disagreements resulted in legal suits against the healthcare professional and the institution. Nowadays institutional arrangements are made to deal with the concerns raised by the patients in receiving healthcare.[18] In my study, patients were asked about their knowledge on giving consent to doctors on medical treatment. In the existing work most patients are aware of what informed consent is (86.21%). In terms of the importance of informed consent, majority of patients believed that informed consent was important before doing a medical procedure (93.1%).

The process of receiving healthcare involves sharing of information which would potentially threaten individual control over privacy. When patients seek treatment, they give health professionals access to their bodies, provide information about their habits and personal relationships, and provide access to their otherwise private world. Despite a great proportion of patients having knowledge about informed consent, the fact cannot be denied there are still patients who are not aware of what informed consent is and its importance in medical

for damages. In PNG other healthcare workers such as nurses are trained in other special medical and administrative roles so that in the absence of a doctor or a nurse could operate a health care facility. The difficulties may be too great but in principle the ethical standards should be the same for everyone. On this matter there are useful experiences to learn from PNG.

[17] Canterbury v Spence (1972) 464 F (2d) 772; Sidaway v Bethlem Royal Hospital (1985) 1 AC 871; Rogers v Whitaker (1993) 67 ALJR 47; Riebl v Hughes (1980) 114 DLR (3d) 1.

[18] Canterbury v Spence (1972) 464 F (2d) 772.

treatment (6.9%). It is through the intrusion of medical tests results, records of which and other known information about the patient are kept, before the patient himself or herself gets to know. This implies a duty of confidentiality. The professional duty of confidentiality arises because of the loss of privacy. It refers to the duty of doctors not to disclose to others the information that a patient divulges and the corresponding right of patients not to have the information they divulge made available to anyone else (Richards & Louise, 2014).

Consent

I gathered through the patients' interview that generally, patients agree that the healthcare professional knows what is wrong with their health. In PNG, patients agree to anything concerning the medical procedure to be undertaken without asking for information about the procedure so long as they can get well soon. That has been the attitude of most patients in this study. I argue that a patient has ultimate knowledge of what would bring him or her most happiness and as such this sort of behaviour of the healthcare professional is inexcusable (Minei et al., 2020). Consent implies that the patient agrees to undergo a medical procedure which comprises of many other interventions which are all necessary steps in the medical treatment, so any discussion about consent requires not only the examination of its elements, but also consideration of its functions in the clinical context.

There is a need for research of this type to be conducted in societies or areas characterized by widespread traditional customs, sociological and cultural differences that exist among the local populations. The community settings which are significantly different in their social-cultural structures, for example, in communities of clan groups, the capabilities of local institutions, minority groups, and communities that lie within the local settings are relevant in the research. However, research study in this aspect has been rarely conducted in PNG.

In PNG patients live together with their families, both immediate and extended, and communally share shelter, food, and water and they do almost everything and anything as one big family. Happiness and sickness not only burden an individual but the entire group feels for him or her as well, either they enjoy or they feel the same pain implying that the family ties are stronger than an individual's interest. This is where the young people learn from adults what is expected of them to do whilst living in a traditional customary setting. Issues relating to family and health are largely centred on the immediate family, while other issues including marriage, bride price, funerals, land, water, and resource rights are discussed together in the family group comprising of extended families, sub-clan leaders, and the clan leader. I concur with other researchers that decision-making is a complex and varied phenomenon (Meisel & Kuczewiski, 1996) influenced by the context of the decision based on experience, values, preferences, social relationships, and by the factual particularities of the decision (McLean, 2010), such as many family members usually being involved and thoughts being shared at the family and group gathering (Minei et al., 2020).

The exact place that consent occupies in relation to decision-making is a matter of dispute with commentators (Capron, 1990) alleging that consent is synonymous with decision-making and others disagreeing with that premise (Meisel & Kuczewiski, 1996). Irrespective of whether consent is synonymous with decision-making, the question remains as to whether consent should be regarded as a discrete event (the moment of authorising a particular treatment), or as a process, in much the same way as decision-making is a process of gathering information, deliberating over the information, discerning what information is relevant to oneself, then making a decision about how to proceed. I say that the spouse has more influence on the decision made by the patient, in spite of the fact that the decision is shared with the family members and then told to the healthcare professional. This means that a patient does not have a complete autonomy over what is rightfully "his" or "hers"

to decide but there were parties involved in the making of the decision important for his or her health care (Minei et al., 2019). There are patients who refused to say anything and let their doctor decide what was best for them. A patient said,

> I did not say no to the doctor or said anything. I did not say yes, and I never said no to anyone. I was too sick that I wanted to go through the clinical process quickly and get well soon, so I agreed to be examined because I wanted to receive treatment quickly.

Another patient stated,

> I cooperated by showing interest and thought there were certain benefits to take from the process … I was examined by the care professional, he checked me then said, my general health, … you must look after yourself, my eating habits…, he asked what did I eat this morning? He said, I must reduce eating too much carbohydrates, then said my blood sugar results show that I had high blood sugar. I have diabetes and my blood pressure reading is high…, you have high blood pressure too.

This patient has been visiting the doctor regularly for his illnesses. It is true that consent occurs not as a discrete event but as a process of continuous discourse, information disclosure by the physician and agreement by the patient. This creates uncertainty regarding the point at which a decision is made to proceed with the treatment. As for the medical professional, the enmeshment of the patient in all facets of the treatment process makes obtaining a formal explicit consent to medical treatment unnecessary. The professional and the healthcare facility may influence patient autonomy through their attitude towards patient autonomy and consent. If little value is given to consent, then that approach will filter down and it may become a low priority for the care professionals working directly with the patient.

An individual medical professional may not be sufficiently conversant with the different interventions to inform or advise the patient (Maclean, 2006). For example, should surgeons with little formal training in anaesthetics counsel the patient about the pros and cons of the different options, assuming that they are even aware that those options exist? If appropriate medical staff, that is, anaesthetists are involved, then there needs to be appropriate practical arrangements which would allow patient sufficient time to reflect on the available choices. In my study many patients were reluctant to explain their medical conditions and requested help from their family, usually a spouse or parent or an immediate family member who may speak for their behalf when in the clinical examination room. A female patient said, “I cannot speak or discuss my medical problems with the healthcare professionals unless my husband was present”.

Another female patient said, “Strict adherence to my customs was necessary at my family home and in the rural settings. I must talk to my family members and my husband’s too”.

The patient refused to speak to a male healthcare worker. She must seek first her husband’s authorization. Other female patients also shared same. However, the female patients said that they would speak out if a female healthcare professional attended them. I would argue that in PNG where health care services are inadequate, where shortages of healthcare staff and relevant specialized personnel prevail, and where the services are not reaching many rural areas, the burden can be so great on patients who adhere to their customary beliefs and opinions. Patients who comply with the demands placed on them by their family or husband-spouse can cause detriment to patient care and so the communication between the patient-doctor is important as patients’ views are emphasised to unravel difficult issues. The process of seeking and acknowledging patients and healthcare workers’ views are discussed.

The familiar characteristics typical of the populations in multicultural and resource poor countries are poor education standards and low literacy levels, high prevalence of diseases, and high poverty among the urban settlers and town dwellers. From the foregoing introduction it is clear that there are geographical and cultural barriers to the practice of informed consent in PNG. The communities of clan groups continue to hang on to their cultures, and knowledge and power asymmetry usually exists between the well-off and the poor population in the communities; and similarly applies with patients and healthcare professionals. The cultural factors, such as the belief systems and languages, must be taken into consideration when obtaining informed consent from patients during treatment. Some researchers have suggested that culture plays a crucial role in the contemporary discourse on development, and policy makers have acknowledged that the social and cultural norms of a people can influence their attitude and choices (Minei et al., 2020; Chima, 2006). However, one of the criticisms leveled against traditional bioethics has been that it ignores the role of social and cultural factors in the ethical decision making process, prompting some scholars from developing countries to see globalization as a form of neocolonialism and an attempt by the developed world agencies to advance that biomedical agenda on resources-poor countries and communities (Chima, 2013).

The barriers to communication arising from traditional customs may prevent a common understanding of medical procedures, thereby putting the patient at risk of providing consent without comprehension (Minei et al., 2020). There are other issues including other cultural, social factors and language differences that have bearing too on the patients' understanding that affects the giving of informed consent. Patients must have adequate information if they are to play a significant role in making decisions that reflect their own values and preferences, and healthcare workers play a key role as educators in this process. It is important to recognize the backdrop of marginalization and ongoing challenges of the issues that affect healthcare services (Minei & Kaipu, 2020a). Most societies being culturally complex and paternalistic in nature, for example in PNG (Minei et al., 2020), may require that consent approval be obtained from the family members, or men as heads of the households before the actual patients can provide consent (Minei et al., 2020). The challenge in this setting then, is to ensure that informed consent is truly voluntary and that community or surrogate consent is not substituted for an individual's consent, which ideally should be obtained voluntarily in the absence of coercion and other undue influences.

The conclusion from this study is that in PNG customary constraints and compliances within the family settings have a big impact in the decisions-making, affecting mainly the young women and mothers who make decisions for their healthcare and other needs. Further, a patient's knowledge and opportunities to act autonomously depend not just on removal of obvious external constraints, or compliance with established elements of informed consent, but also on recognition of subtler barriers such as the goals, structure, and strategies of the clinical interaction itself and the patients' way of life governed by their culture—customary law, beliefs, and opinions. Based on my review of the ethical theory, my contention and conclusion are that a medical practitioner educated and conversant with the ethical theories of autonomy has a framework and an armory within which he or she can flexibly adapt to a patient's differing knowledge and practices and abilities to autonomously contribute to the clinical communicative dialogue.

The healthcare professionals value and define their role as the provider of treatment, and the persons responsible for solving patients' problems, or instructing the patient as to how to manage their problems. Most patients tell the healthcare professionals that they are sick; they request to be fixed and get well soon. The healthcare professionals value patient trust on the basis that it enhances their ability to effectively treat their

patient and they value patients who complied with and contribute to the overriding therapeutic goals of the clinical encounter. My contention is that all of these values lead to an overriding one of the primacy of beneficence.

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