Disclosure in Informed Consent: A Modified Conversation Analysis of
Four Male Surgeons’ Speech with Male and Female Patients

by

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A thesis submitted in conformity with the requirements for the degree of
Master’s of Science
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University of Toronto
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0-612-33950-5
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Abstract

Informed consent legislation requires physicians to disclose information that a reasonable person in the patient’s particular situation would need to know in order to make a decision about treatment options. From the perspective of feminist bioethics, gender is inextricably linked to a person’s particular situation. This study analyzed the speech of male physicians in relation to patient gender during discussions of informed consent for identical treatments. Qualitative methods of analysis were used to describe both the structure and content of speech. The results demonstrated that the overall structure of an informed consent encounter did not vary for male and female patients and that male physicians’ speech was not explicitly tailored to account for patient gender. The results also demonstrated that male physicians’ speech included instances of disfluency, particularly prevalent during risk disclosure, when speaking to both male and female patients. Future studies should investigate further, perhaps by alternative methods, whether physicians account for patient gender during disclosure.
Funding

University of Toronto Three Term Open Fellowship 1996-97.
The Toronto Hospital Surgical Directorate Grant 1996.
Acknowledgments

Jan Marta supervised my work, guided me through the research process, continually offered insight and encouraged me to remain committed to those questions that I believed to be of prime importance.

Edward Etchells provided the opportunity for me to collect the data for this study. He helped me develop the research methods and was generous with his time, insights and advice.

Heather Maclean inspired me to use qualitative research methods and shared with me her valuable experience.

Physicians and patients made this research possible by agreeing to participate in the study.

Individuals at the clinic where the data was collected were kind and helpful to me.

Faculty and staff at The University of Toronto Joint Centre for Bioethics were supportive.

Eric Meslin, Alan Tough, Pat McKeever, Sharon Smith, Alina Gildiner, Martin Sommerfeld, James Lavery, Ronnilyn Pustil, Robin Schaffran, Debbie Kurland, Jodene Goldhar, J.D. Rothstein, Michelle Tennen, James Cooper, Abraham Pessis and Michele Peress contributed to the development of this project.

Bernard Zinman, Jean Zinman, Lorne Zinman, Andrew Zinman, Beverley Young and Rega Zucker were (are) invaluable to me.

Robert Cooper edited the written text and, on a daily basis, discussed with me the details of this project. He has reminded me of the value of hard work, the importance of perseverance and of the sheer joy that can be derived in creating “something from nothing.”
This thesis is dedicated to Dr. Rosalind Zinman (1934 -1996)
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Chapter One: BACKGROUND

Overview of the Project

Informed consent is the autonomous authorization of a medical intervention by the patient.\textsuperscript{1} Ontario law\textsuperscript{2} and three medical regulatory bodies\textsuperscript{3} require a physician to obtain informed consent in connection with any medical treatment, in accordance with the ethical principle of respect for patient autonomy. A valid informed consent requires: assessment of patient capacity, disclosure of treatment information, and patient voluntariness. Disclosure involves effective communication of relevant treatment information from the physician to the patient. In Canada, physicians are required to tailor treatment information to a "reasonable person" in the patient's particular situation in a manner that is comprehensible. From the perspective of feminist bioethics, a patient's particular situation is inextricably linked to a patient's gender.

This project will address issues arising in communication between physicians and patients during the process of informed consent, focusing on the speech of physicians and the gender of patients. The purpose of this study is to analyze, and compare, communication between male physicians and male and female patients during the informed consent process. The study will use qualitative methods to address the following questions: 1. Do the major topics discussed during an informed consent encounter vary for male and female patients?; 2. Is the speech of male physicians explicitly tailored to account for patient gender during an informed consent encounter?; 3. Are there differences in the speech features of male physicians when communicating with female as compared to male patients during an informed consent encounter?
**The Origins of Informed Consent**

Faden and Beauchamp (1986), Katz (1984), and Appelbaum et al. (1987) have each provided detailed histories of the court proceedings that led to the formation of the law of “informed consent.” These authors have emphasized the extent to which the practice of seeking and obtaining a patient’s consent, prior to administration of a medical treatment, was foreign to the culture of medicine for years prior to the emergence of the legal doctrine of informed consent. Faden and Beauchamp explain that even the Hippocratic Oath did not require physicians’ to inform patients of intended procedures or to be truthful when communicating with patients.

Faden and Beauchamp believe that informed consent came to be a concern in medicine in the 1950s because of shifting societal values and attitudes. The authors assert that it seems likely that increased legal interest in the right to self-determination and increased philosophical interest in the respect for autonomy and individualism were but instances of the new rights orientation that various social movements of the last 30 years introduced into society. The issues raised by civil rights, women’s rights, the consumer movement, and the rights of prisoners and the mentally ill often included health care components: reproductive rights, abortion and contraception, the right to health care information, access to care, human experimentation, and so forth. These urgent societal concerns helped reinforce public acceptance of the notion of rights as applied to health care.

Jay Katz’s analysis of informed consent recounts the history of “silence” or lack of communication that existed between physicians and patients prior to the birth of informed consent. Katz reviewed early medical writings dating back as far as the medieval period and determined that historical medical literature dealing with physician-patient communication focused primarily on how physicians
should "manage" the information they would choose to reveal to their patients. Physicians would thus disclose information in a strategic or cautious manner that would purposely limit the amount and type of information disclosed, perhaps in an attempt to protect patients.

Faden and Beauchamp deem the landmark California case of *Salgo v. Leyland Stanford Jr. University Board of Trustees* (1957)\(^\text{10}\) a turning point in informed consent's history since it was the first to explore whether or not adequate disclosure by the physician had occurred prior to obtaining patient consent. The ultimate disposition of the court in *Salgo* determined that the physician had neglected to communicate to his patient the potential risks that could result from the procedure. The presiding judge, Justice Bray, coined the phrase "informed consent," explaining that adequate consent by a patient included the consideration of whether or not the patient had been adequately informed of the effects of the proposed treatment. In his decision, Justice Bray submitted the proposition that:

\[
\text{A physician violates his duty to his patients and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.}^{11}
\]

Thus *Salgo* marked a major shift for the informed consent doctrine because it explicitly focused on the importance of adequate disclosure of treatment information by the physician. For the first time, a patient's right to decide whether or not a certain intervention was acceptable to himself or herself, based on the information conveyed by the physician, was considered paramount within the context of the physician-patient relationship. The determination in *Salgo* led to a focus on the content of physicians' speech during their interactions with patients. As a result of *Salgo*, physicians were expected and required to communicate effectively with patients.
Informed Consent to Treatment in Ontario

Ontario legislation\textsuperscript{12} defines three essential components of a valid consent: capacity, disclosure and voluntariness.

1. Capacity:

Capacity, also called competency, is the first step or precondition involved in obtaining a valid consent. Capacity, or decision making capacity, has been referred to as “the ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”\textsuperscript{13} Capable patients have the right to make their own decisions about medical treatment. In Canadian common law, patients are presumed to be capable unless it is unreasonable for the assessor to make this presumption.\textsuperscript{14} In the event that a patient is found to be “incapable,” the physician must obtain consent or refusal from the patient’s designated substitute decision maker.\textsuperscript{15}

2. Disclosure:

Disclosure of treatment information refers to both the type of information that must be disclosed and the scope of information relevant to the particular patient.\textsuperscript{16} The type of information that is to be communicated during disclosure includes: the nature of the proposed treatment; the relevant alternative options to having the proposed treatment; the expected benefits of the proposed treatment and of the alternatives; the relevant risks of the proposed treatment and the alternatives; consequences of not having the proposed treatment; the consequences of delaying the proposed treatment and the expected side effects including duration of hospitalization and recovery and restrictions on daily activities.\textsuperscript{17} The scope of information that is to be communicated during disclosure is based upon the “reasonable person” standard as to what information would be relevant to a
reasonable person in the patient’s particular situation. Treatment information must therefore be disclosed and tailored specifically to the individual patient and not disclosed in a standardized format without regard for the subject. A patient’s gender, age, culture, sexuality, socio-economic status, and religion are among the variables that might comprise a patient’s particular situation.

3. **Voluntariness:**

Ontario legislation requires that the physician administering a treatment to a patient ensure that the decision has been made voluntarily. Thus the physician seeking consent must ensure that the patient was not coerced into making a decision. For example, patients accepting medical treatments that are experimental, as part of a research protocol, must not feel pressured to accept these treatments in exchange for positive favour from the physician.

*The Reasonable Person Standard for Disclosure*

The legal standard for informed consent has evolved dramatically over time. The original regulations emphasized the importance of effective physician-patient communication but relied on physicians themselves to set the standard for the type and amount of information that would be sufficient for achieving adequate disclosure. The current standard in Ontario relies more on the patient to set the standard since it requires that the situation of the particular patient be factored into the treatment information that is communicated by the physician to the patient during disclosure. For example, physicians may need to consider the ways in which a medical treatment will affect a patient’s job-related duties and salary, care giving responsibilities and/or duties at home, sexuality and/or appearance. This raises the possibility that patient gender is relevant to disclosure in that there are known gender differences in society regarding traditional care giving
responsibilities for children and elderly, income levels, hobbies and personal lifestyle concerns.

The 1980 Canadian Supreme Court decision in *Reibl v Hughes* established the current definition of the "reasonable person" standard in connection with disclosure, demonstrating that an individual's age, job, and socioeconomic status are relevant to the informed consent process. To review, Mr. Reibl was evaluated for asymptomatic carotid stenosis by his surgeon, Dr. Hughes, who recommended the surgical procedure known as a carotid endarterectomy. The primary risks of this procedure include death, stroke and/or paralysis. These risks could be considered "reasonably" relevant to any "reasonable" individual. However, Mr. Reibl's *particular situation* was unique in that he was one and a half years away from earning a lifetime retirement pension as a Ford Motor Company employee. Therefore, any reasonable person in Mr. Reibl's particular situation would be concerned with ensuring that his pension vests. Thus, a reasonable person in Mr. Reibl's particular financial situation would need to know, through disclosure, that the risk of stroke within the next six months was higher with the surgical treatment of carotid endarterectomy than with alternative medical treatment. Surgery was more likely to jeopardize Mr. Reibl's pension entitlements than alternative medical treatment.

Ontario legislation elaborates on the findings of the court in *Reibl v Hughes* specifying that "a consent is considered informed if, before giving it, the person received the information...that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and the person received responses to his or her requests for additional information about those matters." Thus reasonableness rests explicitly on the values and beliefs of the patient, and not on those of the physician. Physicians must therefore be aware of the unique circumstances and situation of each particular patient in connection
with a treatment and communicate information accordingly.

**The Reasonable Person Standard and Feminist Perspectives in Bioethics**

In this project, gender is assumed to be relevant to a patient’s particular situation. However, in Ontario, the requirements placed on physicians with respect to the “reasonable person” standard for disclosure do not explicitly state that gender be considered as part of the patient’s particular situation. The following application of feminist bioethical analysis to the reasonable person standard demonstrates that gender is inseparable from the patient’s particular situation.

Rothenberg (1996) explains that all feminist theories would agree that gender is inextricably linked to an individual’s particular situation since all feminists ask what impact a rule, practice, or policy will have on gender and, more specifically, on the lives of women from diverse backgrounds and experiences.²³

Cultural feminism, one theory within feminist bioethics, provides an appropriate framework for analyzing the importance of gender in its application to the “reasonable person” standard for disclosure. Cultural feminism is rooted in the work of Gilligan (1982) who argued that men and women think and speak in “different voices” when approaching moral problems.²⁴ In her study, Gilligan found that men tended to approach moral dilemmas using abstract rules which preserve autonomy while women tended to approach these same dilemmas in a contextual way which aimed to preserve the connections in relationships between individuals. Cultural feminists argue that the traditional male based strategy for dealing with bioethical issues differs from the female based strategy, commonly referred to as the “ethic of care,” which focuses primarily on relationships and the
particular circumstances surrounding an issue. For example,
cultural feminism may also question current standards of proper informed consent. Currently, standards of informed consent require the disclosure of information that a ‘reasonable person’ would want to know in order to make an informed decision. However, if men and women think and speak in ‘different voices,’ there may be no one common conception of a reasonable person. Indeed, current conceptions of such a person tend to reflect a masculine notion of reasonability, and cultural feminists urge that we expand this notion to include women’s values.25

In addition to cultural feminism, both postmodern feminism and radical feminism support the idea that gender is inextricably tied to a person’s particular situation. While radical and cultural feminists both argue that men and women maintain different values, radical feminism, unlike cultural feminism, views these differences as a direct product of gross power imbalances within society manifested as male dominance and female subordination.26 Proponents of postmodern feminism reject the notion that one feminist perspective can explain or account for the situation of all “women” and they argue that each individual woman has a “situated reality” that cannot easily be generalized to other women’s unique situations. Postmodern feminists tend to view a person’s particular situation as dependent upon numerous variables including race, class, sexuality, age and gender.27

Little (1996) believes that it is immaterial which feminist theory one adopts but that it is important that a feminist perspective, accounting for gender, in general be applied to issues in bioethics.28 She identifies a major problem within bioethics--androcentrism--and the way it causes women’s concerns specifically to be ignored while men’s concerns are the focus and standard that is generalized to both genders. Eichler (1991), a sociologist, defines androcentrism best:
Androcentricty is, in its most basic expression, a vision of the world in male terms, a reconstruction of the social universe from a male perspective....Androcentricity results in the maintenance of male over female interests. This may take the form of trivializing problems experienced by women...or it can take the form of an argument for maintaining a situation that favors males over females.29

Little gives concrete examples of androcentrism in medicine and in bioethics, for example, under representation of women in clinical trials, and the propensity for mainstream bioethicists to approach moral problems using abstract rules or principles rather than feminist approaches, such as the "ethic of care."

In summary, from the perspective of feminist bioethics, gender is an essential criterion for defining and meeting the "reasonable person" standard for disclosure. In the next chapter, the informed consent literature will be reviewed to uncover whether gender issues have been addressed in this area.
Chapter Two: LITERATURE REVIEW

This literature review is comprised of two main sections. The first reviews the philosophic, legal and empirical literature pertaining to informed consent with special attention to patient gender. The second reviews studies of medical communication (outside of the informed consent literature) that have investigated the importance of patient gender. Many of these studies suggest that patient gender is an important aspect of physician-patient communication and therefore by extrapolation an important aspect of informed consent.

The Philosophical Literature on Informed Consent

Most philosophical discussions pertaining to informed consent advocate an examination and remodeling of the physician-patient relationship and propose more elaborate communication as a means to achieving truly "informed" consent, while remaining silent with respect to patient gender as a potentially important aspect impacting this process. The recent shift from physician paternalism to patient right to self-determination or autonomy has received considerable attention within this domain of literature dealing with informed consent. Authors have debated the meaning and definitions of patient rights and have questioned whether this novel way of conceptualizing the patient role can be effective in clinical practice.

Philosophical literature has consistently identified a myriad of problems with informed consent and has listed reasons why the goals of informed consent in theory--the shifting of autonomy and control in decision making from physician to patient--do not translate adequately into practice. The difficulties that result from evolving patient autonomy include the implicit vulnerability of patients, due to illness, when informed consent is sought, conflicting information that physicians
receive from the courts and other health care professionals about how to achieve adequate informed consent; time constraints; and the explicit and implicit conflict between the values, needs and goals of the physicians and patients. Authors consistently stress the importance of focusing not only on the legal tenets of informed consent but also on the potential for effective communication between physician and patient and thus a more meaningful informed consent.

The field of feminist bioethics offers an explanation for why there is a lack of concern for gender issues within the philosophical literature in mainstream bioethics. This critique, applied to informed consent, demonstrates why the importance of patient gender has not been a focus of philosophical debate. Wolf (1996) consistently asks why mainstream bioethics has neglected to embrace gender as analytically central and, furthermore, why feminist critique has systematically been left out. In her recent work she suggests:

[T]he answer is to be found in the deep structure of bioethics--in its early embrace of a liberal individualism largely inattentive to social context; in its emphasis on deduction from ethical principles rather than induction from concrete cases; in its tendency to view ethical problems either dyadically as problems between individuals, or nationally as problems for the entire society, but rarely at an intermediate level attentive to the moral significance of groups; and in the failure of bioethics to be sufficiently self-critical by examining whom the field serves and how.

Sherwin (1996) also laments the lack of serious discussion of gender issues in mainstream bioethics, and elaborates its effects:

For the most part, bioethicists proceed as if bioethics is simply neutral in its effects on oppression, pursuing questions that seem to be separate from those that occupy feminists. With the exception of a few topics that clearly affect women differently than men (particularly abortion and the new reproductive technologies), most bioethicists assume that their work has no impact on questions of gender oppression... Feminists, however, are unlikely to be comforted by these omissions,
having learned elsewhere that invisibility is no assurance of irrelevance in matters of oppression.\textsuperscript{42}

Warren (1992) differentiates between “crisis issues” that are popularized in mainstream bioethics and “house-keeping issues," or day-to-day relational issues that have been identified within the sub-field of feminist bioethics:

...with crisis issues, moral decisions are more or less final. A moral problem arises; one decides; one moves on and feels a sense of progress. With housekeeping issues, however, the problematic situation is ongoing, rather than resolved once and for all; and decisions need to be made continually (her emphasis).\textsuperscript{43}

Warren’s critique concentrates on the paternalistic approach to decision making within bioethics. She uses the example of informed consent to demonstrate the way in which feminist bioethics would approach issues, and seek to reform current problems, differently:

[I]nformed consent is standardly interpreted as a crisis issue: ‘Was the autonomous and informed consent obtained from the patient before this treatment, or did the physician withhold relevant information or pressure the patient?’ Compare this to informed consent interpreted as a housekeeping issue: ‘How should we foster the conditions which make informed consent more likely?’ The whole physician-patient relationship is thereby called into question: How much time should physicians spend with patients, and on whose terms—when it is convenient for the doctor or when the patient is well-rested and psychologically prepared? How involved should physicians be with patients’ value choices and anguish? Should the relationship between physicians and nurses be changed so that they can work together more effectively to encourage patient autonomy?\textsuperscript{44}

Warren’s work identifies androcentrism within mainstream bioethics and reveals the traditional ways in which essential questions pertaining to informed consent
have historically been discussed within the field. Her application of the perspective of feminist bioethics to the traditional ways of viewing informed consent demonstrate that both consideration of the importance of patient gender, and of feminist philosophical theory, offer new and enlightening ways of looking at informed consent.

In bioethics, the mainstream philosophical literature on informed consent has not, as yet, looked at the importance of patient gender for seeking and obtaining adequate informed consent from patients, nor has it integrated a feminist theoretical perspective into its deliberations on this topic. In the next section, the legal literature on informed consent is reviewed in order to explore whether patient gender has been a focus in that domain.

**The Legal Literature on Informed Consent**

This section of the review addresses two distinct areas of literature with particular attention to patient gender: the historical legal literature, and the present day response to legislation. An androcentric perspective, which ignores the contribution and/or concerns of women specifically, occurs within the historical legal literature in that scholars have neglected to highlight the significance of the female patient’s role in four landmark cases. When documenting the origins of informed consent, Faden and Beauchamp (1986) focus on four cases of battery—each involving a female patient—that occurred between the years 1905 and 1914 and are almost “universally credited with formulating the basic features of informed consent within American law.” Furthermore, according to Faden and Beauchamp, “[t]he landmark consent cases of the twentieth century...more explicitly examined the principles underlying the physician-patient relationship, and applied that understanding to develop and illuminate the nature and scope of consent.” These landmark cases were *Mohr v. Williams* (1905), *Pratt v. Davis*
(1906)\textsuperscript{48}, \textit{Rotater v. Strain} (1913)\textsuperscript{49}, and \textit{Schloendorff v. Society of New York Hospitals} (1914),\textsuperscript{50} each involving a female patient.

In general, the mainstream history of informed consent ignores the significance of the female patients’ role specifically in the early formation of the informed consent doctrine. This history describes these four landmark cases without considering of the importance of gender and of the life circumstances—such as social, political and economic conditions—surrounding these women’s lives. Furthermore, the history of the cases does not explore how individual rights and gender stratification in society at the time would have impacted the rulings. These historical accounts do however make clear that the four cases were important to the formation of the informed consent doctrine because they enshrined the idea that consent is legally required on grounds of the patient’s right of “self-determination,” the legal equivalent of the moral principle of “respect for autonomy” and that they set “influential precedent[s] for later cases.”

From the perspective of feminist bioethics, the situation and circumstances surrounding each female patient’s “landmark case” are critical to the history of informed consent. For example, one of the four female patients had had her ovaries removed without her consent.\textsuperscript{51} The surgical removal of women’s ovaries—without patient consent and for the purpose of experimentation and/or eugenic sterilization—marks a dark period in the history of obstetrics and gynaecological care.\textsuperscript{52} Feminist bio ethicists would deem these facts critical for understanding both the history and the formation of the original informed consent doctrine. However, in the mainstream history of informed consent, such facts are completely overlooked.

An entire body of literature assesses the impact of legislated standards for informed consent on current medical practice. These writings routinely refer to “the patient” without reference to gender as potentially relevant for adequately
meeting the "reasonable person" legal standard for disclosure.\textsuperscript{53 54} This typifies the problem of androcentricity since "a male viewpoint or frame of reference results in the construction of the actor as male rather than as either male or female or both female and male, while at the same time asserting general applicability."\textsuperscript{55} This occurs in the legal literature on informed consent since traditionally, articles explore how legal standards for disclosure translate into medical and hospital policy and/or practice but do not consider patient gender to be relevant for the informed consent process.\textsuperscript{56 57 58} In addition, articles trace the ways in which the physician's obligations for disclosure of treatment information have expanded and changed over time without suggesting that attention to patient gender may lead to more effective and adequate informed consent.\textsuperscript{59 60 61} Often articles interpret the health care legislation for physicians and provide them with easy to follow guides.\textsuperscript{62 63} These instructions do not routinely suggest that patient gender be considered when defining and determining the criteria that would define the situation of the "reasonable person." Thus, the reasonable woman’s standard versus the reasonable man’s standard for disclosure has not been explored in mainstream bioethics legal literature on informed consent.

\textbf{The Empirical Literature on Informed Consent}

In the empirical literature on informed consent, no study has yet isolated patient gender as a primary focus of investigation. For example, no study has evaluated differences in communication during informed consent for physicians and patients based on gender. Nor have studies identified or evaluated gender specific definitions of a patient’s particular situation in relation to treatment options. However, some empirical studies have conducted exploratory analyses for gender differences among other potentially important variables.\textsuperscript{64 65 66} For example, researchers found that female patients were more concerned about "not
waking up" post-operatively, whereas male patients were more concerned about experiencing pain. In addition, female patients tended to report significantly higher levels of concern about anaesthesia in comparison to male patients. Another study found no statistical differences for patient gender for those who agreed or refused to consent in a hypothetical research trial after reading a consent form and underlining parts they deemed relevant for decision making.

The bulk of empirical studies on informed consent commit the error of androcentrism. Traditionally, analyses are not conducted on patient gender and findings are reported on "the patient," thus neglecting potential differences relating to gender for physician-patient communication or for defining the patient’s particular situation. Though male and female patients are generally included as participants, analyses of gender are not routinely conducted thus potential gender differences are ignored.

The women’s health movement has identified the problem of androcentrism within medical research. Women have continuously and systematically been excluded from clinical trials for conditions that routinely affect both men and women, such as heart disease. Furthermore, when women are included in the study as participants, gender analyses are not routinely conducted, thus precluding potential differences from being detected. Substantial evidence has demonstrated that data collected exclusively on men, for medical treatments affecting both men and women, cannot effectively be extrapolated to women.

Though excluded from medical research historically, female patients have been included as participants in a plethora of clinical trials in the areas of reproductive health and breast cancer. Sherwin (1996) points out, “only in matters of reproduction has gender been acknowledged as a significant variable, and often, not even there.” Similarly, the concerns of the female patient have been explored in the empirical literature on informed consent only for treatments
that affect women exclusively, such as in the area of reproductive health and breast cancer treatment alternatives. Thus, the informed consent empirical literature in bioethics commits the same error of androcentrism that was identified by the women’s health movement as having occurred historically in medical research.

Empirical studies on informed consent have not addressed issues of patient gender for information disclosure for treatments that both men and women receive. The female patients’ unique needs for information disclosure, prior to decision making, have been studied only in the areas of reproductive health and breast cancer. These studies reveal that female patients do not consider standardized forms for disclosure to be adequate for them during the process of informed consent. For example, one study described the complexity involved in decision making for breast cancer treatment and addressed the informational needs of women by identifying the multiple variables involved including decision making style; age; coping mechanisms; stage of disease; risk of recurrence; state of the art treatment recommendations; and personal preferences. In another study, a tool was developed to assist physicians in disclosing treatment information to female patients specifically whose unique needs for disclosure included elaboration on quality of life issues, and both visual and written material explaining outcome probabilities for various treatments. These studies suggest that female patients may have unique needs for disclosure not only in the realm of these treatments that affect them exclusively but also in the context of treatments that affect men as well.

In summary, the philosophical, legal and empirical literatures on informed consent commit the error of androcentrism in that the gender of the patient has not specifically been addressed. In addition, patient gender has not been considered relevant for physician-patient communication during informed consent. Thus, the
following section turns to medical communication literature, in the field of medical sociology, to review studies that have focused upon the potential relevance of patient gender.

**Medical Communication**

This section reviews both quantitative and qualitative studies that have identified the variable of patient gender as potentially relevant to physician-patient communication or for defining the patient’s particular situation. Generally, the quantitative studies focus on an evaluation of male versus female physician practice style more than on physician practice styles as they may vary for male and female patients. For example, Hall et al. (1994) analyzed physician and patient gender in relation to verbal and non-verbal communication and found that female physicians conducted longer visits, made more positive statements, and more “partnership statements,” asked more questions, made more “back-channel responses,” smiled and nodded more. Partnership statements are ones that include paraphrases, requests for other’s opinion, requests for understanding, and requests for assurance. Back-channel responses are verbal indicators of sustained attention and encouragement emitted by a speaker who does not hold the speaking floor. Irish and Hall (1995) found that both male and female patients interrupted male and female physicians more than the reverse. Wallen, Waitzkin and Stoeckle (1979) focused on patient gender specifically and found that it clearly affected the communication process since female patients asked more questions than male patients when communicating with male physicians and received a greater number of explanations overall. Bernstein and Kane (1981) found that both male and female physicians believed that female patients were more likely to make excessive demands on physicians time and were more likely than male patients to have medical complaints influenced by emotional factors. Waitzkin
found that female patients elicited more interpersonal involvement from physicians as compared to male patients in the primary care setting. Roter et al. (1991) found that the gender of the physician is highly relevant to the nature of the communication during primary care visits. This study investigated effectiveness of communication by numbers of open questions, closed questions, types of information conveyed, either biomedical or psychosocial, and found that female physicians engaged in more talk that was "socio-emotional in nature" which means that they used more "positive" and "partnership building" language. As well, female physicians engaged in more "task-focused exchanges" which means that they did more question asking of male and female patients and gave them more information than male physicians. Female physicians also spent the most time with female patients as compared to male patients.

Within the qualitative literature on medical communication, Waitzkin (1991) found that the content of physicians’ speech during the medical encounter reinforces certain ideological beliefs about male and female roles in society, and about social control. The content of male physicians’ speech within the primary care setting emphasized the importance of the female patient’s role within the family as a mother and caregiver and de-emphasized her struggle in coping with work demands both at home and at her place of employment. Therefore, "medical discourse tends to marginalize the contextual issues of greatest concern," and, "social roles in the family are rarely open to critical analysis, even when contextual conditions become the principal source of a client’s distress." Furthermore, "the doctor-patient encounter rarely elicits a critical analysis of troubling social patterns affecting women, let alone strategies for change."

Borges and Waitzkin (1995) found that the female patient’s particular situation is different from that of the male patient. This study employed a discourse analysis of patients narratives and found that female patients’ narratives,
or descriptions of their problems, in the primary care setting, often express emotional problems related to difficulties women specifically face in society. The speech of male physicians was analyzed and found to marginalize the kinds of issues that contribute to female patients' emotional distress. Davis (1988) set out to investigate the power imbalance that exists between male physicians and female patients during the medical encounter. The author found that power itself is difficult to study empirically because it is so pervasive and implicit. She thus suggested that most empirical work in the area of medical communication is flawed because it does not account for the implicit power differential between male physicians and female patients specifically.

West (1984) used the qualitative method of “conversation analysis” to study medical communication and reported that “only through systematic empirical study of the minutiae of medical exchanges can we learn what constitutes the alleged communication gap between doctors and patients and how it might be transformed.” In this work, the researcher analyzed “turn-taking,” also called “interruption,” in physician-patient conversations and found that there are two types of interruptions that typically occur in conversation: “violation of speaker’s speech” and “simultaneous speech.” The results showed that white male physicians interrupted the speech of black female patients more than they do that of white male patients. In addition, black female patients interrupted white male physicians less than white male patients did. The study also demonstrated that black female patients interrupted white female physicians at the same rate as white female physicians interrupted these same patients. However, white male patients interrupted white female physicians more than white female physicians interrupted these patients. West (1993) later focused on the language of physicians during medical communication and found that male and female physicians gave advice to patients in dramatically different ways.
physicians gave advice, or "issued directives," in an "aggravated form" which is like a command, while female physicians issued directives in a "mitigated form" which is like a proposal.

Research by both Fisher (1986) and Todd (1989) investigated medical communication by the method of "participant observation" in settings where the treatments received were exclusive to women, such as in a gynaecological treatment clinic. Fisher examined how cultural, structural and institutional factors affected female patients during the medical encounter and found that these factors impact women negatively since male physicians have almost total control over the process. This power imbalance can harm female patients in that treatment decisions are made solely by the male physician and female patients are discouraged from contributing information that they themselves deem to be important. Todd (1989) investigated communication between female patients and male physicians and analyzed their conversations in connection with societal structures and institutional hierarchies that impact the physician-patient relationship overall. Todd found that the power imbalance in the physician-patient relationship is exacerbated when the patient is female, and that physicians concentrate on biological and technical issues related to a disease at the expense of ignoring contextual issues affecting women's daily lives.

The foregoing studies within the medical communication literature provide convincing evidence that gender is relevant to physician-patient communication and for defining the patient's particular situation.

Summary

The criticisms launched by feminist bioethicists regarding the lack of attention to gender issues within mainstream bioethics are substantiated by this broad literature review on informed consent. This review demonstrated that
informed consent philosophical, legal and empirical literature do not adequately address the potential importance of patient gender for physician-patient communication or for defining the patient’s particular situation in accordance with the “reasonable person” standard for disclosure. The review of medical communication literature demonstrated that gender is relevant to both physician-patient communication and for defining the patient’s particular situation.

This study will investigate the potential importance of patient gender for informed consent by comparing the speech of male physicians when speaking to male and female patients who are scheduled to undergo identical treatments. Specifically, the analysis will focus on both the structure and content of male physicians’ speech and compare these for male and female patients.
Chapter Three: METHODOLOGY AND METHODS

The qualitative method of "conversation analysis" will be used to analyze the conversations between physicians and patients during the informed consent process. This method offers an alternative approach to the empirical study of informed consent since studies in this area have traditionally implemented quantitative methodologies. The history and philosophy of ethnomethodology will be reviewed in this chapter for the purpose of explaining why the method of "conversation analysis" is an appropriate choice, and a positive new direction, for the study of physician-patient communication during informed consent.

Methodological Critique of Studies on Informed Consent

Traditionally, informed consent empirical studies have aimed to measure "how informed" patients really are after the process of informed consent has been completed. Generally, these studies have found that legislated standards for disclosure are rarely met within clinical practice. In order to determine the validity of such findings, it is first necessary to evaluate the methods that were selected for analysis.

Four main conceptual and methodological flaws have been identified within empirical studies that have attempted to measure the quality of the informed consent process. First, most studies have neglected to use the actual conversations that occurred between physicians and patients during informed consent as data. Instead, such studies have relied primarily on post-operative questionnaires to test patients. Second, few studies have actually taped physician-patient conversations during the informed consent process as a method of data collection. As a result, the evaluation of empirical studies pertaining to the informed consent process is directly related to the evaluation of the data source.
employed. Thus, the failure to obtain actual physician-patient conversations for analysis may result in the inability to adequately assess the actual topics discussed during informed consent encounters, the structure of these conversations, and the manner in which they are conducted.

A third flaw, studies have relied on outcome measures such as “patient satisfaction” and “patient recall” to measure “how informed” patients are subsequent to their discussions with their physicians. There is no empirical evidence to demonstrate that patient satisfaction and/or recall are relevant measures for determining whether or not adequate “informed consent” has occurred, yet these outcome variables have been routinely used to measure the quality of the informed consent process.¹⁰⁷ ¹⁰⁸ ¹⁰⁹ Most of these studies have found that patients recalled very little of what was disclosed to them however these findings do not necessarily indicate that communication was ineffective or that adequate informed consent did not occur.

The fourth flaw is that studies have falsely equated “patient recall” with “patient comprehension” when no such connection necessarily exists. It is possible that the patients, who comprehended the information disclosed by the physician at one time, forgot this information at a later date when recall was tested, for example, post-operatively. Mainstream studies are also problematic in that they have used experimental conditions rather than actual clinical practice as a research setting resulting in non-patient participants who are typically asked to contemplate hypothetical situations regarding treatment decisions.

The current empirical project will heed the methodological errors identified in prior critiques, and attempt to eliminate such flaws by audiotaping the actual conversations that occurred between physicians and patients during the informed consent process. The qualitative method of “conversation analysis” will be used to analyze both the content and the structure of physician-patient conversations
and allow for comparison for patient gender. The method of conversation analysis is derived directly from the method and theory of “ethnomethodology.”

**Ethnomethodology**

Ethnomethodology investigates the mechanisms of social interaction.

[It] is the empirical study of methods that individuals use to give sense to and at the same time to accomplish their daily actions: communicating, making decisions, and reasoning.¹⁰

Garfinkel (1967) was the founder of ethnomethodology and his work arose directly in response to the sociological theories professed by his teacher Talcott Parsons.¹¹¹ Parsons taught that individuals, during social interaction, responded to societal structures that were external to them.¹¹² He thus described the social order as controlled by institutionalized systems that dictated norms, rules and roles for behaviour.¹¹³ The movement of ethnomethodology was said to have “declared war” on the discipline of sociology because it directly questioned, and ultimately contradicted, Parson’s theory, the theoretical underpinnings of the field. Sociologists, for the most part, believed that individuals interact based on “shared meanings” of appropriate behaviour and that these “rules” were responsible for shaping and affecting everything individuals did and said. Therefore, the purpose of the professional sociologist was to uncover and explain the various ways in which the external world controlled and impacted human behaviour.

The movement of ethnomethodology radically opposed sociological theory of human behavior by asserting that individuals *themselves* produce social order through their own interaction. Garfinkel claimed that individuals are not “judgmental dopes” who merely respond to external societal forces and structures around them. Rather, individuals “produce” patterns during their everyday
interactions and *these patterns* are a key to understanding the “objective” and thus identifiable discourse in social settings. Garfinkel argued that researchers should treat practical activities, practical circumstances, and practical sociological reasoning as topics of empirical study...by paying to the most commonplace activities of daily life the attention usually accorded extraordinary events [and thus] seek to learn about them as phenomena in their own right.114

From the ethnomethodological perspective, speech and action are continually interpreted by individuals themselves, which is how they understand the meaning of what is being communicated. Even more disturbing to mainstream sociologists, the ethnomethodologists claimed that the task of interpreting the meaning of social interaction is not a specialized craft that requires the esoteric knowledge and tools of a sociologist. Rather, the theory of ethnomethodology asserted that any “member” of a society, researcher or layperson, can interpret social interaction and understand its meaning because of the recognizable patterns that occur within speech or action. Therefore, the ethnomethodological perspective deliberately reduced the hierarchy between the researcher and the researched (the subject) since it is believed that these individuals or “members” have the same capacity to interpret, understand and give meaning to social interaction. The ethnomethodologists, however, did not aim to uncover the intentions or motivations of any given individual. Instead, they claimed that individual motivations or thoughts are not easily accessible through analysis since there exists no analytic method that can reveal what participants *really* think, what their words *really* mean, or were intended to mean. To speculate on speaker motivations would be considered, from the ethnomethodological perspective, to impose bias in favour of the researcher’s attitudes and opinions.

Garfinkel believed that social interaction is worthy of analysis for the sole purpose of demonstrating that a clear pattern exists within it when analyzed in a
detailed manner. The purpose of analyzing speech in this way is to reveal the "orderliness" or patterns that emerge during the course of a conversation and to show how two speakers are able to comprehend each other's behaviour based on recognizable patterns within speech. Thus, speech is a "production" and speakers, or "members" are responsible for "producing" and "sustaining" social discourse. Garfinkel lamented that the actual structure of oral discourse itself had, for too long, been taken for granted in favour of analysis of the structure of institutional systems and hierarchies. Zimmerman and Wieder elaborate on the ethnomethodological perspective by highlighting its effectiveness for describing (seemingly) mundane features of speech, such as pauses or interruptions, to expose patterns that are integral to the listener's understanding of the speech itself and the setting where it occurs. 115

In summary, proponents of ethnomethodology profess that determining how individuals speak is just as important and perhaps more important methodologically, as determining why individuals might say the things they do during social interaction. An analysis of how individuals speak involves uncovering the mechanisms of speech and/or action including repeated patterns.

Conversation Analysis

Conversation analysis is derived directly from ethnomethodology and upholds its theoretical assumptions such as its belief that social behavior is "produced" by individuals through their speech and/or action. The basic position of conversation analysis is that social actions are meaningful for those who produce them and that they have a natural organization that can be discovered and analyzed by close examination. Its interest is in finding the machinery, the rules, the structures that produce and constitute that orderliness. 116
Sacks, Schegloff and Jefferson (1974) are the originators of this method and they specifically restricted their analyses of speech to observable quantifiable instances of speech features, such as "turn-taking," also called interruption. Speech features include pausing, coughing, sighing, question asking, exclamations and other features that may be identified within naturally occurring speech.

Like ethnomethodologists, conversation analysts eschew interpretations of the motivations of speakers, and limit their findings to descriptions of the features of speech and the patterns that occur within. For example, if every time a person answers the telephone he/she says hello and then pauses to listen for a response, a pattern has emerged that is identifiable and valuable for understanding how individuals speak when using a telephone. Though these findings are seemingly mundane, for the conversation analyst these descriptions are the goal of the analysis since they generate reproducible findings that support the claim that individuals produce patterns in speech during social interaction.

Atkinson and Heritage (1984) elaborate on the methodological perspective of conversation analysis, mirroring ethnomethodology:

[T]he use of [speech as] recorded data serves as a control on the limitations and fallibilities of intuition and recollection; it exposes the observer to a wide range of interactional materials and circumstances and also provides some guarantee that analytic conclusions will not arise as artifacts of intuitive idiosyncrasy, selective attention or recollection, or experimental design.

This study employs conversation analysis by adhering to its methodological perspective yet modifies the application of the method by focusing exclusively on physicians' speech in physician-patient dialogue and not on both physician and patient speech. This modification of the method was implemented because specific speech features were prominent and recurring in physicians' speech.
during certain topic areas and because physicians did most of the talking during informed consent encounters in the sample. In addition, analysis of male physicians' speech alone was useful because it allowed for comparison of speech during the informed consent process for male and female patients.

According to Morse (1996), qualitative methods can be freely adapted and altered as long as the changes that are made are purposeful, sensible, defensible and solid.\(^{119}\) The method of conversation analysis was also modified in this project primarily for the purpose of incorporating forty-two physician-patient encounters. Since in depth analyses on interaction are always done when using conversation analysis, researchers generally focus their analyses on one conversation and avoid large samples. This study employed a modified method of conversation analysis by analyzing only physicians' speech during interaction for specific speech features across a large sample (of forty-two encounters), in order to compare for patient gender, rather than within one physician-patient encounter only.

**Conversation analysis and medical communication**

Several studies in the area of medical communication have employed the method of conversation analysis and produced useful results. Two studies reviewed below demonstrate *how* physicians' use of speech permitted them to control both the structure and the content of a conversation.

Paget (1993) employed conversation analysis to study medical communication, and analyzed instances of "topic changes" during a medical encounter between a male physician and female patient.\(^{120}\) Her findings revealed that topic changes can be divided into three categories: topics that were raised during the conversation; topics that were hinted at but were not actually raised; and topics that were clearly evaded. Paget identified specific instances in speech
where the patient attempted to raise the topic of "breast cancer" and the physician immediately changed the topic and inhibited her concerns from entering into the conversation. In addition, there was no explicit reference to the surgical procedure the patient had undergone, or to the patient’s post-operative or current condition, during the course of the conversation. Rather, the physician repeatedly told the patient, throughout the encounter, that the medical troubles she was experiencing were related to her nerves.

Paget uncovered specific “discontinuities” in the conversation, as there were instances of radical and sudden shifts in topic that inhibited the patient from raising the topic of breast cancer. Her findings showed how the male physician continuously directed and controlled the conversation “through questions and other ‘requests’ for action, and sometimes through commands, he introduce[d], develop[ed], and dissolve[d] discourse topics.” The physician “managed and directed” the conversation by utilizing speech features such as interruption, questioning, and redirection of topics to maintain control over the topics raised and discussed.

Frankel (1993) used the method of conversation analysis to describe the existence of a relationship between speech features and gesture during medical communication. He analyzed patterns of gesture in conjunction with patterns of speech features and discovered that these work together in a way that produces a predictable and stable pattern during a pediatric medical encounter. In his study, the male patient (a young boy), the patient’s mother and the male physician were video taped in order for both gesture and speech to be successfully analyzed in a detailed way.

In the tradition of conversation analysis, Frankel analyzed how individuals speak and move and patterns of these during conversation. The purpose of his study was to uncover the relationship between gazing, speaking and touching, and
thus the role of gesture during the medical encounter. Frankel found that "phase transitions" which occur following the conclusion of the "history taking phase" and prior to the commencement of the "physical examination phase" of the medical encounter are initiated and controlled by the physician. Frankel claimed that the pediatrician used the rules of visual attention (gaze) to successfully shape the character of the patient's coparticipation as the physical exam begins by limiting the available options for appropriate response...the speaker and hearer mutually monitor and regulate each other's behaviour from moment to moment.123

Frankel examined the videotape frame-by-frame and found that the physician's control emerged because he was able, through features of gesture such as gaze, to direct the patient's attention away from his touch on the patient's body. In addition, the act of touching and gazing in conjunction with specific speech features, such as asking questions, all worked together in a clear pattern that permitted the physician to control the encounter.

One begins to sense a pattern in which the physician is using the questions to direct the visual attention of the patient away from the work of the hands and to the task of conversing. It also seems that as quickly as the patient's obligations to attend are exhausted, his attention returns immediately to monitoring the work of the hands. It is against this background of ongoing manual activity that a sequence of questions, topically connected, and also locating action references outside of the immediate scene, is being used strategically by the physician to create an alternative focus of attention for the patient.124

Transcription

The method of conversation analysis requires that features of speech, such as pausing, sighing, stuttering, hedging, coughing, laughing, interrupting, and the asking of questions, be included in the data for analysis. However, speech cannot
easily be transcribed into text or adequately represented once transcribed. Speech transcription is an interpretive process and therefore not an objective one. The inclusion and placement of speech features within the transcript can change the meaning of what was said and thus alter or affect the analysis. In qualitative research, the transcription of spoken words has traditionally been considered an objective task and it is generally assumed that transcripts are an accurate representation of what was said during the conversation. The process of transcription is commonly considered to be part of data preparation rather than within data analysis; data preparation being a task done before analysis and not necessarily within the responsibilities of the researcher.

Mishler (1984) emphasizes the importance of including the process of transcription as part of the methods for analysis for any study on communication and he identifies some of the problems that begin to arise if the “speech-text gap” is ignored. The speech-text gap is the disparity that exists in what has been said orally and what has been transcribed into written text. This gap presents methodological challenges for all types of “communication” research.

A transcription of speech is neither a neutral or ‘objective’ description. Transcription rules incorporate models of language in that they specify which features of speech are to be recorded and which are to go unremarked. Thus, they define what is relevant and what is significant. Mishler argues for detailed transcriptions of speech for analyses of physician-patient communication because the speech features when included in transcription can significantly impact the meaning of the speech and the interpretations of the text that will ensue. Whether using the method of conversation analysis or other methods for the study of communication, Mishler suggests that detailed transcription of the data, conducted by the researcher himself/herself, will reduce the speech-text gap and produce more accurate data and analyses.
Jefferson (1978), an ethnomethodologist, first designed a transcript notation system for the purpose of minimizing the speech-text gap and as a means of achieving uniformity and comparability across studies investigating communication. Numerous researchers have modified and adapted her work, including Silverman (1993) who designed a transcription system, derived directly from Jefferson’s original, that aimed to include the “messy” features of speech allowing for a text to represent speech more accurately. Silverman cautions researchers against the tendency to “tidy up” or clean the messy features of speech during the process of transcription, as this will likely widen the speech-text gap resulting in text that may not accurately represent speech.

Summary

Conversation analysis is an appropriate method for the study of physician speech during informed consent in relation to patient gender. This method encourages researchers to conduct detailed transcriptions, identify speech features within the data itself and uncover identifiable patterns of these within conversation.

Methods

Method of Data Collection

This study was part of a larger study on informed consent. The author of this project was employed as research coordinator of the larger study on informed consent during the summer of 1996 and then subsequently used the data obtained there for this master’s thesis. The data were 42 audiotaped physician-patient conversations that were used for both the larger study on informed consent and for this thesis. In order to obtain audiotaped physician-patient conversations, the research coordinator (myself) was present at a surgical outpatient clinic for a four
month period. Patients were referred to the clinic for assessment for surgical treatment, to monitor their condition until surgical treatment was indicated, or for follow-up post-operatively. The patients who were potential surgical candidates were identified by the secretaries at the clinic and then approached by the research coordinator for their consent to participate in the study. The purpose of those patients' visits was to grant informed consent for surgery or an alternative treatment (watchful waiting until surgery may be required). Patients who were to have a follow-up meeting with their surgeon subsequent to surgery were excluded from the study because major decisions were not likely to occur at these encounters. In addition, information signs had been posted in the waiting room of the clinic in order to indicate to patients that a study on communication and informed consent was in progress at the clinic and that their participation may be solicited. The inclusion criteria for patients was that they speak and understand English language, that they had were a potential candidate for surgery and that they consented to have their conversation with their physician observed and audiotaped by the researcher.

The principal investigator (Dr. E. Etchells) of the larger study on informed consent first recruited the four male surgeon participants in the study prior to hiring the research coordinator (myself) to collect data at the clinic. The inclusion criteria for the surgeons was that they held a weekly or bi-weekly clinic at the surgical outpatient clinic and that they had consented to have their conversations with patients observed and audiotaped by the research coordinator. Informed consent was then obtained from the four male surgeons a second time by the researcher coordinator, subsequent to the data collection, in order to seek consent to conduct a gender analysis on the data. The surgeons, therefore, did not know that patient gender and their treatment of male and female patients was relevant to the study at the time when their conversations were observed and audiotaped.
Ethical Considerations

Patients were assured that the researcher (myself) and principal investigator (Dr. Etchells) and perhaps a hired transcriptionist would be the only individuals permitted to listen to the audiotapes of the physician-patient conversations. In addition, patients were assured that any identifying names and characteristics would be eliminated from the transcripts and that the tapes themselves would be securely stored.

The risks and benefits of the study were described to each patient. Patients were informed that they would not benefit directly from the study and that there existed a risk that they would become upset and/or aggravated by the presence of the researcher and/or by the audiotape device during their meeting with their physician. Each patient was informed that the researcher could be asked to leave the examination room at any time during the encounter and that the audiotaping device could be turned off and/or erased.

Sample

There were 42 patients in the sample, 17 female and 25 male (see Appendix I for patient demographic information). This sample had an unusually high percentage (71%) of patients with post-secondary school education. There were 4 male vascular surgeons in the sample (see Appendix II for physician demographic information). In total, 42 physician-patient conversations were observed and audiotaped. Male surgeons spent an average of 12 minutes with female patients in the sample and an average of 11 minutes with male patients. Male and female patients were represented in each of four diagnostic categories listed in Appendix I.
Methods of Data Analysis

The empirical study conducted includes three stages of analysis. Each stage answers a specific question concerning communication during the informed consent process with a specific focus on the speech of the male physician and the gender of the patient.

1. Stage One

The purpose of Stage One was to answer the research question: "Do the major topics discussed during an informed consent encounter vary for male and female patients?" The analysis was conducted to identify the major content areas that were discussed between male physicians and male and female patients in the sample during the informed consent process and to compare them for patient gender. All 42 physician-patient conversations were included in this stage of the analysis and the tapes were analyzed aurally by the researcher. For each conversation the researcher created a list of the topics discussed during the encounter and coded each topic with one term that captured the essence of that topic. For example, if a physician asked a patient a series of questions about the symptoms he/she was experiencing, that section of speech was entitled "the symptom search phase."

Forty-two lists were created each representing the topics discussed during each physician-patient conversation. Then, the lists were separated into two groups, one for female patients and one for male patients. For each group a master list was created that summarized the topic areas that were discussed between male physicians and patients in the group. One master list represented the "macrostructure" of an informed consent encounter for a male physician and a female patient conversation. One master list represented the "macrostructure" of an informed consent encounter for a male physician and a male patient
conversation. The two master lists of topics discussed for each gender were then compared.

2. Stage Two
   The purpose of Stage Two was to answer the research question: “Is the speech of male physicians explicitly tailored to account for patient gender during the informed consent process?” The analysis was conducted to identify explicit references to patient gender in the speech of male physicians when speaking to male and female patients during the informed consent process. The researcher conducted the analysis for this stage aurally and was listening for speech content that referred specifically to patient gender. Examples of this occurred when the physician stated that patient gender was relevant to decision making or to the treatment decision, such as: “...since you are a man, this treatment might have this kind of affect on you...” or “...since you are a woman, this treatment might affect you in this way...”

3. Stage Three
   The purpose of Stage Three was to answer the research question “Are there differences in the speech features of the male physicians when communicating with female patients as compared with male patients during the informed consent process?” The analysis was conducted to identify instances of specific speech features in male physicians’ speech and to compare these for male and female patients.

   The findings of Stage One and Stage Two were used to plan Stage Three of the analysis. The findings of Stage One provided the researcher with two master lists, one of the major topics that were discussed by male physicians with female patients, and one of the major topics that were discussed by male physicians with
male patients. These lists provided the researcher with a structure for analyzing speech features during specific topic areas.

The first step of Stage Three of the analysis was to conduct detailed transcriptions of physician's speech. All of the transcriptions were done by the researcher (myself) who designed and developed a transcription system suited specifically for this study and derived from the transcription systems used by noted conversation analysts (see Appendix III). The researcher selected which features of speech would be included in the transcription system based on initial listening of the tapes, also called "immersion" into the data, to determine which features of speech were more prominent than others. Prominent features of male physicians' speech were selected for the design of the transcription system and thus for analysis.

Detailed transcriptions of three speech features--disfluency, diction and volubility--were conducted by the researcher. The researcher compared male physicians' speech for male and female patients to determine if instances of specific speech features occurred with both male and female patients.

Transcription System: Definitions of Speech Features

In this section, the speech features of disfluency, diction and volubility will be defined and their specific codes for data transcription described.

Disfluency

Disfluent features of speech are instances of incoherence. The types of disfluencies to be identified within a physician's speech include 1. Hedges; 2. Phrase hedging; 3. Word hedging; 4. Filled pauses; and 5. Word repetition.

1. Hedges: Hedges occur in speech when phrases or words do not contribute
anything to the information being conveyed but rather function as a “filler” or “bridge” in speech. Hedges can be defined simply as words or phrases which “make things fuzzier.” Words and phrases that are hedges include: you know, alright, okay, so, now.

example:
Male physician: Okay, alright, so you’ve had a symptom from this.

In the example above, the words “okay,” “alright” and “so” are hedges. Hedges are identified in the text by bolded lower case letters.

2. Phrase hedging: a “phrase hedge” is an instance in speech where an individual cuts off his or her speech mid phrase.

example:
Male physician: And you’ll go to the—let’s talk about your heart.

In the example above, the phrase “And you’ll go to the—” is cut off mid phrase. A “phrase hedge” is represented by bolded lower case letters and with a double hyphen (--) at the exact placement of the “phrase hedge.”

3. Word hedging: a “word hedge” is an instance in speech where an individual cuts off his or her speech mid word.

example:
Male physician: Th-the side effects of the procedure.

In the example above, the word “Th-” is hedged which means that it is cut off mid-
word. Word hedges are identified by bolded lower case letters and a single hyphen (-) at the exact place of the word hedge.

4. **Filled pauses**: “Filled pauses” are instances in speech where individuals say “um” or “ah.”

**example:**
Male physician: *I can tell you that this, umm, ahh, this test tells us the rate of growth of your aneurysm.*

In the example above, the words “um, ah” are an example of a “filled pause.” Instances of filled pauses in the text are identified by bolded lower case letters and are not italicized.

5. **Word repetition**: “Word repetition” are instances in speech where an individual immediately repeats a word or a phrase.

**example:**
Male physician: *The best time to schedule schedule the appointment is next year.*

In the example above, the word “schedule” is repeated. Instances of word repetition in the text are identified by bolded lower case letters and underlining.

**Diction**

1. **Register**:  
   In sociolinguistics, register variation identifies words that are defined by specific social settings and are used appropriately within these settings.\(^\text{130}\) “Low
"register" terms are words that are commonly used when speaking to a child or in situations and contexts where children are present. The meaning of the low register word or phrase is determined by the context of the discussion.

A phrase or word was recorded by the researcher as low register if it met the following criteria:

a. The specific term or phrase is customarily used in the context of speaking to children;
b. The specific term or phrase was used by at least two physicians in the sample to refer to the same event or concept.

Example:
Male physician: *We make an incision in your tummy*.

In the example above, the word “tummy” refers to the patient’s stomach.

Instances of low register speech in the text are identified by bolded lower case letters and asterisks.

2. Euphemisms:

A euphemism is an “inoffensive word or phrase substituted for one considered offensive or hurtful.” The meaning of a euphemism is determined by the context of the discussion. A word or phrase was recorded as a euphemism if it met the following criteria:

a. It was clear by the context of the word or phrase that the physician was referring to something that was not explicitly mentioned or labeled.
b. It was said by at least two physicians in the sample to refer to the same event or concept.
concept.

example:
Male physician: *You need to have your aneurysm* <fixed>.

In the example above, the word "fix" refers to performing surgery on the patient. Instances of euphemisms in the text are identified by bolded lower case letters and arrows.

**Volubility**

Volubility refers to words that are said more loudly than other words in the same sentence. Increased volubility resulted in the accentuation of certain words in relation to others. In this project, the extent of increased volubility was not measured using a formal device but rather the words or phrase were identified aurally by the researcher as having increased volubility. Thus, words and phrases that are *noticeably* louder than others were identified as having increased volubility.

example:
Male physician: *The RISKS of your operation*...

In the example above, the word "risks" was said more loudly than other words in the sentence. Instances of increased volubility in the text are identified by bolded upper case letters.

**Saturation**

The researcher continued to transcribe and analyze sections of speech until
saturation was achieved. Saturation occurs when an analytic category is complete with examples of repetition from the data.
Chapter Four: ANALYSIS AND FINDINGS

Stage One

The “macrostructure” of informed consent identifies the sequence of major topics discussed between male physicians and both male and female patients. This macrostructure occurred repeatedly across informed consent encounters for both male and female patients. Each major topic of the macrostructure has been labeled a “phase.” The phases of the macrostructure are: 1. The Introduction and Greeting Phase; 2. The Symptom Searching Phase; 3. The Disclosure Phase; 4. The Elicitation of Joint Decision Making Phase; 5. The Ending Phase. All of the phases, save and except for phase four, were found to occur consistently across informed consent encounters with both male and female patients. Phase four did not occur consistently but when present, was present in conversations with both male and female patients.

Introduction and Greeting Phase

During the introduction and greeting phase, physicians typically entered the room, introduced themselves to patients or greeted them in a friendly manner. “The introduction and greeting phase” was brief in relation to the other phases of the macrostructure. In most cases, physicians did not ask patients about matters relating to their personal lives during this phase, i.e. job, family issues. This phase was routinely initiated and ended promptly by the physician.

The Symptom Searching Phase

“The symptom searching phase” routinely followed “the introduction and greeting phase.” During this phase, physicians typically asked male and female patients a series of questions relating to the patient’s disease. There did not appear
to be a pattern related to patient gender in the types of questions asked by physicians of patients during this phase. Physicians asked male and female patients who were to undergo identical treatments the same questions during “the symptom searching phase.”

The Disclosure Phase

Physicians spent more time speaking during “the disclosure phase” than during any other phase of the macrostructure. During “the disclosure phase,” male physicians usually recommended one of two treatments to male and female patients, either surgery or watchful waiting. Patients who were recommended the treatment of “watchful waiting” would perhaps become surgical candidates in the future but were to be treated with medical treatment, such as aspirin, in the meantime. The information disclosed to male and female patients varied, not by gender, but rather by the disease of the patient, and by the patient’s proximity to requiring the treatment of surgery. For example, the risks and benefits of the treatment of surgery were disclosed only to male and female patients who were imminently requiring surgery. Risks and benefits related to the recommendation of watchful waiting, an alternative to surgery, were not usually explicitly disclosed.

The Eliciting of Joint Decision Making Phase

“The eliciting of joint decision making phase” usually followed the disclosure phase in informed consent encounters but sometimes preceded it. The variation was unrelated to patient gender. During this phase, physicians attempted to elicit patient participation in deciding the most appropriate recommendation for treatment, either surgery or watchful waiting. Physicians attempted to elicit joint decision making with only a few male and female patients in the sample.
The Ending Phase

"The ending phase" was the final phase of the macrostructure of informed consent encounters and was similar to "the introduction and greeting phase" in that it was brief and concise. The ending phase was routinely initiated by the male physician for both male and female patients in the sample. The physicians routinely asked male and female patients whether they had any questions regarding the information that had been disclosed during "the disclosure phase." Subsequent to the ending phase physicians routinely left the examination room prior to the patient.

Stage Two

There were no explicit references to patient gender in the speech of male physicians when speaking to male and female patients during informed consent encounters. Male physicians' speech did not include information that was explicitly tailored to account for patient gender such as "...since you are a man, this treatment might affect you in this way..." or "...since you are a woman, this treatment might affect you in this way..."

Stage Three

For each phase of the macrostructure of informed consent an example is presented below which demonstrates whether or not there were instances of disfluency, specific uses of diction, or instances of increased volubility within that phase. The examples selected were chosen because they are representative of the speech of physicians during that phase with respect to each of the speech features found. For "the disclosure phase," the disclosure of risks associated with the recommended treatment was isolated by the researcher from the rest of the disclosure phase because of the specific speech features that occurred in high
concentration during that aspect of disclosure.

The Introduction and Greeting Phase

1. Disfluency Analysis

example 1:
**Male physician speaks to female patient:**
*Hi, how are you?* (5:14:001)

During this phase, instances of disfluency were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of hedges, word hedging, phrase hedging, word repetition, or filled pauses.

example 2:
**Male physician speaks to male patient:**
*Hi Mr. S, I'm Dr. X. How are you?* (5:9:001)

During this phase, instances of disfluency were not usually found in the speech of male physicians when speaking to male patients. In example 2 above there are no instances of hedges, word hedging, phrase hedging, word repetition, or filled pauses.

2. Diction Analysis

example 1:
**Male physician speaks to female patient:**
*You're here to see me about your legs, is that right?* (2:10:001)
During this phase, instances of low register speech or uses of euphemisms were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of low register speech or uses of euphemisms.

example 2:

Male physician speaks to male patient:

*How are you doing?* (5:07:00)

During this phase, instances of low register speech or uses of euphemisms were not usually found in the speech of male physicians when speaking to male patients. In example 2 above there are no instances of low register speech or uses of euphemisms.

3. Volubility Analysis

example 1:

Male physician speaks to female patient:

*What can I do for you?* (3:13:00)

During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to male patients. In the example above there are no instances of increased volubility.

example 2:

Male physician speaks to male patient:

*Hi, how are you doing?* (3:15:00)
During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to female patients. In example 2 above there are no instances of increased volubility.

The Symptom Searching Phase

1. Disfluency Analysis

example 1:

Male physician speaks to female patient:

*How long have you had trouble with your veins?* (3:12:001)

During this phase, instances of disfluency were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of hedges, word hedging, phrase hedging, word repetition or filled pauses.

example 2:

Male physician speaks to male patient:

*Have you had any episodes when you had weakness or numbness in one arm?* (5:08:020)

During this phase, instances of disfluency were not usually found in the speech of male physicians when speaking to male patients. In example 2 above there are no instances of hedges, word hedging, phrase hedging, word repetition or filled pauses.

2. Diction Analysis
example 1:

Male physician speaks to female patient:

*Now what happens when you walk?* (2:10:003).

During this phase, instances of low register speech or euphemisms were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of low register speech or uses of euphemisms.

example 2:

Male physician speaks to male patient:

*Did you ever have an episode where you lost vision in your eye?* (5:08:027)

During this phase, instances of low register speech or uses of euphemisms were not usually found in the speech of male physicians when speaking to male patients. In example 2 above, there are no instances of low register speech or uses of euphemisms.

3. Volubility Analysis

example 1:

Male physician speaks to female patient:

*Last year you had another blackout and what were you doing when you blacked out, remember?* (3:13:042).

During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of increased volubility.
example 2:

**Male physician speaks to male patient:**

*Did you ever have a time where half your body didn’t work right? (5:08:035).*

During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to male patients. In example 2 above there are no instances of increased volubility.

**The Disclosure Phase**

1. **Disfluency Analysis**

example 1:

**Male physician speaks to female patient:**

*Alright. Alright. Umm... as you know, you have a pretty ahhh, ummm, you know, ahhh, large—you have an aneurysm that’s been there for a number of years. (5:14:035).*

During this phase, there were instances of disfluency found in the speech of male physicians when speaking to female patients. In example 1 above there are instances of disfluency: word repetition: *Alright, Alright*; a filled pause: Umm; a filled pause: ahhh; a filled pause: ummm; a hedge: you know; a filled pause: ahhh; a phrase hedge: large—.

example 2:

**Male physician speaks to male patient:**

*You have an ann-aneurysm in your *tummy*, okay, and it’s bigger than it used to be. (5:09:013).*
During this phase, there were instances of disfluency found in the speech of male physicians when speaking to male patients. In example 2 above there are instances of disfluency: a word hedge: *ann*; a hedge: *okay*.

2. Diction Analysis

example 1:
**Male physician speaks to a female patient:**
*Um, well, to do this, ahh, you have to make an incision in the *tummy* to do this--you have to have an anaesthetic first of all* (3:17:159).

During this phase, there were instances of low register speech found in the speech of male physicians when speaking to female patients. In example 1 above there is an instance of a low register speech. The word *tummy* is used to refer to the patient’s abdomen.

example 2:
**Male physician speaks to male patient:**
*Now this is--what this is, sir, is a--is in your *tummy* here, your artery--your main artery is bigger than it’s supposed to be* (5:09:015).

During this phase, there were instances of low register speech found in the speech of male physicians when speaking to male patients. In example 2 above there was an instance of low register speech. The word *tummy* is used to refer to the patient’s abdomen.

3. Volubility Analysis
example 1:

**Male physician speaks to female patient:**

*And we replace it—we would have to replace that section that’s wide.* (2:17:18)

During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there were no instances of increased volubility.

example 2:

**Male physician speaks to male patient:**

*Ahm, the aneurysm, okay, that you have in your *tummy* is not something that I think we need to operate on now.* (5:9:05)

During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to male patients. In example 2 above there were no instances of increased volubility.

**Disclosure of Risks (The Disclosure Phase)**

1. **Disfluency Analysis**

example 1:

**Male physician speaks to female patient:**

*You’ve got—ahh, ah, they-they’ve—, if we say—, you—y-having a small heart attack around the time of the operation is not really what we’re worried about and that may not have much in the way of consequences. What we’re really worried about is whether you have a big heart attack and die and that’s the biggest risk to-*
-ah. by far the biggest risk that we're looking at and ahh I think that there is—there's probably ahh, somewhere between a five and ten percent chance that that event could occur. Now, looking at the rate of growth of your aneurysm and the—and the ahh RISK of it rupturing, ahhm, you know, we're probably looking at about a rate of about twice that but over two to three years. (5:23B: 303).

During this phase, there were instances of disfluency found in the speech of male physicians when speaking to female patients. In example 1 above there are instances of disfluency: a phrase hedge: got—; a filled pause: ahh; a filled pause: ah; a word hedge: they-; a phrase hedge: they've—; a phrase hedge: say—; a phrase hedge: you—; a word hedge: y-; a phrase hedge: to—; a filled pause: ahh; a filled pause: ahh; a hedge: now; a phrase hedge: the—; word repetition: the, the; a filled pause: ahh; a filled pause: ahhm; a hedge: you know.

example 2:
Male physician speaks to male patient:

Ahm, the, the reason we want to do this operation—explain to you, okay, in your right neck is to—is reduce your risk of stroke in the future. Okay? Alright so you've had a symptom from it and you've got what we call a severe stenosis on on examination on the right side. Okay. Now, the risks—ahmm. There are some risks in—to your heart—to this—to any operation as there are to this one. just the fact of coming in and having this done. (5:37:422).

During this phase, there were instances of disfluency in the speech of male physicians when speaking to male patients. In example 2 above there are instances of disfluency: a filled pause: Ahm; word repetition: the, the; a phrase hedge: operation—; a hedge: okay; a phrase hedge: to—; a hedge: okay?; a hedge:
Alright; a hedge: so; word repetition: on, on; a hedge: okay; a hedge: now; a phrase hedge: risks—; a filled pause: ahmm; a phrase hedge: in—; a phrase hedge: heart--; a phrase hedge: this—.

2. Diction Analysis

example 1:
Male physician speaks to female patient:
*Why don’t you sit down for a second. Ahm, you know, it’s it’s, ahhh, ahm, you know, it’s not a—it’s a fairly—you know, significant operation to <fix that>, ahm, because you, ahhhhhhh, come to hospital the day of the surgery (2:17:206).*

During this phase, there were instances of euphemisms found in the speech of male physicians when speaking to female patients. In example 1 above the physician refers to performing the treatment of surgery as <fix that>.

example 2:
Male physician speaks to male patient:
*So you can see it over on this side as well, you see it’s supposed to be this big all the way down and even a little bit bigger and it’s very narrowed going up here. Okay, now, that’s what causes the problem and that’s what we have to <fix>. (5:46:080)*

During this phase, there were instances of euphemisms found in the speech of male physicians when speaking to male patients. In example 2 above the physician refers to the area that requires surgical treatment as the area he must <fix>. 
3. Volubility Analysis

example 1:
Male physician speaks to female patient:

*The RISKS of your operation, okay?* (5:46:110)

During this phase, there were instances of increased volubility found in the speech of male physicians when speaking to female patients. In example 1 the physicians says the word *RISKS* more loudly than other words.

example 2:
Male physician speaks to male patient:

*Now, looking at the rate of growth of your aneurysm and th-ri-and th-and the the ahh RISK of it rupturing.* (5:39:201)

During this phase, there were instances of increased volubility found in the speech of male physicians when speaking to male patients. In example 2 above the word *RISK* is said more loudly than other words.

The Eliciting Joint Decision Making Phase

1. Disfluency Analysis

example 1:
Male physician speaks to male patient:

*Well, I'd like to know what you're thinking.* (5:39:203)

During this phase, there were not usually instances of disfluency found in the speech of male physicians when speaking to male patients. In example 1 above
there is a disfluency. The disfluency is a hedge: well.

example 2:

**Male physician speaks to male patient:**

*Are your legs bad enough that you need to have them* <fixed>*?> (1:20A:042).

During this phase, there were not usually instances of disfluency found in the speech of male physicians when speaking to male patients. In example 2 above there are no instances of disfluency.

2. Diction Analysis

example 1:

**Male physician speaks to female patient:**

*Ahm, this artery on the left side is very narrowed, okay, and we have to decide whether we should* <fix>*it or not.* (5:38:130)

During this phase, there were instances of euphemisms found in the speech of male physicians when speaking to female patients. In example 1 above the physician says the word <fix>* to refer to the treatment of surgery.

example 2:

**Male physician speaks to male patient:**

*Are your legs bad enough at this point that they’re interfering with your life enough that you want us to try to* <fix>*them, I mean--cause let me tell you the bottom line is* <fixing>* they would mean very major surgery.* (1:20B:101)

During this phase, there were instances of euphemisms found in the speech of
male physicians when speaking to male patients. In example 2 above the physician uses the euphemisms <fix> and <fixing> to refer to the treatment of surgery.

3. Volubility Analysis

eample 1:

Male physician speaks to female patient:

*Does it hurt you enough that you'd like something done about it?* (3:13:193).

During this phase, instances of increased volubility were usually not found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of increased volubility.

eample 2:

Male physician speaks to male patient:

*If by that point it's more than five or a little more then, you know, we'll have to consider getting it <fixed>.* (2:29:170)

During this phase, instances of increased volubility were not usually found in the speech of male physicians when speaking to male patients. In example 2 above there are no instances of increased volubility.

The Ending Phase

1. Disfluency Analysis

eample 1:

Male physician speaks to female patient:

*Which means we should leave her alone, OKAY?* (5:14:050)
During this phase, instances of disfluency were not usually found in the speech of male physicians when speaking to female patients. In example 1 above there are no instances of disfluency.

example 2:

Male physician speaks to male patient:
So talk to Dr. X and tell him what we found and what we're going to do, OKAY?
(5:9:72)

During this phase, instances of disfluency were not usually found in the speech of male physicians when speaking to female patients. In example 2 above there are no instances of disfluency.

2. Diction Analysis

example 1:

Male physician speaks to female patient:
She will get things—uh, will get everything <teed up> for you. (2:41:403)

During this phase, there were instances of euphemisms found in the speech of male physicians when speaking to female patients. In example 1 above the phrase <teed up> is a euphemism used to refer to the pre-admission process patients undergo prior to surgery.

example 2:

Male physician speaks to male patient:
So we'll see you Monday morning and we'll get everything <teed up> for you.
(2:16:158)
During this phase, there were instances of euphemisms found in the speech of male physicians when speaking to male patients. In example 2 above the euphemism \textit{<feed up>} is used to refer to the pre-admission process prior to surgery.

3. Volubility Analysis

example 1:
\textbf{Male physician speaks to female patient:}
\textit{OKAY? Alright. OKAY? Alright. Take Care.} (2:30:504)

During this phase, there were instances of increased volubility found in the speech of male physicians when speaking to female patients. In example 1 above the word \textit{OKAY} is said twice and more loudly than other words in the context.

example 2:
\textbf{Male physician speaks to male patient:}

During this phase, there were instances of increased volubility found in the speech of male physicians when speaking to male patients. In example 2 above the word \textit{OKAY} was said more loudly than other words in the context.

Summary

The findings of Stage One demonstrate that the major topics discussed during informed consent encounters were the same for male and female patients. The findings of Stage Two demonstrate that male physicians' speech did not
include explicit references to patient gender in relation to treatment information. The findings of Stage Three demonstrate that specific speech features were found in male physicians’ speech during specific phases of the “macrostructure” and that these instances of speech features appeared in physicians’ speech when speaking to both male and female patients.
Chapter Five: DISCUSSION

In this chapter, the findings of Stage One, Two and Three of the analysis will be summarized and discussed from the perspectives of mainstream bioethics, feminist bioethics and ethnomethodology.

Stage One: Summary and Discussion

The major topics raised by physicians during informed consent encounters were summarized in a “macrostructure” comprising five phases: 1. The Introduction and Greeting Phase; 2. The Symptom Searching Phase; 3. The Disclosure Phase; 4. The Elicitation of Joint Decision Making Phase; and 5. The Ending Phase. All of these phases, save and except for phase four, were consistently found in the conversations that male physicians had with male and female patients in the sample who were scheduled to undergo identical treatments. This finding suggests that male physicians followed a similar format when raising topics for discussion with male and female patients during the informed consent process.

From the perspective of mainstream bioethics, the findings of Stage One are useful because they identify the major topics that are generally discussed between physicians and patients during the informed consent process in the clinical setting. In addition, these findings are revealing because they demonstrate that physicians follow a distinct pattern when communicating information to patients. These findings may suggest that the legal requirements for a valid informed consent have, to some extent, been integrated into clinical practice. For example, during the disclosure phase, physicians often disclosed some of the risks of the treatments to patients and thus potentially fulfilled part of the legal requirements for the type of information that is to be disclosed during informed consent. Stage One also demonstrates that legal requirements may be adhered to
by physicians since male physicians in the sample routinely asked patients if they had “any questions” during the ending phase of informed consent encounters. Responding to patient questions also forms part of legislative requirements for obtaining adequate informed consent. However, this finding does not demonstrate whether patients' questions were adequately answered by physicians, but rather only that physicians in the sample consistently asked patients if they had any questions subsequent to the disclosure phase.

The findings of Stage One also demonstrate that physicians, in some cases, attempted to include patients in the decision-making process with respect to treatment options. From the perspective of mainstream bioethics, this finding is important because it too suggests that the legal requirements for informed consent are followed in clinical practice to some extent. Furthermore, this study offers empirical evidence that joint decision making between physicians and patients may occur in the clinical setting during informed consent to some extent.

From the perspective of feminist bioethics, the findings of Stage One are important because they demonstrate empirically that in some cases male physicians may have attempted to include female patients in the process of decision making with respect to treatment alternatives. This finding suggests that male physicians do not exercise unilateral control over treatment decisions involving women in all cases and that they may include female patients in the decision-making process to some extent. Feminist bioethicists would find this evidence of elicitation of joint decision making by male physicians with female patients surprising and requiring further investigation, perhaps in additional contexts where male and female patients are scheduled for identical treatments.

Stage Two: Summary and Discussion

The findings of Stage Two demonstrate that male physicians do not
explicitly tailor the content of their speech to account for patient gender during the informed consent encounter. This finding does not demonstrate whether or not male physicians in the sample accounted for the patient's particular situation with respect to gender. Since explicit references, and not implicit ones, were recorded from the data, it is not possible to conclude with any certainty whether patient gender was taken into account. From the perspectives of mainstream and feminist bioethics, this finding does not identify whether or not male physicians meet the "reasonable person" standard for disclosure because it merely suggests, but does not determine, that patient gender is not deemed relevant by male physicians when speaking to male and female patients. This finding suggests that tailoring of speech to patient gender can be uncovered by a more in depth qualitative method of analysis, for example, by either the method of "content analysis," or "discourse analysis."

From the perspective of feminist bioethics, the findings of Stage Two raise concerns about the quality of medical information conveyed to women during the informed consent process. Since the findings demonstrate that female patients did not receive any gender specific information during informed consent, feminist bioethicists would raise questions about whether or not female patients should receive medical treatment information that is explicitly specific to them. Recent feminist work has indicated that treating male and female patients the same medically is problematic for female patients specifically because women have historically been excluded from clinical trials and evidence on male subjects has been generalized inappropriately to female patients. Based on the findings of this study, one would assume that the diseases treated in this clinic affect male and female patients in the same way. This raises questions about whether sex differences for response to these treatments has been adequately studied in clinical trials.
**Stage Three: Summary and Discussion**

The findings for Stage Three will be divided into three sections in order to discuss the speech features—disfluency, diction and volubility—which were analyzed.

**Disfluency**

Instances of disfluency occurred in male physicians’ speech when speaking to both male and female patients, primarily during the disclosure phase of informed consent encounters. The types of disfluency that occurred were word hedging, phrase hedging, word repetition, hedges, and filled pauses. These types of disfluencies occurred throughout the disclosure phase but were found in high concentration specifically when the risks associated with a treatment were disclosed. Patient gender did not play a role since instances of disfluency were found in male physicians’ speech when disclosing risk information to both male and female patients.

From the perspectives of ethnomethodology and conversation analysis, the high concentration of disfluencies in male physicians’ speech represents a pattern since these speech features were seen repeatedly in the same place, i.e. during disclosure and during risk disclosure. Ethnomethodologists would argue that disfluency in physician speech is fundamental to the meaning of a conversation and sends out a message that is interpreted and understood by patients and other listeners. Ethnomethodologists and conversation analysts alike would argue that how an individual speaks is as important to the listeners understanding as what the individual says. Therefore, they would claim that the instances of disfluency in physicians’ speech mark risk disclosure as something requiring special attention. Since disfluency occurred during risk disclosure in high concentration, these
sections of speech are distinguishable from the others and are unique.

Research in the area of sociolinguistics has suggested that disfluency is a normal characteristic of speech, however researchers have demonstrated that disfluencies within speech are correlated with the speaker's anxiety. Empirical studies have shown that induced anxiety increases the number of disfluencies in speech, save and except for filled pauses. The presence of filled pauses in speech demonstrated that the speaker is faced with challenging choices, rather than in an anxious state. One study demonstrated that the number of options available to a speaker would increase the likelihood that the speaker will produce a filled pause in speech. Research in this area has also investigated empirically the effect of filled pauses on listeners and found that listeners attribute the presence of filled pauses in speech to the anxious state of the speaker.

In light of research in the area of sociolinguistics described above, both mainstream and feminist bioethicists would regard instances of disfluency in male physicians' speech as a potential impediment to achieving adequate informed consent. Given the connection between disfluency in speech and contemplation of "options" by the speaker, it is possible that the disfluency found in physicians' speech resulted from physicians pondering treatment options, such as surgery, and alternatives during the informed consent encounter. Standards for disclosure during informed consent require that treatment information be disclosed in a comprehensible manner. Since disfluency potentially causes speech to be unclear, patient comprehension may be compromised as a result of the manner in which treatment information is conveyed.

The finding of disfluency within physicians' speech is important for bioethics research on informed consent because it demonstrates that the manner in which information is disclosed may be just as crucial as the content. This finding therefore may offer new insight to current discussion in bioethics which debates
appropriate methods for improving the quality of informed consent. This study suggests that patient comprehension during informed consent is not necessarily related to the complexity of the medical information conveyed, as commonly suggested in bioethics literature, but rather that patient comprehension is also tied to the mere coherency of physician speech.

**Diction**

Instances of low register speech and uses of euphemisms were found in male physicians' speech when speaking to both male and female patients during informed consent. Male physicians used the low register word "tummy" when referring to male and female patients' abdomens. Male physicians used the euphemism "fix" when referring to the treatment of surgery for male and female patients and the phrase "teed up" when referring to the preoperative procedure patients would undergo prior to receiving surgical treatment.

From the perspectives of both mainstream and feminist bioethics, low register words found within physicians' speech may call into question the nature of the physician-patient relationship during informed consent. These findings demonstrate that physicians routinely referred to a patient's abdomen as his/her "tummy" when specifically discussing with patients the nature of the proposed treatment of surgery during the disclosure phase. The term "tummy" is one that is most appropriate for speaking to a child, and thus suggests that physicians may maintain control over conversations with patients by using low register terms to reinforce a paternalistic relationship. The finding also suggests that physicians may attempt to disclose treatment information in a non-threatening manner by use of low register speech, as a method of minimizing the severity of the treatment information disclosed when it relates to surgical treatments specifically.

From the perspective of feminist bioethics specifically, it is surprising to
find that male physicians used the word "tummy" when speaking to both male and female patients. This finding suggests that a paternalistic relationship may exist between physicians and patients of both genders. Based on prior empirical studies on "male physician-female patient" communication reviewed earlier, one would hypothesize that male physicians would routinely treat female patients, and not male patients, in a paternalistic manner. The use of the word "tummy" calls into question whether male physicians genuinely aim to include male and female patients as equal partners in decision making, since low register speech indicates that physicians may not consistently speak to patients as competent adults. Since the median age of the patients in this study was sixty five, it is also important to consider that the physicians may have used low register terms because the sample population was aged.

From the perspectives of both mainstream and feminist bioethics, euphemisms in male physicians' speech may call into question both the quality of the information disclosed by physicians and levels of patient comprehension. The word "fix" was said consistently in phrases such as "fix it," "get it fixed," to refer to the treatment of surgery by male physicians when speaking to both male and female patients. This finding suggests that male physicians in the sample tended to replace the words "surgery" and "operation" with the word "fix" when speaking about treatment options. This finding raises questions about whether patients understood the meaning of the word "fix." It is possible that physicians avoided explicit references to the word "surgery" or "operation" in order to protect patients from hearing threatening information. This finding suggests that physician speech may not be clear, or explicit, when disclosing surgical treatment information specifically to male and female patients.

The euphemism "teed up" was said by male physicians during the ending phase of informed consent encounters in the context of phrases like "get
everything teed up for you” or “get you all teed up” to both male and female patients in the sample. “Teed up” referred to either a medical examination or to the pre-admission process that patients would undergo prior to surgery. “Teed up” is a golf phrase that refers to the process of preparing to begin a game of golf. To be “teed up” is to be ready to hit the ball onto a golf course off of a “tee” that props a golf ball up into the air. The phrases “tee up,” “teed up,” “tee off” and “teed off” are ones that are well known to golfers, and possibly to some non-golfers, but not necessarily ones that would be easily comprehensible to male and female patients in the sample. This euphemism in physicians’ speech may call into question patient comprehension of surgical treatment information disclosed during informed consent. Since physicians used the phrase “teed up” to indicate to patients that pre-operative procedures would commence, it is important to determine if patients comprehended this directive. Whether or not the physician had explicitly stated that the patient would, go for a preoperative assessment, the use of the phase “get you all teed up” may have confused patients as to what the physician was recommending as a next step.

From the perspective of feminist bioethics specifically, the euphemism “teed up” represents an example of class-bound language. This term is clearly comprehensible to individuals who are golfers however, golf is a leisure sport traditionally conducted at exclusive and/or expensive resorts and clubs and therefore golf terminology is not likely comprehensible to individuals who have never golfed or associated with golfers. Since the male physicians in the sample used the phrase “teed up” when speaking to male and female patients in the sample, feminist bioethicists would interpret this as indicative of their privilege and status and possibly their insensitivity to issues of class.

Volubility
Male physicians said the word "okay" loudly, and in the form of a question, during the ending phase of informed consent encounters when speaking to both male and female patients. From the perspectives of ethnomethodology and conversation analysis, this finding is the most relevant one of this study. According to the theory of ethnomethodology, the specific speech features of the word "okay"--increased volubility and in the form of a question--sent a clear message from physicians to patients that the conversation would end. This finding demonstrates how ordinary speech features--volubility and intonation--may have worked within the conversation to direct what would occur next.

When the word "okay" was said by physicians to patients with specific speech features (volubility and intonation), one of two things consistently occurred in the conversations in the sample: either the physician left the examination room or the patient immediately attempted to delay the departure of the physician by initiating the asking of questions. This finding demonstrates empirically how features of speech are interpreted by listeners to have meaningful messages that are understood by both the speaker and researcher. In addition, this finding demonstrates how features of speech were able to direct a conversation, and in this case, physicians were able to control when an informed consent encounter would end. This finding may reveal an aspect of male physicians' control during informed consent and raises questions about the potential for male and female patients autonomy and empowerment in this context.

Summary
The findings of Stage One of this study demonstrate that the major topics discussed did not differ for male and female patients during the process of informed consent. The findings of Stage Two demonstrate that male physicians'
speech did not include explicit references to patient gender during informed consent encounters which indicates that further research is required on whether physicians account for patient gender during informed consent. Finally, there are several important findings from Stage Three of this study, most notably the existence of disfluency and euphemisms within physicians’ speech during disclosure and the use of specific speech features by physicians to control the duration of informed consent encounters.
Chapter Six: CONCLUSIONS

In this chapter, each important finding will be summarized and the implications, limitations and future directions reported.

Androcentrism in the Bioethics Literature

The literature review for this study demonstrated that androcentrism exists within mainstream bioethics literature on informed consent in that philosophical, legal and empirical literatures have not adequately considered the relevance of patient gender for the informed consent process. A review of medical communication literature demonstrated that patient gender is relevant to both physician-patient communication and for defining the “reasonable person” legal standard for disclosure. Furthermore, feminist bioethicists argue that patient gender is relevant to all bioethical issues, including informed consent.

This study recommends that further critique of the philosophical and legal literatures on informed consent be conducted, specifically from the perspective of feminist bioethics, in order to expand on the findings of the current project. Ultimately, philosophical and legal discussions on informed consent should include serious discussion of the importance and relevance of patient gender for the informed consent process, both historically and today. Empirical projects on informed consent require a shift in focus. It is insufficient to study the situation of “the patient” when analyzing any aspect of the communication during informed consent. Based on the findings of this study, future studies on informed consent should look at “male” and “female” patients separately within the study design.

The Benefit of Using Real Conversations as Data

The literature review and findings of this study made clear the importance
and value of using actual conversations that occurred between physicians and patients as data. The qualitative method of conversation analysis modified and used for this project demonstrated that detailed microanalyses of speech led to important findings that could not have been obtained by use of quantitative outcome measures such as patient post-operative questionnaires. Future empirical research on informed consent should shift its focus from reliance on outcome measures to study designs and analytic methods that make use of the audiotape speech of physicians and patients. This shift will allow researchers to evaluate whether physicians meet the legal requirements for informed consent in the clinical setting. Furthermore, the nature of communication between physicians and patients during informed consent can be studied closely if the data source is improved.

**Physicians Attempted to Elicit Joint Decision Making**

The findings of this study revealed that, in some cases, male physicians attempted to elicit joint decision making with male and female patients during informed consent. This finding is limited because it does not determine whether patients *actually* contributed to the decision making process, but rather only that the physician, in a few cases, attempted to include the male or female patient’s perspective. Based on this finding, this study recommends that future empirical projects investigate the phenomenon of joint decision making to determine the nature of physician-patient communication during periods when patient perspectives and opinions are solicited by physicians during the conversation. Gender analyses should be conducted to determine whether physicians take different approaches to elicit joint decision making with male and female patients, and the varying responses of these patients based on gender as well as their impact on the decision ultimately made regarding treatment.
No Explicit References to Patient Gender

Male physicians’ speech did not include explicit references to patient gender during informed consent. Given that Ontario requires tailoring of disclosure to the patient’s particular situation, and that core feminism includes gender as part of the patient’s particular situation, this finding is androcentric and should be addressed. However, this study demonstrated that evaluating whether physicians’ speech is tailored to a patient’s particular situation is a challenging task for researchers. For example, identification of explicit references is not likely the most effective method for evaluating whether physicians’ speech has been tailored to include gender as part of what a “reasonable person” in the patient’s particular situation would need to know in order to make a treatment decision. This finding is thus limited since it does not adequately reveal whether or not physicians’ speech was tailored to patient gender implicitly. For example, if a physician discussed with a patient his or her need for time off work subsequent to receiving surgical treatment, this would not be included as an explicit reference to patient gender but may have implications for the varying ways in which physicians consider the life circumstances of male and female patients.

This study recommends that future empirical research begin to develop appropriate methods for evaluating whether the speech of physicians is tailored to gender, and other variables that may be relevant to a patient’s particular situation. For example, future studies should focus on male and female patients’ own definitions of what constitutes their own “particular situation” in relation to various treatment options, and interview these patients to generate criteria. By requesting that male and female patients define the events and circumstances that appropriately characterize their particular situations, researchers can begin to learn how to appropriately define the “reasonable person” standard. These criteria can
be used effectively to aid physicians in meeting the standard, and researchers in evaluating whether or not the standard has been met in various clinical situations.

This study raises questions about the interface, and potential conflict, between physicians’ obligations to tailor information to the patient’s particular situation during informed consent, and the expectation that physicians maintain appropriate “boundaries” during physician-patient interaction. In Ontario specifically, strict guidelines exist for physicians, which dictate the ways in which speech must be tailored during medical visits in order to maintain comfortable boundaries and thus not sexually offend or harass patients.140 141 This study has focused on the need for physicians to explore the patient’s particular situation in relation to treatments, relating to gender and perhaps sexuality among other factors. Therefore, future work should investigate whether two contradictory policies currently exist to guide physician behaviour since these policies dictate, in differing ways, the extent to which physicians should discuss personal issues with patients during the medical encounter.

Disfluency in Physicians’ Speech

This study demonstrated that physicians’ speech was disfluent during the disclosure phase and particularly when disclosing risks associated with a recommended treatment. The findings of this study, in conjunction with sociolinguistic research, suggest that disfluent speech is related to speaker anxiety. Therefore, physician anxiety during disclosure, rather than “patient anxiety” (as thought in the informed consent literature), may be related to poor comprehension by patients during informed consent. Furthermore, patient comprehension of treatment information disclosed may not be related to the complexity of the medical information conveyed, as is also believed in informed consent literature but rather, to the manner in which the physician speaks, i.e. the disfluency of the
speaker.

Future studies can build on this one by testing the effect of disfluent speech on patient comprehension and of patient perceptions of physician competence during informed consent. Studies could expand to a variety of medical settings to determine if physicians’ speech includes disfluent features in other contexts and whether disfluency is related specifically to revealing “bad news,” such as the disclosure of serious risks or news that is likely to compromise patient compliance with treatment recommendations. Physician anxiety levels during disclosure could be tested to determine if there is a relationship to disfluent speech and whether disfluency is related to “pondering options” as demonstrated in prior research. 142

Euphemisms in Physicians’ Speech

Physicians refer to important treatment information, such as the treatment of surgery, in a vague and euphemistic manner. The term “fix” was used to refer to the treatment of surgery and the phrase “teed up” was used to refer to the pre-admission process prior to surgery. These euphemisms may not be comprehensible to patients and this raises concerns about the adequacy of informed consent to surgical treatment specifically. Based on these findings, this study recommends that future empirical projects investigate whether euphemistic speech during disclosure is an impediment to patient comprehension. For example, patients could be tested subsequent to their conversations with physicians to determine whether or not they comprehended the meaning of the euphemistic speech spoken in the context of the encounter.

Physician Control and Paternalism

Male physicians may treat male and female patients in a paternalistic
fashion during informed consent. This study demonstrated that physicians tended to speak in a child-like manner when disclosing the nature of the proposed treatment to patients, and that they exerted control by determining when informed consent encounters would end. Based on these findings, this study recommends that empirical research on informed consent begin to investigate whether specific terminology in physicians’ speech encourages a paternalistic relationship which inhibits patients from participating in decision making. In addition, since physicians control aspects of the conversation, such as the time it will end, future studies should investigate whether this inhibits patients from acquiring the breadth of information they require during informed consent.

Summary

This study recommends that research on informed consent shift its’ current focus. Future work should be aware of the error of androcentrism that will occur if female and male patients are not assessed separately within the study design. Also, future work should consider the value of using the real conversations that occurred between physicians and patients as data in order to uncover what transpires during their conversation. This study offers new ideas and directions for informed consent research that will benefit the field of bioethics by inclusion of the interests of both male and female patients’ and by close investigation of the phenomenon of informed consent itself.
APPENDIX 1

Patient Demographics

The median age of the patient sample was 65 years old.

Primary Diagnosis of Patients:
- Peripheral Vascular Disease 37%
- Carotid Artery Disease 29%
- Varicose Veins 21%
- Abdominal Aortic Aneurysm 13%

Religion:
- Christian 64%
- Jewish 10%
- Muslim 3%
- Hindu 3%
- Multiple 3%
- None 16%

Highest Completed Level of Education:
- Professional/Graduate Degree 57%
- University/College Degree 14%
- High School 20%
- Primary School 6%
- None 3%
### APPENDIX 2

**Physician Demographics**

<table>
<thead>
<tr>
<th>Physician Identification Number</th>
<th>Age</th>
<th>Number of Years in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>48</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>37</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>40</td>
<td>5.5</td>
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<tr>
<td>4</td>
<td>54</td>
<td>24</td>
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</tbody>
</table>
APPENDIX 3

Transcription System

<table>
<thead>
<tr>
<th><strong>DISFLUENCY</strong></th>
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</thead>
<tbody>
<tr>
<td>Hedges</td>
<td><em>you know</em>; identified by bolded lowercase letters.</td>
</tr>
<tr>
<td>Phrase Hedging</td>
<td><em>the</em>— ; identified by bolded lowercase letters and a double hyphen.</td>
</tr>
<tr>
<td>Word Hedging</td>
<td><em>th</em>— ; identified by bolded lowercase letters and a single hyphen.</td>
</tr>
<tr>
<td>Filled Pauses</td>
<td><em>um</em>; identified by bolded lowercase unitalicized letters.</td>
</tr>
<tr>
<td>Word Repetition</td>
<td><em>the the</em> ; identified by bolded lowercase letters and underlining.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DICTION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Register</td>
<td><em>tummy</em> ; identified by bolded lowercase letters and asterisks.</td>
</tr>
<tr>
<td>Euphemism</td>
<td><em>fix</em> ; identified by bolded lowercase letters and arrows.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>VOLUBILITY</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Volubility</td>
<td><em>OKAY</em>; identified by bolded uppercase letters.</td>
</tr>
</tbody>
</table>
APPENDIX 4
CONSENT FORM

I have been asked to participate in a study which is designed to test how well I am informed about my medical care. I understand that the purpose of this study is to attempt to help doctors develop methods for ensuring that patients are properly informed about the treatments they receive.

The study involves the audiotaping of the encounters I have with my physician during my scheduled appointment time. A researcher will be present during the encounter and will simultaneously observe and audiotape the encounter. After the encounter with my physician, the researcher will ask me some questions and my responses will be audiotaped as well. The tapes will be heard only by other research personnel working on the study.

The risks of the study are minimal. I may become tired, anxious or upset from being observed and answering questions during the interviews.

I am aware that the study will not benefit me specifically. The benefits of the study are yet to be determined in the future, but they may include increased understanding of consent methods that ensure patients are properly informed.

I have had the opportunity to discuss the study with the research coordinator and my questions have been answered to my satisfaction. If I have any further questions regarding the study I can contact Dr. Etchells at 416-340-4710.

Any information learned about me during this study will be confidential. Neither my name nor any other identifying particulars will be made available to anyone other than the investigators or appear in any publication without prior approval from me.

I consent to take part in the study with the understanding that I may withdraw at any time without prejudice to my treatment.

I have been offered a copy of this form.

I confirm that I am not at present participating in any other research study.

Dated at ___________ this _______ day of _________ 19_______.

________________________________________
Patient’s Name (please print)

______________________________ ____________________________
Witness’ Signature Patient’s Signature

________________________________________
Person Obtaining Consent and Professional Relationship Signature
CONSENT FORM

I have been asked to participate in a research project that will investigate the process of consent as it occurs in a clinical setting. The study involves a detailed analysis of the conversations I had with patients regarding treatment information.

The investigator, Deborah Zinman, is pursuing a Master’s of Science degree in Bioethics through the Institute of Medical Science at The University of Toronto. The purpose of Ms. Zinman’s work is to investigate the role of both the physician and patient during discussions of consent to treatment. Her study will provide an empirical analysis of the consent process.

Ms. Zinman will analyze the transcripts obtained at our clinic with particular attention to the gender of the patient. The speech of male and female patients will be coded and analyzed for its structure and content. The speech of physicians will be coded and analyzed with attention to structure and content of information disclosure for female and male patients. Of prime importance to Ms. Zinman’s work is confidentiality. She will pay careful attention to protecting identities the participants in her study. There will be no identifying characteristics of the participants revealed by Ms. Zinman at any time hereforward. The setting of the outpatient clinic where the data was collected will be loosely described in her analysis of doctor-patient communication.

The risks of the study are minimal. Since the conversations I had with patients have already been obtained through audio-tape, the harms or burdens I might incur from this study are based only on the dissemination of findings. The findings will be discussed at seminars held at the Joint Centre for Bioethics and Institute of Medical Science and submission of papers to scholarly peer reviewed journals. In all instances of research dissemination, Ms. Zinman will carefully protect the identity of my patients and myself. There is however a risk that the identity of my colleagues or myself could be revealed through knowledge that Ms. Zinman has worked with Dr. Edward Etchells at our outpatient clinic. It is perhaps known among the staff at the _______ that Dr. Etchells has worked at our Centre investigating consent.

I am free to contact Ms. Zinman at home (923-0951) or at The Joint Centre for Bioethics (978-2709) at any time should I have questions about the analysis of the data, her progress on her thesis, or the research findings.

I consent to take part in the study. I have read this form and understand the implications of my participation.

Dated at ________ day of __________ 19 ______.

Participant’s Name_____________________________ Signature ________________________

Witness Signature and Relationship_______________________________.

Person Obtaining Consent and Relationship_____________________________________.

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