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Università degli Studi di Padova

Dipartimento di Scienze Cardio-Toraco-Vascolari e Sanità Pubblica

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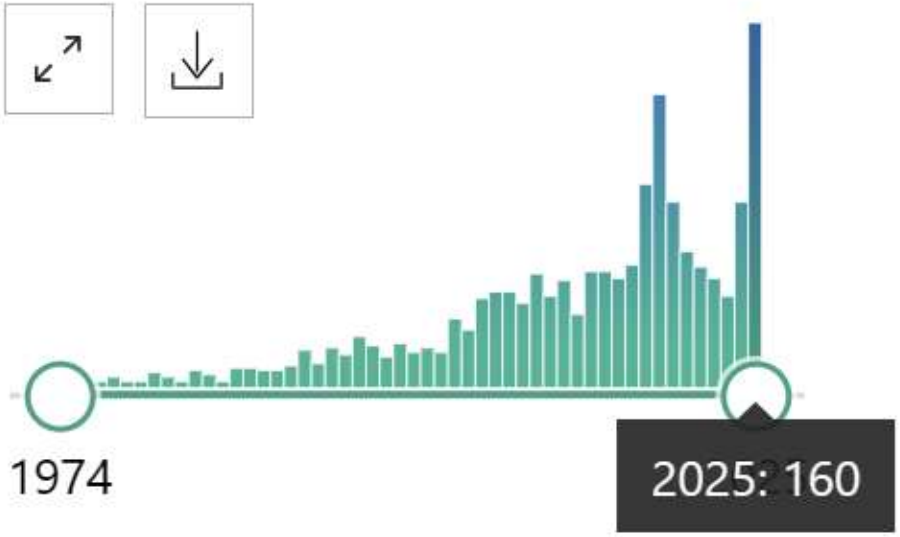

SPECIAL ARTICLE

ASSESSING PATIENTS' CAPACITIES TO CONSENT TO TREATMENT

PAUL S. APPELBAUM, M.D., AND THOMAS GRISSO, PH.D.

Abstract The right of patients to accept or refuse recommended treatment requires careful reassessment when their decision-making capacities are called into question. Patients must be informed appropriately about treatment decisions and be given an opportunity to demonstrate their highest level of mental functioning. The legal standards for competence include the four related skills of communicating a choice, understanding relevant information, appreciating the current situation and its consequences, and manipulating information rationally.

Since competence is a legal concept and can be formally determined only in court, the clinical examiner's proper role is to gather relevant information and decide whether an adjudication of incompetence is required. Treatment for impairment of mental functioning can sometimes restore patients' capacities, making it unnecessary to deprive them of their decision-making powers. (N Engl J Med 1988; 319:1635-8.)

1988!

2025!

Psychiatry Research 344 (2025) 116343

Contents lists available at ScienceDirect

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journal homepage: www.elsevier.com/locate/psychres

Review article

Decisional capacity to consent to treatment in children and adolescents: A systematic review

Giovanna Parmigiani [a], Marcello Benevento [b,*], Biagio Solarino [b], Anna Margari [b], Davide Ferorelli [b], Luigi Buongiorno [b], Roberto Catanesi [b], Felice Carabellese [b], Antonio Del Casale [c], Stefano Ferracuti [d], Gabriele Mandarelli [b]

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[b] Interdisciplinary Department of Medicine, University of Bari "Aldo Moro", Bari, Italy
[c] Department of Neuroscience, Mental Health and Sensory Organs, "Sapienza" University of Rome, Rome, Italy
[d] Department of Human Neurosciences, Sapienza University of Rome, Rome, Italy

19 yrs ago…
Feeling old?

2006!

BECOMING A PHYSICIAN

The Script

Benjamin Brody, B.A.

"What happened?" the patient asked. She was coming out of anesthesia after six hours of surgery. A weary resident cleaned dried blood and iodine from the skin around the surgical wound on her abdomen. The anesthesiologist had just removed her breathing tube. The patient, to my surprise, was staring straight at me — the medical student. She asked again: "What happened?"

During the previous 6 months, a rapidly expanding abdominal mass had developed. Early in her surgery, a frozen section had been sent to the laboratory, and 20 minutes later a voice over the intercom had confirmed what the surgeons had surmised: she had ovarian cancer. The tumor had spread through the pelvis and abdomen, attaching the uterus and loops of bowel. The surgeon and residents meticulously resected all visible disease, but the prognosis was grim and everyone in the operating room knew it — except the patient. But surely it was not my place to relay this news.

The surgeon hailed me out. "Your surgery's over," he said in a calm, soothing voice. He told her they would talk more when she had fully awakened. But what — and how, exactly — would he tell her?

In medical school, we're taught to follow a script: "What brought you to the hospital today?" it begins. It's a starting point based on the assumption that you haven't already read a triage nurse's notes, reviewed the results of laboratory tests ordered in the emergency department, or met the patient during a previous examination. We learn to take a detailed history of the present illness before proceeding to the medical history, the social history, and a series of questions: Current medications? Allergies? Surgical history? Prior hospitalizations? "Ask the questions in the same order, and you'll never forget anything," I was advised during my medicine clerkship.

"But I've already answered these questions five times," patients occasionally protest midway through the script. "I'm sorry, but it's important that we don't miss anything," I respond, noting that the patient is alert and oriented. From the first weeks of medical school through the licensing exam, this initial encounter is the focus of medical education. Whether you're examining an elderly woman with diabetes who has a foot ulcer, a young man having a panic attack, or a vomiting infant, instructors drill this script into your head. Taking his-

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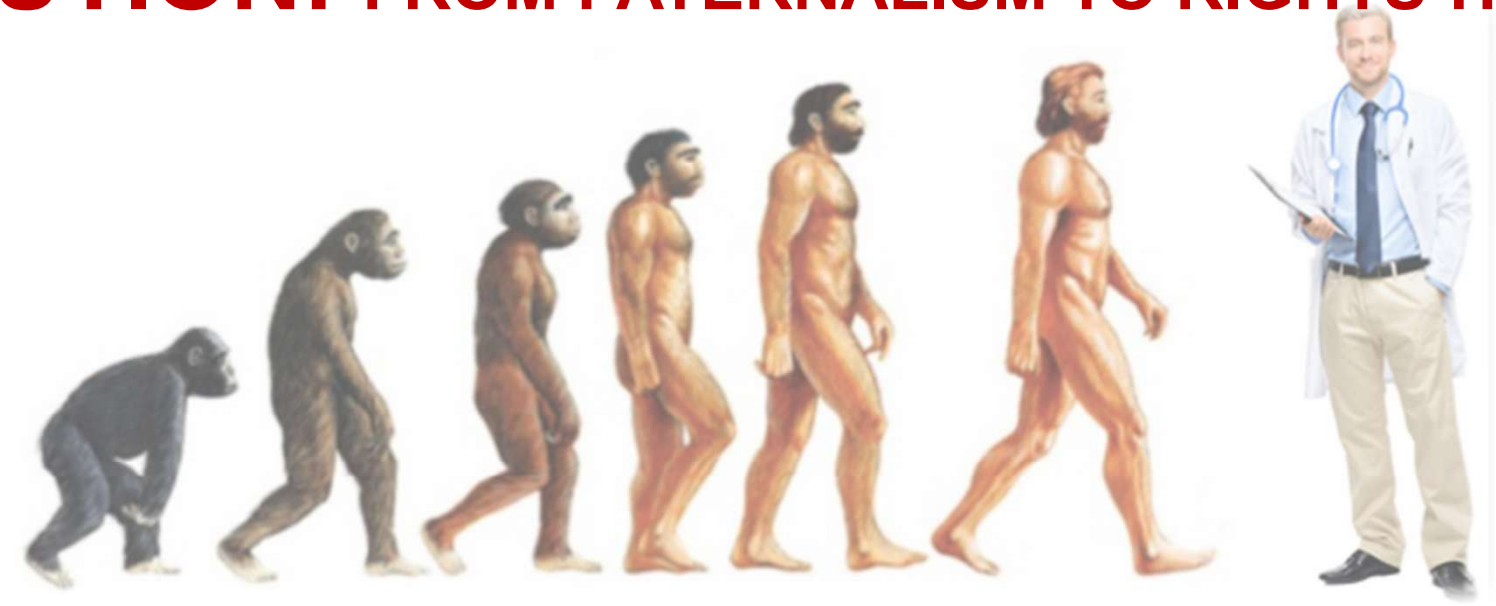
EVOLUTION: FROM PATERNALISM TO RIGHTS-HOLDERS



Disease Centered Medicine

Health = Objective

Paternalistic Model

Patient Centered Medicine

Health = *«Empowerment»*

Informed Consent Model

- ✓ Shift from viewing patients as passive recipients to active rights-holders
- ✓ Impacts on consent to treatment and involuntary hospitalization

1. Introduction
2. Legal and Ethical Framework
3. Clinical Dimensions of Capacity
4. Instruments and Tools for Assessment
5. Capacity in Special Populations
6. Forensic Psychiatry Implications
7. Multimedia and Innovative Approaches
8. Future Directions
9. Conclusion

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INTRODUCTION

- **Mental capacity**: ability to make informed treatment decisions → understand + communicate

- **Consent to treatment**: permission before they receive any type of medical treatment, test or examination → Informed consent = cornerstone of patient rights

INTRODUCTION

1. **VOLUNTARY** = the decision **to either consent or not to consent** to treatment **must be made by the person**, and must not be influenced by pressure from medical staff, friends or family

2. **INFORMED** = the person must be given **ALL of the information** about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead

3. **CAPACITY** = the person **must be capable of giving consent**, which means they understand the information given to them and can use it to make an informed decision

Legal competence: intersection of law, ethics, and psychiatry

INTRODUCTION

CONCEPT

A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time.

Someone with such an impairment is thought to be **unable to make a decision if they cannot**

INTRODUCTION

Someone with such an impairment is thought to be **unable to make a decision if they cannot**

understand information about the decision

remember that information

use that information to make a decision

communicate their decision by talking, using sign language or any other means

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ETHICAL PRINCIPLES

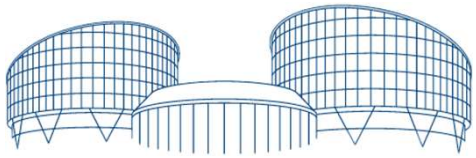
Autonomy
(self-determination)

Beneficence
(improve the patient's condition)

Non maleficence
(avoid causing harm)

Justice
(tension between respecting and protecting)

LEGAL FRAMEWORK



European Convention on Human Rights (ECHR)

UN Convention on the Rights of Persons with Disabilities (CRPD)

National legislations: UK (Mental Capacity Act 2005), Italia (Law 219/2017), US (AMA Code rev. 2001, 45 Code Federal Regulations 2018)

CRPD CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

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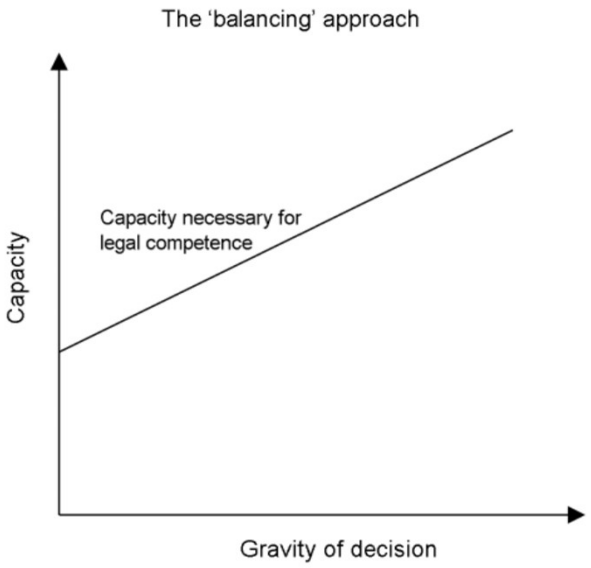
PROPORTIONALITY PRINCIPLE

JOURNAL OF THE ROYAL SOCIETY OF MEDICINE Volume 97 September 2004

Mental capacity, legal competence and consent to treatment

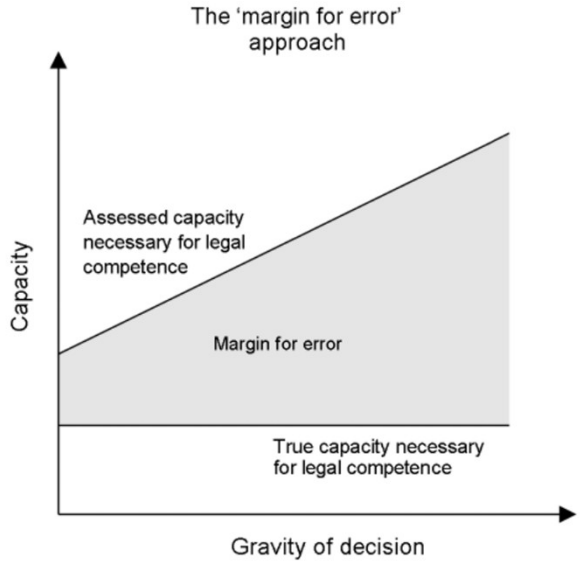
Alec Buchanan PhD MD

J R Soc Med 2004;**97**:415–420



a. **Greater capacity** required for more **serious decisions**

b. The ***'margin of error'*** principle in forensic settings



CLINICAL DIMENSIONS OF CAPACITY

The NEW ENGLAND JOURNAL of MEDICINE

CLINICAL PRACTICE

Assessment of Patients' Competence to Consent to Treatment

Paul S. Appelbaum, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

N ENGL J MED 357;18 WWW.NEJM.ORG NOVEMBER 1, 2007

Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient.

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make valid decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make "unreasonable" choices

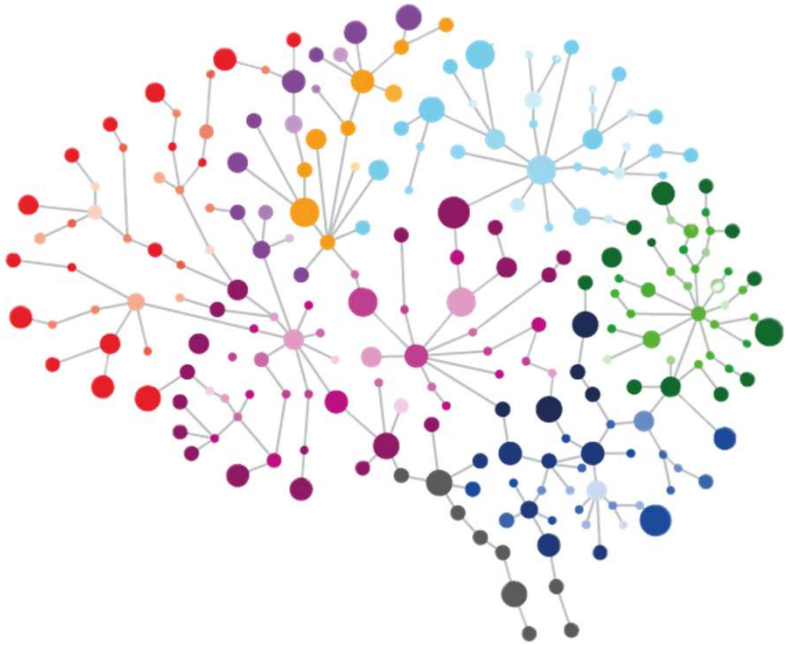
* Questions are adapted from Grisso and Appelbaum.[31] Patients' responses to these questions need not be verbal.

FOUR DOMAINS OF CAPACITY

Grisso & Appelbaum model

Understanding

Appreciation



Expression of choice

Reasoning

Task-specific, time-specific assessment

CHALLENGES

1. **Variability** across patients and contexts

2. **Influence** of psychiatric symptoms and cognitive impairment

3. Risk of **under- or over-estimating** capacity

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ASSESSMENT INSTRUMENTS (1)

Journal of
Clinical Nursing

REVIEW

Assessing patient capacity to consent to treatment: an integrative review of instruments and tools

Journal of Clinical Nursing, **22**, 2387–2403, doi: 10.1111/jocn.12215

Scott Lamont, Yun-Hee Jeon and Mary Chiarella

Capacity and consent: Knowledge and practice of legal and healthcare standards

Nursing Ethics
2019, Vol. 26(1) 71–83

10.1177/0969733016687162
journals.sagepub.com/home/nej
SAGE

Scott Lamont
Prince of Wales Hospital, Australia

Cameron Stewart and Mary Chiarella
The University of Sydney, Australia

ASSESSMENT INSTRUMENTS (2)

frontiers | Frontiers in Psychology

TYPE Original Research
PUBLISHED 19 March 2024
DOI 10.3389/fpsyg.2024.1309909

Reliability of clinical judgment for evaluation of informed consent in mental health settings and the validation of the Evaluation of Informed Consent to Treatment (EICT) scale

Nicola Di Fazio[1], Donato Morena[1*], Federica Piras[2], Fabrizio Piras[2], Nerisa Banaj[2], Giuseppe Delogu[1], Felice Damato[1], Paola Frati[1], Vittorio Fineschi[1], Stefano Ferracuti[3], Gabriele Sani[4†] and Claudia Dacquino[1†]

ASSESSMENT INSTRUMENTS
&
TOOLS COMPARISON

1. **MacCAT-T** widely validated tool

2. **ACE** (Aid to Capacity Evaluation)

3. **EICT** (Evaluation of Informed Consent to Treatment) scale

4. **CCTI, UBACC, SICIATRI**

ALL USEFULL!

STRENGTHS AND WEAKNESSES

1. Standardization improves reliability

2. Cannot replace nuanced clinical judgment

3. Time and training requirements

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POPULATIONS AT RISK

MCI	AD	Psychosis	Adolescents

1. Mild Cognitive Impairment (MCI)
2. Alzheimer's Disease (AD)
3. Psychosis
4. Adolescents

MILD COGNITIVE IMPAIRMENT & ALZHEIMER

International Psychogeriatrics (2022), 34:6, 529–542
doi:10.1017/S1041610220004056

REVIEW

Decisional capacity to consent to treatment and research in patients affected by Mild Cognitive Impairment. A systematic review and meta-analysis

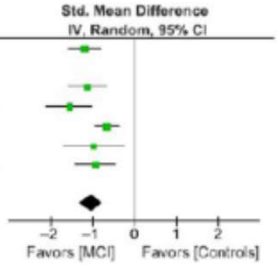
Giovanna Parmigiani,[1,*] Antonio Del Casale,[2] Gabriele Mandarelli,[3] Benedetta Barchielli,[2] Georgios D. Kotzalidis,[1] Fabrizia D'Antonio,[2] Antonella Di Vita,[2,4] Carlo de Lena,[2] and Stefano Ferracuti[2]

[1]*Department of Neuroscience, Mental Health, and Sensory Organs, "Sapienza" University of Rome, Rome, Italy*
[2]*Department of Human Neurosciences, "Sapienza" University of Rome, Rome, Italy*
[3]*Interdisciplinary Department of Medicine, Section of Criminology and Forensic Psychiatry, University of Bari "Aldo Moro", Bari, Italy*
[4]*Department of Psychology, "Sapienza" University of Rome, Rome, Italy*

(A) Understanding

Study or Subgroup	MCI Mean	MCI SD	MCI Total	Controls Mean	Controls SD	Controls Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Okonkwo 2007	49.78	12.6	60	62.61	8.32	56	19.4%	−1.19 [−1.58, −0.79]	2007
Okonkwo 2008	47.56	12.17	116	63.4	8.08	88	0.0%	−1.49 [−1.80, −1.18]	2008
Jefferson 2008	21.3	3.2	40	24.2	1.7	40	16.4%	−1.12 [−1.59, −0.65]	2008
Griffith 2010	46.93	12.93	29	63.9	9.12	42	14.2%	−1.55 [−2.09, −1.01]	2010
Lui 2012	4.8	0.8	99	5.3	0.7	97	24.2%	−0.66 [−0.95, −0.37]	2012
Duron 2013	16.9	2.5	26	19	0.7	12	9.8%	−0.97 [−1.69, −0.25]	2013
Oshima 2020	3.42	1.27	40	4.44	0.78	33	16.0%	−0.94 [−1.42, −0.45]	2020
Total (95% CI)			294			280	100.0%	**−1.04 [−1.31, −0.77]**	

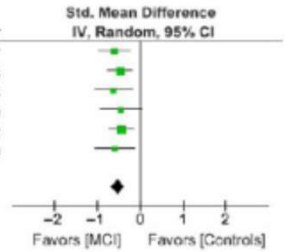
Heterogeneity: $Tau^2 = 0.06$; $Chi^2 = 10.36$, $df = 5$ ($P = 0.07$); $I^2 = 52\%$
Test for overall effect: $Z = 7.60$ ($P < 0.00001$)



(B) Appreciating

Study or Subgroup	MCI Mean	MCI SD	MCI Total	Controls Mean	Controls SD	Controls Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Okonkwo 2007	6.82	1.52	60	7.55	0.71	56	15.6%	−0.60 [−0.98, −0.23]	2007
Okonkwo 2008	7.03	1.3	116	7.57	0.91	88	27.5%	−0.47 [−0.75, −0.19]	2008
Jefferson 2008	5	1.2	40	5.6	0.6	40	10.7%	−0.63 [−1.08, −0.18]	2008
Griffith 2010	6.93	1.39	29	7.5	1.11	42	9.4%	−0.46 [−0.94, 0.02]	2010
Lui 2012	3.5	0.8	99	3.8	0.5	97	27.0%	−0.45 [−0.73, −0.16]	2012
Oshima 2020	3.3	1.29	40	3.91	0.52	33	9.8%	−0.59 [−1.06, −0.12]	2020
Total (95% CI)			384			356	100.0%	**−0.51 [−0.66, −0.36]**	

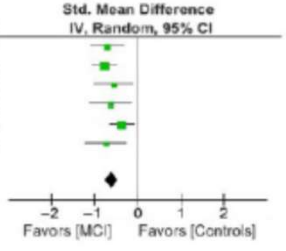
Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.94$, $df = 5$ ($P = 0.97$); $I^2 = 0\%$
Test for overall effect: $Z = 6.81$ ($P < 0.00001$)



(C) Reasoning

Study or Subgroup	MCI Mean	MCI SD	MCI Total	Controls Mean	Controls SD	Controls Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Okonkwo 2007	7.48	3.03	60	9.52	2.64	56	15.6%	−0.71 [−1.09, −0.34]	2007
Okonkwo 2008	7.66	3.61	116	10.7	4.23	88	26.7%	−0.78 [−1.07, −0.49]	2008
Jefferson 2008	5.7	1.3	40	6.4	1.2	40	11.0%	−0.55 [−1.00, −0.11]	2008
Griffith 2010	8.14	4.09	29	10.93	4.55	42	9.4%	−0.63 [−1.12, −0.15]	2010
Lui 2012	5.3	1.8	99	5.9	1.3	97	27.6%	−0.38 [−0.66, −0.10]	2012
Oshima 2020	5.8	2.1	40	7.03	0.68	33	9.7%	−0.75 [−1.23, −0.27]	2020
Total (95% CI)			384			356	100.0%	**−0.62 [−0.77, −0.47]**	

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 4.54$, $df = 5$ ($P = 0.47$); $I^2 = 0\%$
Test for overall effect: $Z = 8.14$ ($P < 0.00001$)



(D) Expressing a choice

Study or Subgroup	MCI Mean	MCI SD	MCI Total	Controls Mean	Controls SD	Controls Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Okonkwo 2007	3.86	0.56	60	3.88	0.36	56	20.1%	0.00 [−0.36, 0.36]	2007
Okonkwo 2008	3.87	0.49	116	3.88	0.37	88	22.5%	−0.02 [−0.30, 0.25]	2008
Jefferson 2008	1.9	0.3	40	2	0.2	40	18.0%	−0.39 [−0.83, 0.05]	2008
Griffith 2010	3.86	0.35	29	3.76	0.48	42	17.2%	0.23 [−0.25, 0.70]	2010
Lui 2012	1.8	0.4	99	2	0.1	97	22.2%	−0.68 [−0.97, −0.39]	2012
Oshima 2020	1.93	0.47	40	2	0	33		Not estimable	2020
Total (95% CI)			384			356	100.0%	**−0.19 [−0.52, 0.14]**	

Heterogeneity: $Tau^2 = 0.11$; $Chi^2 = 17.14$, $df = 4$ ($P = 0.002$); $I^2 = 77\%$
Test for overall effect: $Z = 1.11$ ($P = 0.27$)

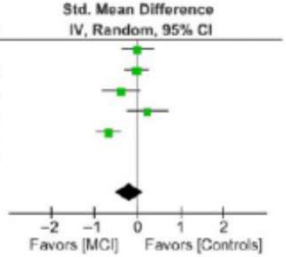


Figure 2. Meta-analysis of the standardized mean difference in Understanding (A), Appredating (B), Reasoning (C) and Expressing a choice (D) of patients with MCI versus HCs.

Study or Subgroup	MCI Mean	MCI SD	MCI Total	AD Mean	AD SD	AD Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Okonkwo 2007	49.78	12.6	60	29.94	9.75	31	33.3%	1.68 [1.18, 2.18]	2007
Lui 2012	4.8	0.8	99	3.7	1.3	95	39.3%	1.02 [0.72, 1.32]	2012
Duron 2013	16.9	2.5	26	9.56	4.68	23	27.3%	1.96 [1.27, 2.65]	2013
Total (95% CI)			**185**			**149**	**100.0%**	**1.50 [0.91, 2.09]**	

Heterogeneity: $Tau^2 = 0.21$; $Chi^2 = 9.05$, $df = 2$ ($P = 0.01$); $I^2 = 78\%$

Test for overall effect: $Z = 4.97$ ($P < 0.00001$)

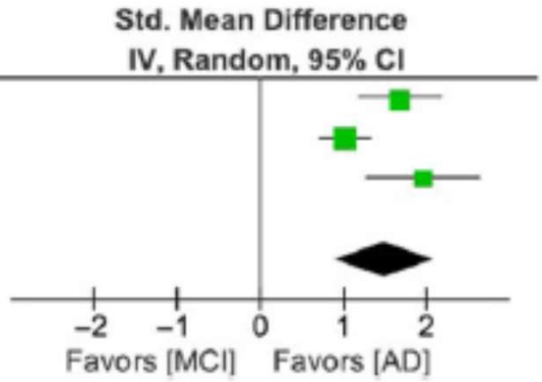


Figure 3. Meta-analysis of the standardized mean difference in Understanding of patients with MCI versus AD.

1. **Impairment** in understanding, reasoning, appreciation

2. **MCI patients between** healthy controls and Alzheimer's disease

3. **Risk of therapeutic misconception**

SEVERE MENTAL DISORDERS

1. **Schizophrenia, bipolar disorder, psychosis**
2. **Variable competence** depending on phase and symptoms
3. Importance of **supported decision-making**
4. **Clinical judgment often unreliable** (Ferracuti et al. 2024)

frontiers | Frontiers in Psychology

TYPE Original Research
PUBLISHED 19 March 2024
DOI 10.3389/fpsyg.2024.1309909

Reliability of clinical judgment for evaluation of informed consent in mental health settings and the validation of the Evaluation of Informed Consent to Treatment (EICT) scale

Nicola Di Fazio[1], Donato Morena[1*], Federica Piras[2], Fabrizio Piras[2], Nerisa Banaj[2], Giuseppe Delogu[1], Felice Damato[1], Paola Frati[1], Vittorio Fineschi[1], Stefano Ferracuti[3], Gabriele Sani[4†] and Claudia Dacquino[1†]

PSYCHIATRIC INPATIENTS

- **Some voluntary patients lack capacity**
- **Many involuntary patients** retain capacity
- **Paradox of voluntary** vs **involuntary patients** (Kelly 2022)

INTERNATIONAL JOURNAL OF PSYCHIATRY IN CLINICAL PRACTICE
2022, VOL. 26, NO. 3, 303–315
https://doi.org/10.1080/13651501.2021.2017461

REVIEW ARTICLE

Capacity to consent to treatment in psychiatry inpatients – a systematic review

Aoife Curley[a,b], Carol Watson[b] and Brendan D. Kelly[a]

[a]Department of Psychiatry, Trinity College Dublin, Trinity Centre for Health Sciences, Tallaght University Hospital, Tallaght, Dublin, Ireland;
[b]Cavan Monaghan Mental Health Service, Monaghan, Ireland

CHILDREN AND ADOLESCENTS

- Influence of **maturity, illness, situational factors**
- **Need for assent** alongside consent
- **Acceptable decisional capacity from ~13 years** (Ferracuti et al. 2025)

Psychiatry Research 344 (2025) 116343

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Review article

Decisional capacity to consent to treatment in children and adolescents: A systematic review

Giovanna Parmigiani [a], Marcello Benevento [b,*], Biagio Solarino [b], Anna Margari [b], Davide Ferorelli [b], Luigi Buongiorno [b], Roberto Catanesi [b], Felice Carabellese [b], Antonio Del Casale [c], Stefano Ferracuti [d], Gabriele Mandarelli [b]

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2. Legal and Ethical Framework
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FORENSIC PSYCHIATRY IMPLICATIONS

Forensic Context

Criminal Law ≠ Civile Law ≠ Medical Law

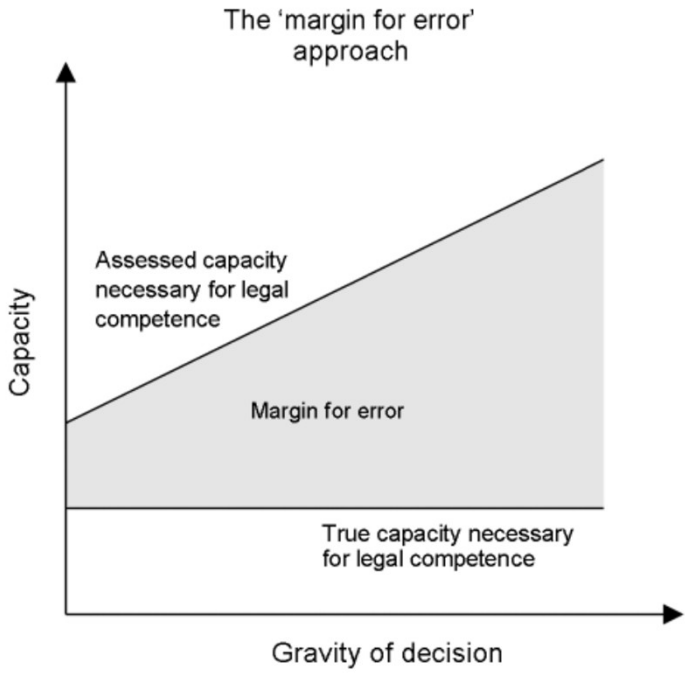
Assessment in criminal responsibility

Involuntary treatment decisions

Advance healthcare directives

MARGIN OF ERROR

- **Stricter scrutiny** when consequences are grave
- **Proportionality** in legal decision-making



JOURNAL OF THE ROYAL SOCIETY OF MEDICINE Volume 97 September 2004

Mental capacity, legal competence and consent to treatment

Alec Buchanan PhD MD

J R Soc Med 2004;**97**:415–420

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International Urogynecology Journal (2019) 30:1635–1637
https://doi.org/10.1007/s00192-019-04046-0

CLINICAL OPINION

Use of multimedia during informed consent: novelty or necessity

Henry H. Chill [1] · Uri Dior [1] · David Shveiky [1]

Received: 1 June 2019 / Accepted: 8 July 2019 / Published online: 13 July 2019

Abstract

The process of informed consent is an integral part of the preoperative encounter. In theory, it has the potential to educate patients, enabling them to reach a true autonomous decision regarding the treatment offered. Unfortunately, in recent years informed consent has become overly complicated for the average patient. Questions have been raised regarding the ability of the process, as practiced nowadays, to actually increase knowledge and achieve its goals. In search of new ways to increase patient comprehension, researchers have suggested use of multimedia during the process of informed consent. Visualization of complex ideas, interactive learning and tailoring the procedure to fit patient needs are all advantages presented by use of multimedia during the process. Several randomized prospective trials have looked into this topic and have presented promising data in favor of multimedia use. Informed consent is a process with unfulfilled potential, and use of multimedia may be part of the solution. In our opinion, it is time to change the way we educate patients.

The Use of Multimedia Consent Programs for Surgical Procedures: A Systematic Review

Surgical Innovation
20(1) 13–23

DOI: 10.1177/1553350612446352
http://sri.sagepub.com
SAGE

Jean Nehme, MSc, MRCS[1], Ussamah El-Khani, MSc, MRCS[1], Andre Chow, BSc, MRCS[1], Sherif Hakky, MSc, MRCS[1], Ahmed R. Ahmed, BSc(Hons), FRCS[1], and Sanjay Purkayastha, MD, FRCS[1]

Abstract

Objective. To compare multimedia and standard consent, in respect to patient comprehension, anxiety, and satisfaction, for various surgical/interventional procedures. **Data sources.** Electronic searches of PubMed, MEDLINE, Ovid, Embase, and Google Scholar were performed. Relevant articles were assessed by 2 independent reviewers. **Study selection.** Comparative (randomized and nonrandomized control trials) studies of multimedia and standard consent for a variety of surgical/interventional procedures were included. Studies had to report on at least one of the outcome measures. **Data extraction.** Studies were reviewed by 2 independent investigators. The first investigator extracted all relevant data, and consensus of each extraction was performed by a second investigator to verify the data. **Conclusion.** Overall, this review suggests that the use of multimedia as an adjunct to conventional consent appears to improve patient comprehension. Multimedia leads to high patient satisfaction in terms of feasibility, ease of use, and availability of information. There is no conclusive evidence demonstrating a significant reduction in preoperative anxiety.

Keywords

ergonomics and/or human factors study, evidence-based medicine/surgery, surgical education, the business of surgery

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DOI: 10.12659/MSM.894147

Use of Multimedia Technology in the Doctor-Patient Relationship for Obtaining Patient Informed Consent

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Marcin Stopa
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2 Clinical Eye Unit and Pediatric Ophthalmology Service, Heliodor Swiecicki University Hospital, University of Medical Sciences, Poznań, Poland

Patient informed consent for surgery or for high-risk methods of treatment or diagnosis means that unlawful breach of the patient's personal interests is avoided and the patient accepts the risk of surgery and takes the brunt of it. Patient awareness – their knowledge of the condition and circumstances of continued therapeutic procedure, including offered and available methods of treatment and their possible complications – constitutes a particular aspect of the informed-consent process.

The rapid development of technologies and methods of treatment may cause communication problems between the doctor and the patient regarding the scope and method of patient education prior to surgery. The use of multimedia technology (e.g., videos of surgical procedures, computer animation, and graphics), in addition to media used in preoperative patient education, may be a factor in improving the quality of the informed consent process. Studies conducted in clinical centers show that with use of multimedia technology, patients remember more of the information presented. The use of new technology also makes it possible to reduce the difference in the amount of information assimilated by patients with different levels of education. The use of media is a way to improve the quality of preoperative patient education and, at the same time, a step towards their further empowerment in the healing process.

APPLICATION TO PSYCHIATRY

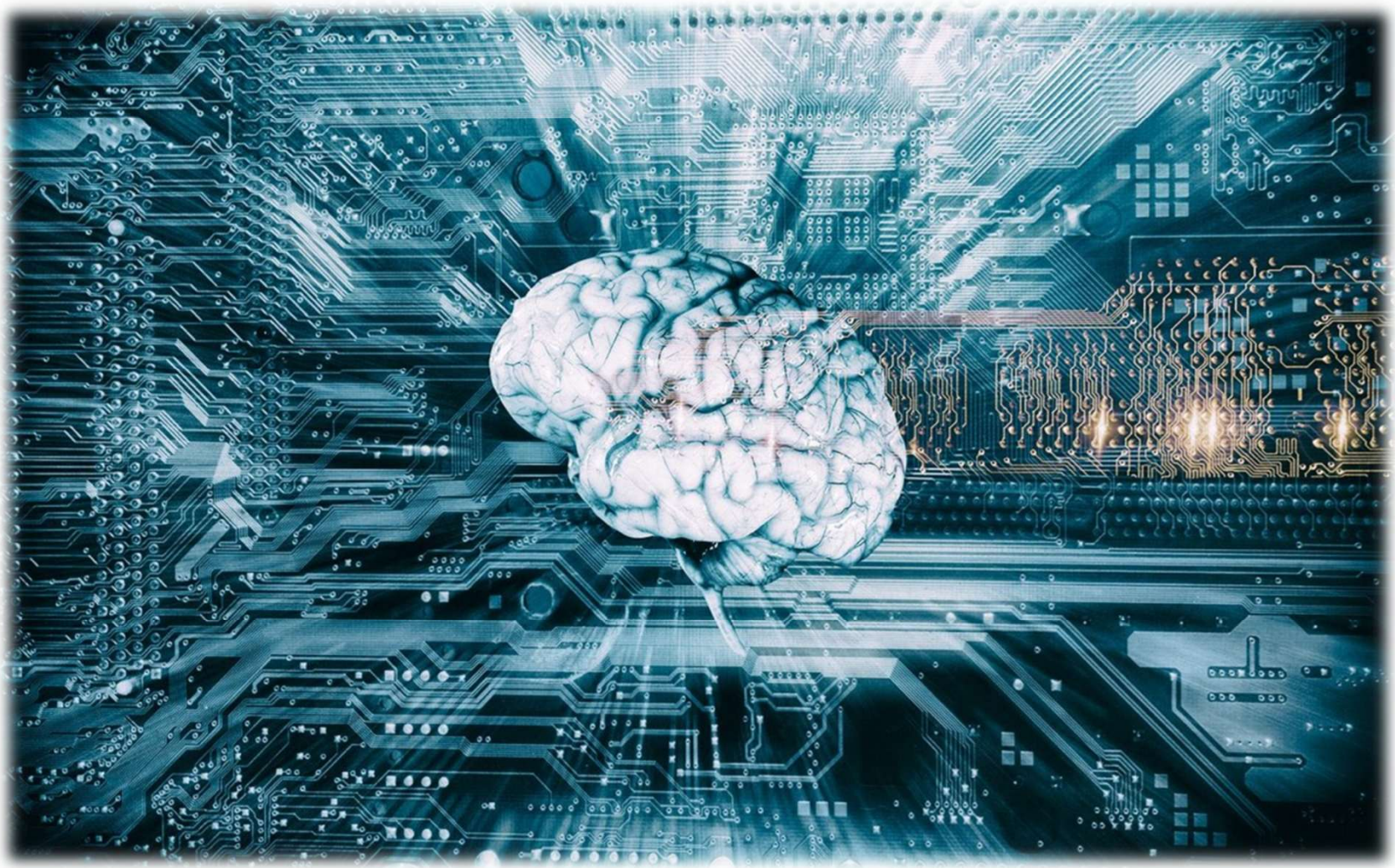
- **POTENTIAL TO SUPPORT** patients with limited capacity
- **REDUCTION OF PATERNALISM**
- **FACILITATING** shared decision-making

MULTIMEDIA ADVANTAGES

1. Improved **COMPREHENSION** and recall

2. **ENHANCED TRANSPARENCY** and patient engagement

3. **RETENTION**




WILL BIG DATA
&
ARTIFICIAL INTELLIGENCE
REVOLUTIONIZE THE WAY WE HEAL?

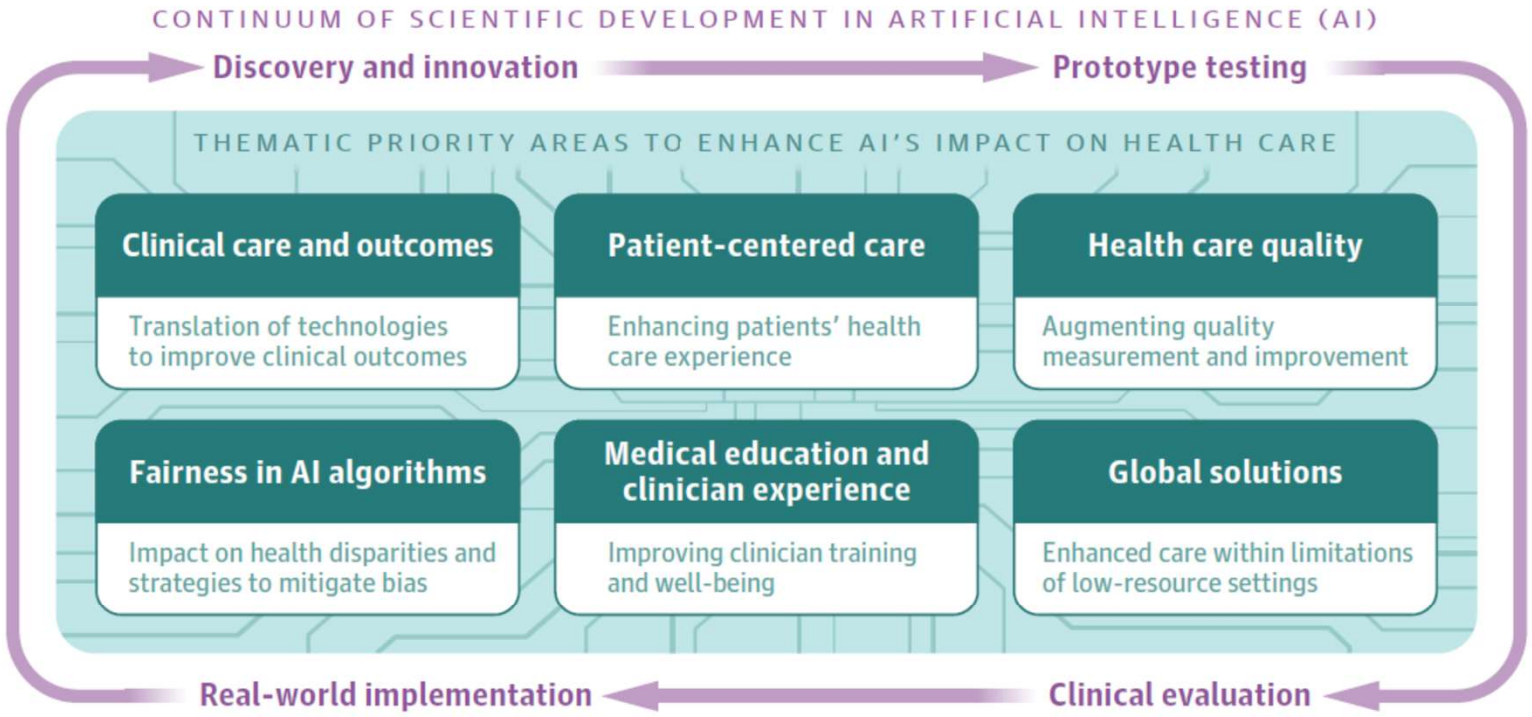
EDITORIAL

JAMA September 5, 2023 Volume 330, Number 9

AI IN MEDICINE

AI in Medicine—*JAMA*'s Focus on Clinical Outcomes, Patient-Centered Care, Quality, and Equity

Rohan Khera, MD, MS; Atul J. Butte, MD, PhD; Michael Berkwits, MD, MSCE; Yulin Hswen, ScD, MPH; Annette Flanagin, RN, MA; Hannah Park; Gregory Curfman, MD; Kirsten Bibbins-Domingo, PhD, MD, MAS



PERSPECTIVE

Medicine in the Era of Artificial Intelligence
Hey Chatbot, Write Me an H&P

JAMA Internal Medicine Published online April 28, 2023

We should be clear-eyed about the risks inherent to any new technology, especially one that carries existential implications. And yet, I am cautiously optimistic about a future of improved health care system efficiency, better patient outcomes, and reduced burnout; a future where AI enables us to get back to the reason why we decided to pursue medicine in the first place—to get up from the computer and back to the bedside.

SCIENTIFIC DISSEMINATION

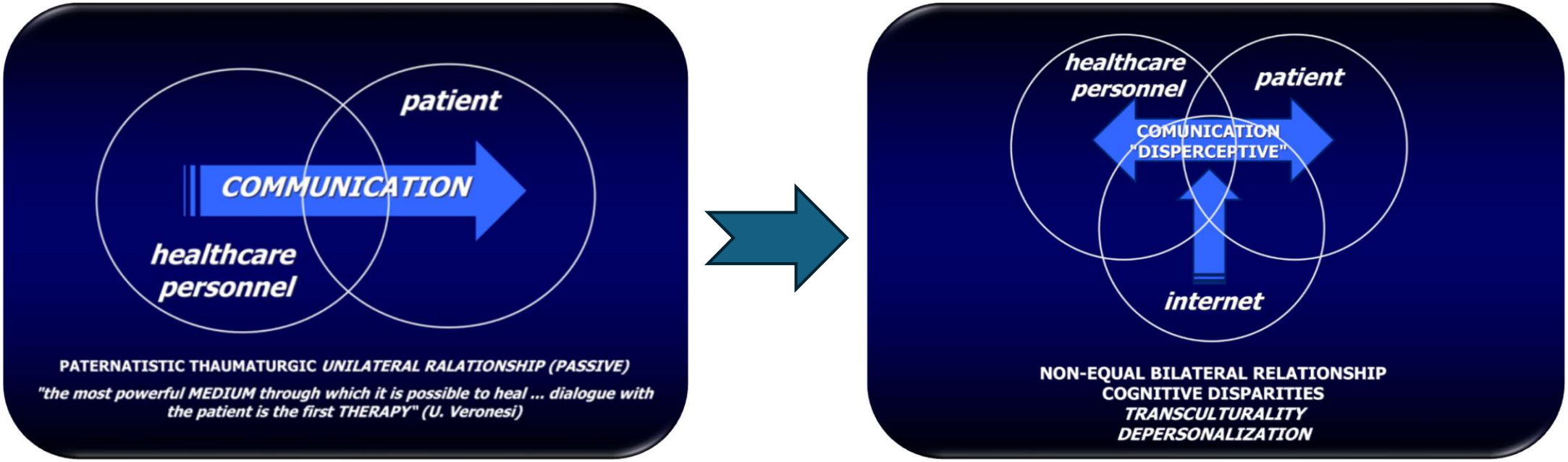
ORIGINAL ARTICLE

bioethics WILEY

Artificial intelligence and the doctor–patient relationship expanding the paradigm of shared decision making

Giorgia Lorenzini[1] | Laura Arbelaez Ossa[1] | David Martin Shaw[1,2] | Bernice Simone Elger[1,3]

Bioethics. 2023;37:424–429



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FUTURE DIRECTIONS

- **BALANCE** between standardization and flexibility
- Interdisciplinary **TRAINING**
- **INTEGRATION** of ethics, law, and psychiatry

TECHNOLOGICAL INNOVATION

- **AI AND DIGITAL PLATFORMS** for consent assessment
- **DECISION AIDS** and cognitive support tools
- **TELEPSYCHIATRY** applications

SUPPORTED DECISION-MAKING

- **EMPOWERMENT** of vulnerable patients
- From substitute to **ASSISTED DECISIONS**
- **SUPPORTED AUTONOMY** in psychiatry (Kelly 2022)

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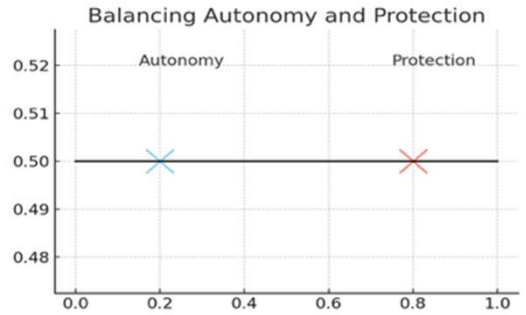
CONCLUSION (1)

- **Mental capacity is**
  dynamic, contextual, multidimensional

- **Assessment requires ethical balance:**
  autonomy vs protection

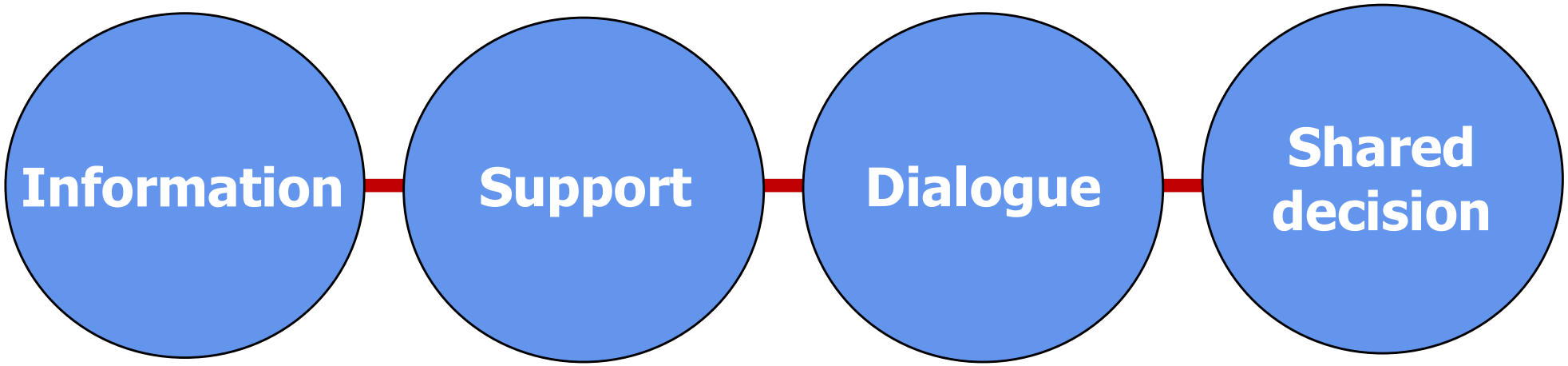


- **Consent is a process, not a signature**

~~Information~~ - - ~~Understanding~~ - - - ~~Decision~~ - - - - - - ~~Consent~~

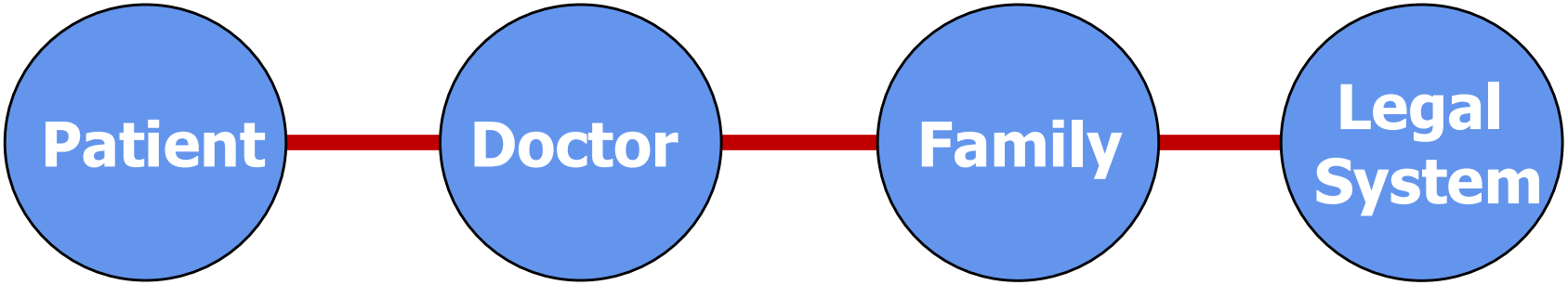
CONCLUSION (2)

SUPPORTING DECISION-MAKING



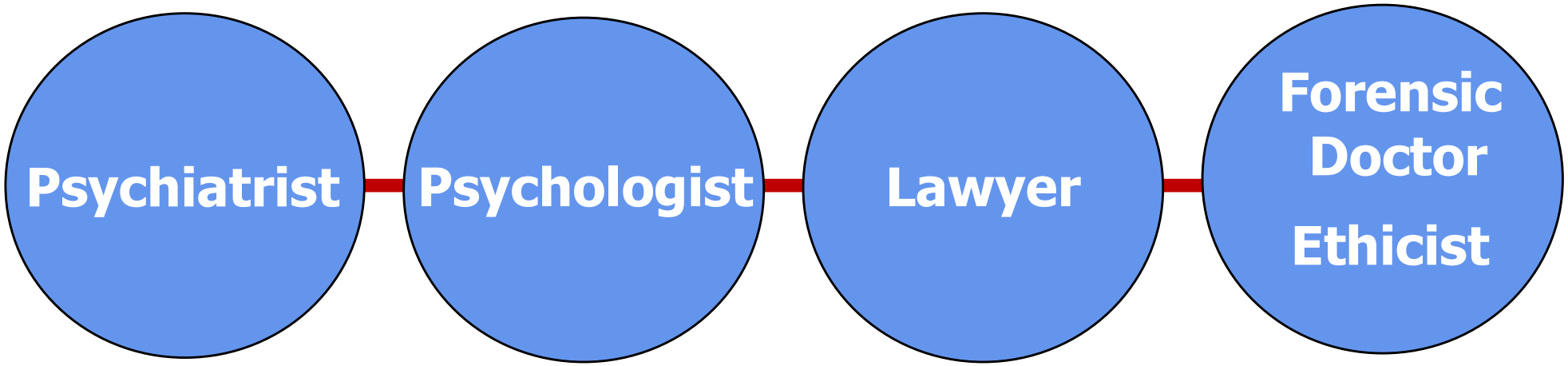
CONCLUSION (3)

KEY STAKEHOLDERS



CONCLUSION (4)

TEAMWORK IN CAPACITY ASSESSMENT




QUESTIONS
ANSWERS