

The Bureaucratization of Responsibility: The Case of Informed Consent†

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One of the fundamental characteristics of modern society has been the growing bureaucratization of social relationships. This phenomenon involves greater functional differentiation as well as increasing impersonalization. Much of the unique structure of social relations in the modern West can be seen as derivative of these two facets of bureaucratization.

One domain of social life that has been most affected by the bureaucratization of social relations is health care. In the modern West, much of the activity that we call "healing" takes place in the hospital, a social institution which has been undergoing a rapid process of bureaucratization. An appreciation of the fact that the modern hospital is a bureaucratic organization is indispensable for understanding much of what goes on in it.

One of the major models that presume to regulate modern therapeutic relationships is the legal doctrine of informed consent.¹ This doctrine puts much emphasis on the information given to patients about their prospective treatment, which may include — especially in psychiatry — their rights as patients. The doctrine indicates that it is not the patient's consent which is at stake, but, rather, his or her *informed* consent, and that before patients are asked to commit themselves to accepting treatment, they ought to be provided with such information.

The present discussion purports to shed some light on some of the structural complexities which surround the phenomenon of information disclosure within the context of a psychiatric hospital. Even though many of the problems involved in the actual implementation of the doctrine of informed consent would probably be totally irrelevant in a non-bureaucratic context, most of the literature on the doctrine has so far utterly ignored the phenomenon of bureaucratization. This paper thus brings into focus some of the major aspects of the process of bureaucratization which pertain to information disclosure.

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Mary Ashley and myself in an urban teaching psychiatric hospital in 1976-77 as part of a larger study concerning informed consent in psychiatry. Over a period of approximately six months, we observed the way in which information was presented to 137 patients in the hospital's admitting unit, outpatient clinic for cognitive disorders, and clinical research ward. The information presented to those patients related to their admission to the hospital, their treatment plans, their rights as patients, their participation in a psychiatric research project, and the renewal of their medication prescriptions. The present analysis focuses not only on what information was given, but also on *who* gave it and *how* it was given. These problems have some significant organizational — as well as moral — implications that are central to the sociological understanding of modern therapeutic relationships.

Floating Responsibility

One of the fundamental characteristics of modern society is the growing division of labor, which involves an increasing *functional differentiation* along professional lines.² Viewing the modern hospital from a sociological perspective, therefore, entails noticing the structural and functional segmentation of the category of "healer" into physicians, nurses, social workers, aides, technicians, and so on. This also involves a *segmentation of the responsibility* for patients, an appreciation of which is essential for a fuller understanding of the phenomenon of information disclosure within the context of the modern hospital.

Modern hospital care involves a most fundamental transformation of the traditional one-to-one relationship between the healer and the healed. That hospital patients are taken care of by several clinicians rather than one implies that the responsibility for them does not lie exclusively with any one clinician. Rather, it is shared by a number of hospital staff. In some instances, this responsibility is collectively shared as a whole by the entire staff of a unit. In others, it is split among them, so that each of them is responsible for the patients only in part — for ordering their medications, for administering them, and so on. In both cases, however, the *full* responsibility for the patients is "located" in a collective entity ("the hospital," "the service," "the team," and so on), so that no particular individual staff member is *exclusively* responsible for them. (Legally speaking, of course, there is usually one physician who is held ultimately responsible and accountable for each patient.)

When patients go to a private psychiatrist, there is hardly any question as to who is responsible for providing them with information. There is only one person who is fully and exclusively responsible for *everything* which relates to their patienthood, and this responsibility is transferred to another person only upon the termination of that therapeutic relationship. Private psychiatrists can never claim, for example, that they did not inform a patient because they thought that somebody else would do it or had already done it. Informing patients is their

responsibility which they share with no one.

In the hospital, however, patients are typically taken care of by more than one person. The question as to who is responsible for providing them with information, therefore, does arise there. It is within such a therapeutic context that the phenomenon of "*floating responsibility*" with respect to informing patients is most likely to emerge.

The situation whereby patients are taken care of by a multiplicity of clinicians often involves "gaps" in the responsibility for informing them.³ It has already been demonstrated that when responsibility can be assumed by more than one person, it is very often not assumed at all!⁴

Hospital authorities usually try very hard to prevent "gaps" in the responsibility for patients and to maintain the continuity of their coverage despite the multiplicity of caretakers and the frequent interruptions caused by transitions among staff around vacations, holidays, rotation changes, weekends, lunch breaks, and shift changes.⁵ However, they do not seem to have similar concerns about preventing "floating responsibility" regarding information disclosure. This is one indication that the latter concern is perceived as secondary in priority to coverage and actual care.

Hence the occasional "gaps" whereby a certain piece of information is not presented to the patient at all because the responsibility for disclosing it "floats" among the hospital staff. The following are several levels of possible "floatation" of responsibility, based on the observations we have made. The responsibility for informing patients may "float" first of all at the level of a particular unit, when, for example, the psychiatrist who admits the patient to the hospital assumes that the nurse who had the patient sign the admission forms had already disclosed to the patient a particular piece of information, and when she in turn assumes that the psychiatrist himself will do it later. With both of them leaving it for one another to do, it is often not done at all, and the patient remains uninformed. Second, the responsibility for disclosing information may "float" at the level of the entire hospital, when, for example, the staff on an admitting unit assume that the patient will receive a certain piece of information on the ward, whereas when the patient arrives on the ward the staff assume that the piece of information was already disclosed to the patient in the admission unit. Finally, "floating responsibility" can also be identified at the level of the more general health care delivery system when, for example, private psychiatrists practicing at a distance from the hospital (even in other states) assume that information will subsequently be given to the patient by the hospital staff, and the hospital staff assume that the patient has already been fully informed by the referring physician. "Floating responsibility" results not only in some types of information not being given to patients but also in contradictory information being given by different caretakers.

The Use of Standard Forms

Another major aspect of the bureaucratization of modern life has been the introduction of a strong element of *impersonality* into social relationships. There is an increasing distinction — social as well as existential — between being and doing, that is, between persons and their *roles*. In bureaucratic organizations, this is manifested in a basic distinction between the “office” and any of its incumbents.⁶ Impersonality is at the very basis of officials’ obligations, sphere of competence, and authority, since these are all temporally bounded by their term in office and are not really an integral part of them as persons.

This is also true of their responsibility. Bureaucratization involves not only a segmentation of responsibility, but an *impersonalization of responsibility* as well. Physicians’ responsibility for patients whom they admit to the hospital is, in part, impersonal, and is associated with the professional’s role as a professional. That it is not entirely personal is evident from the simple fact that when a physician rotates to another service, goes on vacation, or leaves the hospital altogether, his or her responsibility for any patient is easily transferable to another physician!⁷ The impersonalization of coverage and responsibility is even more evident with respect to nursing staff, since whereas doctors are — at least in part — also personally responsible for their patients, nurses are definitely not. While patients are usually associated with particular physicians and are typically referred to as “Dr. _____’s patients,” they are hardly ever associated with particular nurses and referred to as “Ms. _____’s patients.” Nurses’ responsibility for patients is almost entirely impersonal and is hardly ever expected to even transcend the temporal boundaries of their shifts.⁸

Given all this, it seems to me that, when clinicians provide patients with certain information, they usually do that not necessarily because they personally believe that patients ought to be informed, but, rather, because it is an official obligation which is involved in the “offices” they occupy as “physicians” or “nurses.” In other words, their responsibility for informing patients is primarily impersonal. Clinicians’ responsibility for informing patients involves not a personal commitment of one person to inform another person, but, rather, a largely impersonal duty of “clinicians” to inform “patients.”

Probably the best evidence of the increasing impersonalization of the responsibility for informing patients is the fact that a considerable amount of the information which patients receive is presented to them in a written form, rather than orally. In our study, patients were supposed — according to the law — to be able to read a form listing their initial evaluation, the treatment proposed to them, the restrictions they would encounter if admitted into the hospital, and their rights as patients.⁹ Written communication is inherently imbued with a pseudo-objective existence which transcends the particularity of the individual

who happens to produce it.¹⁰ Documents, for example, are clearly among the most effective mechanisms of impersonalizing and de-individualizing bureaucratic processes.¹¹

Presenting information as a *standard* written formula allows an almost total separation and dissociation of the information from the particular clinicians who present it to patients, because it makes their individual characteristics totally irrelevant to the process of informing. While clinicians may be held responsible for reading to patients the explanation of their rights, they can never be held responsible for what those forms say. It is well understood by everyone that these forms were designed independently of them and that they do not necessarily personally endorse what is in them. In fact, the information they hand over to patients about their rights may very well even conflict with their own personal attitudes towards informed consent!

The bureaucratization of the responsibility for informing patients is most evident from the way some clinicians manage to distance themselves from the information which they themselves present to patients. It has been pointed out that by displaying "role distance," people can perform certain procedures while discounting them at the same time.¹² This is obviously facilitated when the communication between the informer and the informed is mediated by a standard written form. In our study, we observed numerous instances whereby staff managed to dissociate themselves from the information that they provided to patients by communicating to them quite explicitly that they were informing them primarily because they *had* to. That implied that they regarded the act of informing them as a purely *pro forma* matter which involved the official roles that they occupied, but not them as persons.

This is most evident from clinicians' frequent use of the words "have to" when communicating with patients. Consider, for example, the following interchanges which we observed:

There is something I have to give you. I have to give you your rights.

We have to give you some idea of the treatment you will be getting.

At admission we have to tell the patient the general treatment plan and what the restrictions are.

These are Dr. _____'s initial findings. He has to tell you how he plans to treat you.

There is something else I have to let you know.

I, as a clinician, have to give you this choice.

In one extreme instance, we observed a nurse clinician telling a patient that, before he could see a doctor, he *had to* listen to his rights. At a

certain point while she was reading them, the patient forcefully interrupted her by saying: "Stop!" The clinician replied, "I am almost done," and continued reading. The duty to inform patients has become so bureaucratized that even when patients do not wish to hear their rights, clinicians may still feel that it is their duty to go through the procedure anyway. Thus, what was originally intended as a right has become a rite!¹³

From the standpoint of the informed consent doctrine, there are a number of major advantages to the dissociation of the information from the informer. And yet, the impersonalization of the responsibility for informing patients through the institutionalization of standard written communication has definitely brought about a substantial decrease in the *personal commitment* of the provider of the information to inform. Clinicians who hand standard forms over to patients obviously do not feel as personally committed to the information that is in them as they would were they to generate it themselves. Rather, they feel committed to it more as representatives of some impersonal, collective entity. This is quite evident from the way clinicians use first-person pronouns when presenting patients with information. In order not to be held personally responsible and accountable for the information which they convey, they very often tend to use the plural pronoun "we" instead of the singular "I"!

Conclusion

My purpose in this paper was to shed light on two major aspects of the bureaucratization of modern health care which pertain to information disclosure, namely the segmentation and the impersonalization of the responsibility for informing patients. Both seem to me to be structurally inevitable aspects of a process which underlies modern organizational life and cannot be ignored by anyone who is concerned with modern therapeutic relationships. The totally uninformed — or only partially informed — patient is highly characteristic of an organizational context within which no one is held fully, exclusively, and personally responsible for any particular patient. Phenomena such as "floating responsibility" do not necessarily result from the neglect of particular clinicians. Rather, they are manifestations of the structurally inevitable — even though unfortunate — consequences of the segmentation of responsibility which results from the multiplicity of caretakers in a modern therapeutic relationship. Along the same lines, statements such as "I, as a clinician, have to give you this choice" should not be seen necessarily as manifestations of personal indifference on the part of clinicians. Rather, they are manifestations of the structurally inevitable — even though probably pathetic — consequences of the impersonalization of the responsibility for informing patients. As for the use of standard written forms — it is important to remember that they were originally introduced in order to improve the situation regarding information disclosure. It is,

therefore, quite ironical that they happen to undercut the purposes and hurt the spirit — of the doctrine of informed consent.

The law has so far ignored the above-mentioned aspects of the bureaucratization of modern health care. Their significance should be taken into serious consideration whenever the implementation of the informed consent doctrine within the context of the hospital is attempted. While the law ought not to blindly follow the dictates of practical reality, its thorough implementation is doomed if its logic ignores a consideration of the logic of the actual structure of patient care in the modern hospital.

References

1. Meisel A, Roth LH, Lidz CW: Toward a model of the legal doctrine of informed consent. *Am J Psychiatry* 134(3):285-289, 1977
2. Durkheim E: *The Division of Labor in Society*. New York, Free Press, 1964
3. Gray BH: Some vagaries of consent. In: Katz J (ed): *Experimentation with Human Beings*. New York, Russell Sage, 1972, p. 661
4. Latané B, Darley JM: Bystander "apathy." *American Scientist* 57:244-268, 1969
5. Zerubavel E: *Patterns of Time in Hospital Life*. Chicago, University of Chicago Press, 1979, pp. 37-59. Zerubavel E: The temporal organization of continuity: The case of medical and nursing coverage. *Human Organization* 38:78-83, 1979
6. Gerth HH, Mills CW (eds): *From Max Weber*. New York, Oxford University Press, 1958, pp. 196-204. Weber M: *The Theory of Social and Economic Organization*. New York, Free Press, 1964, pp. 329-336
7. On the impersonalization of coverage, see Zerubavel E: *Patterns of Time in Hospital Life*, pp. 43-46
8. Zerubavel E: Private time and public time: The temporal structure of social accessibility and professional commitments. *Social Forces* 58:38-58, 1979
9. For further description of this form, see Ashley M, *et al.*: Legislating human rights: Informed consent and the Pennsylvania Mental Health Procedures Act. *Bull Am Acad Psychiat Law* (this issue)
10. Wolff KH (ed): *The Sociology of Georg Simmel*. New York, Free Press, 1950, pp. 352-355
11. Gerth HH, Mills CW (eds): *From Max Weber*, p. 197
12. Role distance. In: Goffman E: *Encounters*. Indianapolis, Bobbs-Merrill, 1961, pp. 85-152.
13. Katz J: (personal communication)