Excerpt from Nir Eyal, “Informed Consent,” Stanford Encyclopedia of Philosophy

5. Voluntary consent

When is consent sufficiently voluntary? Let us discuss three potential barriers to voluntariness: (1) literal coercion, (2) “undue inducement”, and (3) “no choice” situations.

5.1 Coercion

Voluntary consent is usually thought incompatible with [coercion](http://plato.stanford.edu/entries/coercion/), which philosophers define, roughly, as a threat to make someone seriously worse off than she is or should be, unless she consents. However, the prevailing medical ethos tends to set the threshold for condoning conduct as too coercive far lower than this definition would suggest. A threat to cause even slight pain unless a patient acquiesces would be taken to invalidate her consent. It would do so even if the patient and the physician have common knowledge that it would not make her seriously worse off and so, that it would not amount to coercion. A threat to deny care that is not otherwise owed—which therefore rarely amounts to a threat to make the patient worse off than she is or should be—unless the patient consents to an intervention would also be frowned upon.

How much do “implicit threats” count as threats? Imagine a practitioner who asks her own patient to participate in a study that the practitioner runs, and the patient fears that care would suffer if he declines, without the practitioner actually saying so. When the fear is well-founded and intentionally instilled by the practitioner, the norm has been to consider consent invalid. This clearly makes sense if what makes coercion problematic is (unjust) curtailment of options. However, even when the fear is unfounded and unintended, the hierarchy and the power inequality of the physician-patient relationship are often still thought to make such consent involuntary. The thought is that someone's options are curtailed even when what curtails them is her own psychological state; or that what matters for ascriptions of coercion or involuntariness is actual probabilistic impact on decision-making, and not some other conditions. Still, in such situations, the relevant psychological states probably do not obtain across the board and any presumption about involuntariness should remain defeasible.

5.2 Undue inducement

Another category often thought to undermine voluntariness is undue inducement, a term of art usually meaning that something is being offered that is alluring to the point that it clouds rational judgment, for instance cash in hand or airline tickets in return for kidney donation. Attention is fixated on the benefit, disallowing proper consideration of the risks from, say kidney loss or trial participation. The thought here is not that the offer is too good to decline rationally, but that, as in hypnosis, proper reasoning about it becomes impossible.

Basic questions about undue inducement remain under-explored. Is the size or benefit that constitutes undue inducement the same across individuals and income levels? Is it the same regardless of the risks taken in return for the benefit? What empirical questions would help address the preceding questions?

5.3 Only bad alternatives

In some areas of practical ethics, the lack of decent alternatives to accepting a bad offer, a so-called no-choice situation (Wertheimer 1987, e.g., p. 13), is said to make us forced or compelled to choose the offer (Cohen 1979), or to undermine voluntariness otherwise. While in such cases, the alternatives that we are compelled to avoid remain in principle open to us—the offer is not physically imposed on us, it is just bad—the same could be said of most literal coercion. In “your money or your life” situations, the option of dying remains open in principle. Consider then a poor person who knows that his only way to gain access to an expensive life-saving drug is to participate in a risky or very unpleasant study where the drug is provided free of charge. He is not, strictly speaking, coerced (Hawkins 2008, 24–5), but some believe that his consent is involuntary and the trial is unethical. None of the options available to him are decent.

There is a problem with this claim. Its logic suggests that whenever a sick, rich person has no decent alternative to taking a badly unpleasant life-saving drug, there is no voluntary consent, and drug delivery is therefore illegitimate. Even when the nasty side effects remain far better for her than her only alternative—to die of the disease—she is not providing voluntary consent to take the drug, and it is unethical to give it to her. Since the latter reasoning is surely flawed, the former reasoning may be flawed as well.

Some have responded that the poor man's inability to give voluntary consent to trial participation stems from injustice, not natural disease, and that this makes a big difference. But surely medical aid that saves consenting victims from the horrible results of *injustice* and carries unpleasant side effects can remain fully permissible. For example, following the 2010 earthquake in Haiti, it was fully permissible for the US military and its physicians to perform consensual life-saving leg amputations. It was permissible whether earthquake injuries were purely natural, partly the result of non-US injustice (self-initiated neglect of safety rules by local contractors), or partly the result of US-perpetrated injustice (long-standing US meddling in Haitian politics at the expense of accountability, including, downstream, accountability for neglectful construction projects).

A more promising way out is to say that consent is insufficiently voluntary when the patient's options are unfairly curtailed by the offer itself (Miller and Wertheimer 2010, 92, 97). “Your money or your life” offers curtail our options, and that is why these offers compromise our voluntariness. By contrast, the above-mentioned offers to the poor trial candidate and to the rich patient do not curtail options and they maintain voluntariness. This response notwithstanding, imagine impoverished potential study participants who lack alternative ways to obtain life-saving drugs. Imagine further that the investigators offer them these drugs whether or not they consent to participate, free of charge. The intuition is that this free, unconditional offer increases the voluntariness of these potential participants' decisions on whether to participate, and it makes their invitation to participate in the trial easier to defend ethically. The free offer keeps their options open and thereby, we feel, renders their consent more genuinely voluntary. Note, however, that the options that the offer opens for them are*not* ones that the invitation to participate would otherwise have curtailed.