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Practice of informed consent in Guangdong, China: a qualitative study from the perspective of in-hospital patients

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ABSTRACT

Objective This study aimed to investigate the practice of informed consent in China from the perspective of patients.

Design A qualitative study using in-depth interviews with in-hospital patients focusing on personal experience with informed consent.

Setting Guangdong Province, China.

Participants 71 in-hospital patients in rehabilitation after surgical operations were included.

Results Medical information is not actively conveyed by doctors nor effectively received by patients. Without complete and understandable information, patients are unable to make an autonomous clinical decision but must sign an informed consent form following the doctor's medical arrangement. Three barriers to accessing medical information by patients were identified: (1) medical information received by patients was insufficient to support their decision-making, (2) patients lacked medical knowledge to understand the perceptions of doctors and (3) patient–doctor interactions were insufficient in clinical settings.

Conclusions Informed consent is implemented as an administrative procedure at the hospital level in China. However, it has not been embedded in doctors' clinical practices because, from the perspective of patients, doctors do not fulfil the obligation of medical information provision. As a result, the informed part of informed consent was neglected by individual doctors in China. Reforming medical education, monitoring the process of informed consent in clinical settings and redesigning medical institutional arrangements are pathways to restoring the practice of informed consent and patient-centred models in China.

Strengths and limitations of this study

- This study used grounded theory as its methodology and in-depth interviews as its data collection method to achieve a deep understanding of the practice of informed consent in China.
- All participants were in rehabilitation and recruited from hospitals; hence, the qualitative data of this study are reliable.
- This study is a cross-contextual study exploring the barriers of informed consent, a Western origin moral guide applied to the context of China.
- Data collection was limited to Guangdong, one of the most developed provinces in China; further research in other provinces, especially less-developed provinces, is needed to maximise generalisability.
- In order to further investigate the practice of informed consent in clinical settings, the views of medical doctors may be needed in future studies.

INTRODUCTION

The economic reform launched in 1978 profoundly changed every corner of Chinese society by introducing market mechanisms to the national economy. Healthcare, like many other sectors, has been experiencing dramatic marketisation in China.[1] With the advent of reform, the Chinese government gradually reduced the state budget for healthcare and pushed hospitals to become self-funded. In order to sustain themselves, hospitals had to maximise revenue by selling medications and charging patients for medical examinations.[2] Currently in China, doctors' income is divided into two parts: one part is the basic salary paid by the state; the other is called the performance-related salary based on the revenue made by individual doctors for the hospital. This revenue-driven framework has led to widespread corruption because of financial incentives, leading to excessive testing and procedures, the overprescription of medications, kickbacks from drug companies and so forth.[3] Many researchers argue that one negative consequence of the marketisation of China's healthcare system is the increasing distrust between patients and doctors.[4–7]

In 2009, the Chinese central government launched the New Healthcare Reform by issuing (The Opinions of the Communist Party of China Central Committee and the

State Council on Deepening the Health care System Reform), with the aim of delivering quality and timely healthcare services to patients, providing more comprehensive medical insurance to Chinese citizens and improving the poor patient–doctor relationship. Despite this reform, research has suggested that patient–physician relationships in China have worsened in recent years because of distrust.[8 9] Notably, medical disputes and violence against doctors in China have been reported as an increasing problem.[10–12]

Informed consent is believed to be an effective approach to building mutual trust between clinical practitioners and patients.[13] In the last century, the ethics of clinical practice and scientific research involving human subjects have profoundly changed from a paternalistic model to a patient-centred approach. The idea of informed consent has therefore become a practical principle for healthcare and medical research. Informed consent empowers patients to establish dialogue with doctors in clinical decision-making and to make autonomous decisions by addressing power imbalances between medical professionals and vulnerable patients. Under this paradigm, doctors' obligations are to provide proper and sufficient medical information about a patient's condition and available treatment options.[14 15] In addition to information disclosure, informed consent must also consider patients' voluntary choices and decision-making capacity. Capacity is the ability to understand the information provided by clinicians, ask questions and express concerns before giving consent to certain treatments.[16 17] In practice, obtaining informed consent is sometimes considered a one-time formality in which patients are presented with a written document,[18] but it should be an interactive process in which medical practitioners communicate to the patient accurate information regarding conditions, possible consequences of treatment and all other information considered helpful for patients giving consent.[19]

The concept of informed consent originated in the West and was based on Western liberal individualism, in particular, the notion of autonomy.[4] The intellectual foundation of informed consent is based on human rights, a core value in Western society. Thus, informed consent procedures have been systematically ingrained into the healthcare system of Western countries.[14 20] However, Confucianism has dominated Chinese culture and moral tradition for thousands of years until the establishment of the People's Republic of China. Even today, many Chinese people still adhere to traditional Confucian moral values. In the Confucian model, Chinese traditional society was a hierarchical society of patriarchal clan systems, under which the autonomy and rights of individuals were completely submerged by family interests. Chinese traditional culture stressed an individual's moral obligations to the family or clan but did not address individual rights. Therefore, the notion of 'human rights' has never appeared in Chinese classical literature.[21]

Due to cultural differences between China and the West, informed consent is introduced to China at legal and institutional-level initially and thereafter implemented in clinical practices.[21] The earliest document that codified 'consent' is (The Hospital's Work Institution) promulgated by the Ministry of Health in 1982, which says 'consent (or signature) must be obtained from the representative of patients' family or employer before conducting surgical operation, but this regulation was not compulsory for superficial surgeries'. In (The Administrative Rules of Medical Institution) (1994), the State Council acknowledged the importance of consent by individual patients or their family members before conducting surgical operations, special tests and special treatments. Yet, these two early regulations only describe the presence of consent without addressing information provision. In order to resolve and prevent patient–doctor disputes, simple consent was replaced by informed consent in the healthcare system when the term 'informed consent' was codified in (Practitioner Law of the People's Republic of China) (1999) and (The Regulation on the Handling of Medical Accidents) (2002).[4 22]

Theoretically, the implementation of informed consent, described as making autonomic clinical decisions based on adequate medical information, is a way to improve patients' trust in doctors. In practice, however, Tucker *et al*[23] reported that high levels of mistrust still exist in China,[9] although Chinese regulations and laws require doctors to implement informed consent in everyday clinical care. Informed consent has drawn considerable attention from the Chinese academic community. A large body of research has focused on legal issues,[24–26] the consent capacity of cognitively impaired and learning-disabled patients,[26 27] and the issues of decision-making by family members.[22 28] Some researchers argue that medical education and training in China focus too much on technical skills and research skills. The National Qualification Examination for Medical Practitioners only assesses technical skills, and research skills are considered useful for increasing publication volume.[29 30] Both teachers and students in medical schools treat medical ethics as a non-essential module so it is generally only learnt through textbooks, without case studies and on-site teaching. Assessments are merely paper-based exams.[31 32] Given the persistently high levels of mistrust in clinical settings and the absence of ethical training in medical education and training, it is necessary to understand patients' experiences and perceptions of the informed consent process in China. This study aims to contribute to the evidence-based literature on distrust to improve patient–doctor relationships.

METHODS

Study design

Overall, this study is informed by grounded theory, a systematic methodology in the social sciences.[33] Grounded theory starts from qualitative data collection and analysis to construct theories as opposed to the traditional model of research, which requires first building a theoretical

Table 1 Overview of sampling at each hospital

	No of participants
Hospital 1 Tertiary referral hospital	28
Hospital 2 Tertiary referral hospital	24
Hospital 3 University Teaching Hospital	19
Total	71

framework.[34] In order to develop deep understanding of the practice of informed consent from the perspective of patients, we used in-depth semistructured individual interviews and thematic analysis.

Sampling and participant recruitment

A purposive sampling strategy was adopted because inpatients in rehabilitation have more experience with informed consent and opportunities to communicate with doctors compared with outpatients. We selected three hospitals as field sites in Guangdong Province. This province was chosen because its medical capacity and services are considered to be one of the highest in China, and numerous patients from other parts of China seek medical care in the large hospitals of Guangdong Province (table 1). Another reason for this selection was the accessibility to hospital leaders.

According to this sampling strategy, participants must fulfil two criteria: (1) in-hospital patients after surgical operation and (2) aged over 18 years. In order to establish credit, one of the research team members (YC) led the recruitment with the assistance of nurses, explaining the background, aims and significance of the study. The nurses made recommendations for recruitment based on their assessment of the physical capability and mental state of patients. Only patients who were willing to give verbal consent to participate in the study were recruited. Two postgraduate researchers (XW and JC) subsequently approached the individuals to schedule interviews. The recruitment process continued until data saturation, that is, no further themes could be found. In total, 71 in-hospital patients have participated in the study (table 2).

Data collection

Data collection was conducted between February and April 2014 by the researchers (XW, XL, GC and JC) who have solid experience in conducting interviews in hospital settings. The interviews occurred in the inpatient wards of research participants or private rooms in each hospital on request and lasted 45–90 min.

Before the interview, the researcher provided the participant with a set of information sheet and consent form. At the same time, the researcher briefly described the purpose and significance of the study and explained that this study protected patient privacy by anonymously processing and using data. In addition, participants were also advised that they could decline to answer any question during the interview or withdraw their participation at any time in the research process. The interview formally started after both participant and researcher had signed the consent form. The interviews followed a question guide including personal background, current health status, experiences with medical treatments, decision-making process and interaction and communication with doctors (online supplementary file). The guide was adapted during fieldwork to accommodate emerging themes. All interviews were audio recorded unless participants declined.

Table 2 Demographic characteristic of participants

Characteristic	Category	No of participants
Gender	Male	33
	Female	38
Age (years)	20–29	10
	30–39	9
	40–49	12
	50–59	20
	Above 60	20
Education level	Secondary	30
	Higher education	41

Data analysis

Audio-taped interviews were transcribed anonymously in Chinese, and a thematic analysis was applied to the transcripts by using Atlas.ti software. As this study is informed by grounded theory,[33] the analysis and development of coding framework were performed by two researchers (NG and YZ): (1) NG and YZ analysed the initial five transcripts and develop a draft coding framework by line-by-line coding, respectively. After a careful comparison and discussion on divergences between NG and YZ, the open coding was finalised. (2) To further develop axial coding, a team discussion was organised in which all authors categorised and regrouped the codes by reading and discussing the open coding, analytical memos developed by NG and YZ and coded transcripts. A draft axial coding, therefore, was built up after the discussion. (3) NG and YZ revised the draft axial coding and wrote memos, respectively, by analysing another five transcripts. The revised axial coding, memos and coded transcripts were presented to and discussed by all authors until a consensus on finalised axial coding had been made. (4) NG and YZ, respectively, analysed the next five transcripts by using the axial coding, and wrote memos and organised codes accordingly focusing on developing categorises that capture the inadequacies of the practice of informed consent. (5) To identify the selective coding/themes, a team discussion was organised enabling all authors to compare and discuss codes, analytical memos and coded transcripts. This coding framework was then applied to

all transcripts. In order to ensure the quality of the data collection and data analysis, the research team launched a series of meetings every 2 weeks to discuss interview guidelines and themes and compare coding trees.

Patient and public involvement

Two patient advisers involved in the research at an early stage in order to help us to refine the interview question guide. They were also invited to attend a workshop organised by the research team and made valuable comments for future research. We will disseminate the research results to study participants and the public via the WeChat platform which is a popular social network APP in China nowadays.

RESULTS

All participants stated that they had signed informed consent forms before surgery. However, rather than consenting based on sufficient information, patients signed these forms due to hospital regulations. The empirical data suggested that patient faced barriers in medical information acquisition that caused them to consent based on incomplete information. We, thus, categorised empirical data into three themes: inadequate information provision, medical knowledge disparities between patients and doctors, and insufficient patient–doctor interaction with regard to medical information acquisition.

Inadequate information provision

The idea of informed consent emphasises that the patient's right to know, to choose and to be respected are fundamental human rights.[35] In the practice of medicine, the patient's right to access information is a prerequisite to participate in clinical decision-making. However, patients reported that providing medical information was not embedded within the doctors' routine work, as revealed by the following patient's narrative:

> In my initial appointment with a consultant, he just asked me three questions: 1) What's your problem? 2) How do you feel now? 3) How long has it been like this? He then prescribed me a list of medical tests and asked me to leave for the examination room. When I tried to ask why I should take those tests, he had already called the next patient in. I think he spent less than three min talking to me. (aged 30–39, male)

This narrative revealed that Chinese patients often receive inadequate information from their doctors with regard to their condition, prescription and medical options. Even when doctors had time to provide reassurance, patients reported that doctors still omitted important information:

> The doctor just told me her decision but never explained why her decision is the best for my condition. Mostly, she only told me something like 'relax', 'take it easy', 'don't worry' and so on. This kind of information means nothing to me and makes me very nervous. (aged 30–39, male)

In addition, when doctors mentioned informed consent, it was typically in the context of following hospital regulations.

> He [the doctor] told me not to be worried because he had already found the way to treat my condition. He also said that, due to regulations, I should sign an informed consent form so he would be able to do the surgical operation for me. (aged 20–29, female)

In addition to clinical decision-making, patients' frustrations with their medical bills reflected the inadequate information they received. Overprescribing is regarded by Chinese patients as an ordinary measure to maximise the hospital's or an individual doctor's revenue, particularly when patients have not received necessary information about payment, as stated in the following quotation:

> During hospitalization, I saw an expensive daily bill with a long list of charges. You know, I'm not very clear about these items or services because nobody had explained them to me before, like why I need each item and service and why they are so costly. I attempted to seek explanations from the doctors and they just said these items are good for my condition. So, I think as long as these items are not harmful to me, I took them without any choice. (aged 40–49, male)

Other patients linked the inadequate clinical information they received with doctors' financial motives.

> Money, money, only money is their [doctors'] concern. I moved to this hospital as my previous doctor suggested. The doctor in this hospital prescribed me several expensive tests, which I'd already done before in the previous hospital. I did ask him why, but he just replied, 'This is the process that new patients must follow.' You know what? The test results didn't show anything different from the previous tests. This makes me feel bad. (aged 30–39, male)
>
> These doctors are robbers. The only thing they care about is making money. I get injected every day. They don't even make it clear to me why I need so many injections. (aged 40–49, female)

The above two quotations demonstrated that patients viewed themselves as disadvantaged in the lopsided patient–doctor relationship, which favours the doctor's financial interests over clinical benefits.

Medical knowledge disparities between patients and doctors

When patients were provided with medical information, they often reported limited comprehension, in contrast to the requirements of informed consent and principles of autonomy. One patient stated,

> Although I agreed and signed the informed consent form, I still worry about my condition and treatment

because I couldn't fully understand what the doctor told me in terms of my treatment. (aged 20–29, female)

Even in the case of doctors who were willing to provide explanations to patients, disparate level of medical knowledge between doctors and patients was an obstacle resulting in patients' lack of understanding and uncertainty.

A patient with colorectal cancer said,

I had talked with my doctor with regard to my condition, but I was unable to understand his words because he used English abbreviations a lot. For example, I still don't know what FAP is and its proper Chinese translation. (aged 40–49, female)

Another patient complained,

The doctor told me that he would consider using the PPH to treat my condition. However, I completely have no idea about the PPH and what the difference is between ordinary operations and PPH at all. (aged 20–29, male)

Overuse of medical jargon or doctors' habit of communicating with patients using medical terminology[36] showed that doctors did not think from the perspective of patients. In an exchange riddled with medical terms, such as exemplified in the above cases, a patient would likely find it was difficult to understand the doctor's message, such as the term (familial adenomatous polyposis) and PPH (stapled haemorrhoidectomy). Today, Chinese doctors are obliged to obtain informed consent from patients like their peers in Western countries. To help patients make clinical decisions, doctors should give patients necessary information about their condition, treatment options and potential risks. Nevertheless, most doctors communicated with patients using professional and scientific language. As a result, patients may still be unclear about their treatment. In effect, there was an enormous gap between knowing something and understanding something.

Insufficient medical knowledge might hinder the ability of patients to understand doctors' remarks; patients then had to try other approaches to understand the meanings and implications of those remarks. Our observations showed that patients frequently consulted doctors about their condition based on information retrieved from online search engines during morning rounds. The interviews echoed this point as many patients trusted information from relatives/friends and online sources more than information from doctors simply because they could not understand medical jargon. This conclusion was demonstrated in the following statement:

People always say that we should follow the instructions of doctors. I agree because my life is in their hands. I remember, once I wanted to know more details about my condition, and I asked my doctor to explain a medical term. The doctor was nice and spent about another five min talking with me. But what he explained made me more confused because he introduced several new medical terms in his words. What I can do is to write down these medical terms and resort to Baidu [a popular Chinese search engine]. (aged 30–39, male)

Sometimes I want to yell at the doctor, 'Please speak human language' because our talk is so weird, just like a duck speaking to a chicken (Cantonese slang). In my hometown, if somebody was ill, his/her friends and relatives would sit together and share the information and knowledge by word of mouth. (aged 50–59, female)

Insufficient patient–doctor interaction

The insufficient information received by patients and different levels of medical knowledge between patients and doctors may create serious misunderstandings that further lead to patients' mistrust. This problem should be addressed through patient–doctor interactions in which patients have opportunities to understand the rationale for diagnosis and treatment and to ask questions. In reality, however, doctor may not have time and energy to communicate and inform individual patients because of heavy workloads.[9] This is due to the fact that the medical system and healthcare provisions are crowded as a large number of patients bypass primary care and seek medical care directly from large hospitals in urban area.[37]

Patients often reported perceptions of mistrust in the patient–doctor relationship from both parties stemming from poor rapport.

My doctor said that I don't trust him and the nurses. But do they trust us? When did they listen to us carefully? They rush in and out so I even can't find a time slot to talk to them. (aged 40–49, male)

That was the day before my operation. When I saw him [the doctor] in the ward, I couldn't help asking questions about my condition, the operation and so forth. He responded to my questions while walking, without looking at me. His voice became lower and lower until I could barely hear it; he then went out of my ward. (aged 30–39, female)

It was normal for patients to attempt to seek more detailed information on other occasions, such as in the ward or corridor, if they felt their interaction with doctors was limited in the consulting room. In addition, patients felt that doctors' body language and tone often detracted from their ability to obtain medical information. Some doctors neglected the patient's desire for further information, as described in the following interviews:

I overheard two doctors' conversation in which they said some patients are poorly educated because these patients kept asking similar questions although they had answered them before. The doctors should stop complaining because it is reasonable that we are unable to understand their professional words. If we

asked for detailed information, we can feel a hint of impatience in their tone. (aged 40–49, female)

I don't want to speak with the doctors, so I let my son handle them. I could never understand their words anyway, and I hate the sign of impatience on their faces. (aged above 60, male)

DISCUSSION

This study found that inadequate information provision, medical knowledge disparities between patients and doctors and insufficient patient–doctor interactions constitute three barriers to patients' access to information in clinical settings. The practice of informed consent in China remains problematic because informed consent is enshrined in regulations and the law, but not practised in reality. Both information provision to patients and consent making by patients are clearly codified as important elements in (Practitioner Law of the People's Republic of China) (1999) and (The Regulation on the Handling of Medical Accidents) (2002). In practice, however, patients' right to be fully informed, particularly to understand clinical information, is neglected by doctors. This leaves little room for patients to make autonomous clinical decisions based on complete and comprehensible information. In this sense, Chinese patients must sign informed consent forms as a part of doctors' rote practices rather than as autonomous agents.

Our findings suggest that medical information is not actively conveyed by doctors nor effectively received by patients. The information provided by doctors is considered minimal by patients and lacks detailed explanations of some core elements, such as the patient's condition, treatment options, medical recommendations and economic factors. Power dynamics between doctors and patients may provide a clue to explain this phenomenon. The traditional patient–doctor relationship is doctor centred and paternalistic because doctors dominate information and knowledge. The purpose of requiring informed consent in clinical settings is to rebalance the power structure between doctors and patients by limiting doctors' power over patients' interests and empowering patients to make autonomous clinical decisions for their own health. Nonetheless, the traditional doctor-dominated model is still prevalent in China, and giving sufficient and understandable information to patients is considered by some doctors to be irrelevant to conducting medical practice.[4] From the patient's point of view, the absence of key explanations may lead to a severe conflict of interest, that is, doctors and hospitals attempt to maximise revenue by exploiting patients and placing financial interests over the patient's clinical benefits. Given the fact that corruption is considered widespread in China's healthcare system,[3 32] patients tended to be sceptical of clinical recommendations by doctors, in particular those that entail significant cost.[5] We do not mean to imply that every doctor tries to hide information in order to maximise profit. Yet, if patients receive detailed information on all aspects of their treatment and understand the justifications for out-of-pocket share of healthcare expenditures, trust will improve in general.

Our data suggest that inadequate information may result from medical knowledge disparities and insufficient interaction between patients and doctors. Many patients cannot fully understand what doctors tell them due to the asymmetry of professional knowledge between doctors and patients. Patients normally lack the capability to inquire about or scrutinise the medical options and recommendations made by doctors, which leaves them little choice but to follow the doctor's advice. To cope with their state of powerlessness, Chinese patients often attempt to obtain quality healthcare through informal approaches. It is unsurprising for patients to use strategies such as establishing personal relationships (Zhao *et al*) with medical professionals and bribing doctors with red packets (Hong Bao) to access medical care in China.[38] Researchers have proposed the idea of the 'moral stranger,' arguing that doctors and patients come from different cultural backgrounds whose values and perceptions vary.[39] Our research found that doctors had neither attempted to understand patients' values and perceptions nor actively investigated their implications for medical practices. Medical jargon, as we have discussed, cannot meet the patient's need for information.

The empirical data from our research also revealed that patients' dissatisfaction and complaints stemmed from insufficient communication in their interactions with doctors. Patients' activities of seeking medical care are unregulated in China for two reasons. On the one hand, China did not have a comprehensive primary care system and referral system until 2009 when the Chinese government launched the new medical reform, in which a comprehensive community-based primary care system covering both urban and rural areas was considered one of six main tasks. On the other hand, visiting primary care institutions is not compulsory. Thus, numerous patients seek medical care from large hospitals in urban areas without a referral from a primary care institution. Doctors in large hospitals must cope with the heavy pressure of an intense workload, such as seeing 40–60 outpatients within a 4-hour outpatient shift or performing 6–8 surgical operations per day.[23] This does not allow doctors to elicit detailed information from patients nor motivates doctors to address patients' desire for further information.

Our research has several limitations. First, we limited data collection to one province, which is one of the most developed provinces with a high-level medical capacity in China. Further research in other provinces and regions in China is necessary to improve generalisability. Second, our investigation focused on tertiary referral hospitals in urban areas without examining township-level hospitals. Third, our study did not focus on outpatients. Fourth, although the purpose of our study was to investigate the practice of informed consent from the perspective of patients, the perspective of medical doctors would add to

our understanding of how informed consent changes the doctor–patient relationship.

In this paper, we showed that the nuances within informed consent have not drawn much attention from the medical profession in China. This phenomenon reflects an imbalance between patients and doctors. Patients are clearly disadvantaged as they give consent for many treatments despite not being fully informed. Their doctors' power, underpinned by expertise and knowledge, can dominate the entire process of healthcare provision. Theoretically, informed consent is a way to empower patients power in the imbalanced patient–doctor relationship and thus improve patients' trust in doctors. However, informed consent requires complete and thorough information provision by doctors. In practice, the implementation of informed consent is problematic because, from the perspective of patients, doctors frequently failed to provide sufficient information. Given the complex medical landscape of China, the reasons are multiple: (1) Doctors might lack ethical training and/or communication skills; (2) Heavy workload assigned to doctors could limit patient–doctor communication and (3) Corruption in China's healthcare system.

Patient–doctor distrust and various issues relating to informed consent, in particular the informed part of informed consent, are results of the absence of patient-centred care in clinical practice and the healthcare system in China. Although inadequate information provision, medical knowledge disparities between patients and doctors and insufficient patient–doctor interactions may hinder patients' access to information in other contexts, these issues are improved in the West because humanistic and patient-centred care have been embedded into medical training and clinical practices. For instance, the medical schools in the UK and USA emphasise ethical training, and the cultivation of humanistic skills. Both are assessed in the medical licensing examinations. Apart from technical skills, clinical communication, managing patients' concerns and maintaining patient welfare are core skills assessed in the Membership of the Royal Colleges of Physicians (UK) Part 2 Clinical Examination (Practical Assessment of Clinical Examination Skills) (www.mrcpuk.org); While the United States Medical Licensing Examination Step 2 Clinical Skills also 'test medical students and graduates on their ability to gather information from patients…and communicate their findings to patients…' (www.usmle.org/step-2-cs/). Apparently, medical information provision is well addressed in the UK and USA.

To promote the practice of informed consent in China's healthcare system, humanistic training in areas, such as communication skills, medical ethics and professionalism, must be given more weight in the medical school curriculum and licensing process by medical policy-makers. Furthermore, to address the difficulties surrounding informed consent, we propose that hospitals ought to pay particular attention to informed consent and monitor its implementation in clinical settings by emphasising the informed part of the consent process. Lastly, more appropriate institutional arrangements are needed to improve medical services, such as maintaining reasonable and controlled workloads enabling doctors to communicate with patients and respond to patients' concerns and questions, breaking the link between medical staff bonuses and the revenue of hospitals, implementing a zero-tolerance policy on the acceptance of bribes, favours and any other side payments, and regulating how patients seek medical care through behavioural interventions to promote care seeking at primary care institutions.

CONCLUSION

This paper discussed the practice of informed consent in China and found out that the informed part of informed consent was neglected by individual doctors as doctors do not fulfil the obligation of information provision from the perspective of Chinese patients. This phenomenon resulted from inadequate information provision, medical knowledge disparities between patients and doctors and insufficient patient–doctor interactions. Drawing on the experience of the Western countries, such as the USA and UK, we suggest that reforming medical education, monitoring the process of informed consent in clinical settings and redesigning relevant institutional arrangements are pathways to improve the practice of informed consent in China.

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