Int. J. Sci. R. Tech., 2026 3(8)
A Multidisciplinary peer-reviewed Journal
www.ijsrtjournal.com [ISSN: 2394-7063]

Original Article

Informed Consent Under Institutional Control: A Normative-Doctrinal Framework For Medical Autonomy

Ishaan Deepak Joshi*

Forensic and Criminal Intelligence Expert, Founder and Director - Centre for Crime Sciences and Forensic Intelligence (CCSFI), Pune, Maharashtra, India

ABSTRACT

Informed consent is a principal mechanism through which medicine recognises patient autonomy, yet formally valid consent may not establish that a decision is genuinely autonomous where institutional power structures the conditions under which choices are made. This problem is especially acute in prisons, involuntary psychiatric facilities, secure hospitals and comparable high-control settings. This study develops a normative account of medical autonomy under such conditions through qualitative normative-doctrinal analysis of bioethical scholarship, professional standards, international human-rights instruments and literature on voluntariness, relational autonomy, structural coercion, prison healthcare, involuntary psychiatry and dual loyalty. The analysis identifies five recurrent vulnerabilities: constrained option structures, institutional leverage, epistemic dependence, dual loyalty, and deficits in contestability and exit. In response, it proposes an Institutionally Situated Autonomy framework requiring decisional capability, informational integrity, freedom from institutionally generated retaliation or leverage, meaningful option sufficiency, relational and professional independence, and contestability and reversibility. The framework treats institutional control as generating positive autonomy obligations: the greater the institution's control over the patient's decision environment, the stronger its duty to preserve meaningful conditions of choice. Consent remains necessary in high-control medicine, but it should not be treated as self-validating proof of autonomy. Ethical evaluation must consider not only whether permission was obtained, but whether refusal, questioning and reconsideration were genuinely possible.

Keywords: Informed consent; Medical autonomy; Institutional control; Coercion; Prison healthcare; Relational autonomy.

INTRODUCTION

Respect for autonomy occupies a central position in contemporary biomedical ethics. In its conventional clinical expression, respect for autonomy requires clinicians to recognise patients as persons entitled to deliberate about healthcare in accordance with their own values and to accept or refuse interventions without improper interference. Informed consent translates this ethical commitment into a practical decision-making process. Its familiar components include adequate disclosure, understanding, decisional capacity, voluntariness and authorisation. In medical law and clinical practice, these requirements have become so closely associated with autonomy that the presence of valid consent is frequently treated as sufficient evidence that patient autonomy has been respected.

That association is useful but incomplete. Consent is an event or process through which permission is communicated. Autonomy concerns the conditions under which a person governs a decision as their own. The two concepts substantially overlap, but they are not interchangeable. A patient may possess decision-making capacity, receive formally adequate information, articulate a preference and sign a valid form while still making the decision within a social or institutional structure that has materially shaped what can safely, realistically or intelligibly be chosen. Conversely, the existence of interpersonal influence does not itself destroy autonomy. Decisions are ordinarily made through relationships, dependencies, expectations and practical limitations. The ethical question is therefore not whether influence exists, but whether the environment surrounding a decision

Relevant conflicts of interest/financial disclosures: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

preserves sufficient conditions for the choice to remain meaningfully attributable to the patient.

This distinction assumes particular importance in what this article terms **high-control medicine**. High-control medicine describes healthcare delivered in an institutional environment in which the same institution, or an authority closely connected to it, controls substantial aspects of the patient's liberty, movement, privacy, material conditions, communication, access to professionals, exposure to surveillance, or susceptibility to sanctions. Prisons are a paradigmatic example. Psychiatric detention and secure hospitals can present comparable problems, although the clinical and legal reasons for confinement differ. Other environments may become high-control settings when institutional dependency is sufficiently extensive. The concept is therefore functional rather than merely geographical. A patient is not placed within the category simply because treatment occurs in an institution. The relevant question is whether institutional power materially structures the circumstances in which the healthcare decision is made.

International ethical standards already recognise that deprivation of liberty does not extinguish ordinary medical rights. The United Nations Standard Minimum Rules for the Treatment of Prisoners, commonly known as the Nelson Mandela Rules, preserve professional ethical standards in prison healthcare and expressly protect prisoners' autonomy in relation to their own health. The United Nations Principles of Medical Ethics applicable to prisoners and detainees similarly insist that health personnel owe incarcerated persons the same fundamental healthcare protections as those afforded to persons who are not imprisoned. Professional literature has nevertheless documented the recurrent problem of dual loyalty, in which healthcare professionals face simultaneous obligations or pressures arising from the interests of the patient and the demands of the institution responsible for confinement. Contemporary scholarship in *BMC Medical Ethics* has likewise identified continuing difficulties involving confidentiality, professional independence, equivalence of care and the preservation of bioethical principles in prison health systems.

Institutional control is relevant not only because an authority can issue an explicit threat. Power may operate more subtly. The patient may depend upon the institution for transportation to appointments, continuation of medication, access to specialist assessment, privacy during consultations, communication with family, conditions of detention, records, referrals or practical opportunities to challenge a decision. A person need not be told, “Consent or you will be punished,” for institutional dependency to influence decision-making. The structure of available alternatives may itself communicate what resistance will cost.

The distinction between decisional capacity and voluntariness is therefore essential. Capacity ordinarily concerns abilities such as understanding relevant information, appreciating its significance, reasoning about options and communicating a choice. Voluntariness concerns whether the decision can be made without controlling influence of a kind incompatible with self-determination. Roberts has argued that voluntarism is conceptually distinct from decisional capacity and concerns the person's ability to act in accordance with an authentic judgment about what is best in light of their situation and values. A person may consequently understand a treatment perfectly while confronting pressures that compromise the voluntariness of acceptance or refusal. Psychiatric research further demonstrates why detention or psychiatric diagnosis should not automatically be equated with incapacity: capacity requires decision-specific assessment rather than status-based inference.

The shortcomings of an excessively individualised model of autonomy have generated extensive relational-autonomy scholarship. Relational theories do not necessarily reject individual agency. Rather, they emphasise that agency is socially formed and exercised through relationships, dependencies and structures that can either support or undermine self-determination. A systematic review of argument-based ethics literature in *BMC Medical Ethics* found that relational autonomy has been used to challenge oversimplified portrayals of autonomy as isolated, context-free independence while also revealing the need to translate relational insights into clinically usable standards. The present article responds to that

translational problem in a specific domain: medical choices made under institutional control.

Structural approaches to voluntariness provide an additional foundation. Fisher's account of structural coercion argues that the ethical assessment of voluntariness cannot be limited to direct interpersonal threats when social and economic structures can create powerful pressures surrounding consent. Wilkinson and Levy have more recently argued that informed consent need not be free from every influence; instead, decision-making should be appropriately protected and supported against influences that compromise authorship of the decision. Taken together, these approaches suggest that the ethical analysis of consent should extend beyond the immediate interaction between clinician and patient.

This issue has practical consequences. Consider a person in prison who agrees to psychiatric medication after being told that treatment may improve symptoms. At the level of conventional consent, the relevant questions include whether the patient understands the medicine, its risks, benefits and alternatives, has capacity and accepts voluntarily. Yet additional questions arise if refusal is understood by custodial staff as evidence of non-cooperation, if consultations occur within hearing of security personnel, if no independent second opinion is realistically available, if the prescribing clinician contributes to institutional risk decisions, or if the patient reasonably believes that disagreement will affect privileges or conditions. None of those factors automatically invalidates consent. Collectively, however, they change the ethical meaning of the apparent choice.

A similar problem arises in involuntary psychiatric care. Detention and treatment are conceptually distinct exercises of authority. A patient can lack legal freedom to leave an institution while retaining capacity to make particular treatment decisions. Ethical difficulty arises if the compulsory nature of detention silently migrates into an assumption that ordinary treatment preferences carry diminished weight. Conversely, an insistence that every choice made in detention must be treated as non-voluntary would be equally mistaken. Such a position would erase rather than protect agency. The task is to identify which institutional conditions are ethically relevant and to determine what additional safeguards are required when institutional power is substantial.

Existing international instruments support this contextual orientation. The Universal Declaration on Bioethics and Human Rights places prior, free and informed consent at the centre of medical intervention. The Convention on Human Rights and Biomedicine likewise establishes free and informed consent as a general rule while providing defined exceptions under law. The World Medical Association's Declaration of Lisbon recognises patient self-determination and the right to make free healthcare decisions. Rights-based mental-health guidance has increasingly emphasised supported decision-making, person-centred care and alternatives to coercive practices. These instruments differ in legal status and scope, but they converge around the proposition that autonomy cannot be reduced to professional beneficence or institutional convenience.

The present study therefore asks a normative question: **when does formally adequate consent fail to constitute sufficient evidence of respect for autonomy because the decision is made under conditions of institutional control?** A second question follows: **what additional ethical requirements should govern healthcare decision-making when institutions exercise substantial control over the conditions surrounding choice?**

The purpose of this article is not to argue that patients in controlled institutions are presumptively incapable, nor that all institutional influence constitutes coercion. It instead develops a middle position. Autonomy remains possible under substantial constraint, but protecting it requires more than verifying the internal cognitive competence of the patient and the informational adequacy of the consent encounter. The article proposes an **Institutionally Situated Autonomy (ISA) framework**, according to which respect for autonomy in high-control medicine requires assessment of both the patient's decisional agency and the institutional architecture within which that agency is exercised.

MATERIALS AND METHODS

Study aim and design

This study used a qualitative normative-doctrinal design. Its purpose was to identify the ethical and normative conditions under which informed consent can constitute adequate evidence of autonomous healthcare decision-making in settings characterised by significant institutional control. The study did not involve human participants, patient records, clinical interventions, questionnaires, interviews or experimental data. It instead analysed published bioethical scholarship, professional ethical standards, international human-rights instruments and normative materials relevant to medical autonomy, voluntariness, coercion and institutional healthcare.

Normative-doctrinal analysis was selected because the research question is evaluative rather than epidemiological. It asks what respect for autonomy requires when healthcare choices are embedded in asymmetrical institutional structures. The analysis therefore distinguishes descriptive propositions about institutional conditions from normative conclusions concerning what clinicians and institutions ought to do. This approach is consistent with the journal's recognition of theoretical and context-dependent normative ethics as legitimate forms of medical-ethics scholarship and with established argument-based approaches to bioethical literature.

Materials and source identification

The normative corpus was purposively constructed around five bodies of material. The first comprised foundational scholarship on autonomy and informed consent, including principlist accounts, theories of informed consent, individual autonomy, relational autonomy, clinician-patient relationships and voluntariness. The second comprised international instruments addressing consent, healthcare rights, disability, detention and medical ethics, including the Universal Declaration on Bioethics and Human Rights, the Convention on Human Rights and Biomedicine, the Nelson Mandela Rules, the United Nations Principles of Medical Ethics applicable to prisoners and detainees, and relevant World Medical Association standards.

The third body of material concerned healthcare under detention, including prison medicine, dual loyalty, professional independence and the ethical position of persons deprived of liberty. The fourth concerned psychiatric decision-making, involuntary treatment, capacity and alternatives to coercion. The fifth comprised rights-based materials on supported decision-making and person-centred mental healthcare.

Sources were identified through targeted searches of PubMed, Springer Nature Link and official repositories of international organisations, supplemented by citation chaining from relevant peer-reviewed publications. Search combinations included terms relating to “informed consent,” “autonomy,” “voluntariness,” “coercion,” “relational autonomy,” “prison,” “detention,” “psychiatry,” “involuntary treatment,” “dual loyalty,” “supported decision-making” and “institutional” healthcare. Foundational theoretical works were retained irrespective of publication date because the purpose was conceptual and normative synthesis rather than estimation of a contemporary intervention effect.

Priority was given to peer-reviewed bioethics and medical literature, authoritative professional ethical instruments, and international normative documents with direct relevance to healthcare. Sources concerning research consent were included selectively where their analysis of voluntariness or structural coercion generated concepts transferable to clinical consent. Materials were excluded from the core analysis where they concerned autonomy only in an abstract philosophical sense without identifiable relevance to healthcare decision-making.

The search was purposive rather than a systematic review intended to exhaustively enumerate every publication concerning autonomy or coercion. Accordingly, no claim of exhaustive coverage, meta-analysis or quantitative representativeness is made.

Doctrinal mapping

The first analytical stage mapped the obligations and concepts contained in the selected normative materials. Particular attention was paid to references to free and informed consent, withdrawal of consent, self-determination, equality of healthcare standards, professional independence, confidentiality, supported

decision-making, coercion, detention and medical duties toward persons deprived of liberty.

Doctrinal mapping was functional rather than jurisdiction-specific. International instruments differ in whether they are legally binding, professionally authoritative or normatively persuasive. They were therefore not treated as interchangeable sources of positive law. Instead, they were analysed to identify areas of normative convergence concerning the ethical conditions of medical decision-making. The analysis did not attempt to determine the domestic enforceability of any particular instrument.

Conceptual thematic analysis

The second stage used qualitative conceptual thematic analysis. The materials were examined for recurrent mechanisms through which institutional conditions could affect patient authorship of a medical decision. The analysis focused on the relationship between a conventional consent model and circumstances in which an institution controls the patient's practical environment.

A proposed theme was retained if it met three conditions. First, the condition had to be conceptually distinct from mere disagreement between patient and clinician. Second, it had to be capable of affecting the voluntariness, authenticity, understanding or practical contestability of a medical decision. Third, the condition had to arise specifically or with unusual intensity because of institutional control rather than from ordinary clinical dependency alone.

The analysis generated five principal categories: constrained option structures, institutional leverage, epistemic dependence, dual loyalty, and deficits of contestability and exit. These categories were then tested against established distinctions among capacity, information, voluntariness, authorisation and relational autonomy.

Normative synthesis

The third stage developed the proposed Institutionally Situated Autonomy framework. The normative synthesis proceeded from three premises. First, competent adult patients possess a presumptive claim to govern decisions concerning their own healthcare. Second, autonomy does not require complete freedom from social influence or practical limitation. Third, an institution that itself creates or controls conditions capable of compromising autonomous decision-making acquires positive responsibilities to mitigate those conditions.

The framework was evaluated against four criteria. It had to preserve individual agency rather than treating institutionalised patients as presumptively incapable; distinguish ethically problematic control from ordinary persuasion or relational influence; generate obligations capable of application in clinical governance; and remain compatible with circumstances in which ethically or legally justified treatment without consent may exceptionally occur.

Use of generative artificial intelligence

OpenAI ChatGPT (GPT-5.6 Sol) was used during manuscript development to assist with organisation of literature, initial drafting and language editing. The large language model was not treated as a source of legal, clinical or ethical authority. References and substantive propositions were checked against identifiable academic or institutional sources during manuscript preparation. Responsibility for the accuracy, interpretation, authorship and final submitted version of the manuscript remains with the named author.

Ethical considerations

Ethical approval was not required because this study did not involve human participants, human data, human tissue, animals, clinical interventions, questionnaires or interviews. The analysis was confined to published scholarly and normative materials.

RESULTS

Consent and autonomy are overlapping but non-identical concepts

The first result of the analysis is conceptual. Valid consent and autonomous decision-making substantially overlap, but the first cannot be treated as a complete proxy for the second under conditions of institutional control.

Traditional informed-consent models contain resources for contextual analysis because

voluntariness is already a recognised component of valid consent. The difficulty is operational. Disclosure and capacity lend themselves more readily to encounter-level assessment: clinicians can identify what information was disclosed, evaluate whether a patient understood it and record whether the patient authorised treatment. Institutional influence is less visible because its source may be outside the immediate consultation.

The analysis therefore distinguishes **transactional validity** from **situated autonomy**. Transactional validity concerns whether the consent interaction satisfies the familiar requirements of disclosure, understanding, capacity, voluntariness and authorisation. Situated autonomy asks whether the wider environment permits the patient's decision to function as a sufficiently self-governed choice. The distinction does not imply that two independent consent procedures are required. Rather, situated autonomy identifies contextual facts that become relevant to the existing requirement of voluntary and autonomous authorisation.

This distinction also avoids an excessively demanding conception of freedom. Patients outside institutions routinely make decisions under financial constraints, family responsibilities, illness, fear, cultural expectations and dependence on professional expertise. Autonomy cannot require the absence of influence. The relevant concern arises when control over the decision-making environment is concentrated in an institution capable of creating, modifying or exploiting the pressures surrounding the healthcare choice.

Five autonomy vulnerabilities under institutional control

Constrained option structures

The first vulnerability concerns the architecture of available options. Consent is often analysed by examining whether a patient was informed of clinically reasonable alternatives. Under institutional control, however, the availability of an option on paper may differ materially from its availability in practice.

A detained patient may theoretically possess the right to refuse a proposed treatment while lacking access to another clinician, another facility, a timely second opinion or a realistic mechanism for obtaining an alternative intervention. A psychiatric inpatient may formally be able to refuse one medication while believing that refusal will prolong conflict with an institution that controls discharge-related assessments. A person may therefore confront a set of options partly manufactured by the institution itself.

This does not mean that autonomy requires institutions to provide every treatment a patient requests. Scarcity, clinical indications and legitimate safety limitations exist throughout medicine. The ethical distinction concerns whether the institution uses its control over non-clinical conditions to narrow healthcare choice unnecessarily or presents an administratively convenient course as though it were the only clinically possible course.

A meaningful option is therefore more than a formally stated alternative. It must be sufficiently available for the patient's choice between alternatives to carry practical significance. When institutional arrangements themselves render every alternative excessively burdensome, the formal existence of alternatives can obscure rather than establish autonomy.

Institutional leverage

The second vulnerability is institutional leverage. Direct coercion involves an identifiable threat or controlling intervention. Institutional leverage can operate without such an explicit act. The patient may know that the institution controls privileges, accommodation, observation levels, movement, communication, disciplinary classifications, access to activities or assessments relevant to release or discharge. Where medical cooperation is perceived as relevant to these domains, treatment decisions may acquire consequences that extend beyond health.

This vulnerability is especially important because a clinician need not intend coercion for leverage to exist. A patient may reasonably infer consequences from institutional practice, prior experience, statements by non-clinical staff or the blurred role of healthcare professionals. The relevant ethical question is therefore not limited to whether the clinician personally threatened the patient. It includes whether acceptance or refusal is embedded in a

structure in which unrelated institutional benefits or burdens predictably depend upon compliance.

Research involving prisoners illustrates the broader conceptual point. Literature concerning prison research has long recognised that constrained environments can raise concerns about whether apparently voluntary consent is affected by dependence and susceptibility to pressure. Clinical healthcare is ethically distinguishable from research, but the underlying lesson concerning voluntariness remains relevant: the absence of an overt threat does not exhaust the analysis of freedom.

Institutional leverage should nevertheless be defined narrowly enough to avoid treating every consequence as coercive. Refusing an intervention may legitimately have clinical consequences. A person who refuses a sedating medicine may continue to experience symptoms; a person who declines infection treatment may remain infectious; a person who rejects a procedure may not obtain its therapeutic benefits. Those are consequences intrinsic to the medical choice. The ethically problematic form of leverage arises when refusal is connected to **extraneous institutional consequences** or when clinical consequences are exaggerated, obscured or strategically presented to obtain compliance.

Epistemic dependence and informational control

The third vulnerability concerns epistemic dependence. Informed consent assumes that relevant information can be communicated from professional to patient. Under high institutional control, however, the institution may exercise substantial control over not only treatment but also the channels through which the patient can verify, challenge or contextualise medical information.

Patients ordinarily depend on clinicians for expertise, but they may retain access to outside professionals, family, independent information, personal electronic communication or alternative services. Institutionalised patients may have fewer such opportunities. Consultation may occur under surveillance. Records may be inaccessible. Communication with external advisers may be delayed. Security rules may constrain what information can be independently obtained. The patient may therefore depend heavily on the same institutional system whose recommendation is being evaluated.

This condition may be described as **epistemic dependence**. It does not imply deception. A clinician may communicate accurately and in good faith while the institutional structure still gives the patient unusually limited capacity to test the recommendation against independent sources or seek another interpretation. The problem becomes more serious where the same professional has therapeutic, evaluative and institutional functions.

Informational integrity in a high-control environment therefore requires more than technically accurate disclosure. It includes reasonable privacy, sufficient opportunity to ask questions, intelligible communication, disclosure of the clinician's institutional role and, where the stakes justify it, access to independent advice or a second opinion.

Dual loyalty and role ambiguity

The fourth vulnerability is dual loyalty. Prison healthcare provides the clearest literature on the problem. Pont and colleagues describe the ethical conflict that arises when healthcare professionals experience obligations toward both patients and prison authorities. Professional independence and equivalence of care have accordingly been identified as essential protections in healthcare for incarcerated persons.

Dual loyalty undermines autonomy in two connected ways. First, the clinician's recommendation may be influenced, or appear to be influenced, by institutional objectives other than the patient's health. Second, the patient may not know whether information disclosed during a medical consultation will remain within the therapeutic relationship or inform disciplinary, security, risk or administrative decisions.

Trust becomes especially important here. Autonomy is sometimes portrayed as independence from others, but clinical autonomy depends extensively on trustworthy relationships. Patients must often rely upon expertise they cannot reproduce themselves. If the clinician's role is ambiguous, the patient may be unable to determine whether advice is therapeutic, evaluative or institutionally strategic.

The relevant safeguard is not a fiction of absolute separation. Healthcare professionals may have legitimate legal obligations concerning safety, reporting or public protection. Rather, autonomy requires clarity about roles, protection of clinical independence, minimisation of non-therapeutic conflicts and disclosure of limits on confidentiality. Where a professional's institutional function creates a substantial conflict, independent clinical review may be necessary.

Deficits in contestability, withdrawal and exit

The fifth vulnerability concerns the patient's ability to contest a decision. In ordinary consent theory, a person's ability to withhold or withdraw permission is central to continuing autonomy. In a high-control setting, however, nominal withdrawal may be ethically weak if no meaningful mechanism exists for challenging how the institution interprets or responds to refusal.

Exit can take several forms. The patient may exit the particular treatment, seek another clinician, appeal a compulsory intervention, obtain advocacy, request ethics review, access legal review, or ask for reconsideration after acute circumstances change. Not every setting can provide all these mechanisms. Detention itself may lawfully prevent physical exit from the institution. Yet the greater the restriction on physical exit, the stronger the case for alternative forms of contestability.

This result is particularly significant because coercive interventions cannot be ethically evaluated only at the moment authority is exercised. The legitimacy of an exceptional override also depends upon procedures surrounding it: whether reasons are given, whether capacity is assessed, whether less restrictive alternatives are considered, whether the decision is independently reviewable and whether coercion ceases once its justification no longer exists.

Contestability therefore serves two functions. It protects against mistaken or abusive use of power, and it preserves the patient's status as an agent even where a particular preference cannot ultimately be honoured. A person who can demand reasons, communicate disagreement, obtain review and revisit a decision occupies a different ethical position from a person whose objection is merely recorded before institutional authority proceeds.

The Institutionally Situated Autonomy framework

The five vulnerabilities were synthesised into six requirements for evaluating medical autonomy under institutional control. The framework does not replace informed consent. It specifies what valid respect for autonomy requires when institutional power makes a conventional encounter-level assessment insufficient.

Decisional capability

The first requirement is decisional capability. The patient must possess the abilities relevant to the particular healthcare decision or receive appropriate support to exercise those abilities. The requirement is deliberately framed in terms of capability rather than a binary status of competence because the ethical goal is not merely to classify patients but to maximise their ability to decide.

Capacity must remain decision-specific. Detention, psychiatric diagnosis, intellectual disability, substance-use history, previous disagreement, criminal status or unusual beliefs cannot independently establish incapacity. The psychiatric literature demonstrates variation in capacity among inpatients and reinforces the importance of individual assessment. Similarly, supported decision-making approaches seek to strengthen the person's ability to exercise legal and ethical agency rather than moving immediately from difficulty to substituted choice.

Where decision-making ability is impaired but potentially improvable, autonomy requires reasonable support. This may include accessible explanations, interpreters, communication aids, repeated discussions, treatment of reversible causes of confusion, appropriate timing, involvement of a trusted supporter where desired, and sufficient opportunity for reflection. High-control environments should not allow operational convenience to convert remediable difficulty into a presumption of incapacity.

Informational integrity

The second requirement is informational integrity. Conventional disclosure asks whether material information has been communicated. Informational

integrity additionally asks whether the conditions of communication allow the patient to understand, question and evaluate that information with reasonable confidence.

Informational integrity requires accurate and comprehensible disclosure of the intervention, expected benefits, material burdens and risks, reasonable alternatives, and consequences of refusal. In a high-control environment, it also requires clarity about the professional's role and any circumstances in which clinical information may be disclosed to institutional authorities.

Privacy is ethically relevant because surveillance can alter what a patient is willing to disclose. A consultation conducted within unnecessary hearing of custodial or non-clinical personnel may inhibit questions about psychiatric symptoms, medication effects, sexual health, substance use, self-harm or abuse. The ethical harm is not limited to confidentiality after information is disclosed; the expectation of surveillance can alter the informational quality of the decision before disclosure occurs.

Informational integrity also opposes strategic uncertainty. Clinicians must distinguish what is medically known from what is institutionally predicted. If refusal may lead to a legitimate clinical response, that consequence should be explained. If the clinician does not control an administrative consequence, this should also be made clear rather than presenting speculation as medical inevitability.

Freedom from institutionally generated retaliation or leverage

The third requirement is freedom from institutionally generated retaliation or leverage. A patient's healthcare decision should not ordinarily determine unrelated privileges, disciplinary treatment, living conditions, communication access or other institutional interests.

This requirement does not insist upon freedom from every adverse consequence. Instead, it distinguishes **intrinsic consequences** from **extrinsic consequences**. Intrinsic consequences arise from the medical decision itself. Extrinsic consequences are imposed through institutional authority and are not necessary to manage the clinical consequences of that choice.

The distinction is important in both directions. A patient should not be told that every consequence following refusal constitutes coercion. Neither should an institution be permitted to convert administrative preferences into apparently clinical necessities. Where a consequence serves mixed clinical and institutional purposes, necessity and proportionality require explicit evaluation.

Perceived leverage also matters. An institution may have no formal policy linking treatment adherence with privileges, but patients may reasonably believe such a connection exists because of informal practice. Healthcare governance should therefore identify and correct arrangements that predictably create such beliefs. Clinicians should expressly state, where accurate, that refusal will not result in unrelated punishment and should document unavoidable institutional consequences separately from the consent discussion.

Meaningful option sufficiency

The fourth requirement is meaningful option sufficiency. Autonomy does not require an unlimited menu of treatments. It requires that the options represented to the patient accurately reflect clinically reasonable alternatives and that institutional arrangements do not unnecessarily make one option practically compulsory.

Meaningful option sufficiency may require access to watchful waiting, another clinically acceptable medicine, delayed decision-making, a non-pharmacological intervention, an independent assessment or a second opinion where those alternatives are medically reasonable and practically feasible. The exact options will depend on the clinical context.

The framework therefore rejects two extremes. The first is the proposition that autonomy exists whenever the patient can say yes or no. A binary choice can be profoundly structured by institutional power. The second is the proposition that autonomy exists only where unrestricted alternatives are available. Medicine necessarily operates within constraints. The normative requirement is instead that the institution

not **manufacture avoidable scarcity** in order to secure the preferred decision.

Relational and professional independence

The fifth requirement is relational and professional independence. Autonomy does not demand social isolation. It requires relationships sufficiently trustworthy to support rather than appropriate the patient's decision-making authority.

Clinical independence is especially significant where the healthcare professional is employed by or contractually connected to the institution controlling the patient's liberty. The patient should be able to identify whether a clinician is acting as a treating professional, forensic evaluator, institutional assessor or in another role. Combining therapeutic and non-therapeutic functions should be avoided where the resulting conflict could materially affect care or trust.

Confidentiality is part of this requirement. Limits on confidentiality should be explained in terms the patient can understand. Medical information should not be casually repurposed for disciplinary or administrative objectives. Where disclosure is legally or ethically required, the disclosure should be limited to what is necessary.

The professional relationship should also protect the patient's capacity to disagree. A clinician who treats refusal itself as evidence of pathology, manipulation or non-cooperation risks converting professional authority into an instrument of institutional compliance. Clinical concern about a refusal may be legitimate, but disagreement should trigger assessment and dialogue rather than automatic moral or psychiatric disqualification.

Contestability and reversibility

The sixth requirement is contestability and reversibility. A patient must have a meaningful ability to question the recommendation, express refusal, withdraw consent where the intervention permits withdrawal, request reconsideration and, where appropriate, obtain independent review.

Contestability becomes more important as institutional control increases. A person unable to select another hospital or leave the physical setting may require alternative routes to challenge medical authority. Depending upon the setting and severity of the intervention, these can include a second clinical opinion, independent advocate, ethics consultation, formal review body, judicial review or another mechanism external to the immediate treatment team.

Reversibility concerns time. Consent is not a single historical event that permanently resolves autonomy. A patient who agreed yesterday may withdraw today. A patient who refused during acute distress may reconsider when circumstances change. A coercive intervention justified during an emergency may become unjustified when the emergency resolves. High-control institutions should therefore regard re-evaluation as an autonomy safeguard rather than administrative redundancy.

Proportionality of institutional responsibility

The six requirements operate according to a proportionality principle: **the greater the institution's control over the patient's decision environment, the greater its positive obligation to demonstrate and protect the conditions of autonomous choice**.

This principle follows from responsibility for the structure of choice. An ordinary outpatient clinician does not control most aspects of a patient's social environment and cannot reasonably be required to eliminate all external pressures. A custodial or secure institution, by contrast, may control the patient's physical movement, access to alternative clinicians, communication, privacy and daily conditions. Where the institution possesses unusual power to create or remove autonomy-threatening conditions, requiring it to mitigate those conditions is not an expansion of responsibility without limit. It follows from the institution's own control.

The proportionality principle also avoids categorical assumptions. Institutionalisation is not itself proof of non-autonomy. A person in prison may make a highly autonomous treatment decision. A person outside any formal institution may experience severe coercion. The framework is therefore based on functions of control rather than labels.

For practical purposes, the degree of institutional control can be assessed across several domains: physical exit, provider choice, communication,

privacy, access to records and information, material dependency, exposure to institutional sanctions, and the overlap between therapeutic and administrative authority. The accumulation of control across domains increases the ethical burden on the institution to provide independent safeguards.

Requirement	Central ethical question	Examples of institutional safeguards
Decisional capability	Can the patient understand, evaluate and communicate the decision with appropriate support?	Decision-specific capacity assessment; accessible communication; interpreters; supported decision-making; reassessment
Informational integrity	Can the patient obtain and evaluate reliable information under conditions conducive to candid deliberation?	Private consultations; role disclosure; understandable information; access to records; independent advice when warranted
Freedom from institutional leverage	Is acceptance or refusal separated from unrelated rewards, punishment or administrative pressure?	Non-retaliation policies; separation of clinical and disciplinary consequences; documentation of unavoidable consequences
Meaningful option sufficiency	Are clinically reasonable alternatives genuinely available rather than merely theoretical?	Alternative treatment where appropriate; reasonable delay; second opinion; referral; avoidance of administratively manufactured scarcity
Relational and professional independence	Does the clinical relationship support the patient's decision rather than institutional objectives?	Clinical independence; confidentiality; separation of therapeutic and forensic roles; disclosure of conflicts
Contestability and reversibility	Can the patient challenge, withdraw or seek review of the decision?	Advocacy; independent review; ethics consultation; appeal mechanisms; repeat consent; ongoing review of coercive intervention

Table 1. Institutionally Situated Autonomy Framework

The framework is cumulative but neither mechanical nor algorithmic. Failure of one requirement does not automatically determine that consent is invalid in every legal or ethical sense. Instead, a deficiency generates a reason for heightened scrutiny and remediation. Severe failures, such as an explicit unrelated threat imposed to secure consent, may directly defeat voluntariness. Less severe deficiencies may require additional safeguards before adequate respect for autonomy can be established.

DISCUSSION

From consent as a form to consent as an institutional practice

The principal implication of this analysis is that high-control medicine exposes a limitation in transaction-centred accounts of consent. Modern clinical ethics has rightly rejected the proposition that a signature alone constitutes informed consent. Yet practice can remain procedurally narrow even when the consent discussion itself is substantive. Clinicians may verify disclosure, understanding and apparent voluntariness without examining whether the institution has

constructed the environment in which the decision occurs.

The ISA framework relocates part of the ethical inquiry from the patient to the institution. Instead of asking only whether the patient was capable of choosing, it asks whether the institution preserved conditions in which choosing could remain meaningful. This matters because concentrating scrutiny on the patient's cognition can unintentionally obscure the power of the environment. A patient can be perfectly rational within a choice structure that is ethically distorted.

This repositioning should not be interpreted as a rejection of established autonomy theory. Beauchamp and Childress treat voluntariness and intentional action as important components of autonomous choice. Faden and Beauchamp similarly locate informed consent within a broader theoretical account of substantially autonomous action. The ISA framework is best understood as a specification of these principles for environments in which power over surrounding circumstances is unusually concentrated.

Relation to relational autonomy

Relational autonomy provides an important theoretical foundation for the framework. Individualistic caricatures of autonomy can imply that an autonomous person is independent, self-sufficient and free from social influence. In clinical reality, dependence is ubiquitous. Patients depend upon clinicians for expertise, healthcare systems for access and other persons for care and deliberative support. Relational autonomy demonstrates why dependence and autonomy are not opposites.

The ISA framework nevertheless differs from a general relational account in its narrower purpose. It does not attempt to provide a complete theory of the socially constituted self. Instead, it operationalises one relational insight: social and institutional structures can change the degree to which a person can author a healthcare decision.

This distinction is important because relational approaches themselves can be misused paternalistically. If autonomy is said to consist partly in socially approved relationships or responsible choices, institutions may claim authority to correct decisions regarded as unhealthy, irrational or socially undesirable. The ISA framework resists that move. Its purpose is to protect the patient's authority to decide, including the authority to make choices professionals consider unwise, unless an ethically and legally recognised justification for overriding the choice is independently established.

Relational autonomy should therefore enlarge scrutiny of power surrounding the patient without reducing the normative importance of the patient's own expressed will.

Capacity cannot carry the whole burden of autonomy

A second implication concerns capacity assessment. In high-control settings there is a risk that autonomy disputes are transformed into capacity disputes. If a patient agrees, the decision may be accepted as competent. If the patient persistently refuses, capacity may become the focus of professional concern. Such assessment can be entirely appropriate where there is genuine reason for doubt, but disagreement itself cannot establish incapacity.

Capacity asks whether the patient can perform particular decision-making functions. It does not answer whether the institution has exerted improper pressure. A person can have capacity while being coerced, and a person with impaired capacity can still exercise meaningful agency with appropriate support.

This separation becomes particularly important in psychiatry. The review by Curley and colleagues confirms that treatment decision-making capacity among psychiatric inpatients cannot be inferred solely from inpatient or involuntary status. Ethical debate concerning involuntary psychiatric treatment likewise demonstrates the tension between protection, beneficence and respect for capable refusal. International psychiatric guidance increasingly calls for reduction of coercive practices and greater attention to alternatives.

The clinical implication is that capacity and voluntariness should be documented separately. A statement that the patient “understands and has capacity” should not function as shorthand for the conclusion that the decision was voluntary.

Prison medicine as the paradigm case

Prison healthcare demonstrates the framework most clearly because institutional authority is both extensive and visible. The prisoner cannot ordinarily choose to leave the institution, may have limited provider choice, depends upon custodial processes for access to care and lives within a system in which security concerns permeate ordinary routines. Yet professional standards insist that incarceration does not extinguish ordinary medical ethics.

The dual-loyalty literature shows why professional independence is indispensable. Where a prison clinician acts simultaneously as caregiver and an agent serving security, investigation or discipline, the patient's ability to interpret clinical advice becomes unstable. This is not merely a conflict-of-interest problem affecting professional integrity. It is also an autonomy problem because the patient's decision depends upon understanding whose interests the professional is advancing.

The equivalence principle further supports a positive conception of autonomy. Equivalence cannot mean only that the same medication is technically available inside and outside prison. If a community patient can seek another clinician, discuss treatment privately and decline without disciplinary implications, while a prisoner receiving nominally identical treatment cannot do so, the ethical conditions of the healthcare encounter are not equivalent.

Recent prison bioethics literature reinforces this concern. Esposito and colleagues identified continuing deficiencies involving human rights and bioethical principles in prisons. Moser and colleagues' work concerning research consent in prisoners also illustrates why susceptibility to coercion must be examined separately from cognitive ability. Hayes similarly connects prisoners' autonomy with the special vulnerabilities created by confinement.

The ISA framework consequently interprets prison consent through a presumption of retained agency combined with heightened institutional duties. Prisoners should not be presumed non-autonomous because they are incarcerated. Rather, prison healthcare systems should bear a heightened obligation to demonstrate non-retaliation, professional independence, privacy, access to review and reasonable alternatives because they control many of the patient's ordinary mechanisms of self-protection.

Involuntary psychiatric care and the separation of detention from treatment

Psychiatric detention presents a different but related challenge. The legal authority to detain a person does not conceptually establish unlimited authority over medical treatment. Jurisdictions vary considerably in how detention, capacity and compulsory treatment interact, and this article does not seek to resolve those legal differences. The ethical distinction nevertheless remains important.

A patient can be involuntarily present in a hospital yet capable of deciding whether to accept a particular medicine. The institution should therefore avoid allowing the coercive background of detention to contaminate every treatment interaction. Where treatment without consent is legally and ethically authorised, its justification should be explicit rather than disguised through nominal consent.

This is one of the most important practical conclusions of the study. **Obtaining apparent consent should not become an ethical laundering mechanism for an intervention that the institution is effectively compelling.** If the institution intends to proceed irrespective of the patient's decision because a lawful and ethically justified compulsory-treatment threshold has been met, transparency requires acknowledging the coercive character of the intervention and applying the relevant safeguards. Asking the patient to sign a consent form in circumstances where refusal has no operative meaning risks converting consent from a protection of autonomy into evidence manufactured for institutional protection.

The opposite problem must also be avoided. A patient's decision should not be dismissed simply because the institution possesses compulsory powers. Where consent is genuinely sought, refusal must have genuine normative significance.

Informed refusal as a test of autonomy

Consent systems are often evaluated by examining how institutions obtain agreement. A stronger test of autonomy is how the institution responds to refusal.

When acceptance is welcomed but refusal triggers repeated pressure, punitive consequences, pathologisation, administrative escalation or loss of unrelated privileges, the institution reveals that the apparent choice was asymmetric. The right to agree is ethically weak where the right to disagree is merely formal.

The Declaration of Lisbon's emphasis on self-determination and the broader bioethical requirement of free consent are therefore connected to the ability to refuse. Barugahare has similarly argued that valid consent requires conceptual attention not merely to information but to the ethical foundations from which consent requirements derive. Pierscionek's analysis of presumed consent illustrates the importance of examining what is actually being assumed when consent substitutes for expressed authorisation.

The ISA framework therefore treats informed refusal not as an exceptional problem but as a diagnostic test of institutional respect for autonomy. Institutions genuinely committed to autonomy should be able to explain what happens when a capable patient says no.

Clinical records and the documentation of voluntariness

Clinical documentation is another area in which the framework has practical implications. Consent records often document disclosure, capacity and the patient's ultimate decision while providing little information about contextual pressures. In high-control environments, this creates a reconstruction problem. Later reviewers may see a signed form and conclude that autonomy was established without knowing whether a security officer remained within hearing, whether the patient had requested a second opinion, whether refusal was linked to privileges, or whether the clinician also exercised a forensic role.

Documentation should not become so elaborate that consent becomes bureaucratically unworkable. Nevertheless, high-risk or coercion-sensitive decisions justify greater contextual recording. Relevant documentation can include whether the consultation was private, whether the patient was informed that refusal would not generate unrelated punishment, whether independent advice was requested or offered, whether role conflicts existed, and whether institutional consequences of refusal were distinguished from medical consequences.

Such documentation protects the patient and the clinician. It makes ethical reasoning reviewable and prevents retrospective reliance on a signature as a complete account of the decision.

Autonomy-supporting institutions rather than autonomy-neutral institutions

A further theoretical implication is that institutions exercising substantial control cannot ethically remain neutral about the conditions of autonomy. The conventional negative formulation of autonomy requires others not to interfere improperly with patient choice. High-control medicine additionally creates positive duties because the institution itself governs the environment in which choices occur.

This does not mean institutions must produce autonomous patients or guarantee that every decision is free from pressure. Such a demand would be impossible. It means that institutions should actively maintain the procedural and relational infrastructure through which autonomy remains exercisable.

Examples include private clinical consultations unless a specific safety reason requires otherwise, separation of healthcare from discipline, clear policies against retaliation for treatment refusal, access to interpreters and accessible information, independent second opinions for sufficiently serious disputes, mechanisms for advocacy and review, and periodic reassessment of continuing coercive treatment.

This positive account is consistent with the broader movement toward supported decision-making. The World Health Organization's rights-based mental-health guidance emphasises person-centred services and approaches aligned with human rights. The Convention on the Rights of Persons with Disabilities and subsequent interpretation of equal recognition before the law have also intensified debate concerning support for the exercise of legal agency rather than routine substitution of professional judgment.

The problem of justified coercion

A theory concerned with institutional power must distinguish the claim that coercion requires justification from the stronger and untenable claim that coercion can never be justified.

Medicine includes circumstances in which emergency treatment, public-health measures or psychiatric intervention may occur without contemporaneous consent under applicable ethical and legal standards. The ISA framework does not purport to abolish these exceptions. Instead, it clarifies what follows when consent cannot provide the justification.

Where treatment is imposed, the ethical basis should be identified independently: for example, an emergency involving impaired decision-making, a legally authorised compulsory-treatment regime, or another narrowly defined justification. The intervention should then be governed by necessity, proportionality, least-restrictive alternatives, review and temporal limitation. It should not retrospectively be described as autonomous simply because the patient eventually acquiesced.

Acquiescence and consent are not necessarily equivalent. A patient may stop resisting because resistance is futile, exhausting or costly. High-control institutions should therefore distinguish agreement, compliance, acquiescence and valid autonomous authorisation rather than collapsing them into the single category of cooperation.

The World Medical Association's Declaration of Malta provides a particularly clear illustration in the context of hunger strikes. It places substantial weight on the voluntariness and authenticity of the person's decision and warns against pressures that undermine free choice. Although hunger strikes are a specialised context, the underlying insight generalises: institutional control creates a special obligation to determine whether the patient's expressed decision belongs to the patient rather than to the structure surrounding the patient.

Institutional control is dimensional, not binary

An important limitation of categorical labels such as “prisoner,” “psychiatric patient” or “inpatient” is that they may reproduce the very status-based reasoning that autonomy ethics should resist. Institutional control is better conceptualised as dimensional.

A person in a prison with an independent health service, private consultations, accessible external specialists, strong confidentiality rules and meaningful review may possess stronger practical autonomy protections than a nominally voluntary patient in another institution who is completely dependent upon a single clinician and unable to obtain information or leave without severe consequences.

The ethical burden should therefore correspond to actual domains of control. This dimensional approach also permits application beyond prisons and psychiatry. Immigration detention, compulsory residential care, military detention, secure disability services and other environments may generate analogous concerns where the institution substantially controls healthcare access and daily life. Application to any such setting requires contextual analysis rather than automatic transfer of conclusions.

Implications for healthcare governance

The framework suggests several governance implications. First, institutions should audit whether treatment refusal produces direct or indirect non-clinical consequences. Policies may formally prohibit retaliation while informal practices continue to associate treatment adherence with cooperation, privileges or institutional favour.

Second, clinical and security roles should be separated as far as practicable. Where separation is impossible, role boundaries and confidentiality limitations should be explicit to the patient.

Third, privacy should be treated as an autonomy condition rather than only a confidentiality rule. Unnecessary observation of healthcare discussions can distort deliberation before any confidential information is recorded.

Fourth, serious or contested treatment decisions in high-control settings should provide proportionate access to independent review. Not every prescription requires an external opinion. The need increases with invasiveness, irreversibility, disagreement, coercive background and potential consequences.

Fifth, institutions should train both healthcare and non-healthcare personnel to understand that treatment refusal by a capable patient is not inherently misconduct. Security staff can undermine consent even when clinicians act appropriately if institutional culture links medical compliance with obedience.

Sixth, consent documentation should distinguish clinical consequences of refusal from institutional consequences and should record material contextual safeguards where the setting creates an elevated risk of coercion.

Finally, institutional ethics committees and regulators should assess autonomy at system level. Review should not be confined to whether individual clinicians know how to obtain a signature or discuss risks. The relevant question is whether the institution has constructed an environment in which refusal, questioning and independent review remain genuinely possible.

Implications for legal and medico-legal evaluation

Although this article develops an ethical rather than jurisdiction-specific legal framework, the analysis has implications for medico-legal reasoning. Legal disputes concerning consent frequently focus on disclosure, capacity and authorisation. In high-control environments, evidence of institutional context may be equally relevant to evaluating voluntariness.

A signed form should therefore be treated as evidence of consent, not conclusive proof of autonomous authorisation. The evidentiary weight of documentation depends partly upon how the decision was produced. Where the same institution controlled the treatment recommendation, the patient's living conditions, access to alternatives and the documentation later relied upon to prove consent, independent scrutiny becomes especially important.

The framework does not propose a universal legal test because domestic standards of consent and coercion differ. Its contribution is antecedent to legal classification. It identifies ethically relevant facts that legal and professional decision-makers should not ignore merely because formal consent has been documented.

The approach also guards against the opposite error: treating every institutionalised patient as legally or ethically incapable of consent. Such a presumption would reproduce discriminatory status-based reasoning and deprive patients of agency. The appropriate inquiry is contextual and decision-specific.

Comparison with existing scholarship

The proposed framework extends several established strands of bioethical thought rather than claiming that institutional influence has been previously ignored. Traditional informed-consent theory already recognises voluntariness. Relational autonomy demonstrates the social constitution and support of agency. Structural-coercion scholarship identifies social conditions capable of affecting ostensibly voluntary decisions. Prison-health literature exposes dual loyalty and institutional dependency. Supported-decision-making approaches emphasise strengthening rather than replacing agency.

The gap addressed here concerns synthesis and clinical operationalisation. These insights are usually discussed within separate literatures. The ISA framework places them into a single model structured around the healthcare decision and asks what an institution must establish before relying upon consent as evidence of autonomy.

Its central innovation is therefore not the claim that context matters. That proposition is well established. The innovation lies in treating **institutional control as a source of positive autonomy obligations** and specifying six conditions through which those obligations can be evaluated.

The framework additionally distinguishes institutional pressure from social embeddedness. Relational autonomy can sometimes be described so broadly that almost any social influence becomes ethically significant. ISA is narrower. It is triggered particularly where an institution possesses concentrated control over the practical environment and where that control bears upon healthcare choice.

Limitations

This study has several limitations. First, it is a normative-doctrinal analysis rather than an empirical

study. The proposed framework has not been prospectively validated through patient interviews, clinician studies, institutional audits or outcome measures. Its categories should therefore be understood as analytically derived requirements that warrant subsequent empirical evaluation.

Second, the literature search was purposive rather than a systematic review of all publications concerning autonomy and coercion. The analysis sought conceptual adequacy and normative synthesis rather than bibliometric completeness. Relevant literature from disciplines such as sociology, political philosophy, disability studies and carceral studies is considerably broader than the core medical-ethics materials examined here.

Third, the framework draws on international instruments and cross-jurisdictional ethical scholarship. Legal rules governing capacity, detention, compulsory treatment, confidentiality and consent differ between jurisdictions. The proposed framework should not be interpreted as a statement of positive law in any particular country.

Fourth, institutional control is difficult to quantify. The framework deliberately avoids creating an artificial numerical score because different forms of control may have qualitatively different ethical significance. Future research may determine whether structured assessment tools can be developed without reducing contextual judgment to a checklist.

Fifth, the framework is designed for institutions possessing substantial structural control. Its concepts may illuminate ordinary hospital care, but applying the complete framework to every routine clinical encounter could impose unnecessary procedural burdens.

Finally, additional safeguards can themselves become paternalistic. Repeated capacity assessments, mandatory advocacy or excessive review may delay care or convey distrust of a patient's expressed choice. Safeguards should therefore be proportionate and should support rather than displace patient agency.

CONCLUSION

Informed consent remains indispensable to ethical medical practice, but under conditions of substantial institutional control it cannot be treated as self-validating evidence of autonomy. A patient may understand information, possess decision-making capacity and communicate agreement while the surrounding institution materially structures the practical meaning of acceptance and refusal.

The analysis identified five recurrent vulnerabilities: constrained options, institutional leverage, epistemic dependence, dual loyalty, and deficits in contestability and exit. In response, the proposed Institutionally Situated Autonomy framework requires six conditions: decisional capability, informational integrity, freedom from institutionally generated retaliation or leverage, meaningful option sufficiency, relational and professional independence, and contestability and reversibility.

The framework does not presume that prisoners, psychiatric inpatients or other institutionally dependent persons are incapable of autonomous choice. Its normative premise is the opposite. Their agency should be presumed and protected. Precisely because the institution controls unusually large portions of their decision environment, the institution bears an unusually strong obligation not to convert that control into medical compliance.

The central ethical question should therefore move beyond **“Did the patient consent?”** to **“What conditions made this consent possible, and did the institution preserve a meaningful possibility of refusal?”**

Respect for autonomy is not completed by obtaining permission. In high-control medicine, it requires the construction and maintenance of institutional conditions under which permission, refusal and reconsideration can genuinely belong to the patient.

ACKNOWLEDGMENT

Not applicable.

CONFLICT OF INTEREST

The author declares no conflict of interest related to this manuscript.

REFERENCES

1. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 8th ed. New York: Oxford University Press; 2019.
2. Faden RR, Beauchamp TL, King NMP. A History and Theory of Informed Consent. New York: Oxford University Press; 1986.
3. Dworkin G. The Theory and Practice of Autonomy. Cambridge: Cambridge University Press; 1988.
4. O'Neill O. Autonomy and Trust in Bioethics. Cambridge: Cambridge University Press; 2002.
5. Entwistle VA, Carter SM, Cribb A, McCaffery K. Supporting patient autonomy: the importance of clinician-patient relationships. J Gen Intern Med. 2010;25(7):741-745. doi:10.1007/s11606-010-1292-2.
6. Mackenzie C, Stoljar N, editors. Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self. New York: Oxford University Press; 2000.
7. Dove ES, Kelly SE, Lucivero F, Machirori M, Dheensa S, Prainsack B. Beyond individualism: is there a place for relational autonomy in clinical practice and research? Clin Ethics. 2017;12(3):150-165. doi:10.1177/1477750917704156.
8. Gómez-Vírseda C, de Maeseneer Y, Gastmans C. Relational autonomy: what does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature. BMC Med Ethics. 2019;20:76. doi:10.1186/s12910-019-0417-3.
9. United Nations General Assembly. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Resolution A/RES/70/175. New York: United Nations; 2015.
10. United Nations General Assembly. Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment. Resolution 37/194, Annex. New York: United Nations; 1982.
11. Pont J, Stöver H, Wolff H. Dual loyalty in prison health care. Am J Public Health. 2012;102(3):475-480. doi:10.2105/AJPH.2011.300374.
12. Eichelberger M, Wertli MM, Tran NT. Equivalence of care, confidentiality, and professional independence must underpin the hospital care of individuals experiencing incarceration. BMC Med Ethics. 2023;24:13. doi:10.1186/s12910-023-00891-3.
13. Esposito M, Szocik K, Capasso E, Chisari M, Sessa F, Salerno M. Respect for bioethical principles and human rights in prisons: a systematic review on the state of the art. BMC Med Ethics. 2024;25:62. doi:10.1186/s12910-024-01049-5.
14. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Engl J Med. 1988;319(25):1635-1638. doi:10.1056/NEJM198812223192504.
15. Roberts LW. Informed consent and the capacity for voluntarism. Am J Psychiatry. 2002;159(5):705-712. doi:10.1176/appi.ajp.159.5.705.
16. Curley A, Watson C, Kelly BD. Capacity to consent to treatment in psychiatry inpatients: a systematic review. Int J Psychiatry Clin Pract. 2022;26(3):303-315. doi:10.1080/13651501.2021.2017461.
17. Fisher JA. Expanding the frame of "voluntariness" in informed consent: structural coercion and the power of social and economic context. Kennedy Inst Ethics J. 2013;23(4):355-379. doi:10.1353/ken.2013.0018.
18. Wilkinson D, Levy N. Scaffolding informed consent. J Med Ethics. Published online 20 December 2024. doi:10.1136/jme-2024-110105.
19. United Nations Educational, Scientific and Cultural Organization. Universal Declaration on Bioethics and Human Rights. Paris: UNESCO; 2005.
20. Council of Europe. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. European Treaty Series No. 164. Oviedo: Council of Europe; 1997.
21. World Medical Association. WMA Declaration of Lisbon on the Rights of the Patient. Adopted 1981; subsequently amended, revised and reaffirmed. Ferney-Voltaire: World Medical Association.

22. World Health Organization. Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches. Geneva: World Health Organization; 2021.
23. World Health Organization. WHO QualityRights: Supported Decision-Making and Advance Planning. Geneva: World Health Organization; 2019.
24. Mertz M, Inthorn J, Renz G, Rothenberger LG, Salloch S, Schildmann J, et al. Research across the disciplines: a road map for quality criteria in empirical ethics research. BMC Med Ethics. 2014;15:17. doi:10.1186/1472-6939-15-17.
25. Moser DJ, Arndt S, Kanz JE, Benjamin ML, Bayless JD, Reese RL, et al. Coercion and informed consent in research involving prisoners. Compr Psychiatry. 2004;45(1):1-9. doi:10.1016/j.comppsych.2003.09.009.
26. Hayes MO. Prisoners and autonomy: implications for the informed consent process with vulnerable populations. J Forensic Nurs. 2006;2(2):84-89. doi:10.1111/j.1939-3938.2006.tb00063.x.
27. Hudson H. Coercion in psychiatry: is it right to involuntarily treat inpatients with capacity? J Med Ethics. 2019;45(11):742-745. doi:10.1136/medethics-2019-105357.
28. Herrman H, Allan J, Galderisi S, Javed A, Rodrigues M, WPA Task Force. Alternatives to coercion in mental health care: WPA position statement and call to action. World Psychiatry. 2022;21(1):159-160. doi:10.1002/wps.20950.
29. United Nations General Assembly. Convention on the Rights of Persons with Disabilities. Resolution A/RES/61/106. New York: United Nations; 2006.
30. Committee on the Rights of Persons with Disabilities. General Comment No. 1 (2014): Article 12—Equal Recognition Before the Law. CRPD/C/GC/1. Geneva: United Nations; 2014.
31. Barugahare J. Bioethical reflexivity and requirements of valid consent: conceptual tools. BMC Med Ethics. 2019;20:44. doi:10.1186/s12910-019-0385-7.
32. Pierscionek BK. What is presumed when we presume consent? BMC Med Ethics. 2008;9:8. doi:10.1186/1472-6939-9-8.
33. World Medical Association. WMA Declaration of Malta on Hunger Strikers. Adopted 1991; revised 2017. Ferney-Voltaire: World Medical Association.
34. Osuji PI. Relational autonomy in informed consent as an ethics of care approach. Med Health Care Philos. 2018;21(1):101-111. doi:10.1007/s11019-017-9789-7.
35. Lidz CW, Meisel A, Osterweis M, Holden JL, Marx JH, Munetz MR. Barriers to informed consent. Ann Intern Med. 1983;99(4):539-543. doi:10.7326/0003-4819-99-4-539.
36. Aleksandrova-Yankulovska S, Orzechowski M, Hancke K, Bundschu K, Steger F. Ethical analysis of the European normative framework on fertility preservation. BMC Med Ethics. 2026;27:38. doi:10.1186/s12910-026-01393-8.

HOW TO CITE: Ishaan Deepak Joshi*, Informed Consent Under Institutional Control: A Normative-Doctrinal Framework For Medical Autonomy, Int. J. Sci. R. Tech., 2026, 3 (8), 671-689. https://doi.org/10.5281/zenodo.21989958