AMJ Australasian Medical Journal [AMJ 2015;8(10):334–336]

Book Review

AMJ 2015, 8,10

Self-determination in Health Care. A Property Approach to the Protection of Patients' Rights

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"Traditionally health care was delivered on the basis that the doctor knew what was best for the patient." (Edozien, 2015:1)

In this book, the author takes as his starting point the hypothesis that the kind of "medical paternalism" inherent in the quote above has gradually been replaced by an assumption that, regardless of the usually demonstrably superior knowledge and experience of the doctor, "patients have a right to be proactively involved in decisions about their treatment and that a breach of this right is a breach of the patient's bodily integrity." From this starting point, the author identifies correctly the inherent difficulty in such an approach: namely, that consent is not a "right", but a process, and a process almost impossible to define in terms of objective criteria.

At a very basic level, a patient may in fact be informed and may give genuine consent on the basis of an inadequate comprehension of the information, however, comprehensively and appropriately it may have been given by the doctor. In reality, except in the most minor of medical cases, it will be all but impossible for the doctor to provide all possible information—including risks and benefits, potential side effects, and possible adverse consequences—that might possibly, or even would definitely, be influential in determining whether the patient gave or withheld consent. What Edozien calls "the subsisting consent model" (which he considers in chapters 3, 4, and 5) has long been recognised as being limited in both theory in practice, although he is one of the few writers who, having considered those limitations (which he does in detail in chapter 5), has proposed an alternative approach. Any process whereby consent is obtained (or, indeed, withheld) is almost inevitably flawed in any real-world situation and, one might note, especially in many, if not most, medical settings.

Before examining the author's arguments it is important to note that problems with the consent model are not merely academic, particularly in the Internet era where medical information of various quality is readily available to most citizens of developed countries. It is not difficult in the present climate to identify clinical scenarios where information was not provided, even if not consciously and deliberately withheld, by the doctor which the particular patient, or even the "average patient" would, in retrospect, wanted to have known, and to therefore argue that informed consent had not been obtained.

The most notable case in this regard in Australian law, and one which significantly changed the standard for the "informed" part of "informed consent" in this country, was Rogers v Whitaker (1993 67 ALJR 47). Put simply, that case considered whether a doctor had an obligation to warn a patient of a risk which the doctor, on the basis of his specialist knowledge and considerable professional experience, did not consider to be a "significant risk", especially when he was concerned that the patient might be unnecessarily distressed by information about the (to him) "insignificant risk". The standard applied in Australia law at that time was "the standard of the profession"; that is, did the doctor do what appropriately competent doctors in the specialty would have done. There was, in that case, no question that he had done so. Indeed, the "standard of the profession" adduced in that case was that none of his colleagues would have given the warning that he failed to give. The court, however, determined that a second additional standard should have been applied: what might be called "the standard of the patient". Would a patient in the situation of the patient concerned want the information that had been withheld?

The case was both complicated and simplified because the patient in that case had specifically asked questions,

which implied a desire for the information that was withheld although, given that she was not a medical specialist in the area concerned, did not explicitly specify the additional information that she sought. The author convincingly argues that such cases are, in fact, compelling examples of the manifest failure of the consent model.

A doctor with (let us assume) substantial specialist knowledge and considerable professional experience in the field, all of whose education has been undertaken using technical, and to the outsider complex and esoteric, language must, having somehow assessed the patient's linguistic competence, intellectual capacity, and knowledge base, translate specialist medical information into terms that the patient can comprehend. And, having regard to Rogers v Whittaker, must also be able to take into account questions that the patient does not ask and concerns that the patient does not (as least in clear language) articulate. To which one must add, the doctor must do this in what may be a highly emotionally charged and stressful situation for the patient. Of course, one should also add, the doctor must often do this in a less than optimal environment for effective communication (for example, the crowded emergency department of a large hospital), and in limited (or in the case of emergency surgery, severely limited) time. The doctor should, presumably, also take into account the cultural setting in which, for many people, questioning, let alone arguing or disagreeing with, persons in authority, may be all but impossible.

These are not issues that have not been previously recognised, discussed, and written about by those in both law and medicine who have sought to improve the process of obtaining informed consent. However, Edozien argues persuasively that "while their efforts are rich in intellectual content, they are too complex for application in clinical practice and for implementation in law." Thus, he seeks not to improve an imperfect approach but to develop a basis for a new approach, concluding that:

> *"Vulnerability in the face of a steep informational (and sometimes social) gradient between doctor and patient is a major threat to patient self-determination. Protection of the right to self-determination will remain inadequate for as long as vulnerability is not adequately addressed. The law has stepped in to protect the vulnerable party in various arenas, such as product-liability and consumer protection, and a similar approach could be made regarding patient self-determination. Property rhetoric intrinsically carries greater security, and patient self-determination gets stronger protection through a property model that recognised a proprietary right in the patient's expectation of engagement in decision-making. In this context, engagement means a transaction in which the doctor is aware of the patient's goals and provides tailored information that enables the patient to make a self-determining decision."* (Edozien, 2015:207-8).

To this point, Edozien's work is compelling. He has skilfully analysed the "the subsisting consent model" and the problems associated with it (chapters 3, 4, and 5) and comprehensively laid the foundation for "the property model" (chapters 6, 7, and 8). It is in his consideration of how "the property model" could be implemented in practice, and how in practice it is different from "the subsisting consent model", that flaws seem to arise in his argument. It is in practice, rather than in theory, that his thesis fails, not because it is fallacious, but because, in the reality of medical practice, it does not seem to make any difference.

Whilst a statutory or regulatory system based on "the product-liability and consumer protection model" may have considerable advantages, notably in terms of cost to the patient, over the common civil litigation model currently used, it would also present almost insurmountable problems. For example, while it may be easy to prove that a pharmaceutical product claiming to contain 50mg of paracetamol in fact only contains 40mg, it is difficult to see how this approach could be applied in any but the simplest of medical procedures. A surgeon who described his "product" as the removal of the right foot below the ankle, but, in fact, removed the left foot, has manifestly failed to deliver "the product as described". But there can be very few medical procedures, let alone the potential adverse effects of such procedures, that can be accurately, and "measurably", described with sufficient precision to provide a basis for a "product liability" model.

Edozien seems essentially to be arguing for a new philosophical or (more especially) legal-ethical basis for "the subsisting consent model": a new theoretical basis upon which to engage in, essentially, the old practice.

The book is extremely well researched, and the author's thesis is clearly and comprehensively argued, making use of an impressive range of sources. It is a valuable and stimulating work, which, even if the fundamental hypothesis is not accepted, encourages critical reflection

and provides very valuable material on a major issue in medical practice.

About the book:

Edozien LC. Self-determination in Health Care. A Property Approach to the Protection of Patients' Rights. Ashgate Publishing Ltd; London: 2015. ISBN: 978-1-4724-6198-8.