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# When It Ain't Broke . . .

RICHARD T. HULL

"From Both Sides Now" professes to offer a model of information communication and consent to treatment for transplantation cases as an alternative to the current doctrine of informed consent. The chief feature of this model is that it requires communication of a widened range of risks and benefits to the close relatives of the patient. The model is that "in heart and perhaps other transplant cases as well, doctors be [legally] required to notify the entire family or other living unit before proceeding with the operation. The other members of the family would not be given a veto power, of course, but they would be required to be notified of all the relevant elements of informed consent - diagnosis, prognosis, treatment, risks, and so on."

Only the patient has "veto power." In effect, the patient and physician have the power on this model to expose other members of the family to a broad range of risks: financial, disruption of family relationships due to the "changed patient problem," transmission of contagious disease from donor organs and tissues (such as HIV-AIDS, hepatitis, cytomegalovirus), imposition of caregiver duties of vigilance against rejection, even imposition of preoccupation with transplantation as a quasi-religious calling. And the expanded information communication requirement is predicated on a duty to warn, similar to that involved in the majority opinion in *Tarasoff v Regents of the University of California*.

Left unaddressed is the range of rights of family members to be warned by such information. If a family member who is to be exposed to these risks is not empowered to veto a transplant, what is he or she to do with the information? Will the 16-year-old whose college plans are disrupted by a prospective expensive transplant whose costs the family must bear have any rights to exclude the college funds from being devoted to a highly risky, experimental surgery? Will the spouse who may be exposed to fatal infection be able successfully to sue for divorce in prospect of such a surgical procedure, and thereby protect both her health and share of community property, on the grounds that her husband contemplates an action that will expose her to financial and health risks, and will transform him into "another person" with whom she had not agreed to share a life?

In the practice of transplantation under the proposed model, how will the one-time-only perfunctory nature of consent forms be avoided? The physician will now be under a legal duty to inform a wider range of people; that duty will require evidence that it has been satisfied; such evidence is likely to take the form of a larger number of forms containing descriptions

of the information provided to family members about their risks in the contemplated procedure, with affidavits asked of them that they have been provided such information and an opportunity to ask questions. Such forms will then be signed and dated, and the problem of one-time-only perfunctory consent simply will have been multiplied.

Further, how does imposing a new legal duty avoid "the legalistic approach" that distorts doctor-patient, and now doctor-family, discussion? Grover correctly envisions the general problem with achieving high quality medical practice through legal impositions, but she does not address the question of how that problem is avoided with yet another legal requirement.

If "the entire informed consent construct" is "an enchanting legal fiction' that fails abjectly to capture the dynamics of sick people who will do whatever they are told to do," why won't the expanded information construct involve a similar fiction, not empowering families as decision makers but simply providing them with the opportunity to contemplate in advance the grim transformations to which they are about to be subject by physician and patient? And, "given that doctors rarely have a gift for communicating with those in much different circumstances from theirs, and that medical schools have done little or nothing to remedy this deficiency," why suppose that increasing the doctor's legal duty to inform will be any more successful? Why suppose that the doctor will give this expanded range of communicatees anything more than "a checklist of risks and consequences?" These individuals will not, on the new doctrine, be asked whether they want this to be done to them, for they have no veto power. Won't this be another case of what CLS abhors: following the expanded informing procedure, the parties go about their business as before, with little change? What power is distributed to the family?

A really radical approach would be to embrace the Critical Race Theory alternative, where informed consent would be sought from all the members of the family, who would then be accorded the opportunity to negotiate gains against their prospective risks. The first section of this article seems to raise more radical alternatives to the traditional practice of informed consent than are realized in the second part, which still accepts the traditional location of power within the physician-patient relationship and seems to enjoin wider communication as a kind of courtesy to those whose lives are about to be transformed by others' decisions. The paper makes some effort to defend itself against a number of charges by pointing out various positive features of the proposal, such as that "bringing healthy persons who care about the patient into the decision can help redress this imbalance [in power between patient and physician]." But what of those who, though family members, do not care about the patient? Families are not simply uniform support systems; they are often battlegrounds, rife with disparate values. Forcing the physician and patient to incorporate persons into the decision-making process who may not have the patient's best interest at heart seems unwise.

Nothing about the current law prohibits patients from involving those family members that are caring and supportive in a decision. The growing popularity of legal mechanisms for designating health care decision proxies adds further weight to the ability of families to have access to information and to participate in the determination of all treatment decisions where disease has limited the patient's decision capacity. No data have been presented to support a departure from an established practice in favor of the proposed one that would warrant breach of confidentiality, and delay transplantation in order to contact family members required to be informed. Without data indicating the degree to which family members are actually harmed by accompanying effects of transplantation procedures, we are left without a factual basis for evaluating this alternative.

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