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Informed Consent to Rationing Decisions by Managed Care Organizations

by

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ABSTRACT

It has been argued that the rationing of medical resources effected by managed care organizations violates the philosophical doctrine of informed consent, which is linked to the principle of respect for patient autonomy. Two models which purport to protect patient autonomy, in consonance with the doctrine of informed consent, and in the face of institutional rationing decisions, via prior disclosure, are examined. It is found that the 'prior global consent' model is less effective at preserving patient autonomy through prior disclosure than is the 'waiver of informed consent' model. The immediate conclusion for managed care is that institutional rationing need not be antithetical to the doctrine of informed consent. The broader philosophical conclusion is that the hierarchical notion of autonomy espoused by the 'waiver' model is, in some cases, more effective than the integrated notion espoused by the 'global consent' model.
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CHAPTER 1: INTRODUCTION

Managed care organizations, so prevalent in contemporary American healthcare, are essentially motivated by the desire of those who pay for health care to reduce costs. This end is achieved through the rationing of medical resources, specifically, through limiting the utilization of expensive, marginally useful diagnostic or treatment interventions. It has been argued that such organized rationing violates the so-called principle of autonomy—including the medical incarnation of this principle in the form of the ‘doctrine of informed consent’. The upshot of this doctrine involves the designation of competent patients as the locus for medical decision-making, ceteris paribus. It should be noted at this juncture that the managed care agenda of limiting access to expensive, marginally beneficial interventions is not uncontroversial prior to our concerns regarding patient autonomy. Firstly, the data which purports to establish certain diagnostic and treatment interventions as marginally useful is quite unclear, and, therefore, possibly quite unreliable. Secondly, the time and opportunity costs involved in attempting effectively to disclose exactly what is at stake in many decisions to limit access to expensive, marginally beneficial diagnostic and treatment protocols may simply be overwhelming. Nonetheless, we shall focus our attention on the circumstances under which full disclosure might be avoided at specific times of institutional rationing.

following enrollment. For this pervasive consent-seeking would encourage increased utilization and/or straying from the managed care organization. Further, it would return the locus of decision-making to the doctor and patient, especially the patient, which is demanded by the doctrine of informed consent. However, apart from questions of practicality in time-management and their relation to economics, if decision-making is consistently the prerogative of the patient in managed care organizations, then, if we accept the inverse variation of choice and cost,\(^2\) the end of managed care is hindered.

This thesis shall examine two potential models for preserving patient autonomy in consonance with the doctrine of informed consent and in the face of institutional rationing decisions—firstly, global, blanket, or bundled consent prior to enrollment in a managed care organization, and, secondly, the waiver of one’s right to informed consent prior to enrollment. Both models attempt to obviate the physician’s obligation to obtain isolated, case-specific informed consents or refusals at the time of particular, discrete treatment decisions motivated by an economic rationing mechanism, by way of a prior disclosure at the time of enrollment. The further implications of this analysis include questions of the extent to which managed care organizations ought to be regulated, and insulated from a substantial class of lawsuits which might claim violation of a patient’s right to informed consent on both the tort model of Salgo v. Stanford and the malpractice model of Natanson v. Kline, at the very least. At most, our analysis addresses the moral foundations of managed care, and whether such organizations can be justified.

Philosophically, the ensuing analysis can be seen as an extended, albeit somewhat indirect inquiry into the concept of autonomy, which motivates the doctrine of informed consent. In Chapter 1, §2, we shall offer a rudimentary and ostensibly uncontroversial

\(^2\) Chapter 1, §1.
account of autonomy for health care decisions. For traditional, discrete informed consent events, this account of autonomy shall be quite sufficient. However, in the case of the prior disclosure of a rationing mechanism, we shall be confronted with divergent models which purport to preserve autonomy in conformity with the doctrine of informed consent without full disclosure at the time of each future intervention. We shall take our first look at these two models in the second chapter, as they are presented by Mark A. Hall. The import of these alternative models are essentially alternative understandings of autonomy. Therefore, the rationing of medical resources by managed care organizations can be regarded as a heuristic; it forces us to further clarify our seemingly adequate theory of autonomy.

In the third and fourth chapters, we shall examine the two models in detail. In both cases, we shall be concerned with the extent to which our model of choice can effectively bind a given patient over time, as would seem to be the end of enrollment with a managed care organization, while remaining consistent with our original idea of autonomy. Over the course of our inquiry into the extent to which 'prior global consent' and 'the prior waiver of consent' can be regarded as consistent with our theory of autonomy, we shall come to see two radically different general ideas of autonomy, which, of course, will have application far beyond the test case of managed care. The accounts of autonomy which emerge according to our two models might be dubbed the 'integrated' and 'hierarchical' conceptions of autonomy, respectively. In the fifth and concluding chapter, we shall attempt to recount the merits and demerits of the two models, and draw conclusions about what we have learned about patient autonomy, and,
more generally, our theory of autonomy and how best to understand autonomous actions which serve to bind the agent over a period of future time.

§ 1. Managed Care

During the latter part of the twentieth century, spending for U.S. healthcare services grew at a rate of 3% faster than spending on all other goods and services combined, and jumped from 9.3% of the GDP in 1980 to 13.6% in 1992. In 1993, the average American spent $3900 on healthcare, for a total of $942.5 billion. The remarkable escalation in medical spending during this time created the impetus for the creation of strategies of cost-containment, including, most notably for the present undertaking, the concept of the managed care organization. Whether an HMO, PPO, or EPO, it is often part of the cost-containment strategy of managed care organizations to ration medical resources.

Managed care presents an alternative to traditional fee-for-service arrangements in healthcare. Given the fee-for-service model, patient health plans are provided by passive third parties, which in general make the doctor and patient the locus for medical decision-making (generally, the fee-for-service model involves a third party, although it may be comprised of simply the doctor and patient, in which case, the physician and patient are obviously the locus for medical decision-making). While third party insurers guarantee optimal freedom in medical decision-making, they cannot predict or control the prices of their premiums insofar as they cannot control the healthcare market. In fact, it is reasonable to assume that the fee-for-service model of healthcare provision contributed significantly to the rapid escalation in healthcare costs during the latter half of the twentieth century, noted above. Along with the development of more sophisticated and accordingly more expensive medical technologies during this time, came a “trend
toward broad benefits under provider control [which] was supported by a feeling...that a person should not be forced to weigh costs and benefits at the time of illness—that individuals should not have to forego needed care on account of cost at the time that care is needed.\(^4\) Thus, not only were the doctor and patient the locus of medical decision-making, but they were essentially “insulated from the economic consequences of their health care spending decisions,” enabling patients to “freely demand ‘the best, no expenses spared’,” and physicians to “freely order every intervention of the slightest potential benefit.”\(^5\) The seeming historical implication of the fee-for-service model is that the value of the free and unconstrained choice of patients and providers, and the value of the containment of healthcare costs,\(^6\) vary inversely. In taking this implication seriously, managed care organizations have sought to offer an alternative to the high costs of fee-for-service arrangements. The choice of patients and providers are constrained in the interest of affordability, as informed by their inverse relationship.

The most basic way that managed care organizations are able to constrain patient and provider choice is through actively and effectively decreasing the utilization of resources. In the case of patients, resource use can be minimized by limiting access to specialists and special diagnostic tests through the imposition of a gatekeeper, ordinarily the primary care physician, and by imposing financial disincentives for straying from the managed care organization. In the case of physicians, freedom to make use of potentially

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cost ineffective procedures and tests may be subject to scrutiny by utilization review boards, and both incentives for economical use (bonuses, capitated payments), and disincentives for overuse (withholding of compensation) may be imposed. It is evident that the incentives for providers on the managed care model are quite contrary to those of providers on the fee-for-service model. The economical management of resources, aimed at cost reduction for those who pay for healthcare, will henceforth be called rationing.

However, competition between the values of affordability and range of choice need not represent a catch-22. Although affordable healthcare accompanied by complete patient control might seem optimal, given the limitation of resources faced by most patients, there can be good reasons for allowing a managed care organization to limit utilization of resources. In the extreme case, over-diagnosis may lead to over-intervention and eventuate in detrimental results for the patient. Essentially, the limitation of access to resources may, in many cases, reduce the patient’s risks to morbidity and mortality. Additionally, it remains an ostensibly prudent tradeoff to limit access to diagnostics and treatment which can be regarded as marginally useful, not to mention potentially harmful, in the interest of conserving one’s resources. This conclusion “is substantiated by a growing body of evidence.” While the success of managed care organizations at providing service at a lower cost than fee-for-service arrangements has been empirically documented, there have been no studies which have been able to conclude that the overall quality of healthcare provided by health

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6 The assertion of these two values as implicit in American healthcare is taken originally from, Engelhardt, H.T. ‘Hand-out—Managed Care’. 3/1/00.
7 Engelhardt, H.T. ‘Hand-out—Managed Care’, 3/1/00.
management organizations differs from that of their fee-for-service counterparts, and some studies suggest that it is better.\(^{10}\)

Nonetheless, when we consider the trade-off achieved by managed care organizations, namely, the reduction in patient and provider choice, which makes possible the reduction in price, we are confronted with ethical questions surrounding the imposition of a limitation on choice. Specifically, we must inquire into the role of informed consent, which is ordinarily depicted as the patient's right and the physician's obligation, in this unique setting. When a patient is enrolled in a managed care organization, which makes economically-motivated rationing decisions in the interest of limiting utilization, is his or her right to free and informed consent abridged at discrete junctures by such decisions? Likewise, when a physician conforms to institutional standards of care by limiting access to expensive but potentially important or informative treatments, does he or she have a responsibility to inform the patient?

§2. Informed Consent and the Principle of Autonomy

In order to understand fully the rights and obligations relative to the doctrine of informed consent which may or may not be present for the patient, physician and managed care organization, we must more fully explicate the doctrine of informed consent. Firstly, informed consents and refusals are autonomous actions of persons, as we shall see, and, in conformity with the philosophical tradition, we shall suggest that the doctrine of

informed consent is "straightforwardly linked to the principle of respect for autonomy."\textsuperscript{11} This is relatively uncontroversial. The more interesting (and controversial) question which this begs is the question of how we are to understand the idea of 'respect for autonomy'. Etymologically, autonomy can be traced to the idea of 'self-legislation', but how are we to understand this new idea of 'respect for self-legislation'.

We could offer a Kantian interpretation wherein making laws unto oneself in conformity with the dictates of pure reason necessitates that we respect other persons in their law-making capacity. This formal aspect of the categorical imperative, which links respect for autonomy with respect for other persons as free and rational, may be insightful, but we may not want to accept the further Kantian specifications of duties based upon his notion of the 'pure rationality' which informs autonomy. We may not be able to secure the actual content in particular circumstances of how we are to respect the autonomy of persons from this abstract and undetermined idea of pure reason. Thus, autonomy as 'self-legislation' involving adherence to a list of specific duties gives way to autonomy as 'self-determination', where the formal character of respect for persons as free and rational becomes paramount and the specific content of actions becomes variable.

The question now becomes, how can we optimally respect the autonomy of other persons as free and rational? Firstly, we must provide sufficient relevant information material to the decision at hand (the selection of the standard of sufficiency is immensely controversial, and we shall address this more fully in what follows\textsuperscript{12}). If the patient is to make an autonomous decision, one in which he determines himself in a manner

consistent with his beliefs, values, principles, etc., he must sufficiently understand the facts material to the decision, or have a "fully adequate apprehension of all the relevant propositions or statements (those that contribute in any way to obtaining an appreciation of the situation) that correctly describe...the foreseeable consequences and possible outcomes that might follow as a result of performing and not performing the action." It is certainly not the case that people universally have a duty to respect the autonomy of others by providing them with sufficient relevant information regarding all of their decisions—this *prima facia* duty is obviously subject to considerations in practice such as proximity. However, the duty to inform as a means of respecting autonomy must be regarded as a universal actual duty of physicians, insofar as the fiduciary relationship obtaining between doctor and patient requires it in conjunction with the idea that people ought to be free to determine themselves in accordance with their own beliefs, values, principles, etc.\(^{14}\)

Secondly, in respecting the autonomy of other persons as free and rational, we must not coerce them in any way, nor permit them to be subject to any coercion. Coercion is clearly at all times inconsistent with respect for autonomy, as it interferes with the freedom and capacity for self-direction which we have seen are essential to autonomy. As was the case in the first necessary element for the respect of autonomy, the duty not to *permit* coercion may not at all times and in all instances be the actual duty of all persons, but in the fiduciary doctor-patient relationship, it must be regarded as such.

The third and final necessary element of respect for autonomy is the assurance that the person making the decision has some degree of understanding and appreciation

\(^{12}\) Specifically, in Chapter 2, §6.
\(^{13}\) Faden and Beauchamp, 252.
of the nature of his or her decision as an intentional authorization or refusal, permission or forbearance. Respect for autonomy is informed by the idea that persons ought to be respected as free and rational. However, if a person is unable to comprehend the nature of his or her action, then the rationality of the alleged person is in doubt, regardless of the beliefs, values, principles, etc. which may have informed the particular alleged person. It is not so much important what the specific beliefs, values, principles, etc. are in order to determine decisional capacity. Rather, the critical aspect for decisional capacity is that actions are considered in light of ones beliefs, values, principles, etc., whatever they may be.

Henceforth, the informed consent or refusal of a patient will be treated as a specific instance of an autonomous action, and one which must be ensured by the physician, as noted. In addressing the questions of informed consent relative to rationing decisions in managed care organizations, we shall inquire into whether or not particular actions qualify as autonomous in light of the three criteria above. Further, as we delve into the two proposed models, we shall see alternative understandings of autonomy emerge, which shall prove successful to varying degrees in the case of institutional rationing.

§3. The Principle of Beneficence

While informed consent is, as we have said, 'straightforwardly linked' to the principle of respect for autonomy, this is not the only principle which informs bioethical thinking. The principle of beneficence, which essentially says that one ought to do good for others, and in the case of bioethics says that the physician ought to do what is best for the patient, appears to come into direct conflict in many instances with the principle of

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respect for autonomy. (Once again, while the obligation unto beneficence may in general be a *prima facia* consideration, it is universally actual in the case of physicians.) For instance, the physician may see the good of the patient and the outcome of his autonomous decision as divergent, in which case, the principles of autonomy and beneficence would appear to conflict. However, if the conditions for an autonomous decision are met (the patient is fully informed, free from coercive forces, and acts with understanding of intent), then the patient must be recognized as having a prior knowledge of his good, to which the physician, in seeking the good of the patient, must defer, regardless of his considered opinion. This is not to claim that the physician has an obligation to treat when there is a disagreement regarding the good of the patient, but only to respect the autonomous decision of the patient.

§4. Autonomy and Beneficence in Rationing Decisions

If we consider rationing decisions in isolation following patient enrollment in a managed care organization, then it would appear that they violate the doctrine of informed consent as informed by respect for autonomy. In fact, they effectively preclude autonomous action. The patient is ostensibly coerced, i.e., the decision concerning his or her future course of treatment, diagnosis, etc. is made for him or her taking no cognizance of his or her right to self-determination. It may be that autonomy could be preserved according to the patient’s right to exit the managed care organization and freely and independently seek treatment more consistent with his or her ends. However, if the decisions are simply being made without informing the patient about the details, potential and probable risks and/or benefits, alternative treatment plans with their accompanying potential and probable risks and/or benefits, along with an explanation of the voluntary nature of the
treatment, as subject to consent or refusal, then the patient has no means of establishing criteria for when exit would be prudent.\textsuperscript{15}

Is it the case that physicians have a responsibility to inform patients at each isolated point at which a rationing decision may be made, especially when the physician’s opinion differs from that of the managed care organization? Ideally, this may be desirable, but the critical issue is that if we offer an affirmative answer, then we may have effectively hindered what is unique about managed care, as reviewed in Chapter 1, §1.

In response to this question, it has been suggested that what is needed, if managed care is unavoidable and potentially desirable, is a more robust notion of beneficence, which supercedes institutional decisions based on economic benefit, and makes possible decisions based on benefit to the patient. Essentially, the claim is that if the principle of autonomy must, in some sense, be overlooked in the interest of economic considerations, then the principle of beneficence must pick up the slack, as it were. Ultimately, these responses attempt to recapture something of the Hippocratic beneficence traditionally found in the doctor-patient relationship by translating it to the institutional level.\textsuperscript{16} These attempts to extend the good sought by institutional decisions through the principle of beneficence may have some merit, but if we can salvage the rights of the patient in the context of managed care in terms of the principle of autonomy outlined in Chapter 1, §2, there may be less necessity to oversee the good of the patient. Further, if we can rescue the autonomy of the patient in the face of rationing decisions by managed care


organizations, rather than resorting to some form of institutional or other beneficence, then we have asserted the primacy of the principle of autonomy over the principle of beneficence in an area where this may not seem unreasonable.

We have proposed that the patient does have the most intimate knowledge of his or her best interests, values, principles, etc., although the physician will know better how to achieve the good in question, and that respecting autonomy, as defined above, secures the good of the patient more effectively in most cases than some form of beneficent action.\textsuperscript{17} The principle of beneficence itself is problematic insofar as it is unclear what and whose notion of the good is to be employed, and how this notion is to be ascertained. If we grant that the good of the patient ought to be procured by the physician or managed care institution, then it is still dubious that the physician or managed care institutions could at all times be privy to the good of the patient, whereas we can assume that the patient is a better and less circuitous judge. Further, it may not always be desirable that the purported good be effected, especially in nontrivial matters, in which case the conditions for the purported act of beneficence must be negotiated in the face of some sort of forbearance rights, which is another assertion of the primacy of the principle of autonomy over that of beneficence.\textsuperscript{18} It seems then that if we can offer an account of rationing decisions by managed care organizations which retains the autonomy of the patient in question, despite apparent conflicts, this account would be preferable to giving up patient autonomy and 'making it up', as it were, \textit{via} the principle of beneficence.

\textsuperscript{17} Chapter 1, §3.
§5. Salvaging Autonomy

Taken in isolation and following enrollment in a managed care organization, rationing decisions appear to violate a patient's right to informed consent as expressed in the principle of autonomy. Essentially, we have said that in response to the question as to whether physicians (or institutions) have a responsibility to seek an informed consent or refusal to each and every isolated rationing decision, if consent is not sought, it appears that the principle of autonomy is violated, but if consent is sought, we have turned recreant to managed care. However, it would be preferable to provide an account of the conditions under which autonomy would be preserved despite the apparent problems, rather than revert to the principle of beneficence as the solution. The most promising opportunity to rescue the principle of autonomy is to make the case that such rationing decisions can be preemptively authorized at the time of enrollment in the managed care organization. We would like to suggest that there are two models which purport to account for this authorization and that they are radically divergent, although often conflated.19

The first model seeks to secure consent to all future treatments on the basis of informed consent to the criteria for and results of rationing decisions at the time of enrollment. The reasoning behind this justification is that "enrolling with an HMO

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18 Engelhardt, 103-29.
19 See e.g., Wear, S. Informed Consent: Patient Autonomy and Clinician Beneficence Within Health Care. 2nd Ed. Washington D.C.: Georgetown University Press, 1998. 23, in his section on the ‘Waiver Exception’ to the informed consent requirement: “the least troublesome exception would seem to occur when the patient voluntarily gives up his right to an informed consent...For this exception to be legitimate, the patient...must still give a prior generic consent to treatment”; Dresser, R. “Bound to Treatment: The Ulysses Contract.” The Hastings Center Report. June 1984. 13-17: “By furnishing a means of consenting in advance to treatment for a mental disorder and of waiving the right to refuse that treatment when it is administered...”; and, Hull, R.T. “Informed Consent: Patient’s Right or Patient’s Duty?” The Journal of Medicine and Philosophy 10(1985), 183-97, 184. “The typical blanket consent form presented to a patient to sign upon admission encourages the patient passively to waive [his rights]."
constitutes blanket advance consent to the subsequent denials of marginally beneficial care created by the rules, procedures, and incentives disclosed at the outset (and periodically reaffirmed through annual open enrollment decisions); thereafter, additional disclosure at the time of treatment is unnecessary."\textsuperscript{20} This first model might be described as \textit{global, blanket, or bundled consent}. We shall find that the notion of autonomy which is supported by this model of informed consent is an integrated understanding of autonomy. The second model authorizes rationing decisions by way of a waiver of one’s right to free and informed consent (within limits) at the time of enrollment. Under this second characterization, informed consent requirements “are not satisfied—they are dispensed with at the patient’s request.”\textsuperscript{21} This second model might be described as a \textit{waiver of informed consent}. We shall find that the notion of autonomy which is supported by this model of informed consent is a hierarchical understanding of autonomy. The question which we shall seek to address in what follows is whether either of these can do the job of retaining patient autonomy in consonance with the doctrine of informed consent and in the face of future discrete rationing decisions on the part of managed care organizations. Our analyses of these two models will have implications for how best to understand autonomy relative to prior commitments such as enrollment with a managed care organizations, and how such prior autonomous actions can effectively bind over time.

\textsuperscript{20} Hall, 656.
\textsuperscript{21} Hall, 660.
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CHAPTER 2: MARK A. HALL’S ARGUMENTS

The two models which purport, via prior disclosure, to preserve patient autonomy in the face of rationing decisions introduced in the preceding chapter, namely, prior global consent and the waiver of one’s right to informed consent, have been proposed by Mark A. Hall in an article from the legal literature entitled “Informed Consent to Rationing Decisions.”¹ Before examining the adequacy of the two models themselves in the following two chapters, we shall undertake the task of explicating the arguments made by Hall on their behalf.

§6. Hall on Informed Consent

It is important to remember that when Hall alludes to the doctrine of informed consent, he is describing the legal doctrine which emerged in 1957, it is generally agreed,² in Salgo v. Leland Stanford Jr. University Board of Trustees. The essence of Hall’s analysis is “to inquire whether adequate global disclosure at the time of enrollment (or re-enrollment) suffices to satisfy legal requirements of informed consent.”³ However, while Hall is primarily concerned with the legality of informed consent to rationing decisions rather than the philosophical implications of such a practice, with which we shall concern

² See Beauchamp, T. and R. Faden. 1986. A History and Theory of Informed Consent. New York: Oxford University Press. p. 56-60, in which the authors note that agreement on this date is a notable exception to the broad disagreement between historians of informed consent, Martin S. Pernick and Jay Katz.
³ Hall, 646, emphasis mine; the global disclosure alluded to ought not to be confused with global consent. The former is presupposed as a de facto event. The question for Hall is whether there is a model whereby it can be understood to be consistent with the legal doctrine of informed consent, global consent being one of
ourselves in the chapters to come, we cannot conclude that his notion of the legal doctrine of informed consent is narrow by any means. Rather, upon looking at case histories involving informed consents and refusals, Hall proposes a “more fully developed version of informed consent doctrine,” based upon the premise that “the central purpose of informed consent law is to enhance personal autonomy over decisions that affect physical and mental well-being.” Thus, it appears that Hall agrees with Beauchamp and Faden’s assertion, noted earlier, that the doctrine of informed consent is “straightforwardly linked to the principle of respect for autonomy.” In concurring with Beauchamp and Faden, Hall is appealing to the philosophical underpinnings of the doctrine of informed consent, for autonomy is primarily a philosophical concept, albeit one which arose in medical ethics largely in response to the courts’ advocacy of informed consent (along with certain developments in medical technology, and more stringent standards on research protocols at e.g., Nuremberg, Helsinki).

Hall begins his inquiry by posing the obvious question of how the doctrine of informed consent is relevant to and possibly required in the case of institutional rationing decisions. Given that the legal doctrine of informed consent has its roots in battery law, “a branch of tort law that compensates for harmful or offensive touchings,” it is not initially clear how the failure to disclose information regarding a particular therapeutic or diagnostic measure which would otherwise not be undertaken might constitute a breach of one’s ‘right’ to an informed consent, given that the patient is not touched in this case.

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Footnotes:

4 Hall, 648.
5 Chapter 1, §2.
6 Beauchamp and Faden, 101.
7 Ibid., 91-101.
A failure to disclose information regarding an expensive, marginally beneficial intervention precluded by a rationing scheme cannot be litigated on the battery model, because the patient is never touched.

The second model of the legal doctrine of informed consent, advocated in *Natanson v. Kline*, which is grounded in negligence or malpractice law, does little to further the cause of the patient in the case of institutional rationing decisions. The malpractice model holds physicians liable for the adverse consequences resulting from a failure to disclose information “which a reasonable medical practitioner would make under the same or similar circumstances.” However, given the development of managed care, it is not clear whether the professional standard is sufficient to preserve the autonomy of the patient, given that managed care organizations can refrain from disclosing rationing decisions with impunity, if they can make the case that the disclosure of marginally useful treatment is not customary. More generally, it may simply not be the case that any disclosure is customarily made regarding cases which conform to the standard affirmed in *Salgo v. Stanford*, i.e., where the patient is not touched, which would effectively render the malpractice model as impotent as the battery model in this regard. Further, the legal moorings of the doctrine in malpractice law ensure that the physician is under no obligation to inform the patient of anything, so long as there are no adverse consequences. As we shall see later in this section, this professional standard of disclosure, which appears at least to be an improvement on the rudimentary battery model, is still an inadequate standard of disclosure. The more promising standards of disclosure, which Hall does not address at the present juncture, are the objective or

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8 Hall, 647; this is the tort model of the legal doctrine of informed consent advocated in *Salgo v. Stanford*, 317 P.2d 170, 181 (1957).
reasonable person standard, advocated in *Canterbury v. Spence*,\(^\text{10}\) and the subjective standard, advocated in *Scott v. Bradford* and *Spencer v. Seikel*.\(^\text{11}\) We shall soon see how the latter standard makes the doctrine of informed consent quite relevant to institutional rationing decisions.

After noting the dubiousness with which legal precedent addresses the demand for an informed consent to an economically-motivated decision not to provide some specific treatment or diagnostic procedure, Hall cites proponents of an extension of the doctrine of informed consent beyond its legal history, such that the law can further personal autonomy, as is its "central purpose."\(^\text{12}\) This "logical extension" of the legal doctrine of informed consent involves the following four emendations: 1.) *heightened duty*—requiring not simply a disclosure of information in conformity with legal requirements, but the assurance that the patient has understood the information; 2.) *no injury*—allowing the patient to recover damages for the physician's failure to disclose information adequately regardless of whether or not the physician's failure to disclose resulted in injury to the patient; 3.) *no causation*—allowing the patient to recover damages for the physician's failure to disclose information adequately regardless of whether further information would have been material to the patient's decision; 4.) *no touching*—requiring that patients be informed not only about the recommended course of treatment, but also about alternative treatments or non-treatments.\(^\text{13}\) The above proposed

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\(^\text{12}\) Hall, 648.

ramifications of the legal doctrine of informed consent have been "partially successful only with respect to the touching element,"\textsuperscript{14} which is the element most critical for the present inquiry, according to Hall.

The weakening of the requirement that the patient be subject to touching, in accordance with battery law, can be observed in cases which have affirmed the right to an 'informed refusal'.\textsuperscript{15} Generally, when a physician seeks an informed consent, it is necessary that he, 1.) explain the diagnosis to the patient for which a further intervention is proposed; 2.) recommend the further intervention along with the significant benefits and risks attendant to it; and, 3.) suggest alternative interventions along with the significant benefits and risks attendant to them.\textsuperscript{16} The right to an informed refusal which the courts have affirmed, further requires the physician to, 4.) offer the significant risks and benefits attendant to the absence of intervention.\textsuperscript{17} Furthermore, this fourth requirement may not even be necessary in many cases. As noted by Beauchamp and Faden, unless the physician opts to forgo all treatment, the decision not to treat may be subsumed under (3.) above. Although not an intervention, the decision not to treat must be categorized as an alternative to the proposed treatment, which would require the physician to disclose the attendant risks and benefits.\textsuperscript{18}

Hall is content to cite the legal extension of the doctrine of informed consent to cases of informed refusal, thereby making informed consent relevant to physician's obligations concerning institutional rationing decisions, as we shall see. However, it

\textsuperscript{15} E.g., Truman v. Thomas, 611 P.2d 902 (Cal. 1980).
\textsuperscript{17} Hall, 649; Wear, 10.
might be useful to explicate the philosophical argument on behalf of this extension. As we have noted repeatedly, Hall believes that the "central purpose of informed consent law is to enhance personal autonomy."\textsuperscript{19} The rather basic notion of autonomy advanced in Chapter 1, §2, claimed that for one to act autonomously, one must be privy to all of the information relevant to the decision at hand. Thus, if informed consent law is to "enhance personal autonomy," it must ensure that the patient is privy to the information relevant to the decision at hand. Therefore, all that is presupposed in making the claim on behalf of the right to an informed refusal, is that the risks and benefits attendant to non-treatment are relevant to the decision to be made by the patient. This claim is so eminently reasonable, that we shall not deter our progress with corroborative examples. In fact, more is presupposed in making this claim concerning the standard of relevancy, but we shall return to this.

Have we now finally answered the question as to how the doctrine of informed consent is relevant to institutional rationing decisions? It appears that we can answer this question in the affirmative, insofar as we can make sense of the physician's obligation in this regard in two ways. Firstly, if the physician is to promote patient autonomy, then when the decision to provide no treatment carries with it significant risks (i.e., information regarding this decision is relevant to the patient), the physician, as fiduciary, must inform the patient accordingly. Secondly, if the proposed clinical judgment is non-treatment or an economically constrained treatment, the physician must inform the patient of viable alternative treatments, however expensive.

\textsuperscript{18} Hall, 650.
\textsuperscript{19} Ibid., 648.
But alas, our final qualification to the above may deter us further. Is it in fact the case that the physician has an obligation to inform the patient of the significant benefits and risks attendant to all treatment alternatives, *however expensive*? Or, given our first attempt to answer the question of how the doctrine of informed consent is relevant to institutional rationing decisions, is it really the case that information regarding treatments which will not be covered by one's managed care organization, is relevant to the patient, if the patient cannot afford these treatments? As Stephen Wear has noted, there are conflicting values present in any informed consent 'event', such that one must strike a balance between the desire to provide sufficient information and the desire not to hyperinform, or provide so many options, that the patient is overwhelmed, and the crucial issues obscured.²⁰ Further, there are significant prudential constraints on the amount of information which can be conveyed to patients, and these constraints are especially salient when the information appears immaterial to the decision at hand, as might be the case for many patients with exorbitantly priced treatments.²¹ Finally, the prudential constraints on the amount of information which a physician might be expected to give are intensified in the managed care setting, where incentives are in place to limit resource use beyond that recommended by the managed care organization.²² Clearly, there are several factors present which would seem to induce the physician into limiting his or her disclosure, such that expensive treatment options beyond the scope of the managed care organization's plan would be excluded from the information provided. However, we must inquire whether such a truncated disclosure is truly consistent with the autonomy of the patient.

²⁰ Wear, 19.
²¹ Hall, 653-6;
Firstly, we must distinguish expensive but otherwise viable, effective, or appropriate treatment or diagnostic options from nonviable, ineffective, or inappropriate treatment or diagnostic options. The latter might be described as those treatment or diagnostic options which hold an insignificant probability of providing alleviation from symptoms or diagnostic information respectively, either in general or in the particular case of a given patient. Clearly, it is impossible for the physician to recite the litany of all possible treatments which hold a positive probability of success for every patient. Rather, treatment options with an insignificant chance of success are discarded because they must be regarded as irrelevant to the decision at hand. Once again we are confronted with the need for a criterion for selecting the relevant information to be presented. At this juncture, we shall attempt to provide some argument in favor of one such standard. The available standards of disclosure, which were foreshadowed in Hall’s review of the legal precedent, are the reasonable person\textsuperscript{23} standard, the subjective\textsuperscript{24} standard, and the professional\textsuperscript{25} standard.\textsuperscript{26} We shall argue for the rejection of the reasonable person and the professional standard, because the connection between these standards of disclosure and the philosophical doctrine of informed consent is tenuous at best.

We have repeatedly asserted with Beauchamp and Faden that the doctrine of informed consent is "straightforwardly linked" to the principle of respect for autonomy. Further, we have claimed that in the case of the doctor-patient relationship, the doctor

\footnote{\textsuperscript{22} Chapter I, §1; see also, Morriem, 34-9.}

\footnote{\textsuperscript{23} See, e.g., Canterbury \textit{v.} Spence, 646 F.2d (D.C. Cir. 1972).}

\footnote{\textsuperscript{24} This standard has had much more philosophical support than legal, but may be evident in e.g., Cobbs \textit{v.} Grant, 8 Cal. 3d 229, 104 Cal. Rptr. P.2d 1 (1972), along with Scott \textit{v.} Brandford and Spencer \textit{v.} Seikel.}

\footnote{\textsuperscript{25} See, e.g., Natanson \textit{v.} Kline.}

\footnote{\textsuperscript{26} There appears to be broad consensus that this list of disclosure standards is exhaustive for all intents and purposes; see, e.g., Beauchamp and Faden, 30-34; Wear, 17-9; Engelhardt, 310-5.}
ought to promote the autonomy of the patient, *ceteris paribus*. Finally, we have claimed that for an action to be autonomous, the subject must have sufficient relevant information material to the decision at hand. If this is the case, then the disclosure of information necessary for an informed consent or refusal, is undertaken with the end of an autonomous action on the part of the patient. At this point, it seems clear that there is no obvious connection between the disclosure which is relevant to the individual patient’s decision and the disclosure “which a reasonable medical practitioner would make under the same or similar circumstances.” One might attempt to defend the professional standard by claiming that in most cases, medical professionals offer the information which is relevant to the individual patient’s decision. However, if the professional custom is to offer the information which is relevant to the individual patient, then it ceases to be the professional standard and becomes the subjective standard. Possibly, one would want to defend the professional standard by claiming that the relevant information simply is the information customarily offered by reasonable medical practitioners. However, we would like to suggest that there is no reason to think that what is relevant to a patient’s decision and what is customarily disclosed by physicians are necessarily convergent. This latter claim hardly affirms any standard, insofar as it simply begs the question in favor of the physician’s disclosure. It seems clear that in reflecting upon whether a specific piece of information ought to be offered to a patient, the question ought to be, “will this piece of information be potentially relevant to the patient’s decision,” and not, “would this piece of information generally be offered by my colleagues, if polled.” The former question is asked in the interest of preserving patient autonomy; the latter is not in any obvious way.

Likewise, it seems clear that there is no obvious connection between the disclosure which is relevant to that individual patient’s decision and the disclosure which would be relevant to some fictional ‘reasonable person’ in the individual patient’s position. As has been argued in myriad places, “there is no socially or historically unconditioned, atemporal notion of a reasonable and prudent person.”28 so it is initially unclear to what this standard is even appealing. We have avoided asserting any canonical idea of ‘Reason’, as it would be somewhat naïve at the present stage of history. Rather, we have claimed that patients with divergent principles (and also divergent beliefs, values, and experiences) can make equally rational albeit divergent choices. Therefore, the so-called reasonable person standard is hardly an unambiguous standard. It is certainly fallacious to argue that because all autonomous decision-makers are reasonable people, we ought to appeal to the standard of the reasonable person, for we have not granted perfect unanimity among reasonable persons. Beauchamp and Faden note in this regard that:

It is arguable that the reasonable person standard allows more scope for the individual’s peculiar circumstances than proponents of the subjective standard are willing to admit. The potential exists in every case for considering the patient’s distinctive circumstances, while still requiring a reasonable decisionmaking process.29

However, Beauchamp and Faden have confused their criteria for autonomy. As we shall see in the following chapter, the rationality of the decisionmaking process is more congruent with Beauchamp and Faden’s criterion of intentionality. What is at stake at

28 Engelhardt, 314.
29 Beauchamp & Faden, 47, note 36.
present is the standard of disclosure prior to the process, and insofar as the individual's peculiar circumstances are being considered, the reasonable person standard has been effectively abandoned in Beauchamp and Faden's argument.

We shall henceforth advocate the subjective standard. However, regardless of whether the objective or subjective standard of disclosure is more appropriate in this particular case, it is clear that an extensive class of possible treatment options will be excluded as providing no significant chance of benefit to either patients in general, or a particular patient, respectively, given the above definition of nonviable treatment or diagnostic options.

The class of treatment options ruled out above, which has been upheld by the courts,\textsuperscript{30} is quite distinct from viable alternative treatments which are simply too expensive for the patient to afford. Based upon our statement of how the doctrine of informed consent is relevant to the case of institutional rationing decisions, we must show that knowledge of expensive treatments is relevant or material to the patient's decision. We must conclude that it is, insofar as the patient may:

\[ ...pay\ out\ of\ pocket\ or\ seek\ to\ solicit\ donations\ [for\ the\ expensive\ treatment].\]

Even apart from the short-term possibility of acquiring the particular treatment, the information might be material to a longer-range decision of whether to switch doctors within the plan or to switch insurance plans at the next open-enrollment opportunity.\textsuperscript{31}

Thus, it appears that we were correct in claiming that if the proposed clinical judgment is non-treatment or an economically constrained treatment, the physician must inform the

\textsuperscript{30} See, e.g., Novak v. Texada, Miller, Masterson and Davis Clinic. 514 So.2d (La. App. 1987).

\textsuperscript{31} Hall, 652; See also, Menzel (1990), and Morriem (1991).
patient of viable alternative treatments, however expensive. Having noted the prudential constraints on such disclosures, it is at this juncture that Hall seeks to elude such repeated discrete disclosures by way of prior, global disclosure. The intensified impetus against these disclosures in the managed care setting has been noted in Chapter 1, §1 and §4.

§7. Hall on Prior Global Consent

The first model which purports to preserve patient autonomy in accordance with the doctrine of informed consent, while eluding isolated and case-specific post-enrollment disclosures, is that of prior global consent (also referred to as blanket or bundled consent). Proponents of this model argue that “enrolling with an HMO constitutes blanket advance consent to the subsequent denials of marginally beneficial care created by the rules, procedures, and incentives disclosed at the outset (and periodically reaffirmed through annual open enrollment decisions); thereafter, additional disclosure at the time of treatment is unnecessary.”

What Hall undertakes to examine in the argument for prior global consent is the claim that “a fully informed decision to enroll...constitutes actual consent to the subsequent treatment decisions.” The enrollment event is imbued with the power to effect actual consents to future decisions of which the enrollee knows nothing, because “he or she is informed of and consents to a set of broad parameters of a rationing mechanism.” Ultimately, according to proponents of this first model, “advance agreement to a set of rationing rules and incentive binds the insured person by the treatment decisions that result from this mechanism, much as a

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33 Hall, 657.
34 Ibid.
principal is bound by the contracts his agent forms."\textsuperscript{35} The notion of autonomy advocated by the prior global consent model is integrated, for the informed consent given in this case is unique only in degree, rather than kind. This integrated approach to autonomy espouses a multiplicity of scopes of autonomous action over a multiplicity of possible times.

The only objection to the prior global consent model noted by Hall is that it is simply too much to ask of the potential enrollee that he or she assimilate the massive prior disclosure required, given that the "array of choices one must make at that stage are far too vast and complex for ordinary subscribers, let alone health policy experts, to comprehend adequately."\textsuperscript{36} The counter-argument offered by Hall is that the efficacy of the disclosure (or lack thereof) is a poor index of the sufficiency of the disclosure. Hall reaches this conclusion by asserting that if its converse were true, very few disclosures would prove sufficient. The rampant inefficacy of disclosures, resulting in patient failure to understand the information conveyed, in "conventional applications of informed consent" is widely recognized and supported by "dozens of empirical studies."\textsuperscript{37} Despite the astonishing limits and sometime futility of our current informed consent practices, we neither dispense with, nor bolster these practices. Likewise, whether or not prior global consent actually is efficient in imparting information may have little bearing on the profitability of this practice, as offering the individual an opportunity that could be taken to gain full comprehension of the relevant information may be sufficient to justify the

\textsuperscript{35} Ibid.
\textsuperscript{36} Ibid.
practice. In both cases, "we reason that autonomy values are promoted simply by giving patients the opportunity to understand or to make their own mistakes."\textsuperscript{38} It remains to be seen whether Hall's reasoning has turned recreant to his professed philosophical intentions at this juncture, but we shall return to this at great length in the chapter to come.\textsuperscript{39}

We have argued that if the end of disclosure is an autonomous action on the part of the patient, then the end of disclosure ought to be patient understanding to such a degree that this is possible. Hall also alluded earlier to the \textit{heightened duty} emendation to informed consent law as part of the logical extension of the present law, motivated by the autonomy values which underlie it.\textsuperscript{40} However, in defending the prior global consent standard against charges that the initial disclosure is simply overwhelming to prospective patients, Hall rejects the heightened duty requirement and is left with a rationale which "provides no guidance on how much disclosure is required for consent to be truly informed because it concedes that being truly informed is largely a fiction and it argues that autonomy values are satisfied even in its absence."\textsuperscript{41} Hall does not explicate exactly which autonomy values are satisfied by fictional informed consents. Regardless, Hall now needs a positive disclosure standard, given that patient understanding is apparently irrelevant on his account. The "talisman for the adequacy of disclosure" which Hall settles on is an exceedingly vague appeal to "a much more intuitive, pragmatic, and socially constructed judgment about how much effort at disclosure and education is appropriate in a given situation." Thankfully, Hall does explicate this seemingly

\textsuperscript{38} Hall, 658.
\textsuperscript{39} Chapter 3, §15.
\textsuperscript{41} "Postoperatively," \textit{Archives of Ophthalmology}. 104:42-5.
amorphous standard, which, in the present context, "means that the sufficiency of a
global disclosure of rationing incentives, rules, and mechanisms at the time of enrollment
can best be determined by examining how law and ethics regard similar instances of prior
consent." We shall have to distinguish between how the law and ethics deal with his
ensuing examples, but the upshot of his initially cryptic standard is that he wants to argue
for the legitimacy of prior global consent by analogy, which is a fairly safe strategy, it
seems to us, if not wholly successful.

Hall provides three analogies, which purport to be instances of "bundled, prior
consent." Insofar as these three analogies are legal and ethical, there is no reason to think
the contrary of the specific case of bundled, prior consent to a rationing mechanism,
according to Hall. In the Chapter 3, §16, we shall turn a critical eye to these purported
analogies; at this juncture, we shall simply review them. Hall's first analogy is that of the
prior consent on the basis of which "surrogates are allowed to refuse life-sustaining
treatment."\(^{42}\) If one can make an informed consent which appoints a proxy decision-
maker in this extreme case, why ought this not to be the case for the managed care
setting, where the decision-making right delegated is generally far less dramatic? Is not a
family member designated as a surrogate decision-maker often "afflicted by conflicting
economic interests," to at least the same degree as a managed-care organization, and with
the stakes often much higher?\(^ {43}\) The second analogy of bundled, prior consent describes
how we "conventionally view a single decision to be hospitalized or operated on as
entailing consent to hundreds of discrete events of testing, medication, and bodily

\(^{40}\) Chapter 2, §6, above; Hall, 649.
\(^{41}\) Hall, 658.
\(^{42}\) Ibid.
\(^{43}\) Ibid.
examination during the course of what may be a rather long and complex episode of treatment."\textsuperscript{44}

The third analogy, possibly the most relevant, is an example of when the physician is under no obligation to make a consent-seeking disclosure, as in the case of futile treatment. Hall appeals to "conventional thinking" on informed consent law to support the claim that the law cannot be used to "force physicians to provide or even discuss care that, in their view of medical benefit, has no utility whatsoever, such as laetrile for cancer patients, antibiotics for a viral respiratory infection, or megadoses of vitamin C for a common cold."\textsuperscript{45} We have already noted in a somewhat different context that the physician need not disclose information relating to care which "falls outside the prevailing standard of care more because it lacks medical benefit than because it presents a medical risk."\textsuperscript{46} However, Hall’s argument is that different schools of medical thought are free to disagree concerning which treatments may be beneficial—a fact of which we took no cognizance in our preceding discussion. The standard of disclosure, then, is ultimately the professional standard, relative to the specific group’s customs, "so long as that school is accurately reflected in their representations to the general patient community."\textsuperscript{47} In the case of managed care, prior consent is simply a recognition of what the managed care institution customarily regards as marginally beneficial, and therefore, beyond the pale of disclosure. Clearly, this final example is quite divergent from our reflections on the professional standard, and we shall return to it at length in Chapter 3, §15.

\textsuperscript{44} Ibid.
\textsuperscript{45} Hall, 659, italics mine.
\textsuperscript{46} Ibid.
\textsuperscript{47} Ibid.
§8. Hall on the Waiver of Informed Consent

The second model which purports to preserve patient autonomy in accordance with the doctrine of informed consent, while eluding isolated and case-specific post-enrollment disclosures, is that of the prior waiver of one’s right to informed consent. Given this second model, “informed consent requirements are not satisfied—they are dispensed with at the patient’s request.”48 In order to sharpen the distinction between the manner in which the two models address the same problem, Hall notes that “actual prior consent justifies silent rationing by arguing that global disclosure satisfies the primary informed consent duty; waiver invokes an affirmative defense to a prima facia violation of that duty;” Hall further mentions that “it is perhaps easier to characterize an informed enrollment decision” on the latter model.49 Of course, this remains to be seen.

The proponents of this second model argue that insofar as the purpose of the doctrine of informed consent is to promote the autonomy of the patient, it would be inconsistent to force the patient to make use of this ‘right’, i.e., the value which underlies informed consent ensures that informed consent can be waived.50 Insofar as this model appeals to the philosophical underpinnings of the doctrine more than the previous model, we shall have to explicate and evaluate the argument at much greater length.51 Specifically, we shall have to examine how one might advocate or allow for the autonomous waiver of one’s right to autonomy, and the implications of this position. However, it is clear that the waiver model espouses a wholly divergent notion of

48 Hall, 660.
49 Ibid.
autonomy, namely, the hierarchical notion. This second rendering of autonomy is hierarchical in the sense that a waiver is different in kind (not simply degree, like the global consent model) from an authorization or refusal. It is a meta-action upon one’s future rights to authorize or refuse.

The only potential complication to this model which Hall addresses is that the waiver of informed consent must not only be informed, but free. Hall’s account of freely-given consent is consonant with our criterion for autonomous action which provided for the absence of coercion.\textsuperscript{52} If the waiver is to be autonomous, it must be un-coerced; therefore, Hall asks:

Can it be said that the right to informed consent is freely waived if the decision is made on pain of a substantial sacrifice in health benefits or increase in premiums?
What if the only insurance available requires an informed refusal waiver, so that the only means to obtain full disclosure of nontreatment is to pay out of pocket?\textsuperscript{53}

It seems relatively clear that if serious sacrifices are threatened unless one waives one’s right to free and informed consent and joins a managed care organization against his or her will, then that waiver is coerced, and the patient’s autonomy has been breached; likewise, it seems uncontroversial that if a spectrum of healthcare options with patient cost and amount of post-enrollment disclosure varying proportionately is available, then the patient may autonomously choose the plan which is most appropriate for him or her, and consistent with his or her values and priorities, waiving the appropriate amount of disclosure. The more contentious case involves an employer offering one managed care

\textsuperscript{52} See Chapter 1, §2.
\textsuperscript{53} Hall, 661.
plan, which requires a certain waiver of informed consent. Hall concludes that "choice exists within the plan if the subscriber need not accept the waiver, even on pain of paying a higher premium," and justifies this conclusion by citing Beauchamp and Faden's observation that "to chain informed consent to fully or completely autonomous decisionmaking stacks the deck of the argument." However, Beauchamp and Faden do not provide for degrees of autonomous action in order to justify mild coercion, for "coercive actions always entirely compromise autonomy by wholly controlling action." Therefore, in order to justify Hall's conclusion, we shall need to flesh out our notion of coercion, and inquire into the legitimacy of this case anew. Essentially, this second model is so intimately tied to the philosophical notion of autonomy, and Hall's treatment of the philosophical arguments in support of this model is so truncated, that we must delay our inquiry until Chapter 4, where it shall receive the attention it deserves.

§9. The Critique of Hall's Two Models

In the following two chapters, we shall take a somewhat more philosophical look at the two models which purport to preserve patient autonomy through prior disclosure, in the face of institutional rationing decisions, suggested by Mark A. Hall, and elaborated, however briefly, in the present chapter. The focus shall shift from informed consent law, to informed consent as an instance of autonomous action, and we shall have to hold Hall's two models up to the standard of autonomous action asserted in Chapter 1, §2. In the case of the second model, that of the prior waiver of one's right to an informed consent, the critical criterion according to Hall was that of the absence of coercion,
although we shall see that the adequacy of the disclosure is paramount. Further, the waiver model raises more general questions about autonomy, which shall be addressed at length. In the case of the first model, that of prior global consent, the critical criterion shall be that of the adequacy of the disclosure, and whether this can be translated from the mechanism to the specific products of the mechanism. In both cases, we shall also pay close attention to the implications for our theory of autonomy, insofar as managed care is a heuristic for elucidating the advantages and disadvantages for the integrated and hierarchical approaches to autonomous commitments over time.

58 Chapter 4, §20.
Informed Consent to Rationing Decisions by

Managed Care Organizations

Jeremy R. Dorsett

CHAPTER 3: PRIOR GLOBAL CONSENT

The end of the following analysis of the first of our models is to establish the extent to which prior global consent is consonant with the doctrine of informed consent, relative to our rudimentary account of autonomy, stipulated in Chapter 1, §2. We have held, with Beauchamp and Faden, that the doctrine of informed consent is "straightforwardly linked" to the principle of respect for autonomy. However, we might do well to explicate the character of this straightforward linkage, which we have repeated like a mantra throughout, such that we can be clear as to how consonance with our theory of autonomy relates to the doctrine of informed consent.

§10. The Straightforward Linkage

We shall likewise hold with Beauchamp and Faden that "an informed consent is a specific kind of autonomous choice (or action), an autonomous authorization by patients or subjects."\(^1\) The class of autonomous actions of which informed consents and refusals are members, are traditionally subject to considerations of setting (e.g., clinical research), subject-matter (e.g., treatment), and specific agents (e.g., patients and subjects) which bear on assessing the adequacy of consent. However, assuming that these special considerations are met, the critical feature which distinguishes informed consents and refusals from other autonomous actions, is that the agent (in this case that patient or subject) correctly understands his action as an intentional authorization or refusal,

\(^1\) Beauchamp & Faden, 277.
permission or forebearance. The correct understanding of the nature of one’s action was our third criterion for autonomous action.\(^2\) Beauchamp and Faden note that there is “in general a close correspondence between understanding that one is doing “X” and doing “X” intentionally.”\(^3\) However, these authors postpone much of their discussion of understanding one’s action to their separate criterion of understanding, rather than address it under their criterion of intentionality. We would like to distinguish between understanding the information relevant to the decision at hand (Beauchamp and Faden’s criterion of understanding), and understanding the nature of that decision (which Beauchamp and Faden distinguish from both understanding and intentionality). The former is the “adequate apprehension” of certain propositions which describe both possible actions and the possible consequences which might follow as a result of performing and not performing given actions.\(^4\) The latter involves the correct apprehension that one’s action is an intentional authorization or refusal and, in accordance with the intentionality of this action, the “integration” of this specific action into a broader “blueprint for action.”\(^5\)

This integration of one’s decision was alluded to in Chapter 1, §2 as the requirement that the autonomous agent understand his action consistently with certain beliefs, values, principles, etc. This latter aspect of understanding one’s action is essentially Beauchamp and Faden’s criterion of intentionality. We see no reason why understanding one’s action cannot involve both understanding it as an authorization and as consistent with one’s “blueprint for action.” Beauchamp and Faden themselves note

\(^2\) Chapter 1, §2.  
\(^3\) Beauchamp & Faden, 243.  
\(^4\) Ibid., 252.
that “for an act to be intentional, it must correspond to the actor’s conception...of the act
in question.” Further, both are essential for determining the extent to which a patient is
rational, i.e., can he or she (1.) comprehend the nature of the decision at hand, and (2.)
integrate the decision consistently into his or her matrix of beliefs, values, and principles.
The clarity with which one can distinguish the rational from the less than rational is quite
controversial, and we shall do our best to not get deterred by this exceedingly complex
question, simply noting the junctures where it might be relevant.

We can now see that a bona fide informed consent or refusal is an autonomous
action which the patient correctly understands as a consent or refusal, and assimilates into
his or her unique rationale. Further, as an autonomous action, informed consents
presuppose adequate information, adequately understood, and the absence of coercion, as
stipulated in Chapter 1, §2, and in consonance with Beauchamp and Faden.

§ 11. Prior Global Consent and the Criterion that One Understand

The Nature of One’s Decision

We have claimed that for an action to be autonomous, it is necessary (albeit insufficient)
that one understand the nature of one’s decision, both as an authorization or refusal in the
case of informed consent, and as it fits into one’s broader plan for the future. It is now
incumbent upon us to inquire whether prior global consent can remain a candidate for an
autonomous action in this regard.

5 Ibid., 242; see also, Miller, G.A., E. Galanter, and K. Pribram. Plans and the Structure of Behavior. New
6 Ibid.
7 For an extended treatment of the problems associated with demarcating the rational from the less than
rational (or the competent from the less than competent), see Wear, especially Chapter 3.
8 Relative to Beauchamp and Faden’s account, we have retained the criteria of relevant information and the
absence of coercion, and incorporated the understanding of the nature of one’s action as an authorization
into their criterion of intentionality.
According to Beauchamp and Faden, in order for X to understand that X’s action constitutes an authorization, “X must understand, at a minimum, that by consenting, X has given a specific agent, Y, express permission to do something, R. In most cases X must also understand that X’s express permission is required for Y to do R.”9 In this way, informed consent is “the way of gaining permission or authority to use others.”10 In the case of prior global consent, the prospective patient (X) must understand that by consenting, he or she has given the physicians (and possibly various other stipulated employees of the managed care organization in question) (Y), express permission to abide by and treat according to a rationing mechanism (R). Further, the patient (X) must understand that his or her permission is required for Y to do R, or that without X’s prior global consent to the rationing mechanism, Y (the managed care organization) is not free to do R (to ration medical resources) without insolated, case-specific consents.

There is no reason to think that this is not the case for prior global consents. More specifically, it seems that there is no principled difference between global consent and an isolated, more routine informed consent in this regard. Both are ostensibly authorizations, and, therefore, the only necessary elements to fulfilling our first criterion are that the patient or prospective patient understand his or her action as such and understand that his or her consent is required. In this respect, there is no significant difference between global prior consent and isolated, more routine consents.

The second aspect of understanding the nature of one’s decision is that one place one’s consent or refusal into some sort of matrix of values or principles, some sort of “blueprint.” We have stressed that the particular “values, beliefs, and life experiences”

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9 Beauchamp & Faden, 301.
10 Engelhardt, 300.
affirmed by the patient are, in a sense, irrelevant. The critical element for this aspect of understanding the nature of one’s decision is that the decision is somehow consistent with these values, etc., whatever they may be. Stephen Wear has underscored this aspect of the informed consent process by distinguishing the comprehension of the information presented, which we shall address in what follows,11 from the “prioritizing” and “relativizing” of that information to one’s personal circumstance.12 He employs the analogy of a short answer test for the former, and an essay test for the latter, in which the student must “think through” the information presented.13 As Wear admirably shows, the issue of assimilating the data with which one is presented into the matrix of one’s core values in the face of a strange and unfamiliar state of being is anything but an easy task. When substantial values choices arise, “the patient may well need much time, reflection, and counseling to respond to them” and in many cases, “we should probably speak of establishing rather than simply identifying the patient’s views regarding such situations.”14

Regardless, our claim regarding this second aspect of understanding the nature of one’s decision shall be similar to our claim regarding the first aspect. In both cases, there is no obvious principled difference between prior global consent and an isolated, more routine informed consent. Of course, in many discrete informed consent events, there is little need for values clarification or identification, as, for instance, in “the prescription of ampicillin for pneumonia.”15 But when a patient is confronted with a more ominous diagnosis, such as congestive heart failure, and the accompanying proposed treatments,

11 Chapter 3, §15.
12 Wear, 20.
13 Ibid., 19-20, 57-8.
14 Ibid., 45.
the patient may need to reflect at great length upon his or her values, beliefs, principles and life experiences. Likewise, in deliberating about whether to enroll in a managed care organization, the prospective patient must reflect upon his or her values and beliefs relative to healthcare and his or her financial means. There may be controversies in both cases regarding the extent to which one must reflect and clarify in order for one’s deliberation to be effective, and also the extent to which the physician is responsible for verifying that the patient has ‘thought through’ his or her decision. Regardless, our claim is simply that there is no essential difference between placing one’s decision within the broader framework of one’s values and principles in the case of an isolated treatment decision and doing the same in the case of a prior global consent to the results of a rationing mechanism.

In conclusion, we can see that our first criterion is essentially a formal requirement, and the extent to which it is met is in no way dependent upon the content of the specific informed consent. One must understand one’s decision, regardless of what that decision may be. One must understand it as an authorization, regardless of what one is authorizing; one must understand it as consistent with one’s broader values and beliefs, regardless of both what one is authorizing and what one’s broader values and beliefs may be. The formal nature of our first criterion, then, dictates that in the case of a prior global consent to a rationing mechanism, there is essentially no difference between this form of blanket consent and any isolated consent. But for obvious reasons, our first criterion of understanding the nature of one’s decision is insufficient to secure an autonomous informed consent.

15 Ibid.
§12. Global Consent and the Criterion of the Absence of Coercion

If an action, in our case an informed consent, is to be autonomous, it must be free of coercion; it must be a free and informed consent—this is quite uncontroversial. We noted in our rather procrustean theory of autonomy,\textsuperscript{16} that coercion is clearly at all times inconsistent with respect for autonomy, insofar as the respect for autonomy involves respecting others’ freedom and capacity for self-determination. According to Beauchamp and Faden, “a fundamental condition of personal autonomy is that actions...are free of—that is, independent of, not governed by—controls on the person,”\textsuperscript{17} while Engelhardt notes that “since the very fabric of secular morality depends on not using persons without their permission, any agreements extracted under coercion will not be binding.”\textsuperscript{18}

However, if the absence of coercion is such a critical element of autonomous action, and so ubiquitously recognized as such, it may be that the concept of coercion merits a more detailed explication. The most valiant efforts at explicating the concept of coercion have been undertaken by Robert Nozick and Alan Wertheimer in an article and book, respectively, entitled Coercion. At this juncture, we shall briefly review their conclusions, and benefit from their analyses.

§13. A Brief Foray into the Concept of Coercion

In his article “Coercion,” Robert Nozick, following a rigorous extermination of trivial cases,\textsuperscript{19} concludes that there is some sense in which an adequate account of coercion is contingent upon an adequate account of ‘threats’, which recurred in all of his attempted

\textsuperscript{16} Chapter 1, §2.
\textsuperscript{17} Beauchamp & Faden, 256.
\textsuperscript{18} Engelhardt, 308.
definitions. In order to circumscribe the notion of a ‘threat’, Nozick proceeds to contrast a ‘threat’ firstly with an ‘offer’, and secondly with a ‘warning’.

The salient difference between a threat and an offer is described in consequentialist language. If a proposal (taken to include both the class of threats and offers, although not necessarily exhaustively) is such that it makes the consequences of one’s “action worse than they would have been in the normal and expected course of events, it is a threat.” Conversely, if a proposal is such that “it makes the consequences [of one’s action] better [then they would have been in the normal and expected course of events], it is an offer.”

Wertheimer echoes Nozick’s consequentialist distinction in terms of a ‘baseline’, where a threat makes one “worse off relative to some baseline” and an offer makes one “better off relative to some baseline.” This formulation implores an explication of the ‘baseline’ and an explanation of the method of its determination.

The ‘baseline’ according to Nozick is “meant to shift between or straddle predicted and morally required.” Wertheimer prefers to describe the duality of the baseline in terms of a “statistical test” and a “moral test.” One might also say that we can assess a baseline in terms of descriptive expectations and prescriptive expectations. Can we devise a substantive decision criterion with regard to divergent modes of baseline assessment that is not incompatible with our intuitions? Nozick’s response is that when the outcomes relative to the descriptive and prescriptive baselines are divergent, “the proper baseline is the one that [the person to whom the proposal is made] prefers.”

However, Nozick is lead to this conclusion because he has cited instances of divergent

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20 Nozick 24.
22 Nozick 24.
23 Wertheimer 204.
consequences relative to the dual baselines in which both the descriptive and the prescriptive may supervene. However, Nozick admits that *prima facia* "in deciding whether something is a threat or an offer, the (morally) expected course of events always takes precedence over the normal or usual course of events, where these diverge." This precedence of the morally expected baseline over the 'usual' course of events (the prescriptive baseline over the descriptive baseline) is supported by several examples including the proposal to the drowning man, wherein a proposal to save a drowning man if and only if he promises to pay his potential savior $10,000 is regarded as a threat, and the proposal to the slave, wherein the master’s proposal not to give the slave his daily beating, if and only if the slave does A, is likewise regarded as a threat. On the first example, the expectation is for the nearby boater to save the man, and to claim that the proposal to save him for a sum of money was an offer because the man would have drowned anyway is immediately morally repugnant. Likewise, the master of the slave is morally required not to beat his slave for no reason whatsoever. It is equally morally repugnant to think that the master is generously offering to not beat the slave if he does A. What ultimately prevents Nozick from validating our intuitions is the problematic example of the proposal to the addict. This counter-intuitive instance takes the following form:

\[ P \text{ is } Q \text{'s usual supplier of drugs, and today when he comes to } Q \text{ he says that he will not sell them to } Q, \text{ as he normally does, for } \$20, \text{ but rather will give them to } Q \text{ if and only if } Q \text{ beats up a certain person.} \]

14 Wertheimer 212; Nozick 28.
15 Nozick 28.
16 Ibid. 26.
17 Ibid. 27.
On Nozick's account, it is only relative to the descriptive baseline that the proposal to the drug addict is a threat. However, the inadequacy of the prescriptive baseline rests upon the presupposition that the sale of drugs is *de facto* immoral which is at least not uncontroversial. If we consider the sale of drugs as morally equivalent to the sale of any substance that is essential to a particular person's life at a particular time, then it would seem that the prescriptive baseline also implicates the dealer. For instance, if the substance were pharmaceutical, we would say that the dealer is not only coercive relative to the descriptive baseline, but also that the prescriptive baseline requires one to proceed in accordance with some implicit contract. Further, if the dealer is selling bread, there is a clearly prescriptively neutral baseline, but the descriptive baseline renders this proposal coercive, for being without bread and murdering someone are both undesirable relative to purchasing bread as per usual. Why, then, do we consider this proposal non-coercive? It can only be because there is something of prescriptive significance in all of these examples, and there is no implicit norm to continue the sale of bread, as there is to continue the sale of drugs, pharmaceutical or otherwise. Therefore, we see no reason why the prescriptive baseline cannot take precedence over the descriptive baseline in all instances of conflict, which is consistent with the *prima facia* position initially asserted by Nozick.

The second distinction made by Nozick is between a threat and a "nonthreatening warning."29 A proposal is rendered a threat, rather than a warning, by its voluntary nature. The event that is to affect the choice must be brought about by the person making the proposal. For instance, if one says, "If you break up with me, I will have a heart

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28 Ibid. 24.
29 Nozick 31.
attack," it is a warning, because it is beyond the voluntary control of the person making the utterance, and this matter of fact is not originally intended to affect a choice. Conversely, if one says, "If you break up with me, I will commit suicide," this is, most likely, a threat, because it is voluntary and intended to limit freedom in a given choice. However, not all proposals are as clear-cut as the above two, as exemplified by Nozick in the following case: "The owner of the factory announces to his employees that if the union wins the election, he will close his factory and go out of business." Clearly, this can be interpreted as either a threat or a warning, depending upon the intention of the owner and the necessity of the closing.

It is dubious whether one can coerce oneself according to Nozick's and Wertheimer's analyses of coercion, for self-coercion would involve some variety of threat unto oneself. However, insofar as one makes an unwelcome threat unto oneself, which would effectively present one with two alternatives less desirable than the original prescriptive baseline, one can simply retract one's threat. Self-coercion would seem to involve ultimately acting against one's will, which is at least somewhat paradoxical, if not completely contradictory. Regardless, freedom from coercion may simply be one sense of the free in 'free and informed consent'. It was the only one cited in Chapter 1, §2 as a criterion for autonomous action, but we may want to include self-imposed limitations of one's actions as an autonomy limiting condition. This second sense of freedom is quite distinct from that of being free from coercion; it involves being unrestrained or unencumbered by prior commitments."
§14. Prior Global Consent and the Criterion of the Absence of Coercion Revisited

Based upon our preceding exposition of the core of the philosophical literature on coercion, how are we to regard prior global consent? More immediately, how are we to make sense of prior global consent on the Nozickian model of coercion? In order to answer this second question, we must specify the baseline in question, which we have argued is the “morally required” course of events, in cases where the “morally required” and the “predicted” courses of events diverge.\(^{31}\) Further, we shall distinguish between a coerced enrollment in a managed care organization and post-enrollment coercion. Accordingly, we shall distinguish between the pre-enrollment and post-enrollment baseline.

The pre-enrollment baseline is the predicted course of events wherein a potential enrollee continues with his or her pre-managed care health care or absence thereof. Managed care proposals can be interpreted as offers insofar as the potential enrollee recognizes that he or she is not worse off following the proposal. For example, if the managed care proposal involves essentially the same healthcare as was being received by the potential enrollee prior to the proposal, for a reduced price, the potential enrollee might become an actual enrollee, and be better off. This managed care proposal must be construed as an offer because the potential enrollee is afforded an opportunity to improve his or her situation relative to the expected course of events. Conversely, if the managed care proposal involves precarious and overly-risky health care delivery, the potential enrollee might regard the tradeoff as imprudent and reject the proposal. However, this second proposal remains an offer, for the consequences do not render the potential

\(^{30}\) Engelhardt, 307.

\(^{31}\) Nozick, 24.
enrollee worse off, relative to the initial baseline for the initial baseline is maintained upon the prudent rejection of the offer. This second proposal is simply a bad offer, and is rightly rejected as such. The only remaining category of managed care offer is comprised of those proposals which would leave the potential enrollee neither worse off nor better off than he or she was in the pre-managed care setting. Once again, the potential enrollee is, by definition, no worse off relative to the initial baseline. We should briefly mention that there is some controversy in the literature over whether excessive offers or unreasonable incentives (which would fall into the first category of offers above) might be considered coercive.\textsuperscript{32} We shall avoid this contentious question as it is not directly relevant to our thesis.

Managed care proposals can be interpreted as threats insofar as the potential enrollee recognizes that he or she is worse off following the proposal, relative to the initial, pre-enrollment baseline. For example, if the potential enrollee is informed that the medical resources to which he or she is accustomed will henceforth be rationed by an unreliable managed care organization, with his or her consent required upon threat of discontinuation of healthcare, the potential enrollee is rendered worse off relative to the baseline of continued healthcare. Either the quality of the potential enrollee’s healthcare will decline, or his or her healthcare will cease. Both options are clearly undesirable and leave the enrollee worse off. One might imagine this course of action being advocated by a down-sizing corporation, in order to mandate reduced expenditures on health insurance. The intention of the one making the proposal is also relevant, insofar as, despite the potential enrollee’s being left worse off, the proposal may be a threat or a non-threatening

warning. As we saw in our brief foray into the concept of coercion, for a proposal to be a threat rather than a warning, the one making the proposal must exercise some control over bringing about the consequences of the recipient of the proposal's future actions, as was made salient by the comparison of the warning that one will have a heart attack with the threat that one will commit suicide.\textsuperscript{33} It is also important that part of the reason that the one making the threat decides to "bring about the consequence if [the recipient of the threat] does A...is that...this worsens [the recipient of the threat's] alternative of doing A."\textsuperscript{34} This is the additional consideration of intention. The case of the threat/warning made by the down-sizing corporation is similar to that of Nozick's example of the factory owner's threat/warning. If the down-sizing corporation's proposal is to be paradigmatically coercive, it cannot be inevitable that the corporation's healthcare be cheap managed care, i.e., this is the only healthcare which the corporation can now afford, and the proposal must be made freely in the interest of deterring employees from spending money on healthcare.

We must conclude that there is no principled reason why enrollment proposals cannot be enrollment offers and fulfill the criterion of the absence of coercion, i.e., why they cannot conform to our account of prior global consent as offers rather than threats. The more philosophically interesting question is whether there exist cases wherein post-enrollment enforcement of the rationing mechanism can be construed as coercive.

Upon enrollment with a managed care organization, one has not altered the normative baseline, i.e., the course of prescriptive expectations. However, the way in which the prescriptive expectations can be met has been crucially altered. The

\textsuperscript{33} Chapter 3, §13; Nozick, 31-7.
\textsuperscript{34} Nozick, 31.
physician's routine obligations to respect the freedom and rationality of the patient remain intact, but their manifestation has been altered. Rather than respecting the rationality and freedom of the patient through the seeking of routine consents to discrete treatments, the physician can ostensibly accomplish the same by respecting the free consent given upon enrollment with the managed care organization. Given the prior global consent, any information offered by the physician regarding particular instances of rationing can be seen as an offer, which may increase the freedom of the patient, but is in no sense obligatory as a means to respecting the autonomy of the patient.

We are now faced with the question of how to resolve the case in which a patient turns recreant to his or her prior global consent. In this case we have to reconcile the autonomous prior consent with the present autonomy of the patient. As noted in the literature on so-called 'Ulysses contracts', the conflict here is between the autonomy of two 'selves': "the 'past self's' right to select a particular treatment and the 'present self's' right to remain at liberty."35 However, in holding a patient to the stipulations of the contract to which he or she offered prior consent, is the managed care organization infringing upon the present liberty of the patient? We must conclude at least that the managed care organization does not coerce the patient in this respect. Suppose the patient demands more sophisticated, marginally beneficial, and accordingly more expensive treatment or diagnostic procedures. The managed care organization is fully justified in responding in the following manner: we shall provide that to which the patient provided prior global consent or we shall not treat. This response cannot be construed as coercive because the patient is at liberty to accept the treatment to which he or she has

consented, thereby maintaining the original baseline; i.e., the proposal does not render the patient worse off. This proposal is essentially an offer not to treat. The case of prior global consent is not even unique in this regard. The patient is not the only agent whose liberty must be respected in this setting. The doctor (and managed care organization) is also at liberty to a certain extent. The physician's obligation to respect the autonomy of the patient in conformity with the doctrine of informed consent in no way implies that the physician is obligated to treat the patient according to his or her autonomous choice. The physician's right to refuse to treat is not coercive; rather, it evades the coercive circumstance where the patient dictates treatment against the physician's wishes.

If we are to vindicate the purported right of the present patient to choose his or her treatment autonomously, we must supplement the traditional notion of coercion to which we have appealed. We might accept our earlier suggestion that part of autonomous action is that one is free in the sense of being unrestrained by prior commitments. However, this would essentially render contracts impotent. What would it mean to autonomously consent to the product of a rationing mechanism, if this consent cannot bind or restrain in the future? Notice that patient autonomy would be preserved given this supplemented notion thereof, but managed care, along with any institution based on contracts, would be doomed.

The entirety of the preceding argument is contingent upon prior global consent fulfilling the primary duty of respect for patient autonomy. If prior global consent cannot do the work of fulfilling this primary duty, then the prescriptive baseline would dictate that a more traditional isolated, case-specific informed consent event should occur. In the absence of this more traditional event, a managed care proposal to abide by the original
flawed prior consent or not treat must be regarded as a coercive proposal, insofar as the primary duty to respect autonomy, which is certainly material to the prescriptive baseline, has never been met. If the prior global consent is to prove inadequate, there is only one remaining criterion upon which this might be the case, and this must now become the subject of our inquiry.

§ 15. Prior Global Consent and the Criterion of Sufficient Relevant Information

Our final and, in the case of prior global consent, most critical condition for autonomous action stipulates that one must have sufficient relevant information material to the decision at hand. We have previously argued for the legitimacy of the so-called subjective standard of disclosure (or relevancy), and shall continue to employ this standard in this section. However, before delving into this criterion, we must distinguish our criterion of the provision of sufficient relevant information, from the suggestion that the patient must adequately understand the information presented. Recall that the only serious objection to the prior global consent model noted by Hall is the "lack-of-understanding" objection, i.e., it is unreasonable to think that a prospective patient can assimilate the information presented upon enrollment with a managed care organization due to its sheer volume. Note that the requirement that the patient understand the information presented is distinct both from the requirement that the physician supply the information relevant to the decision, and the requirement that the patient understand the nature of his or her decision, although it may be presupposed in the latter case. We have not addressed this further potential requirement heretofore, except to note that it has been

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37 See Chapter 2, §6.
38 Hall, 657.
suggested as an extension of informed consent law, under the rubric of *heightened duty.* \(^{39}\)

The counter-argument offered by Hall to the lack-of-understanding objection is that the efficacy of the disclosure (or lack thereof) is a poor index of the sufficiency of the disclosure, and this conclusion is reached by asserting that if its converse were true, very few disclosures would prove sufficient. However, the rampant inefficacy of our informed consent practices could just as easily imply the need for reform as prove the disjoint between disclosure and comprehension. While for us it is sufficient to say with Hall that the lack-of-understanding objection is not unique to prior global consent, it need not necessarily support the status quo. It may be the case that like more traditional informed consent practices, some degree of patient comprehension ought to be verified in the case of prior global consents. \(^{40}\)

Our concern at present is whether there is in fact anything unique about prior global consent relative to our third criterion for autonomous action. Given a traditional informed consent event, the information disclosed by the physician includes at least the following: (1.) an explanation of the diagnosis; (2.) the recommendation of an appropriate intervention along with the significant risks and benefits attendant to it; and, (3.) the suggestion of alternative interventions along with the significant benefits and risks attendant to them. It seems that (1.), the explanation of the diagnosis, must remain case-specific, and therefore must occur following enrollment; i.e., a managed care organization cannot offer an explanation of every potential future diagnosis nor can it have any selection criterion for offering explanations of some potential future diagnoses, prior to any diagnosis. The best that could be accomplished by a managed care

\(^{39}\) Chapter 2, §6; Hall, 649.

\(^{40}\) For more on the duty to verify adequate comprehension, see Wear, 122; and Beauchamp and Faden, 328.
organization prior to particular diagnoses would be to present the patient with a limited set of core examples which would demonstrate the manner in which diagnosis and treatment are paradigmatically effected upon enrollment. This might prove sufficient to indicate to the prospective patient that which will be involved in a decision to enroll. Further, what must effectively be accomplished by the prior global consent model is (2.) and (3.); i.e., for prior global consent to preserve autonomy in conformity with the doctrine of informed consent, it must impart the recommended and alternative courses of treatment for every class of ailments, along with the risks and benefits attendant to all of the above.

As we noted in the previous chapter, Hall attempts to examine "whether a fully informed consent to enroll...constitutes actual consent to the subsequent rationing decisions."\(^{41}\) The further claim advanced is that "actual consent can be viewed as resulting from informed enrollment, even if all of the multitude of possible nontreatment decisions and their particular risks and benefits are not described to the patient, because he or she is informed of and consents to the broad parameters of a rationing mechanism."\(^{42}\) We must conclude that (1.) cannot be accomplished through disclosure and consent to a rationing mechanism, insofar as the best that exemplars of diagnosis and treatment according to the rationing mechanism can accomplish is to give the prospective enrollee a general idea of that to which he might consent; exemplars cannot be sufficient to create ‘actual’ future consents, as the information contained might be quite irrelevant, even apart from the problems associated with selecting meaningful exemplars. For an actual consent to be effected, the disclosure must concern the actual diagnosis, rather than

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\(^{41}\) Hall, 657.

\(^{42}\) Ibid.
some diagnosis indicative of what an actual future diagnosis might be like. If (1.) must remain case specific, it appears that Hall believes that (2.) and (3.) can be accomplished through disclosure and consent to a rationing mechanism. In response to Hall’s claim, Paul S. Appelbaum has argued that “whether one views their acceptance of enrollment as ‘prior consent’ to rationing or as a ‘waiver’ of consent, it is an action that for almost all persons will be taken in profound ignorance of its implications.”43 We believe that this counter-argument is best advanced against the prior global consent model, and that Appelbaum has overlooked the distinction between the two models in this case.44

Regardless, ignorance of the implications of the mechanism is a serious claim, and comes in direct conflict with Hall’s claim that an informed consent to the results of a rationing mechanism constitutes actual future consents. However, the critical question for us is whether the enrollee ignorance is due to being hyper-informed or overwhelmed by the sophisticated mechanism, the kind of ignorance routine among all varieties of informed consent, or whether there is in fact a principled reason, apart from the particularities of the patient, which accounts for this ignorance. The reason which we shall consider is that it may not be the case that information regarding the rationing mechanism is sufficient to constitute the information relevant to the results of the rationing mechanism, i.e., we may simply not be able to get (2.) and (3.) out of prior global consent to the results of a rationing mechanism.

As we noted in Chapter 1, §1, the end of a rationing mechanism is to eliminate marginally beneficial treatment. Therefore, prior disclosure of a rationing mechanism will include information regarding the courses of treatment and methods of diagnosis

offered for various ailments along with the attendant risks and benefits. Furthermore, prior disclosure will either implicitly or explicitly enumerate an extensive class of treatments which will not be offered, due to a relatively insignificant probability of benefit. Hall alludes to the implicit disclosure of alternative treatments when he notes that "all of the multitude of possible nontreatment decisions and their particular risks and benefits" need not be described to the patient, as information regarding the mechanism implies the marginal benefit of alternative treatments.\textsuperscript{45} There may be reasons to believe that the voluminous information on what treatments shall not be available, and the attendant risks, ought to be available in some form, but this is not critical to our inquiry. The critical question is whether this information could leave the prospective patient meaningfully informed. An example provided by Appelbaum might elucidate the problems associated with moving from prior information regarding a rationing mechanism to specific information regarding a discrete future event.

Appelbaum's example is drawn from one of the first legal cases in which the courts were forced to recognize that "causal and legal responsibility for adverse medical outcomes in the new, cost-conscious practice setting," may devolve upon multiple parties, i.e., the physician can no longer be regarded as solely responsible for critical treatment decisions.\textsuperscript{46} The instructive \textit{Wickline v. State} was prompted by the following case:

Ms. Wickline, a woman hospitalized for vascular surgery, suffers several postoperative complications. As the period of hospitalization approved by her

\textsuperscript{44} This claim will be fully explicated and argued for in Chapter 4, §23.
\textsuperscript{45} Hall, 657.
insurance plan draws to a close, her surgeon requests the insurer’s approval for an additional eight days of inpatient care. Only four days are approved; the surgeon later maintains his belief that he had no choice but to discharge the patient after that period elapsed. Within a few days of leaving the hospital, the patient’s leg begins to hurt and turn blue. She is not seen by a physician for nine days, by which time her leg requires amputation.47 This case is interesting despite the presence of a third-party insurance company rather than a managed care organization. The limited hospital stay approved by the insurance company was certainly in the interest of cost containment, and reduced hospital admissions and stays are, likewise, an integral part of managed care.48 The critical question concerns the extent to which Ms. Wickline was informed prior to her hospitalization. Suppose Ms. Wickline had familiarized herself with the mechanism prior to enrollment such that she fully understood that for the relevant class of vascular surgery, her allotted time of hospitalization would be 10 days, and that any excess days would be marginally beneficial. Suppose further that she understood that for the relevant class of post-operative complications, her extended time of hospitalization would amount to an additional four days, and that any excess days would be marginally beneficial. Had Wickline been a case involving a managed care organization, it would not have been unreasonable to assume that Ms. Wickline would have been presented with or at least had access to this information. However, would we want to say that Ms. Wickline was informed about her specific, post-enrollment vascular surgery? On Hall’s account, would we want to say that Ms. Wickline’s prior consent to this mechanism was sufficient to

48 See Davis, et. al., p. 147-8.
‘constitute’ her future ‘actual’ consent? Appelbaum asks, in this regard, if informed consent law aims to “ensure that patients receive sufficient information to enable them to play a meaningful role in treatment decision making...what prospective disclosure would have allowed Ms. Wickline to function in this way?”

Appelbaum raises two interesting issues in attempting to analyze this case. Firstly, he wonders whether any amount of information regarding the mechanism would prove sufficient to “inform her of limits on length of stay in her peculiar circumstances, which involved several postoperative complications.” Secondly, he asks whether Ms. Wickline would “have had any way of knowing that the discharge decision, among all others, had been affected by this process.” As Appelbaum raises these questions in passing, let us attempt to explicate his concerns.

The first question asks whether information about a rationing mechanism translates into information relevant to a particular, rather “peculiar” case. A rationing mechanism, aimed at eliminating marginally beneficial treatment, is constructed with reference to empirical studies, the controversial status of which we have already noted, purporting to establish the distinction between significantly and marginally beneficial treatment and diagnostic protocols. Therefore, disclosure of a rationing mechanism is only capable of providing information of the risks and benefits of the recommended and alternative treatments ((2.) and (3.) above) in the sense of impersonal statistical generalizations. What is lost in this information is the peculiar personal medical history of the patient in question.

49 Appelbaum, 671.
50 Ibid., 673; emphasis mine.
51 Ibid.
52 Chapter 1, Intro.
What must then be demanded from the empirical studies which justify the rationing mechanism is that they establish (2.) and (3.) for the maximum number of potential medical histories; what must be demanded from the prior disclosure is some intelligible formula capable of establishing (2.) and (3.) for the maximum number of potential medical histories. One might imagine Ms. Wickline referring to her fictional contract, looking up specific postoperative complications, and calculating the extent of her stay for different combinations. Might this unrealistic demand render prior consent capable of constituting future case-specific consents? It is difficult to see how this might be accomplished if we agree with Hall’s rather uncontroversial assertion that “the central purpose of informed consent law is to enhance personal autonomy.” The information presented regarding a rationing mechanism is of dubious personal significance because it is established according to statistical significance from which one might significantly deviate. This is relevant regardless of the extent to which formulae are developed which take cognizance of various combinations of medical histories. When one’s case is marginal, the failure to disclose the risks and benefits attendant to generally marginally beneficial treatment is a rather serious lacuna.

Appelbaum’s second question asks whether Ms. Wickline, even granting that she might have access to a replete account of the mechanism, would have information regarding its application. We noted earlier that the explanation of diagnoses must be disclosed post facto. In this case, Ms. Wickline could presumably access the results of the mechanism. However, her case might be unique to such a degree that an alternative treatment, not resulting from the mechanism, might be prudent. The end result of the answer to Appelbaum’s first question, wherein the rationing mechanism is unable to take

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53 Hall, 648.
cognizance of individual peculiarities, is that the patient is not meaningfully informed at specific junctures. Anytime that departure from the results of the mechanism might be prudent for a patient (i.e., the patient’s case is marginal) and yet the mechanism is employed, patient autonomy has been infringed upon. The caveat that patients can seek alternative treatment or exit their contract at any time is meaningless if the patient is not provided with sufficient information to know when such an exit might be prudent. Ergo, in terms of the questions which were initially posed, we must respond in the affirmative.\textsuperscript{54} The prior global consent model forges a condition in which the patient’s right to free and informed consent may be abridged at discrete future junctures by rationing decisions. Therefore, the physician has an obligation to inform the patient when conformity to institutional standards of care limit access to potentially important or informative treatments.

In the case of Ms. Wickline, it could be that (1.) the mechanism to which she might have hypothetically consented was simply unable to convey the information relevant to her situation, and that (2.) she was uninformed about when the peculiarities of her situation deviated from the data supporting the mechanism, such that she might act in her best interests.

Therefore, in response to our introductory questions which our two models seek to answer,\textsuperscript{55} it appears that on the prior global consent model, economically-motivated rationing decisions by managed care organizations are capable of abridging the patient’s right to free and informed consent at discrete, post-enrollment junctures. Likewise, the physician’s primary duty to respect the autonomy of the patient cannot be wholly

\textsuperscript{54} There questions were posed at the end of Chapter 1, §1.

\textsuperscript{55} See the end of Chapter 1, §1.
satisfied through a prior global consent. Rather, the physician’s obligation to inform the patient of potentially important or informative treatments remains, even when such treatments conflict with the rationing scheme. It is in this sense that if the primary duty cannot be met by the rationing mechanism, as was the case with Ms. Wickline, a proposal to treat according to the mechanism or not to treat at all is coercive, insofar as both alternatives fall below the prescriptive baseline, wherein the primary duty to respect patient autonomy is satisfied.56

Further, it is important to note that the above account is legitimate on both the subjective and reasonable person standards of disclosure, insofar as information unrelated to one’s specific case will surely not meet the demands of a reasonable person.

§ 16. Hall’s Analogies

As we mentioned in the previous chapter,57 Hall’s primary argumentative strategy is that of the argument by analogy. We have now suggested that prior global consent is a somewhat problematic model for preserving patient autonomy in consonance with the doctrine of informed consent, insofar as it falters on the criterion of sufficient relevant information. Therefore, we shall now proceed to take a more perspicuous look at Hall’s three analogies, in the interest of establishing whether they fall prey to a similar criticism as did our prior global consent model, or whether they are significantly flawed analogies.

Hall’s first “recognized example of bundled, prior consent” is that of the prior consent which allows surrogates to “refuse life-sustaining treatment.”58 This case is analogous inasmuch as it recognizes the right to offer prior consent to the appointed

56 Chapter 3, §14.
57 Chapter 2, §7.
58 Hall, 658.
surrogates decision—in this case the proxy decision-maker of choice, in our case the managed care organization. Or, according to Hall:

The argument here by analogy is that an informed enrollment decision in essence constitutes prior explicit consent to appointing the HMO medical director and the primary care physician as agents for a bundle of much less significant but nonspecific treatment refusal decisions.\(^{59}\)

However, Hall’s preceding analysis of prior global consent construed this phenomenon as an informed consent “to the broad parameters of a rationing mechanism” which was sufficient to produce “actual consents,”\(^{60}\) as we saw.\(^{61}\) Consent to the results of a mechanism must be distinguished from consent which serves to appoint a proxy. This latter phenomenon is better understood on the model of the waiver of one’s right to informed consent, inasmuch as one is giving up one’s right in the appointment of another.

Further, if Hall desired to construe prior global consent as an appointment of a proxy decision-maker, it is not clear why the rationing mechanism and its supposed capacity to produce future consents should be so critical. As we shall see, if the appointment of a proxy decision-maker is rightly understood as a waiver of one’s right to informed consent, then one is subject to another’s decisions within certain parameters, rather than one’s appointment constituting future consents. The waiver of a future right to consent and the production of future consents are quite different phenomena. This must not be lost sight of in our efforts to distinguish our two models.

The more basic problem with Hall's first analogy is that it involves the appointment of a surrogate in the event of the primary agent’s incapacitation. Basically,
the consent which appoints a proxy in this case is necessary insofar as the primary agent is unable to consent or refuse. Of course, this is not necessarily the case with a managed care enrollment. In fact, one of the critical junctures in our assessment of our second criterion of the absence of coercion was the potential conflict between the pre-enrollment commitment and the post-enrollment autonomy, which is simply absent in this example. Hall’s first analogy breaks down due to its status as an extreme case. We simply cannot extrapolate any substantive guidance from this marginal case.

Hall’s second example of a global prior consent describes how we “conventionally view a single decision to be hospitalized or operated on as entailing consent to hundreds of discrete events of testing, medication, and bodily examination.”62 The critical claim which Hall advances in his second analogy is that both routine hospitalization and enrollment with a managed care organization can be understood as entailing multiple actual future consents. Certainly, we can construct a model which would accomplish this relationship of entailment. However, we would like to suggest that that which is entailed by these two purported instances of prior global consent are quite different. In the case of a routine blanket consent to be hospitalized or operated upon, the future discrete events which are entailed by this decision are conjunctively related in such a way that we might parse the constituents of the prior consent; i.e., consent to be hospitalized entails consent to be subject to test A, and test B, and bodily examination, etc. In other words, we could produce a more loquacious consent form which would make explicit all that is left implicit in a consent to be hospitalized or operated upon. This is not the case for prior global consent to the results of a mechanism.

61 Chapter 2, §7; Chapter 3, §11, §15, §14.
62 Hall, 657.
The future discrete consents which are purportedly entailed by this decision are related conjunctively, disjunctively, and conditionally. We have argued that even if one could produce the massive consent form capable of parsing prior global consent into the future decisions which are entailed, the information would not necessarily be relevant. The critical difference appears to be the information presented in these cases. There is no obvious reason to believe that the information presented regarding hospitalization or operation is insufficient for the potential or actual patient to decide whether or not he or she ought to consent to or refuse hospitalization or operation and all that is entailed by either. We have argued that in the case of a rationing mechanism, the information regarding the rationing mechanism, even if parsed, is insufficient to produce relevant information regarding the future treatments entailed.

The final example offered by Hall relates to the physician's exemption from obligation to disclose information relating to care which "falls outside the prevailing standard of care more because it lacks medical benefit than because it presents a medical risk."63 Although there may be divergent schools of thought regarding what constitutes a beneficial treatment or diagnostic measure, "physicians are free to limit themselves to their chosen school of practice so long as that school is accurately reflected in their representations to the general patient community."64 In raising this analogy earlier,65 we alluded to the fact that this reasoning may depend upon the professional standard of disclosure. If this is the case, we would have to reject it as untenable in conjunction with our argument that the professional standard is not connected to the respect for patient autonomy in any obvious or necessary way. However, it could also be the case that the

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63 Hall, 658.
64 Ibid.
65 Ibid.
reasoning behind the physician's exemption in this case, which is "widely accepted in bioethics,"⁶⁶ is that there may simply be bona fide disagreements over which treatments provide a significant probability of being beneficial. If this is that case, then we have already vindicated the absence of obligation in this case.⁶⁷ However, our discussion concerned nonviable treatment or diagnostic options, which held an insignificant probability of providing alleviation from symptoms or diagnostic information respectively. In consenting to a rationing mechanism, one is not, as Hall, suggests, consenting to information elucidating a particular medical school of thought on what treatments are futile. The rationing of medical resources involves the avoidance of marginally beneficial treatment, which is avoided in the name of economic prudence. Although the benefit may be marginal, it remains viable.

More centrally, we argued that the physician need not disclose information which he or she believes in good faith to be irrelevant to the patient's decision. However, we have shown that in the case of prior consent to the results of a rationing mechanism, the lack of a disclosure of treatment that may be regarded as marginally beneficial to some class of study participants, may create a situation wherein the physician withholds information which is quite relevant to the personal situation of the patient. The physician in this case has no reason to believe otherwise.

Hall's analogies, which seek to confer their status as "recognized" upon prior global consent to the results of a rationing mechanism, each breakdown at some point. The first analogy is better understood on the upcoming waiver model, than the prior global consent model. The second and third analogies are both capable of offering

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⁶⁵ Chapter 2, §8.
⁶⁶ Hall, 658.
information which is sufficient to preserve patient autonomy. However, we have argued that prior global consent to the results of a rationing mechanism is not sufficient to leave the patient analogously informed.\textsuperscript{68}

\textsuperscript{67} Chapter 2, §6.
\textsuperscript{68} Chapter 3, §15.
Informed Consent to Rationing Decisions by
Managed Care Organizations

Jeremy R. Dorsett

CHAPTER 4: THE WAIVER OF INFORMED CONSENT

In the previous chapter, we saw that the prior global consent model, the first of Hall’s models purporting to preserve patient autonomy in consonance with the doctrine of informed consent and in the face of rationing decisions by managed care organizations, was not entirely successful. Specifically, we found that consent to the disclosure of a rationing mechanism proved insufficient to procure future, case-specific consents, i.e., prior global consent could not pass our third criterion for autonomous action, namely, sufficient relevant information,\(^1\) and thereby created the potential for coercion.\(^2\) We shall now move forward with our analysis and focus upon Hall’s second model, which may elude the problems associated with the first model, while raising new concerns. However, let us begin by reviewing the distinction between Hall’s two models.

§17. The Distinction between the Models

According to Hall, “actual prior consent justifies silent rationing by arguing that global disclosure satisfies the primary informed consent duty; waiver invokes an affirmative defense to a prima facia violation of that duty.”\(^3\) Essentially, the distinction between these two models illumocrates a distinction between two divergent understandings of autonomy to which we have alluded,\(^4\) and will now explicate more fully. In the case of prior global consent, one prior actual consent is capable of doing the

\(^1\) Chapter 1, §2.
\(^2\) Chapter 3, §14.
\(^3\) Hall, 660.
\(^4\) E.g., Chapter 1, Intro., §5.
work of future actual consents. This has been dubbed the integrated notion of autonomy. It is integrated insofar as the primary duty of respect for autonomy is satisfied in the future, through a prior instance of the primary duty. In the case of the waiver of one's right to an informed consent, one prior actual consent does not do the work of future consents, rather, it relieves one of the right unto the same. This has been dubbed the hierarchical notion of autonomy. It is hierarchical insofar as the primary duty of respect for autonomy renders a class of future instances of this duty secondary. On the first model, one's duty to respect autonomy is, for our purposes, inviolate; on the second model, we can speak of primary and secondary duties to respect autonomy (or prima facia and actual obligations).

We noted earlier that the second model relies more heavily upon a philosophical justification than the first. Based upon our preceding explication of the distinction, we can see why this is the case. Once one has established one's theory of autonomy and understanding of the philosophical doctrine of informed consent (no small task), an integrated approach would simply require that one analyze the extent to which one's noteworthy instance of informed consent, for us a prior global consent, conforms to one's requirements. This was, of course, undertaken in the previous chapter. Like a prior global consent, a prior waiver is an instance of autonomous action. However, it is not an informed consent (or refusal); it is, rather obviously, a waiver—a distinct and rather unique class of autonomous actions. More specifically, it is a waiver of something to which one has a right, namely informed consent. Any such waiver is immediately interesting because it introduces the possibility for a hierarchy of obligations. That which the first model purported to accomplish was rather philosophically uninteresting and
relatively uncontroversial. The problem with the first model was simply that it could not
deliver. The second model, however, is philosophically controversial prior to any
questions of its effectiveness. For this reason, we shall commence with a brief
examination of the philosophical arguments for the right to waive some or all of one’s
rights, underscoring the more contentious points.

§18. The Right to Waive a Right

We have spoken heretofore of a ‘right’ to an informed consent as an extension of
our rudimentary theory of autonomy, insofar as informed consent is straightforwardly
linked to the respect for autonomy which all persons are owed.6 Granting this right, what
must be the case if we are to regard a waiver of this right as a component of this right?
At least, the right to have one’s autonomous choice respected is not an inalienable right,
i.e., one’s right to autonomous choice cannot be regarded as an end-in-itself. At this
juncture, we might do well to recall our introductory reflections on autonomy.

In grappling for a reasonable understanding of autonomy, we noted the Kantian
interpretation wherein making laws unto oneself in conformity with the dictates of pure
reason necessitates that we respect other persons in their law-making capacity. Further,
we noted that the categorical imperative secures the content of autonomous action in the
form of primary and secondary duties. For Kant, acting autonomously (which would
include making autonomous choices) involves acting from a sense of duty, and is very
much an end-in-itself. Therefore, any waiver of one’s right to autonomy is irrational on
the Kantian account, for autonomous action is dutiful action, proceeding from the dictates
of reason. In the ideal ‘kingdom of ends’, respect for autonomy is an inalienable right.

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5 Chapter 2, §8.
6 Chapter 1, §2; Chapter 3, §10.
The waiver of one's right to be respected as autonomous is the waiver of one's right to be regarded as an end-in-oneself in the interest of some consequence, and, therefore, involves using oneself as a means.

However, we mitigated the Kantian notion of autonomy by replacing content-full and universal 'self-legislation' with the formal requirement of respect for individual 'self-determination'. Given this understanding of autonomy, there exists no hierarchy of duties derived from the canon of pure reason. Rather, we have asserted that the autonomous agent is to be regarded as the best judge of what is reasonable in his or her unique circumstances, ceteris paribus. Therefore, there is no principled reason to think that one ought not to be able to waive one's right to certain things. Such a waiver is an act of self-determination, although it may eventuate in future limitations on the same. We are now in a position to reconsider the argument for the 'right' to waive a 'right' provided by Hall. The argument on behalf of the right to waive one's right to informed consent is that the value which underlies informed consent ensures that this value can be waived. This value, of course, is the promotion of the respect for patient autonomy. According to Appelbaum, Lidz, and Meisel:

The primary objective of the doctrine of informed consent is to promote individual self-determination. Permitting patients to make such decisions is one way of fostering self-determination. On the other hand, compelling them to receive information they do not want or make decisions they do not wish to make is a denial of the right to self-determination, even though in this case the consequence is that patients will not participate fully (or at all) in decision making. Thus, a waiver, properly given, is in keeping with the values sought to
be promoted by informed consent because the patient remains the ultimate
decision maker.  

If the prospective patient were not allowed to waive his right to informed consent, his
autonomy would be limited, insofar as the waiver of a right is a variety of autonomous
action. If the prospective patient is allowed to waive his right to informed consent, his
autonomy in the future will be limited. However, the extent to which it is in one’s larger
interests to have information and choice within a certain context is best left to the
autonomous agent.  

This was what was meant by claiming that autonomy is not an end-
in-itself. Rather, one’s right to be respected as a free and rational agent might be bartered
away to fulfill something of greater value. Recognized examples of the autonomous
waiver of one’s right to full future autonomy include “joining the Marines or the French
Foreign Legion, entering a monastery, getting married,” and other forms of indentured
servitude.  

In pronouncing that “the patient remains the ultimate decision maker,” Appelbaum et al are explicitly affirming a hierarchical understanding of autonomy.

The more traditional argument employed by Appelbaum, Litz, and Meisel is that
a “waiver permits patients to be protected from any harmful impact they believe
disclosure might have upon them or from the possible anxiety that may accompany the
decisionmaking process.”  

In this case, the patient is free to determine himself or herself
according to his or her values, such that the value of future information and choice might
be outweighed by the value of freedom from anxiety or pressure. The value of relevant
information would seem to be outweighed by the value of a certain ‘peace of mind’ in an

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7 Appelbaum, Litz, & Meisel, 72.
8 See Chapter 1, §§3, 4.
9 Engelhardt, 156.
10 Appelbaum, Litz, & Meisel, 72.
example cited by Beauchamp and Childress, wherein, "a deeply committed Jehovah’s Witness [informs] a doctor that he wishes to have everything possible done for him, but does not want to know if transfusions or similar procedures would be employed."¹² In the case of a prior waiver upon enrolling with a managed care organization, the argument must include economic values, but remains formally the same. Economic benefit may be more valuable than future information and free choice to a class of persons, and these persons must be regarded as the best judges of their best interests in conformity with the promotion of their autonomy.

The final argument cited by Hall on behalf of the informed consent waiver model runs as follows:

Allowing waiver is perfectly consistent with informed consent doctrine because the principal effect of consent is itself a waiver—of the right not to be touched. If the law is willing to allow the right of bodily integrity to be waived, it should be (and is) willing also to recognize the waiver of the secondary right to information about a bodily invasion, so long as the waiver is informed and freely given.¹³

We have spoken rather loosely heretofore of the waiver of the right to informed consent. However, Hall refers here only to the waiver of the right to information. Might one waive one’s right to information, yet assert one’s right to make a (possibly uninformed) choice? This would seem to be one’s prerogative, i.e., one could waive one’s ‘secondary’ right to information, but retain one’s right to bodily integrity in some manner. Henceforth, we must maintain the distinction between the waiver of one’s right to

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¹¹ Appelbaum, Lidz, & Meisel, 72.
information and the waiver of one's larger right to choose. In this sense, "patients should be able to waive either or both of the duties imposed upon physicians. They should be able to give up the right to information without relinquishing the right to decide, or vice versa." We should also note the one's choice may not be autonomous, according to our rudimentary account thereof, if one's right to information is waived, insofar as the physician's obligation to disclose information is a necessary component of the physician's larger obligation to respect autonomous decision making.

We noted earlier that a waiver is an autonomous action, like an authorization or refusal. This is more salient if we recognize Hall's point that an authorization may be interpreted as a covert waiver (of the right not to be touched). For this reason, a waiver, like any autonomous action, must be understood as such, must be informed, and must be free, or uncoerced, as Hall rehearses in his argument. In this sense, we shall have to hold the waiver to the same criteria for autonomous action as the global consent. However, the manner in which we must interpret the criteria will evolve as we make the transition from the first to the second model. Before proceeding to examine the waiver of informed consent relative to our three criteria, let us consider a possible counter-argument to our claim that a waiver is an autonomous action. If the waiver of one's right to information cannot be a rational action, then it cannot be an autonomous action, for an autonomous action must be in some sense rational, at least to the agent, such that it is rationally consistent with certain core values or principles. However, if even this extraordinarily weak standard of rationality cannot be met for the decision to waive one's right to information, then such a waiver cannot, in fact, be regarded as a species of autonomous

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13 Hall, 660-1.
14 Appelbaum, Lidz, & Meisel, 72.
action. This counter-argument has been advanced by David E. Ost, who alleges that there are only two possible grounds for rejecting information, both of which are irrational. Further, “one need not have a full-blown and comprehensive definition of rationality to conclude that a decision which refuses to admit any information as relevant is a decision which has no rational grounds of determination.”

The two potential grounds for rejecting offered information are as follows:

First, the individual’s intentions may be so fixed and unalterable that no information would, in fact, be relevant to them. But this is almost a textbook definition of an obsession. If no information is relevant, then the decision can have no rational grounds of determination, i.e., it is irrational. Second, the individual may be claiming to know what he cannot know prior to your disclosure of the information; namely, his evaluation of its relevance to his decision. But to claim to know what you cannot know is contradictory, i.e., irrational.

However, we would like to claim that one can rationally reject future information. Sufficient information regarding the rejection of information, i.e., what are the risks, what are the benefits, can provide a rational ground for the rejection of a class of future disclosures. In only admitting the two options above, Ost begs the question in favor of an integrated approach to autonomy, rather than considering the hierarchical approach, wherein one may have sufficient information to limit one’s access to information.

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15 Chapter I, §2.
17 Ibid.
18 For a more detailed treatment of Ost’s commitment of an integrated approach, see Sasser, Mark. “Mill and the Right to Remain Uninformed.” The Journal of Medicine and Philosophy. 11(1986), 256-78, wherein Sasser shows that, relative to Mill’s famous example of man crossing the bridge, there may be cases in which one can rightly reject information for good reasons, relative to higher-order information. Ost himself quotes Mill’s claim that “no one but the person himself can judge of the sufficiency of the
The waiver of one’s right to information and consent is an autonomous action on the meta-level. Therefore, we must hold this variety of autonomous action to the same standard as we did the global consent model. However, we shall see that the content of our criteria will be altered on this second, meta-level model.

§19. Understanding the Nature of a Waiver

In the previous chapter, we saw that for an autonomous action to be correctly understood as such, the agent must understand the nature of his or her action. In the case of informed consent (global or otherwise), the patient (or, in our case, the enrollee) must correctly understand his or her action as an authorization or refusal. In the present case of a waiver, one’s action is neither an authorization nor a refusal. Rather, one is waiving one’s right to authorize or refuse, along with one’s “secondary right” to information pertinent to authorizations and refusals. Notice that in the case of the prior waiver of informed consent model, one is waiving both one’s right to ‘bodily integrity’, which prompts the right to authorize or refuse, and one’s “secondary right” to information. We mentioned earlier\(^\text{19}\) that the waiver of one’s right to information in conjunction with the assertion of one’s right to choose, may create a situation in which the patient’s choice is less than fully autonomous.\(^\text{20}\) However, we must remember that in this problematic case, we remain on the primary level of obligations, and one of the requirements for autonomous action is not met. In the case of the prior waiver, while the right to both

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motive which may prompt him to incur the risk.” What Ost overlooks is that fact that insufficient information itself may be a risk which one would prudently want to incur.

\(^{19}\) Chapter 4, §18.

\(^{20}\) This may not necessarily be the case, for the patient may demonstrate that he or she is quite responsible for his or her whimsical choice, and that it is perfectly consistent with his or her values that he or she simply “enjoys choosing capriciously, even about risky matters.” For more on this point, see Engelhardt, 305.
information and choice are waived, the waiver can be fully autonomous if the agent is provided with sufficient information and freedom on the meta-level.

How then is one to understand the nature of a waiver? As a meta-level phenomenon, it would seem that to understand an action as a waiver, one must understand that which one is waiving. In this regard, then, the first requirement for autonomous action is similar in content whether one is asserting or waiving one’s right to informed consent. According to Appelbaum, Lidz, and Meisel’s section on the ‘elements of waiver’:

In order for patients to waive their right to render informed consent, they must know that they have that right. That is, they must know that (1) physicians have a duty to disclose information to them about treatment, (2) they have a legal right to make decisions about treatment, (3) physicians cannot render treatment without their consent, and (4) the right of decision includes a right to consent or refuse treatment.\(^\text{21}\)

Recall that in our chapter on the prior global consent model, we saw that according to Beachamp and Faden one must understand an authorization as an act of permission, required for that which one is authorizing to occur.\(^\text{22}\) In the case of a waiver, one need not understand a specific act of authorization, but rather that one has a right to authorize or refuse, and that authorization is required for treatment to occur. One cannot understand one’s prior waiver as a waiver until one understands that which one is waiving. Once again, we shall not address the extent to which physicians are obligated to verify the patient’s or enrollee’s comprehension of his or her action.

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\(^{21}\) Appelbaum, Lidz, and Meisel, 70.

\(^{22}\) Chapter 3, §11.
The second aspect of understanding the nature of one’s decision is that one can assimilate one’s decision into what Beauchamp and Faden have dubbed a ‘blueprint’ for action. In this regard, a waiver is identical to an authorization or refusal, insofar as this assimilation is a purely formal requirement. The extent to which assimilation of a waiver into any rational blueprint can occur is controversial, and we have already addressed it in the preceding section in our reply to Ost. We argued that, like the recognized example of a value such as the freedom from anxiety taking precedence over the values of future information and choice, economic values can play a salient role in the decision to waive one’s future right to informed consent.23

§20. Prior Waiver and the Absence of Coercion

In Hall’s brief look at the waiver of informed consent model, he was almost exclusively concerned with potential “constraints on free choice,” or, in our language, coercion.24 We shall have to attempt to establish whether or not this attention is justified. Firstly, however, let us answer some questions raised by Hall which we did not have the philosophical machinery to address prior to our brief foray into the concept of coercion.25 Hall asks the following questions relative to our criterion providing for the absence of coercion:

[C]an it be said that the right to informed consent is freely waived if the decision is made on pain of substantial sacrifice in health benefits or increase in premiums? What if the only insurance available requires an informed refusal

23 Chapter 4, §18.
24 Chapter 2, §8.
waiver, so that the only means to obtain full disclosure of nontreatment is to pay out of pocket.\textsuperscript{26}

In answering the preceding questions, we must first establish the normative baseline by which we can judge whether a proposal is coercive. The subject of Hall's first inquiry involves a proposal to waive one's right to informed consent, but presupposes that the one to whom the offer is made is presently involved in some form of healthcare. This much is evident given that the proposal involves a sacrifice in health benefits or increase in premiums. In this case the descriptive and prescriptive expected course of events converge. On both baselines, one is expected to continue with his or her form of health care delivery, presumably replete with traditional informed consent events. The proposal that one waive one's future right to informed consent "on pain of substantial sacrifice in health benefits or increase in premiums" is a threat insofar as the options on pain of which the waiver is committed are clearly both below the baseline, as evidenced by the threatening language employed. However, this threatening aspect of the proposal is insufficient to render the proposal a true threat, or coercive proposal, on the Nozickian account.\textsuperscript{27} If this proposal is to be construed as a true threat, it must also be the case that the waiver of informed consent somehow renders one below the baseline, which is not necessarily so. We have affirmed that there is no canonical way in which we might establish the extent to which a waiver of informed consent (or prior global consent) is beneficial or harmful to someone. Therefore, the most we can say about Hall's first species of potential coercion is that it creates an opportunity for coercion. However, this might be sufficient to condemn or at least avoid the practice of demanding waivers on

\textsuperscript{26} Hall, 661.
\textsuperscript{27} Chapter 3, §13.
pain of certain penalties. Further, in terms of the intention of the proposal in question, it is quite unclear why one would require a waiver on pain of some sacrifice, if such a waiver would be in people's interests in the first place.

The subject of Hall's second inquiry is a somewhat more complicated proposal. In this case, the prospective patient is presumably without healthcare initially. The proposal is for healthcare requiring a waiver of one's right to informed consent. The descriptive baseline in this case would seem to be continued out of pocket healthcare expenditures for the patient. On the descriptive account, the proposal to waive one's right to informed consent in the interest of lower costs would seem to be an offer, insofar as it affords one the opportunity to better one's situation relative to the expected course of descriptive events. However, it may be the case that one's employer, for instance, has an obligation to provide some form of healthcare coverage. If this were, in fact, the case, then the descriptive and prescriptive baselines would seem to diverge, and we have argued that when this is the case, it is the prescriptive baseline which supervenes. Even granting that there is some *prima facia* obligation to provide some form of healthcare, this second example is similar to the first in the sense that it cannot be construed as necessarily coercive. The extent to which it would be coercive is once again relative to the unique recipients of such a proposal. If we grant the not uncontroversial suggestion that there is some form of right to healthcare, then it would seem that, like the former example, this second proposal creates a situation which might be subject to legitimate claims of coercion. However, we would like to question the extent to which this emphasis on the criterion of the absence of coercion is justified for the second model.
For this reason, we must ask the prior question of how the second model differs from the first in significant respects.

In the course of our treatment of the first model, we noted that if a potential enrollee is informed that the medical resources to which he or she is accustomed will henceforth be rationed by an unreliable managed care organization, with his or her consent required upon the threat of discontinuation of healthcare, then the potential enrollee has been coerced.\(^{28}\) However, this exemplar of a coercive managed care proposal is instructive, not only relative to the prior global consent model, but also relative to the prior waiver model, as we saw in our analysis of Hall’s first question. Likewise, the various non-threatening proposals noted in our discussion of the prior global consent model\(^ {29}\) are equally valid on the second model. Why should it be the case that the class of threats and that of offers are respectively coterminous on the two models? The class of threats and the class of offers are respectively coterminous because the explanatory model employed is irrelevant to the determination of whether or not coercion has occurred. Regardless of whether we want to understand enrollment with a managed care organization as involving prior global consent or the waiver of informed consent, the enrollment itself ought to be autonomous.

Coercing a prospective enrollee to join a managed care organization violates his or her autonomy, whether autonomous enrollment involves an authorization or a waiver. For this reason, we must conclude that Hall’s attention to the criterion of the absence of coercion for only the second model is unjustified. It is curious why Hall is unconcerned with the same question when discussing the first model. Why does he not ask whether

\(^{28}\) Chapter 3, §14.

\(^{29}\) Ibid.
one’s prior global consent is freely given if it is made on pain of substantial sacrifice in health benefits or increase in premiums, or if the only insurance available requires a prior global consent. The analysis of these same questions relative to the first model would be identical to the analysis just executed for the second model. In the first case, the descriptive and prescriptive baselines converge and the proposal appears coercive; in the second, the relevant question is how to interpret the prescriptive baseline, i.e., to what extent does one have a right to some form of healthcare?

Insofar as we have argued that coercion relative to the second model is identical to coercion relative to the first model, we must conclude that, like the first model, there is no principled reason why enrollment proposals cannot be enrollment offers and fulfill the criterion of the absence of coercion for the second model. In the course of our ruminations, we have raised some questions critical to establishing whether a proposal is coercive, such as the determination of the extent to which one can be said to have a right to healthcare. However, it is clearly the case that there are paradigmatic examples of managed care proposals which pass this criterion, as we saw in our treatment of the first model.30

The more salient difference between the models is found the manner in which they bind patients, or, more broadly, persons. In the first case, we saw that the prescriptive baseline was not affected by the prior global consent—only the way in which the prescriptive expectations were met. The obligation to respect patient autonomy remained intact. However, this obligation could now be met, not only by discrete and case-specific informed consents, but by respecting the informed consent given at the time of enrollment. Once again, insofar as the duty remains constant (the normative baseline
unchanged), the prior global consent model affirms an integrated notion of autonomy. However, upon waiving one’s right to informed consent, one has crucially altered the normative baseline by relieving a class of physicians of what is now a *prima facia* duty.

We asked ourselves, in dealing with the prior global consent model, how to reconcile the past enrollee’s consent with the present patient’s wishes. In this regard, the second of our models, affirming a hierarchical notion of autonomy, appears to deal with this conflict more easily. On the prior global consent model, we alluded to the potential dissonance between “the past self’s’ right to select a particular treatment and the ‘present self’ s’ right to remain at liberty.”31 The conflict arises due to the integrated approach, where the autonomy at the time of enrollment comes in conflict with the patient’s later autonomy. We suggested that ideally the physician would be able to fulfill his or her primary duty to respect the autonomy of the patient by honoring his or her prior consent, but later found that prior global consent could not always effectively serve to respect patient autonomy, thereby requiring later, case-specific informed consents as a means to fulfilling the primary duty. In the case of the waiver of informed consent model, this potential dissonance can be avoided. The prior autonomous waiver effectively dispels the patient’s later right to be respected as autonomous, *via* informed consent. In this sense, there can be no conflict. The hierarchical notion of autonomy, then, cannot be subject to conflict between past autonomous action intending to bind and present autonomy, as could the integrated notion. On the hierarchical account, one waives one’s right to future autonomy through an autonomous action on the meta-level, and the conflict which arose on the prior consent model simply never arises on the second model.

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30 Chapter 3, §14.
31 Dresser, 14.
The potential for coercion which we noted on the first model was ultimately due to the inadequacy of the pre-enrollment disclosure (that of the rationing mechanism). Any problems with the criterion of the absence of coercion were created by the failure to fulfill the criterion of sufficient relevant information. For this reason, if the second model is able to elude the potential dissonance on the second criterion, it is most likely due to a significant improvement in dealing with the third criterion.

§ 21. Prior Waiver and the Criterion of Sufficient Relevant Information

As we noted earlier, the criterion of sufficient relevant information is the most critical in determining the success or failure of the two models. Our previous two criteria are more or less formal, and, accordingly, proved similar for both models. The third criterion, however, is more substantive, and will take into account the variety of autonomous action for which information is required, whether an authorization or a waiver. It was this third requirement that proved problematic for our first model, as we saw that the authorization of a rationing mechanism could not be translated into future authorizations of the results of that mechanism, as Hall claimed the model could. As we now turn to our analysis of this third criterion relative to the second model, we shall come to more fully understand the difference between the models and also the difference between an integrated and hierarchical understanding of autonomy.

§ 22. What Information is Relevant to a Waiver?

A waiver falls within the class of autonomous actions, and, therefore, must meet our three criteria. Further, we shall retain our conclusion that the subjective standard of

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32 Chapter 2, §9.
33 Chapter 4, §17-18; Chapter 1, §2.
disclosure is most consistent with respect for autonomy.\textsuperscript{34} A traditional informed consent event includes at least the following: (1.) an explanation of the diagnosis; (2.) the recommendation of an appropriate intervention along with the significant risks and benefits attendant to it; and, (3.) the suggestion of alternative interventions along with the significant benefits and risks attendant to them. This much information is necessary to forge the condition that the patient can authorize or refuse the suggested treatment. On the prior global consent model, we suggested that (1.) is best left to post-enrollment, case-specific events, while (2.) and (3.) could occur at the time of enrollment. However, we found that more or less generic statistical information concerning the risks and benefits of suggested and alternative treatments was insufficient to procure meaningful consent to rationing decisions. The critical claim for the first model is that prior global consent to a rationing mechanism is capable of translation into actual future consents. We found that this was not the case. The waiver of informed consent model, however, does not make this claim. Rather than having an instance of informed consent do the work of future consents in consonance with the integrated approach to autonomy, the waiver model invokes a meta-level autonomous action waiving the obligation to future consents. However, this meta-level autonomous action must still be held to our criteria,\textsuperscript{35} and, therefore, must proceed with sufficient relevant information to be a legitimate waiver.

In order for a waiver of informed consent to be informed, the enrollee must have access to the following: (1.) information regarded the content of that which he or she is waiving; (2.) the risks and benefits associated with the waiver of his or her right to

\textsuperscript{34} Chapter 2, §6.

\textsuperscript{35} Chapter 1, §2.
informed consent in this case; and (3.) the risks and benefits associated with retaining his or her right to informed consent in this case. The information relevant to a primary instance of autonomous action, such as an authorization or a refusal, has essentially been elevated to the meta-level, such that the right to informed consent itself is the subject of the information, as was the case with our second criterion providing for the absence of coercion.36

When we refer to information regarding the content of that which is being waived at (1.), we are not referring to information regarding one’s right to informed consent, for this was addressed under our first criterion of understanding the nature of a waiver.37 Rather, we are simply noting that the enrollee must be sufficiently informed about the extent to which and the circumstances under which he or she is foregoing his or her right. This is not to claim that the managed care enrollee must be privy to the particular circumstances in which his or her waiver will be relevant, for this act of prognostication would be impossible. Rather, the circumstances in which one is waiving one’s right simply involve the limits within which one will waive one’s right, and the parties who will assume responsibility. This would presumably involve some disclosure concerning the rationing mechanism which will act to determine treatment in the absence of informed consent, but one is not, in this case, consenting to the mechanism; rather, one is being informed about the rationing mechanism insofar as it is material to the decision to waive one’s right to informed consent. Further, there is no reason to think that the waiver of a right is a binary phenomenon such that the right must be either waived or retained. We could easily imagine one waiving his or her right within certain limits, and retaining

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36 Chapter 4, §20.  
37 Chapter 4, §19.
it within others. The extent to which one ought to waive or retain one's right to informed consent will prove relative to one's assessment of (2.) and (3.).

The risks associated with the waiver of one's right to informed consent are multiple. Firstly, in the case of enrollment with a managed care organization, one will not be privy to marginally beneficial treatment, i.e., the impetus will be to under-treat rather than over-treat. This is the most fundamental risk associated with the managed care project. In addition to the risks of the specific cost-containment measures which we addressed in the first section of our first chapter, we must add the additional risk which plagued the prior global consent model, namely, that one's situation will deviate significantly from that of the patients who supplied the data justifying the rationing mechanism, i.e., the data used to distinguish the marginally from the significantly beneficial. The benefits associated with the prior waiver of one's right to informed consent are also manifold. Firstly, and most obviously, waiving one's right to informed consent is economically beneficial in the case of managed care. Further, the avoidance of over-treatment is often beneficial, as we saw earlier. Finally, one might seek to avoid medical decision-making in order to avoid stress or anxiety, or even for religious reasons, as in Beauchamp and Childress's example. In no way is this list of potential risks and benefits to waiving one's right to informed consent upon enrollment with a managed care organization meant to be exhaustive, but only instructive.

The risks and benefits associated with not waiving one's right to informed consent upon enrollment with a managed care organization are roughly the converse of (2.). If one retains one's right to informed consent, one gains greater information and choice in

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38 Chapter 1, §1.
39 Chapter 4, §18.
the future; however, one also risks massive medical expenditures. The extent to which this tradeoff is prudent, i.e., how the potential enrollee will assess (2.) and (3.), is relative to his or her unique situation, and not only to his or her principles and values, religious and otherwise, but also to his or her economic situation. We raised many of these considerations in a more generic context as early as our introduction; however, while economic and healthcare considerations may be at work in deliberations about enrollment with a managed care organization on both models, they are more meaningful on the waiver model. Given the prior global consent model, the information, risks and benefits are treatment related, as stipulated by the third criterion that one have access to sufficient relevant information; and these, in turn, must be assessed according to one’s matrix of principles and values, as required by our first criterion, stipulating the one understand the nature of one’s decision. The problem with these reflections is that the treatment related information, risks and benefits cannot be successfully accomplished prior to enrollment, as the integrated approach would suggest. As we have seen, this is not the case on the waiver of informed consent model, where the information, risks and benefits, economic and otherwise, have been elevated to the meta-level. Here, the information, risks and benefits, rather than being treatment related, are concerned with the exercise or waiver of the right to authorize or reject treatment. The meta-level reflection required by the waiver of informed consent model has several salutary consequences, when compared to the prior global consent model.

§ 23. The Informed Waiver vs. the Informed Prior Consent

At this point, we have seen how the information required for a waiver or authorization to be autonomous differs between the two models. It is now incumbent upon us to explore

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40 Chapter 1, §1.
the consequences of this difference. In order to illustrate the consequences which we seek to explore, let us revive the regrettable example of Ms. Wickline, which initially elucidated the flawed nature of the prior global consent model.\textsuperscript{41} In analyzing this example for the first model, we cited two problematic concerns raised by Paul S. Appelbaum. Firstly, Appelbaum asked whether any amount of information about the rationing mechanism would prove sufficient to “inform her of limits of length of stay in her peculiar circumstances, which involved several postoperative complications.”\textsuperscript{42} It was the great divide between the information contained in the rationing mechanism and the information relevant to Ms. Wickline’s unique circumstances which ultimately proved to be the demise of the first model, because the prior global consent model needed one instance of informed consent to effect actual future informed consents. However, the waiver of informed consent model is not committed to this claim.

Information about the rationing mechanism to be employed is not a means to authorizing future treatments on the waiver model, rather, it is meta-information relevant to one’s reflections concerning the prudence of retaining or waiving one’s right to informed consent. One of the risks upon which one must also reflect is that one’s “peculiar circumstances” will be significantly deviant from that of the medical histories of the class of patient’s who supplied the data justifying the rationing mechanism, as we noted.\textsuperscript{43} If Ms. Wickline had been presented with information in conformity to the waiver model, and had opted to waive her right to informed consent upon enrollment with the fictional managed care organization following effective deliberation, then her

\textsuperscript{41} Chapter 3, §15.
\textsuperscript{42} Appelbaum, 673; emphasis mine.
\textsuperscript{43} Chapter 4, §22.
unfortunate situation must be regarded as a risk which she was willing to incur for the sake of the more valuable potential benefits that the offer afforded her.

Appelbaum’s second question, which we found was an extension of the first question, was whether Ms. Wickline would “have had any way of knowing that the discharge decision, among all others, had been affected by this process.”\(^44\) We found that, because the rationing mechanism is unable to take cognizance of individual peculiarities, the patient cannot be meaningfully informed at specific future junctures, and his or her autonomy is infringed upon. We can see now that because the prior global consent model purports to satisfy only the primary duty to informed consent, in consonance with the integrated approach to autonomy, when that to which one has granted prior consent fails to be applicable to one’s situation, then the physician’s primary duty to inform remains, and adherence to the rationing mechanism is violative of respect for patient autonomy.

Given a hierarchical understanding of autonomy, when one has contemplated the risks and benefits of a waiver of one’s right, and found that a waiver is prudent, one has released the physician of the duty to inform. In this sense, the waiver option supplies a more meaningful bond over time in the sense the there is a clean break between the pre-enrollment and post-enrollment obligations of the physician, and this is indicative of the hierarchical understanding of autonomy more generally. For this reason, we questioned Appelbaum’s conclusion that “whether one views their acceptance of enrollment as ‘prior consent’ to rationing or as a ‘waiver’ of consent, it is an action that for almost all persons will be taken in profound ignorance of its implications.”\(^45\) As was the case with Ost,

\(^{44}\) Appelbaum, 673.

\(^{45}\) Ibid.
Appelbaum is presupposing an integrated approach to autonomy. His claim, therefore, is quite accurate for the prior consent model, as we saw. However, we must recall that only the prior consent model required that the information be sufficient to effect future actual consents. On the waiver of informed consent model, one can be sufficiently informed about the risks of waiving one's right, and the ensuing ignorance of the implications of this waiver can be an informed ignorance. Recall that information is not an end in itself, but only the primary duty of the physician. When a patient has waived this duty from the meta-level, future ignorance does not abridge the patient's right to autonomy. Appelbaum fails to appreciate the fact the waiver reflections are different in kind then reflections for routine authorizations and, in presupposing an integrated approach to autonomy, fails to see that ignorance can be an autonomously chosen, calculated risk.
Informed Consent to Rationing Decisions by

Managed Care Organizations

Jeremy R. Dorsett

CHAPTER 5: CONCLUSION

As we have effectively reached the end of our inquiry into informed consent to rationing decisions by managed care organizations, and the two models which purport to preserve patient autonomy accordingly, we shall now proceed to review the conclusions justified by our arguments. As noted in our introduction,\(^1\) we shall seek to draw conclusions on two levels. Firstly, we shall discuss the manner in which the preceding arguments pertain to the managed care setting directly. Secondly, we shall employ the case of managed care as a heuristic enabling us to draw broader conclusions about autonomy, and how best to understand autonomous actions which bind agents over time.

§ 24. Conclusions Relating to Managed Care

We found in Chapter 4 that one of the two models proposed by Mark A. Hall was successful at preserving patient autonomy in consonance with the doctrine of informed consent and in the face of rationing decisions by managed care organizations. In simply coming to this initial conclusion, it is clear that there are significant implications to whether one asserts a global consent or a waiver of consent, although, as we noted,\(^2\) these two models are often confounded. Regardless, put rather simply, the most basic conclusion on the first level is that, yes, there is in fact a model which can accomplish the task at hand. The task at hand involved the provision of assurance that patient autonomy would be protected through only a prior disclosure, such that the physician would be

\(^{1}\) Chapter 1, Intro.
under no obligation to obtain future, isolated, case-specific consents. The waiver of
informed consent model provided the assurance sought insofar as the prior waiver was
capable of passing all three criteria for autonomous action, and effectively relieving the
physician of the duty to seek any future consents. Given that the managed care
organization does its part in ensuring that all three criteria for autonomous action are met
in the enrollment process, there is no reason to hold that care violates the autonomy rights
of the patient, or that care ought to be regulated or that there is any need for the
institution to oversee the good of the patient after the patient has enrolled. If the patient
is truly the best judge of his or her good, and he or she is capable of acting autonomously
in enrolling, then there is no need for anyone else to attempt to determine his or her good
for him or her at the present or in the future without his or her consent. Further, the only
lawsuits which patients ought to be able to bring successfully against managed care
organizations are those which can demonstrate a failure of the managed care organization
to respect their autonomy in the enrollment process. Such a demonstration might show
that the managed care organization employed coercive enrollment measures, conforming
to one of our examples of the same, or that the managed care organization provided
information inadequate to make an informed decision. Once the patient has been
effectively and autonomously enrolled, he or she has been adequately informed of the
risks he or she will incur. In the case of Ms. Wickline, for instance, granting that she had
been respected as autonomous in the fictional enrollment process, there is no legitimate

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2 Chapter 1, §5.
3 Chapter 1, §2; Chapter 4, §18-22.
4 These concerns are raised at Chatper 1, Intro., §4, respectively.
5 Chapter 3, §14.
legal course of action which she can bring against her managed care organization for the loss of her limb.

Of course, for the enrollment with the managed care organization to be fully autonomous, the disclosure must conform to our description of a sufficient disclosure for a waiver.6 For this to be the case, the potential enrollee must be made aware of the option to waive his or her right to varying extents, and the possible risks and benefits associated with that waiver, including the risks that his or her future situation will significantly deviate from the data which serves to justify the rationing mechanism, along with the more general disclosure concerning the right he or she is considering waiving required by the first criterion. If this disclosure has been made, and the potential enrollee freely opts to waive his or her future right to informed consent, then the patient will enter the managed care organization on radically different terms than a traditional patient would enter a traditional healthcare establishment. It is this difference in the normative baseline upon the waiver of one's right to informed consent which distinguished our second model from our first, and illustrated a critical point about the capacity of both to bind an autonomous agent over time. What we found to be a significant difference between our two often-conflated models eventuates in significantly divergent theoretical commitments.

§ 25. Conclusions Relating to Broader Issues of Autonomy

Commencing with only our rudimentary theory of autonomy,7 it was unclear which of our models would prove more successful at binding autonomous agents over time. Insofar as the waiver of informed consent model proved ultimately more successful, we

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6 Chapter 4, §21-22.
7 Chapter 1, §2.
must conclude that the hierarchical notion of autonomy implicitly affirmed by this model is a more promising approach than the integrated notion, at least for a class of potentially binding autonomous actions. The heuristic of managed care illustrated several reasons why a hierarchical approach is a more effective way of thinking about autonomous actions intending to bind the agent over time. Firstly, enrollment with a managed care organization exemplified a commitment based upon less than full access to important information. It is not surprising that such a long-term commitment should involve an element of uncertainty relative to the course of future events. However, if we are to operate on the integrated model, wherein the long-term commitment is one autonomous action among others, then as soon as new relevant information comes to light, one's initial global authorization becomes invalidated when forced to compete with a more enlightened present decision. This problem of insufficient information upon enrollment was the downfall of the prior global consent model. The more vexing question is whether it is even material whether one has full access to information upon one's commitment.

Suppose one has all the information one could possibly need to make a certain commitment and proceeds to authorize a certain course of action over a period of time. Now suppose that at some juncture in the future one thinks better of his or her commitment and turns recreant to his or her initial authorization, as we saw might be the case in the managed care setting. In this case, the claim is not that less than full information served to invalidate one's initial commitment. Rather, one's seemingly autonomous commitment is being pitted against one's now present autonomy. What is the criterion for deciding which decision is fully autonomous or reasonable for the person in question? We noted that an integrated notion of autonomy seriously jeopardizes the

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8 Chapter 3, §14.
practice of contracts insofar as there is no apparent reason to take one species of autonomous action (the prior commitment) as more binding than another of the same kind (the later rejection of the prior commitment). What is needed is an autonomous action of an entirely different kind to be asserted as somehow prior to routine authorizations, and this is provided by the hierarchical approach, and illustrated in the managed care setting by the waiver option.

A theory of autonomy based upon a hierarchical understanding is more successful in allowing agents to bind themselves over specified periods of future time, insofar as these bonds (based upon a waiver) do not fall prey to either of the problems associated with the integrated approach. Firstly, the inadequacy of information at the time of commitment can be adequately understood in such a way that the absence of relevant information is itself relevant information at the meta-level of the hierarchy of autonomous actions. As we saw our two models confounded repeatedly, we also saw authors beg the question in favor of the integrated approach such that the absence of information was always assumed to inhibit all autonomous action, when it only necessarily prevents autonomous action on the primary level. These authors overlooked the crucial point that the absence of information is information on the meta-level.

Secondly, regardless of the amount of information present at the time of the prior commitment, the conflict between past and present autonomy is not an issue on a hierarchical level, because one kind of autonomous action, the waiver, takes precedence over another kind of autonomous action, the authorization. This conflict is only present when autonomous actions are taken to be identical in kind, but variant in degree, or scope, as was the case with the integrated approach. Assuming that one has assimilated
all the information relative to the waiver of one's right to e.g., informed consent, and the remaining criteria for autonomous action has been met, a prior commitment based upon a hierarchical understanding of autonomy, is capable of assuring a strong bond over the specified period of time.

\[9\] E.g., Ost and Appelbaum in Chapter 4, §18 & §23, respectively.
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