

Understanding the Consumer's Right to Know

Robert Wachbroit

Five years ago, President Clinton signed into law the Food Quality Protection Act (FQPA), which passed the House of Representatives by a vote of 417-0 and the Senate by unanimous consent. The Act fundamentally changes national goals concerning pesticide regulation and use. It eliminates the Delaney clause, an over forty-year-old federal standard that had outlawed even minuscule amounts of pesticides in processed food. FQPA substitutes a safety standard for all foods treated with pesticides that requires "a reasonable certainty of no harm"—defined as the consumer risking no greater than a one-in-a-million chance of getting cancer from a lifetime of exposure to a treated food.

As the vote on the bill indicated, the legislation enjoyed broad support from a number of constituents, including farmers, food processors, and pesticide manufacturers. Environmentalists and consumer advocates also welcomed the legislation, in part because FQPA includes a consumer right-to-know provision. Although the provision mandates providing consumers with information regarding "risks and benefits of pesticide chemical residues in or on food purchased by consumers," a more important aspect of the legislation is that it is presented as a right to know.

Implementation of the various aspects of FQPA has fallen to the Environmental Protection Agency (and its Office of Pesticide Programs). The Environmental

does not properly understand the scope of the right to know.

Questions Concerning the Right to Know

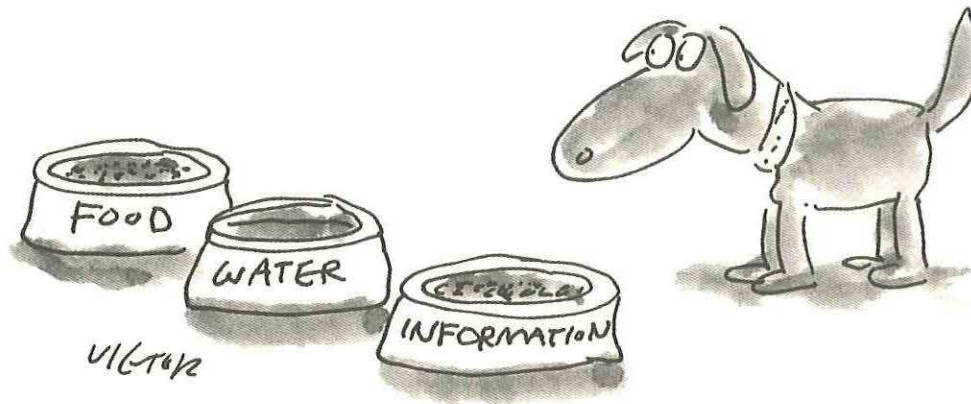
Several questions and concerns arise in considering the notion of a consumer "right to know." For instance, is a consumer's right to know the right to know *anything* of interest to her—including the broadest possible range of risks and benefits of a food or a manner of processing food—or should the "right to know" be understood more narrowly to include *only* those risks and benefits deemed essential to a consumer? To whom does the task of deciding what constitutes essential information belong? How are obligations generated by this right satisfactorily met: by the creation and distribution of informative brochures, the redesign of food labels, the provision of a consumer hot-line?

Nevertheless, one of the first questions one should ask is whether the right to know should be understood in a *weak* sense: does one have the right to be informed about *what is already known* about a food or process; or should it be understood as a *strong* right: does one have the right not only to the available information about a food or process, but also to *the active pursuit of information not yet available*? The difference between a strong and weak understanding of the right to know can have profound implications, particularly in questions at law. For instance, disputes concerning what cigarette manufacturers knew about the health hazards of tobacco often revolve around how active—or inactive—they were in gathering information about the effects of tobacco use.

Although a right to know entails a duty to disclose—which can be understood weakly as the duty to inform, or strongly as the duty to investigate and inform—a duty to inform *does not necessarily* entail a right to know. In order to obtain a patent, for instance, the inventor must disclose the workings of her invention. Disclosure is not based on someone's *right* to know those workings, but, rather, proof of innovation or of uniqueness requires disclosure of the workings of an invention. Disclosure in these cases does not rely

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Protection Agency understands the "right to know" provision of FQPA as the requirement to consult with the Departments of Health and Human Services and Agriculture in "developing consumer information for distribution to large retail grocers and for public display." However, the notion of knowledge as a *right* warrants more careful thought, since one cannot understand properly what FQPA provides for if one



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on any duty to know but on the utilitarian grounds underlying patent protection. In other cases, however, the duty to disclose is based on a right-to-know. For example, the duty of disclosure arising from the "Miranda" warning is not based on any utilitarian beliefs regarding the effect of such disclosures on crime or conviction rates. The Miranda warning rests on the right of individuals to know their legal rights at the time of their arrest.

Medicine is the most prominent area where duties of disclosure are based on a right to know. Both in the clinical setting and in biomedical research, right to

health; but when there is a conflict, the consensus holds that compliance with the patient's right to know should prevail.

Because few other disciplines have more carefully scrutinized—or more strongly endorsed—the right to know, this article examines the right to know as it applies to food consumption by drawing upon the better-examined area of the medical right to know. The article concludes by offering practical suggestions for implementing the right-to-know provisions of FQPA.

The Right to Know in Medicine

Perhaps the most important consideration that has shaped the right to know in medicine is the acknowledgement that patients have a right to autonomy or self-determination. The patient's right to decide how to live her life is based on the fact that it is *her* life. As competent, free adults, patients have the right, in particular, to make decisions regarding medical treatment—whether to undergo treatment, which treatment to undergo, and whether to discontinue treatment. Withheld information might lead a patient to arrive at a decision contrary to the one she would have made with full information—a violation of her autonomy. Though full disclosure may in some cases harm the patient—at

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know concerns have been defended, acknowledged, and incorporated into explicit disclosure and informed consent policies. Indeed, the patient's right to know is arguably one of the pillars of modern medical practice. Further, a patient's right to know commonly does not conflict with the primary mission of the medical profession to treat disease and to maintain and promote

least psychologically—the possibility of harm does not justify the rejection or abridgment of the patient's right to know. Medical paternalism—the notion that medical professionals “know best” what information to provide patients—not only risks limiting the rational exercise of a patient to decide how to live her life, but deception may be the source of even *more* harm to the patient. Such considerations have led health professionals to recognize that they are under an obligation to respect patient autonomy by providing their patients with relevant medical information.

In medicine, although the right to know extends beyond a right to information that the health professional deems necessary for the patient—which would otherwise reintroduce medical paternalism—patients cannot claim the right to know *anything* they may want to know. Patients have authority over such as matters as how to live their lives and the values they choose to live by, but the health professional is the authority over what constitutes *medical* information. The physician who discovers that her patient has cancer, for instance, is obligated to inform the patient of the different medical options—surgery, radiation, chemotherapy—but is under no obligation to provide information of “alternative” therapies—laetrile, crystals, herbs, or homeopathy, for instance—even if the patient expresses interest in such alternatives. In short, in medicine the patient's right to know is a right to know medical information, and the health professional is the authority over what constitutes medical information.

Furthermore, the principal information that must be disclosed concerns the risks associated with various treatments. When surgery is contemplated, physicians should always inform patients of the risks of infection. But the disclosure does not cover all risks. For example, surgical incisions are commonly closed either by sutures or by staples. Each has its benefits and risks—staples result in faster healing, but sutures result in less scar tissue. The better option is a matter of expertise, a judgment to be made by the surgeon. Although patients can refuse or choose surgery, they typically are not informed of the differences between sutures and staples, and they are not asked to choose between the two.

Disclosure is not limited only to likely risks, however. If death is a possible—although improbable—outcome of a procedure, the risk of death must be disclosed. In this case, medical professionals are obligated to disclose salient risks, where salience is understood from the perspective of the reasonable person. The possibility of death is always a salient risk.

The patient's right to know encompasses more than just information concerning the risks and benefits of various treatments. Medical professionals should also disclose the results and significance of tests and examinations; disclosure must be communicated in a way

Genetics and Criminal Behavior

David Wasserman and Robert Wachbroit, Editors

This volume brings together a group of essays by leading philosophers of science, ethicists, and legal scholars, commissioned for an important and controversial conference on genetics and crime. The essays address basic conceptual, methodological, and ethical issues raised by genetic research on criminal behavior but largely ignored in the public debate. They explore the complexities in tracing any genetic influence on criminal, violent, or antisocial behavior, the varieties of interpretation to which evidence of such influences is subject, and the relevance of such influences to the moral and legal appraisal of criminal conduct. The volume provides a critical overview of the assumptions, methods, and findings of recent behavioral genetics.

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that the patient can understand. The area of prenatal genetic testing has been particularly successful in establishing numerous practices that enable patients to make informed decisions. For instance, typically those undergoing prenatal genetic testing are assigned genetic counselors, who are both well-versed in effectively describing the tests in terms of a crash course in Mendelian genetics, and who can clearly and sensitively discuss the social implications of various gene

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conditions—e.g., that some conditions might be subject to discrimination by insurers.

Implementation of this right to know can take various forms, including brochures, face-to-face conversations, and video presentations. Perhaps the most visible implementation of this right is the consent form. These documents are usually worded in such a way that, by signing the form, the patient consents to the treatment and also affirms, in effect, that because she has been informed of information regarding risks and benefits of the proposed treatment, her right to know has been respected. With only a few notable exceptions, no treatment is performed without this kind of declaration.

The Patient's Right to Know and the Consumer's Right to Know: Several Contrasts

The patient's right to know is not a simple matter—many have debated the precise meaning of patient autonomy, and some empirical studies suggest that patients may not fully understand the consent forms they sign. But more than other areas, medicine has scrutinized and developed an understanding of the right to know which has been implemented reasonably well. What can the patient's right to know tell us about the consumer's right to know? It is important to recognize that four crucial differences exist between the two.

Mystery versus Familiarity. Patients typically know little about most medical procedures or medications—and they realize their ignorance. Patients do not typically seek out procedures and medications—they are proposed by their health professionals. And although the patient may have a vague idea of the purpose of a treatment, he commonly is unaware of what risks he should ask about. Patients are often apprehensive and expect their health professional to identify the risks that must be disclosed.

In contrast to the exotica of medical procedures and medications, food consumption is literally an everyday experience. This familiarity leads many to believe that they know and understand the benefits and harms of the foods they consume. Beliefs about their knowledge are not confined solely to matters of aesthetics—this food will taste good, that food will make me fat—many people also believe that they understand the health risks associated with the handling of food, such as how various foods should be stored or cooked. Contrary to common belief, many experts maintain that consumers do *not* know as much as they think they do, and studies show that most health harms from food are the result of improper handling.

General versus Targeted Risk Communication. Because patients are unfamiliar with most medical procedures and medications, health professionals disclose all relevant harms, risks, and benefits. Typically, they develop a standard disclosure of risks and benefits for the particular procedure or medication; this standard disclosure can serve as the basis for a more extended discussion for the patient with more particular concerns.

Because consumers are so familiar with food, by contrast, concerns about a particular products tend to be specific. One consumer might be interested only in fat content, another only in sugar content, while a third cares only whether the item was grown organically, and yet another consumer cares only about whether a

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particular pesticide was used. This is not to say that consumers are closed-minded about learning the risks outside their areas of concern, but unless those risks seem surprisingly significant (to the individual consumer), consumers tend not to broaden their interest.

Lack of interest in risks outside one's concern is rational. Since food consumption is an everyday experience, information about food must be understood efficiently; information about other considerations simply distracts from making food selections with minimal effort. Furthermore, consumers believe that all the food available for purchase passes a certain threshold of safety. With the exception of those with particular food allergies, few believe that any of the food in the stores is lethal. These considerations result in consumer concern over harms that are small, cumulative, and long term. Eating one portion of greasy french-fries may be harmless, for instance, but some con-

sumers believe that a steady diet of greasy foods will, in the long term, be bad for their health.

Professional Relationship versus No Relationship.

In medicine, a patient typically exercises her right to know within a relationship with a medical professional—she is *somebody's* patient. Her health professional works within a network of responsibilities and obligations, a network which includes not just the patient, but also colleagues and other elements in the health care setting. While a patient can receive relevant information in many ways—via brochures, videos, etc.—the ultimate responsibility for patient consent lies with the designated health professional (whose name is often on the consent form).

No such relationship exists with regard to food consumption. Although there are many people involved in the production and delivery of food—farmers, wholesalers, store owners, checkout clerks, among others—the consumer will typically have contact with only the last person in the chain and that contact hardly constitutes a relationship capable of sustaining important duties and obligations specific to an individual consumer.

This is not to deny that the store owner, store manager, and checkout clerk are under the obligation to be honest in their labeling and fair in their pricing. But this is a general obligation.

The Requirement of Understanding. With few exceptions, in medicine no procedure is undertaken without the patient's informed consent. Consequently, the patient's understanding functions as a gatekeeper: understanding the risks and benefits of a procedure are a necessary requirement for allowing the procedure to go forward. The significance of the patient's right to know does not consist simply in receiving answers to her questions. Commonly, treatment cannot go forward unless she acknowledges that she indeed understands what is involved in the procedure or treatment. The requirement of the patient's signature on the consent forms prior to receiving medical services is not some backdoor medical paternalism; rather, it is a strong affirmation of the patient's freedom and autonomy, which cannot be exercised if choices are made in ignorance.

By contrast, consumers need know nothing about the risks or nutritional value of foods—much less affirm such knowledge—in order to make their purchases. Of course, the absence of this requirement can be explained by the belief that, since foods are generally safe, consumer choices can be based on aesthetics or idiosyncratic preference. Because of this presumed familiarity with food, it is assumed consumers understand the various advantages and disadvantages of different foods.

If a particular food is harmful to some for special reasons—e.g., some people have an allergic reaction to a particular food—the responsibility lies with the consumer to know this, make specific inquiries if necessary, and choose appropriately. Requiring food consent forms would be an onerous burden with little benefit.

Apparent exceptions to this situation underscore the point: A food store in Delaware that specializes in hot sauces requires customers to sign waivers acknowledging the potency of some of these sauces. The "food consent form" of course promotes the novel character of the store, but some of the sauces are indeed unfamiliar to the (average) customer and can be harmful if not used properly.



Respecting the Consumer's Right to Know

Many of these contrasts rest on contingent differences between the consumption of food and the consumption of medical service. If the general presumption of food safety were challenged, for instance, then one would expect to see heightened interest in risk information. Indeed, the recent public concern over "mad cow" disease in England resulted in butchers throughout Europe generally taking particular care in informing their customers about the source of the beef they sold, and providing details intended to restore confidence in its quality and safety. Detailed information on display became an expectation of customers.

Food scares are exceptional cases, however, and the purpose of the Food Quality Protection Act was not to counter food safety crises but to respond to increasing consumer demand for information on risk and nutrition. Asserting a consumer's right to know is not

directed at some alleged paternalism in the food industry or refusal to respect or acknowledge the consumer's freedom and autonomy. Rather, it is directed at the changing attitudes and sophistication of consumers.

Accepting a consumer's right to know in matters of food does not require a radical break with previous practice. This is perhaps the most important difference

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between the consumer's right to know and the patient's right to know. A few decades ago, medical practice—particularly, the practice of disclosure and consultation—was seen as patronizing, not properly respecting the patient's autonomy and freedom. Medical scandals led to a call for radical change in the physician-patient relationship and for special assurances that the patient's right to know would be respected. Although food scandals and scares may point to problems with particular producers or distributors—or even with particular safety standards or their implementation—they do not point to the need for fundamental changes in our practices of purchasing foods. Implementation of the consumer's right to know does not require radical change, therefore, but it also does not endorse business as usual.

Few would argue that the consumer's right to know provision of the FQPA mandates that consumers must have and understand all types of risk information—a claim that would constitute a radical departure from past practices. The right to know in matters of food selection can be understood as requiring the facilitation of a *targeted interest* in information, including risk information.

Plainly, targeted interests in information cannot be served by a single label or brochure, regardless how well designed. Any brochure that contained information about which pesticides were used, with their known levels of toxicity, *and* information about which fertilizers were used, organic or synthetic, *and* information about what methods of preservation were used (radiation, chemical, or thermal—or a combination of methods), *and* information about the use of any genetically modified ingredients, would be unwieldy and therefore useless. Although each piece of information might meet some particular consumer's interest, the agglomeration of such information would simply frustrate rather than implement the consumer's right to know.

If this discussion were taking place ten years ago, the prospects for implementing the consumer's right to know would not be promising, but advances in information technology now suggest an approach worth considering. The Internet is well suited for the job of implementation of the consumer right to know in matters of food selection.

Consumers and the Web

The general interest and use of the Internet has grown astonishingly in the past few years. One reason for the widespread of the Internet is its many Web sites, which are convenient and extensive resources of information. Web sites are particularly well suited to accommodate the targeted interests of consumers, and placing risk information about various foods on a Web site is a useful way to implement the consumer's right-to-know provision of FQPA. Again, as discussed above, easy availability of medical information is an inadequate response to the patient's right to know: implementing that right demands a determination by a health professional that the patient does indeed understand the medical information being presented to her. But in the case of food consumption, the demand of informed consent seems unjustified—unnecessary because of the general safety of the food available in

Targeted interests in information cannot be served by a single label or brochure, regardless how well designed.

markets, and burdensome because of the everyday need to consume food. Easy availability of food information itself evidences respect for the consumer's right to know.

Since Web sites can easily be made to respond to targeted interests, the question of the scope of the consumer's right to know—does she have a right to know *whatever* she wants to know, or a right to know *only what is deemed important* for her to know—may be moot. If the consumer's right to know is implemented via the Internet, in all likelihood, one will find a variety of information.

This is not to say, however, that all such information would be reliable. The Internet is not only an extraordinary source of information; it is also an extraordinary source of misinformation. Paranoids, cranks, and provocateurs as well as careful and responsible interest groups post on the Internet. Thus, even if there exists some piece of risk information that is arguably not within the scope of a consumer's right to know, those

consumers who are nevertheless interested in that information and search for it on the Internet will find it—or believe that they have found it. The only reasonable response to the danger of the mischief of misinformation is to provide all available information concerning a food and its production. Even food producers and processors who in the past may have been reluctant to discuss unpopular processes—food irradiation, for instance—or production—genetically modified foods—would be better served in speaking directly to their methods, rather than having another constituency construct a Web site with its own presentation of information.

Posting risk information about various foods on a Web site is a useful way to implement the consumer's right-to-know provision of the FQPA.

Although the widespread use of the Internet introduces to food producers an incentive to provide full disclosure, this by itself does not ensure that people will trust that information. There exist three approaches to establishing and maintaining consumer confidence in food information on the Internet. One can extend the legal authority governing food labels to information food producers provide on their Web sites. False, misleading, or inaccurate information on the Web would be subject to the same penalties as false, misleading, or inaccurate information on a food label. Of course, this approach is effective only insofar as there is consumer confidence in food labels generally.

A second approach would be to have an official trusted Web site. In fact, the Environmental Protection Agency, through its Office of Pesticide Programs, sponsors a site on FQPA, though the information presented is confined to the topic of pesticides. A broader information resource is needed. The site should also be designed in a way that searching is easy, and information is provided in a consumer-friendly form.

Both of these approaches treat the issue of providing reliable and credible information as a Web site

matter: the content of the site is either stringently regulated or the domain of the site indicates governmental authority. A third approach treats the issue by placing more responsibility on the consumer. This consists not only of providing information on the site but also of placing links to other sites that would provide "second opinions." These sites would confirm the information, offer alternative perspectives on their interpretation, or present reasonable concerns and challenges to the claims of the original site. It would be the responsibility of the consumer to visit these other sites before forming a judgment about the credibility of the information provided.

The situation is analogous to the case in medicine when a patient seeks a second opinion on a treatment recommendation. Even if the patient has complete confidence and trust in her physician, she may well seek the judgment of another physician in order to get a different perspective regarding her options and their underlying rationales. Although patients have not tried to seek second opinions as much as they probably should have, patients are increasingly going to the Internet to learn more about their medical conditions and treatment options. Inviting consumers to seek risk information for particular foods by providing links to alternative sources of information may well result in a more sophisticated consumer.

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