

Who May Challenge a Clinically Accepted Decision? A Procedural Justice Framework for Patient-Initiated Ethics Consultation, Independent Review, and Accessible Clinical Appeals

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Abstract

A clinically accepted decision may remain ethically contestable even when it reflects competent professional judgment and ordinary standards of care. The unresolved question is whether patients can trigger a credible process through which disagreement is heard, independently reconsidered when necessary, and connected to an institution capable of giving reasons or providing remedy. This article develops a Decision-Rights / Procedural Justice Architecture for patient-initiated challenge. It distinguishes the right to trigger scrutiny from authority to make, review, uphold, revise, or overturn a clinical decision. Evidence on ethics consultation, rapid review, complaints, patient-safety participation, communication, and ethics-service design indicates that pathway availability alone is insufficient. Meaningful procedural justice requires accessible initiation, intelligible routing, epistemic standing, timely and reasoned response, appropriate independence, defined review authority, and a route to remedy. Ethics consultation, independent review, and clinical appeal therefore perform different institutional functions. A patient may justifiably possess a broad right to initiate challenge without receiving unilateral decisional control, provided that the institutional response is accessible, appropriately independent, reason-giving, timely, and capable of acting on the concern.

Keywords: Procedural justice, Clinical ethics consultation, Patient-initiated challenge, Independent clinical review, Clinical appeals, Patient voice

Introduction

Clinical decisions gain practical authority through professional judgment, multidisciplinary agreement, and organisational policy. Yet a decision may still be experienced by the patient as unsafe, inadequately explained, or insufficiently responsive to values and circumstances. The ethical question is therefore not only

who holds final decisional authority, but also who may reopen deliberation and what an institution owes once a challenge is made. Patient- and family-initiated ethics consultation addresses part of this problem, although patients and families have been comparatively unlikely to initiate consultation despite being directly affected by contested decisions. Limited awareness, institutional practice, and power asymmetry can restrict effective access even where formal eligibility exists [1].

Recent escalation policies sharpen the distinction between initiating review and controlling its outcome. Martha's Rule is structured around access to rapid review when patients, families, or staff remain concerned about deterioration; its ethical significance can be framed as a health-system obligation to provide additional scrutiny rather than a right to command a particular treatment [2].

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Direct digital access does not by itself solve the problem. In one patient-portal implementation, only one of 74 patient or caregiver requests fell within the ethics service's customary remit, indicating that an open entry point can still be poorly aligned with users' understanding of the service [3]. Complaint research adds a further distinction: response quality depends on staff capability, opportunity, motivation, and organisational culture [4]. Entry, routing, review, and response are separate procedural functions.

Procedural legitimacy also has an epistemic and institutional dimension. Healthcare decision processes can remain unjust when relevant contributors are excluded or assigned insufficient epistemic standing despite formally rigorous procedures [5]. Fair healthcare decision-making likewise requires transparent, defensible institutional reasoning when competing claims cannot all be satisfied [6]. Applied to contested clinical decisions, these arguments support a focused proposition: patients need not possess unilateral authority over treatment to hold a legitimate right to raise a concern, receive intelligible reasons, and, where warranted, trigger scrutiny beyond the original decision-maker. The policy problem is to allocate those decision rights across mechanisms that were built for different purposes.

Procedural justice in contested clinical decisions

A meaningful challenge process begins with practical initiation. Patients and caregivers describe safety partly through access to information, advocacy, accountability, and closure when concerns arise [7]. At the same time, involvement can become burdensome when institutions shift responsibility for detecting and pursuing failures onto patients; work on primary-care safety shows that participation is valued only when adequate support accompanies it [8]. Patient initiation should therefore operate as an additional protection, not as a substitute for professional vigilance.

Access also requires intelligibility. Trust, communication, and role clarity shape how patients

understand organisational safety [9], while a survey across four South African referral hospitals found that at least half of patients in each hospital did not know the complaint procedure [10]. These settings differ, but they expose the same procedural vulnerability: a pathway can exist formally while remaining difficult to discover, understand, or navigate.

A second requirement is epistemic standing. Clinical ethics facilitation can structure discussion around values, perspectives, and moral reasoning rather than merely record disagreement [11]. Consumers participating in patient-safety incident review similarly emphasise meaningful voice, communication, documentation, transparency, and accountability [12]. Post-incident review is not equivalent to prospective clinical challenge, but the procedural lesson is relevant: institutions should be able to show how a concern entered deliberation and how the response followed from the information and reasons considered.

Standing must also carry some capacity for influence. Consumer representatives on safety-investigation teams have reported difficulty obtaining equal status, relevant documentation, and full participation despite formal inclusion [13]. Research on responses to patient feedback identifies timeliness, explanation, acknowledgement, and signposting as features of more effective organisational response [14]. Thus, being heard is weaker than receiving a reasoned response that can generate clarification, reconsideration, escalation, or closure.

For contested clinical decisions, procedural justice can therefore be tested through distinct requirements: initiation capacity, routing intelligibility, epistemic standing, reason-giving, timeliness, appropriate independence, review authority, and remedy. These elements are non-substitutable. A pathway may be accessible yet powerless, independent yet unintelligible, or responsive only after the disputed decision has become irreversible.

Table 1 sets out these requirements without assuming that every challenge should succeed.

Table 1. Procedural requirements for meaningful patient-initiated challenge of a clinically accepted decision

Requirement	Institutional test	Failure mode	Minimum institutional function
Initiation capacity	Can the patient activate a route without specialist knowledge or professional sponsorship?	Formal entitlement is practically inaccessible	Clear entry and assisted initiation
Routing intelligibility	Can the concern reach the service able to answer it?	Repeated redirection or wrong-door abandonment	Active routing and handoff

Epistemic standing	Are the patient's reasons and observations treated as decision-relevant?	Voice is ceremonial	Structured opportunity to present concerns and correct misunderstandings
Reason-giving	Is the decision explained in terms responsive to the concern raised?	Authority is asserted without intelligible justification	Documented, understandable reasons
Timeliness	Can review occur while reconsideration remains meaningful?	Only retrospective acknowledgement is possible	Urgency-sensitive escalation
Appropriate independence	Is review sufficiently separated from the challenged decision for its purpose?	Reconsideration simply reproduces prior assumptions	Function-matched independent scrutiny
Review authority	Can the reviewer obtain information and trigger reconsideration?	Problems are identified without action	Explicit authority matched to role
Remedy and closure	Is there a route when consultation does not resolve a substantiated concern?	Acknowledgement becomes the endpoint	Escalation, corrective action, formal decision, or reasoned closure
Institutional ownership	Does the organisation retain responsibility after the challenge is raised?	Burden is shifted back to the patient	Named responsibility for follow-through

The requirements distinguish entry from influence and consultation from remedy. Their institutional allocation becomes clearer once ethics consultation, independent review, and appeal are treated as different functions.

Ethics consultation, independent review, and clinical appeals

Clinical ethics consultation can clarify disagreement, identify ethically relevant facts, articulate competing values, and support communication, but its accessibility depends on service design. Anonymous requests may lower barriers for hesitant requesters while constraining the interaction needed for a full consultation; confidentiality can preserve access without severing dialogue to the same degree [15]. The organisational form of ethics consultation also varies. A review of 103 consultations across a regional healthcare system documented variation in indications, decision-makers, and documentation [16]. At the Uganda Cancer Institute, stakeholders described several forums for difficult cases but also identified the absence of dedicated clinical ethics support and concerns about specialised ethics expertise [17]. "Ethics consultation" therefore does not denote a uniform mechanism with a fixed degree of independence or authority.

Its principal value is often deliberative rather than appellate. Requesters interviewed about ethics consultation during the COVID-19 period emphasised responsiveness, willingness to engage, and perceived value [18]. Early routine ethics involvement in extracorporeal membrane oxygenation care has been used to support expectations, communication, and surrogate decision-making before conflict becomes entrenched [19]. A longitudinal study of mandatory consultation in intensive care found different patterns

across medical and surgical units, underscoring the context sensitivity of compulsory consultation [20]. None of these findings establishes that ethics consultation ordinarily possesses authority to overturn the treating team.

Some challenges instead require another clinical judgment or a more formal institutional decision. Whether patients can articulate that need is itself shaped by communication conditions. A qualitative systematic review of older patients' interactions in primary care identified relational and contextual barriers and enablers to verbal participation [21]. Prospective work on nurse-patient communication likewise found that communication experience varied with context, including language background [22]. These studies do not define an appeals system, but they support assisted initiation and a routing duty that does not require patients to classify the dispute correctly.

Independent review is distinct because its defining concern is who should reconsider the disputed judgment and with what separation from the original decision-maker. A diagnostic or treatment-feasibility dispute may require another qualified clinician; a values conflict may require ethics facilitation; a challenge to institutional policy or process may require organisational review outside the treating team. Independence is therefore functional rather than absolute: the reviewer must be sufficiently separate to test the contested judgment and sufficiently competent to assess it.

Clinical appeal adds a stronger authority claim. An appeal requires a recognised route through which a prior determination can be formally reviewed by an actor or body authorised to uphold, modify, remit, or otherwise act on it. Merging consultation, independent review, and appeal creates two opposite risks. Patients may be told

that a decision has been “reviewed” when the reviewer lacked genuine independence or remedial authority; alternatively, ordinary disagreement may be over-juridified when facilitated deliberation would have been more appropriate.

The policy objective is differentiation with connection. Ethics consultation, independent clinical review, and clinical appeal should remain distinct functions, but patients should not bear the burden of navigating their institutional boundaries unaided. Consultation can clarify values and disagreement. Independent review can test clinical judgment or procedural integrity. Appeal becomes relevant when an authoritative institutional determination or remedy is required. A credible system must therefore match the concern to the level and kind of authority needed to answer it, while preserving routes between mechanisms when the first response proves insufficient.

A procedural justice framework for patient-initiated challenge

A patient-initiated challenge should be understood as a right to activate accountable reconsideration, not as a transfer of final clinical authority. This distinction permits broad access to challenge while retaining differentiated authority among patients, treating clinicians, ethics services, independent reviewers, institutional decision-makers, and, in exceptional cases, courts. Complaint-system research reinforces the importance of separating functions that are often administratively combined. Complaints can contribute to organisational learning, but the methods through which complaint information is converted into quality improvement vary considerably [23]. Realist synthesis likewise identifies access to information, advocacy, signposting, tailored response, and public accountability as distinct mechanisms within complaint handling [24]. Patient complaints can also identify diagnostic-safety problems that ordinary institutional surveillance may miss [25]. Voice, investigation, remedy, and system learning are related functions, but one cannot stand in for the others.

The framework begins with a broad initiation right. A patient, or an authorised representative where appropriate, should be able to raise a challenge when a decision appears inadequately explained, inconsistent with the patient’s values, based on disputed clinical assumptions, procedurally irregular, or likely to create irreversible harm before meaningful reconsideration can

occur. Institutions should not require the patient to identify the correct administrative category before the concern is heard. Communication-support research indicates that clear, reciprocal and facilitated communication can be deliberately designed rather than left to individual confidence or health literacy [26]. The practical obligation is assisted initiation: staff receiving a concern remain responsible for routing it to the function capable of answering it.

A second layer concerns review entitlement. The kind of review should match the object of disagreement. A values conflict may justify ethics consultation; a contested diagnosis, prognosis, or treatment feasibility may require another clinically qualified reviewer; an allegation of procedural unfairness may require organisational scrutiny independent of the treating team. Review entitlement does not guarantee a different substantive decision. It guarantees that the disputed basis of the decision can be examined by an actor with sufficient competence and distance from the original determination.

The third layer concerns remedial authority. Some disagreements can end with explanation, clarification, or facilitated consensus. Others expose a substantiated procedural or clinical problem that cannot be resolved by advice alone. At that point, the institution needs a body or office capable of directing reconsideration, obtaining additional review, modifying an institutional determination, or providing formal closure. The distinction matters because a consultative recommendation can be ethically valuable while remaining incapable of correcting a decision that the institution itself recognises as procedurally defective.

Procedural legitimacy also has substantive limits. Ethical analysis of triage demonstrates that apparently orderly decision procedures can remain objectionable when their criteria reproduce discriminatory assumptions or fail to take equality and disability rights seriously [27]. Likewise, the litigation surrounding treatment conflict in the Charlie Gard case illustrates a setting in which an external decision-maker can acquire authority precisely because disagreement exceeds what ordinary bedside negotiation can resolve [28]. These examples set boundaries rather than templates: most contested clinical decisions should not become legal disputes, but institutional process cannot be treated as legitimate merely because its steps were followed.

This allocation of functions is summarised in **Table 2**.

Table 2. Distinguishing the institutional functions that can answer a patient-initiated clinical challenge

Institutional function	Core trigger	Principal decision right exercised	Required degree of separation	Characteristic output	Capacity to alter the disputed decision	Appropriate endpoint
Ethics consultation	Values conflict, moral uncertainty, disagreement about ethically relevant reasons	Facilitate deliberation and clarify ethically defensible options	Sufficient neutrality to facilitate competing perspectives	Ethical analysis, facilitated discussion, recommendation	Usually indirect and advisory	Clarified agreement, reasoned recommendation, or referral onward
Independent clinical review	Dispute over diagnosis, prognosis, treatment feasibility, urgency, or clinical interpretation	Re-examine the clinical basis of the decision	Reviewer sufficiently independent from original judgment	Independent clinical assessment	Can materially change clinical reasoning if new assessment differs	Confirmation, modification, further investigation, or escalation
Organisational procedural review	Alleged failure of process, communication, policy, documentation, or governance	Test whether institutional procedure was appropriately followed	Separation from actors whose conduct or process is challenged	Procedural finding and corrective direction	Can require reconsideration or process correction	Rectification, explanation, renewed decision process, or escalation
Clinical appeal	Persistent contest of an authoritative clinical or institutional determination	Seek formal reconsideration by an actor with recognised appellate authority	Independence proportionate to the decision being appealed	Decision that affirms, modifies, remits, or overturns an earlier determination	Explicitly remedy-capable within its jurisdiction	Binding or formally authoritative resolution, subject to any further lawful review

The proposed framework treats these functions as connected routes rather than a mandatory sequence. A challenge can resolve at the first appropriate level, move directly to independent review when delay would be

harmful, or require appeal when consultation cannot provide an effective remedy.

Figure 1 illustrates the relationships discussed above.

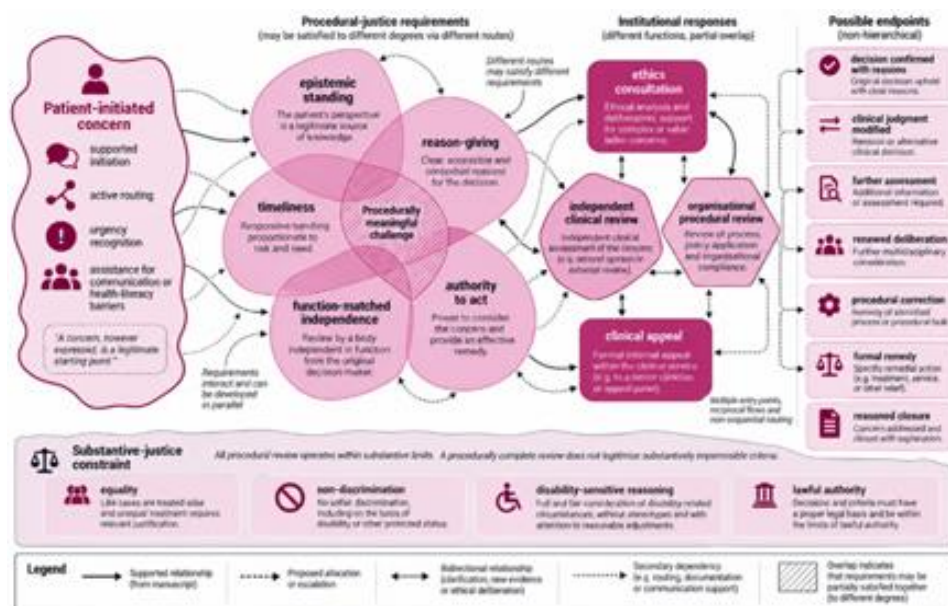


Figure 1. A patient challenge becomes procedurally meaningful only when access is connected to standing, reasons, review authority, and possible remedy

The same distinctions also require an institutional map showing that consultation, review, and appeal possess

different powers even when they address the same underlying disagreement.

Figure 2 illustrates the relationships discussed above.

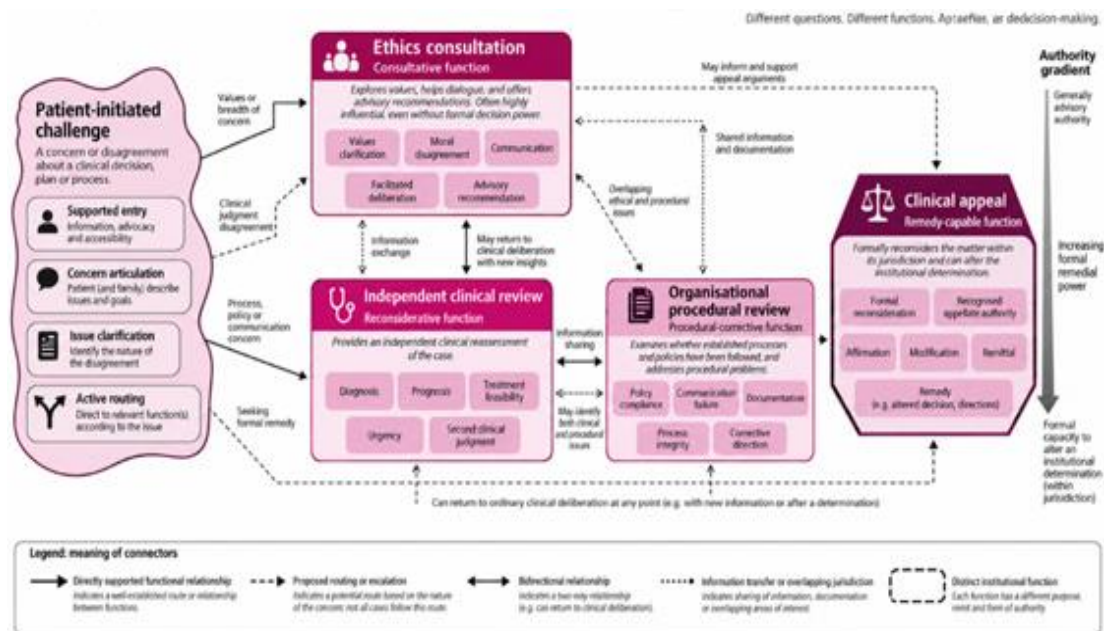


Figure 2. Distinct powers, connected routes: consultation, independent review, and appeal in contested clinical decisions

Policy and implementation implications

Implementation should begin with a no-wrong-door principle. A patient who raises a clinically relevant concern should not lose access because the first service contacted lacks jurisdiction. Direct-access mechanisms can generate misrouting [3], while confidential or anonymous access can create different trade-offs between safety of disclosure and the ability to conduct an interactive consultation [15]. Institutions should accept the initial concern, clarify its object, and transfer responsibility internally rather than repeatedly redirecting the patient.

Response standards should also distinguish acknowledgement from procedural completion. Complaint-response evidence indicates that explanation, timing, staff behaviour, and organisational culture shape how institutional responses are experienced [4]. Effective response frameworks similarly emphasise acknowledgement, reasons and signposting [14], while realist evidence identifies advocacy, tailored response and public accountability as mechanisms linking complaint handling to learning [24]. Hospitals should specify who owns the response, who communicates

reasons, how unresolved concerns are escalated, and what constitutes closure.

Equitable access may require differential support. Patients can face substantial gaps in knowledge of complaint mechanisms [10], while review participants report a need for understandable information, meaningful voice and transparent documentation [12]. Communication barriers are also context sensitive [21]. Accessible challenge should therefore include language support, communication assistance, representative involvement where authorised, and proactive explanation of available routes. These supports enlarge the patient's capacity to exercise an existing decision right; they do not transfer the clinician's professional duties onto the patient.

Governance should define which actors possess advisory, reconsiderative, corrective and appellate powers. Variation in ethics-consultation practice [16], uneven availability of dedicated ethics infrastructure [17], and context-sensitive findings from mandatory consultation [20] caution against a single organisational form. The governance requirement is functional clarity: institutions should identify who may initiate, who must respond,

what information the reviewer can access, what degree of independence is required, and what remedies are available.

Table 3 summarizes the distinctions discussed above.

Table 3. Allocation of decision rights and institutional safeguards for patient-initiated challenge

Procedural function	Patient or representative	Treating team	Ethics service	Independent reviewer	Organisational authority	Core safeguard
Initiate concern	May activate route and present reasons	Must recognise and transmit concern	May receive directly where permitted	May receive routed request	Must maintain accessible entry points	No-wrong-door routing
Clarify disputed issue	Supplies values, observations and questions	Explains clinical basis and uncertainty	Facilitates ethical clarification	Defines clinical question for review	Ensures relevant records are available	Intelligible issue definition
Request additional scrutiny	May request reconsideration	May initiate additional consultation/review	May recommend independent review	Conducts separate assessment	Ensures reviewer access and independence	Function-matched review
Provide reasons	Receives and may challenge explanation	Gives clinical rationale	Gives ethical analysis or recommendation	Gives independent assessment	Gives procedural or appellate reasons where relevant	Documented reason-giving
Correct procedural failure	May identify failure	Participates in renewed process	May advise	May identify implications	Must direct correction where authority rests	Organisational accountability
Decide or alter clinical plan	No unilateral authority merely by challenging	Retains ordinary clinical decision role subject to lawful limits	Usually advisory	May influence through independent clinical judgment	Acts where policy grants formal authority	Role-specific decisional authority
Provide formal remedy	May seek available remedy	Implements lawful/institutional outcome	May recommend escalation	May trigger further review	Must provide or route to remedy-capable forum	Explicit remedial jurisdiction
Close the challenge	May receive explanation and contest unresolved issues	Documents outcome	Documents ethical resolution where involved	Records independent conclusion	Confirms final institutional disposition and further options	Reasoned closure with traceable responsibility

Results and Discussion

The central contribution of this analysis is a decision-rights distinction. Patients need not possess a veto over clinically accepted decisions to hold a robust procedural entitlement to challenge them. Patient-initiated ethics consultation demonstrates why initiation rights matter [1], while rapid-review policies show that additional scrutiny can be conceived as an institutional obligation rather than a transfer of ultimate authority [2]. This distinction protects both patient agency and the differentiated responsibilities of professionals and institutions.

The framework is strongest where a health system can connect access to meaningful institutional power. Ethics consultation can support deliberation and moral agency [11], but confidential access, reviewer competence,

documentation and service boundaries affect what it can achieve [15]. Complaint-system evidence similarly shows that participation and information are useful only when organisations possess mechanisms that convert concerns into response, investigation or learning [23]. A formally impressive pathway can therefore remain procedurally weak if independence is nominal, review occurs too late to matter, or no actor possesses authority to act on a substantiated concern.

The analysis also has limits. Evidence assembled here comes from ethics consultation, complaints, incident review, safety participation, communication, rapid review and related domains rather than from a single mature literature on clinical appeals. Institutional arrangements vary across jurisdictions and specialties. Dedicated ethics infrastructure may be limited [17],

mandatory consultation can behave differently across settings [20], and procedural legitimacy cannot resolve disputes about substantively discriminatory decision criteria [27]. Legal escalation also occupies a special role: judicial involvement may be justified in exceptional high-stakes conflicts without constituting a workable model for routine bedside disagreement [28].

These limitations narrow rather than erase the policy claim. A healthcare institution should be able to answer three questions when a patient challenges an accepted decision: How can the concern enter? Who is sufficiently independent and competent to reconsider it? What authority exists if reconsideration identifies a problem? Systems that cannot answer all three may provide opportunities to speak while withholding meaningful contestability.

Conclusion

A clinically accepted decision may be challenged legitimately by the patient or an authorised representative even when that person does not possess final decisional authority. The ethically important right is a right to activate an accessible, intelligible and appropriately empowered process of reconsideration. Ethics consultation, independent clinical review and clinical appeal should remain institutionally distinct because they perform different functions, require different degrees of independence and possess different capacities to alter a decision.

Procedural justice is strongest when access, standing, reasons, timeliness, independence, authority and remedy are connected rather than merely available in isolation. A patient-initiated challenge does not entitle the patient to a preferred outcome. It does require the healthcare institution to ensure that disagreement can reach the right forum, be examined by an appropriately positioned reviewer, receive reasons responsive to the concern raised, and progress to a remedy-capable process when consultation alone is insufficient. The defensible boundary is thus neither unrestricted patient veto nor professional immunity from challenge, but institutionally guaranteed contestability matched to the kind of decision under dispute.

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