Autonomy revisited: progress in medical ethics: discussion paper[1]

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The history of the emergence of medical ethics as a special subject for study in the past 15 years is in many ways the history of concern for patient autonomy. Particularly in the United States, the centrality of autonomy is reinforced by the work of the President's Commission for the study of bioethical problems. The Commission relies heavily on the concept of patient autonomy in offering advice on matters such as informed consent and cessation of life-prolonging treatment (President's Commission 1982, 1983).

The concept of autonomy is more familiar to philosophers than to physicians, and its central role in medical ethics reflects the movement of philosophers into this field. Physicians have sometimes viewed these new colleagues with disfavour and suspicion (Harrison 1974, Vaisrub 1974). For one thing, physicians have feared that philosophers would construct theories of medical ethics which leaned too much toward philosophical elegance at the expense of a practical understanding of clinical reality. For another, physicians have not been impressed with the history of ethical reflection by philosophers: the penchant for identifying key ethical problems and then, after two millenia of discussion, being no closer to resolving them, does not recommend itself to the practical clinical mind.

I wish to argue that, if one looks at the notion of patient autonomy as it was discussed in the medical literature 10 and 15 years ago, one does find grounds for these fears on the part of the physicians. But, if one then turns to the development of the concept of autonomy in more recent philosophical discussion, one will see that progress has been made, and that the progress is in the direction of bringing a philosophical construct closer to clinical reality and applicability. In short, philosophers are educable, medical ethics is practical, and the notion of autonomy illustrates both these points.

Autonomy: the negative view

First, it is important to recall the state of affairs at the time when philosophers first became interested in medical-ethical matters. Medicine already had a long history of commitment to an ethical ideal, which Veatch (1981) has described as the Hippocratic ethic – do not harm the patient and, where possible, try to benefit the patient, all the while using your best professional judgment to determine what counts as a harm and a benefit. So if physicians found themselves facing ethical quandaries and if patients increasingly complained that this style of medical practice was not meeting their perceived needs, the problem could not be a lack of ethical commitment as such. Searching for what might be the missing element, philosophers found it convenient to pull the notion of autonomy out of their supply of concepts. This concept has a venerable history within philosophy, but is most easily explainable to the physician simply as respecting the right of self-determination of the individual patient. This in turn implies treating the patient as one's own moral equal – since it may be assumed that all of us wish our fellow beings to respect our right to make our own choices, and we feel moral outrage when others knowingly deny us this respect. It also implies that we can distinguish between respect

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for someone else as a free chooser, and respect for the actual choice that is made; we can respect the chooser as an autonomous person while disagreeing with the actual choice.

The concept of autonomy seemed to do a lot of work for the medical ethicist. It showed a gap in the traditional Hippocratic ethic which did not allow a role for the patient in deciding what is to count as a benefit or a harm. Philosophers were quick (perhaps too quick) to conclude that this reflected an indefensible generalization of the physician's expertise. It is natural to regard the physician as an expert in determining which medical technique or intervention will most efficiently lead to a certain outcome; it is much harder to see how the physician could be an expert in assessing whether that outcome appears to be good or bad for an individual patient, given that patient's unique values and life plans (Veatch 1973). The natural next step was to see this generalization of expertise as a reaction to the vulnerability of the sick patient. The model of autonomy which makes the most sense, philosophically, is one that assumes that most of us behave autonomously most of the time – that is, behaviour is viewed as autonomous so long as it meets fairly basic and rudimentary criteria for voluntary and free action. And so philosophers had to explain why patient autonomy seemed to be absent from medicine while those same patients generally acted autonomously in most other life situations. The philosophers' answer was to point to the variety of ways in which physicians could subtly sway and manipulate patients rendered psychologically vulnerable by illness, so as to dictate the desired outcome even while outwardly deferring to the wishes of the patient.

Putting all this together, if one looks at a representative textbook discussion of autonomy in medical ethics dating from 10 or 15 years ago, one sees what I characterize as a negative view of patient autonomy (Ramsey 1970, Campbell 1975, Gorovitz 1976, Brody 1976, Beauchamp & Childress 1979). This view implies that the primary threat to patient autonomy is the paternalistic physician who is always tempted to assume that he is an expert in matters better left to the patient's own discretion. Any statement from the physician of the form, 'I recommend that...' or 'Perhaps you had better...' (let alone, 'I insist...' or 'I order you to...') threatens to destroy patient autonomy, since the sick person is so vulnerable as to be overly swayed by such statements and to be unable to disagree with any such recommendation for fear of losing the physician's help and support. The physician can only overcome this threat to autonomy by, in effect, backing away and standing aside. He must baldly lay out the medical facts of the case and present the different options for the patient's consideration. He must studiously avoid expressing a preference for any option, even by something as subtle as facial expression or tone of voice, lest he inadvertantly influence the patient's freedom of choice.

Criticisms of the negative view

Physicians, naturally enough, objected to this negative view of patient autonomy. They argued that this value-neutral purveyer of objective information was an unrealistic caricature of the physician's role (Laforet 1976). They argued that this inappropriately inverted the power relationship, making the patient the all-powerful 'consumer' while the physician was powerless to influence the patient's behaviour, for good or for ill. They argued that this view of 'respect for the patient' would lead to fearful and uncounselled patients refusing possibly beneficial interventions and, in the end, 'dying with their rights on'. All these arguments gained sympathy among physicians and led to increased scepticism over the role of the philosopher in medical ethics. The philosophers, for their part, tended to discount all of these comments. They felt that the physicians either were so wedded to the traditional Hippocratic ethic that the meaning of patient autonomy eluded them, or else that they were still generalizing physicians' expertise and paternalistically arguing that they knew what was good for the patient better than the patient did.

In the past several years, however, arguments to undermine this negative view of patient autonomy and to replace it with a more sophisticated and positive view have emerged from the internal dialogue among philosophers of medicine. In general this has not occurred as the result of a 'new' group of philosophers appearing to do battle with and vanquish 'old' philosophers; instead the progress has come by a gradual and sometimes imperceptible evolution in

the views of many of the original debaters. For example, Robert Veatch, an early champion of autonomy over Hippocratic paternalism, now writes that the ethics of society and community increasingly occupy centre stage in medical-ethical inquiry, leaving the 'principle of autonomy . . . nothing more than a footnote in a full theory of medical ethics' (Veatch 1984). But, looking at the roles of philosophers as they have become more active within hospitals and academic medical centres, serving on ethics committees and making ward rounds with physicians (Toulmin 1981, Caplan 1983), it is tempting to conclude that the newer philosophical arguments reflect an enhanced understanding of some features of clinical medicine and the physician-patient relationship that were glossed over too quickly in the old negative model. Before describing this positive model of patient autonomy, I will briefly review some of the philosophical arguments aimed against the older model of autonomy.

Criticism of the notion of autonomy, as it appeared in the older medical ethics literature, has been of two general sorts. One line of criticism is aimed less at autonomy than at the notion that the doctor-patient relationship, construed as a relationship between two isolated individuals, is at the heart of any model of medical ethics. This line of criticism suggests that a medical ethic of community and society is necessary to replace the narrowness of the old individualistic ethic. While I have strong sympathy with some features of this criticism, I will not here have the opportunity to discuss it. Instead I shall focus on a second line of criticism – that the idea of autonomy embodied in the negative model does not really do justice to the ethical dimensions of the doctor-patient relationship.

One implicit assumption of the negative model of patient autonomy (not a logically necessary assumption, but one from which the model derives additional credence) is that autonomy is essentially an all-or-none phenomenon. Swayed or influenced by the physician, the patient will lack autonomy; presented with objective medical data in a neutral manner, the patient will display full autonomy. The same all-or-none assumption was also applied to the ethical problem of determining the patient's competence or capacity to participate in medical decisions. Infants, children, the mentally retarded, the senile, the comatose, were all seen as lacking autonomy, and needing to be represented by a proxy decisionmaker; the typical adult was seen as fully competent unless afflicted by some unusual condition such as an acute psychosis or severe electrolyte imbalance.

Four senses of autonomy

Philosophers gradually became aware of the naive simplicity of this all-or-none view of autonomy and the desirability instead of some sort of sliding scale along which autonomy might be measured. Along with the idea that autonomy could vary along a sliding scale came an awareness that autonomy might not be a unidimensional construct at all, but may consist of disparate elements. Miller (1981) has provided one of the most useful analyses of different senses of autonomy. He suggests that autonomy might be analysed in terms of four aspects, some essential for autonomy to be present at all, others reflecting an optimal rather than a minimal state of autonomy. Miller's four senses of autonomy are free action, authenticity, effective deliberation, and moral reflection. Free action simply means that one knows what one is doing and voluntarily chooses to do it. Miller notes that we cannot regard an action as 'not free' merely because the actor is under some form of emotional duress, or is swayed by outside or inside factors toward one choice or another; if we had such a rigid view of 'freedom', it would follow that almost all of our daily actions are nonautonomous, a view that Miller clearly rejects. Authenticity means acting in character; a person fails to be autonomous in this sense if the choice is inconsistent with important, pre-existing values and desires. A devout Jehovah's Witness who readily accepts a blood transfusion would be acting nonautonomously in this sense.

Effective deliberation refers to the rational weighing of the pros and cons of the various options and selecting that option which, on careful reflection, maximizes the goals sought by the individual. This is the core sense of autonomy as reflected in most procedures for formal informed consent; many administrative procedures and legally sanctioned consent forms assume that every autonomous patient will engage in effective deliberation prior to any major

medical decision. Miller, however, points out correctly that only the unusual, highly rational patient explicitly engages in such a process in most settings. The more typical patient will be swayed to adopt a course of treatment because the doctor recommends it, because a friend or relative has had it, or because 'it just seems like the best thing to do'. If this typical patient is acting freely and authentically, Miller would be unwilling to say that the patient was acting nonautonomously simply because of lack of effective deliberation.

Finally, moral reflection is the most abstract and most rarely encountered sense of autonomy. In moral reflection, one carefully reviews one's core values and ideals and either revises or reaffirms one's commitment to them. This is a deeper and more complex process than effective deliberation: in the latter one weighs the possible options in light of one's own values, but one does not question or re-examine the values themselves. Patients facing chronic or terminal illness for the first time may, however, be stimulated to undertake moral reflection.

Miller's four senses of autonomy flesh out considerably the picture of autonomy that allows it to vary along several dimensions instead of being an all-or-none quality. Further, each sense would seem to be determinable by clinical inquiry. (For example, the physician might seek information from family or close friends of the patient to learn if the patient's present behaviour is authentic or not.) Individual judgments can be made with considerable precision – for instance, the alcoholic who is proposing a variety of sophisticated rationalizations as to why he should not enter a treatment unit may be displaying effective deliberation but, due to his addiction, be acting with very limited free action and authenticity. And the physician engaged in a longer-term relationship with the patient may over time discover ways to enhance the patient's autonomy along one or more of these dimensions. Since effective deliberation is less often seen, but is desirable from both a legal and an ethical point of view, the physician who encourages this behaviour in the patient (through providing educational materials and encouraging questions and discussion) will over time be enhancing that patient's autonomy.

The multidimensional, sliding-scale view of autonomy supported by Miller also is illustrated in the work of other philosophers. Komrad (1983), for one, has offered a different slant on the problem of justifying physician paternalism. Paternalism in medicine is fundamentally an elevation of the traditional Hippocratic ethic (the benefit principle) over the principle of respect for patient autonomy when the two are in conflict. In most cases one tries to justify paternalism by pointing to the benefit that (one asserts) will accrue to the patient as a result; this justification is often suspect because it gives relatively little weight to autonomy. Komrad notes that in some cases, one can justify a paternalistic intervention as a trade-off in short-term autonomy in order to gain an enhanced level of autonomy in the future. In our example of the alcoholic, suppose that the physician enlists the family and employer in a sort of benign conspiracy to bring pressure to bear on the patient to enter treatment. This manipulation certainly thwarts the patient's autonomous choice in the short run. But the hoped-for outcome in the long run is enhanced autonomy: without the shackles of a chemical addiction, the patient will be a much freer and authentic chooser of his own destiny. Clearly, Komrad's approach is open to misuse; one might justify all sorts of patient manipulation on the grounds of a purely speculative increase in autonomy at some unspecified future point. And yet Komrad's argument reinforces the basic point made by Miller, that autonomy, to be discussed in the way that Komrad does, must be a much more complex notion than the all-or-none school of thought would have it.

Also in fundamental agreement with Miller is Ackerman (1982), who has taken aim particularly at that part of the negative view of autonomy which seems to encourage a stand-back, noninterference role for the physician. Ackerman, quite reasonably, calls for the physician to intervene actively, and notes that patients, after all, come to doctors precisely because they expect them to intervene actively on their behalf. He admits that a manipulative or paternalistic physician could act as a barrier to patient autonomy; but he also notes that the sickness itself and other aspects of the patient's condition may be much more significant barriers. To the extent that the physician can act to remove these barriers – by ameliorating the symptoms of the illness, by providing patient education, by bolstering the patient's sagging emotions and self-image – an active interventionist role is autonomy-enhancing.

Other criticisms of autonomy

Besides those who take views similar to Miller's, other philosophers have entered the autonomy discussion to offer criticisms of an over-emphasis on the principle of respect for autonomy in medical ethics. One line of this criticism I find basically flawed, but worthy of mention simply because it has received wide publicity in a major medical journal. Another line of criticism is thoughtful and worthy of extended discussion, even though I feel that an adequate response can be given.

The most direct attack on autonomy comes from Clements and Sider (1983) (a physician-philosopher team), who argue that autonomy can serve no useful role in medical ethics because it is strictly a formal concept with no practical content. They trace its historical roots in the philosophy of Kant, and contend that since Kant's fundamental aim was to derive ethics from *a priori* principles, any use of Kantian notions like autonomy necessarily excludes precisely those facts about the real world that physicians must rely upon in making case judgments. After criticizing Miller and others who have used the notion of autonomy in a central way, Clements and Sider propose their own alternative approach to medical ethics which seems to depend heavily upon systems-theoretical notions and the norms observable in homeostatic biological systems. In this way, they argue, the values that should guide medical ethics emerge from clinical judgment based upon the physician's expert knowledge of biological systems.

While sceptical physicians may have found this internecine warfare among philosophers mildly amusing, the fundamental argument unfortunately cannot hold water. Even assuming that Clements and Sider are correct in their interpretation of Kant – a point that many other philosophers would refuse to concede – it is nevertheless the case that philosophers since Kant have used Kantian terms to good advantage while still supplying a good deal of empirical content to their ethical theories. As I have already argued, Miller's four senses of autonomy is a prime example; there is enough empirical content in that view of autonomy for any clinician to go to the patient's bedside and determine upon investigation where that patient stands with regard to each of the four senses. Finally, the alternative proposal – to derive ethical values from the facts of biology – is one that has failed miserably as an ethical theory every time it has been attempted in the past, and Clements and Sider give no evidence of having resurrected this approach with any meaningful modifications.

A more thoughtful and worthwhile critique of the autonomy principle comes from two philosophers, Beauchamp and McCullough (1984), the latter of whom has devoted considerable time to observing interactions between patients and family physicians in an academic family practice programme in Washington, DC. Beauchamp and McCullough differ from most other authors on medical ethics in questioning whether the 'new' autonomy principle really has supplanted the 'old' Hippocratic benefit principle. They wish to give a bit more weight to the history of medicine and insist that the two principles must vie with each other as roughly equal contenders. Which principle will win out in which case, they conclude, is a difficult choice which must be based, in the final analysis, on the specific features of the case under discussion. If this stance condemns them to what would seem to be to others an intolerable reliance on moral intuitionism, they would rather accept this than be so quick to throw out the benefit principle.

A willingness to allow the autonomy and benefit principles to contend as rough equals suggests a willingness to accept and to justify paternalistic behaviour in medicine on a rather widespread scale. Beauchamp and McCullough accept this, and make several interesting observations about medical paternalism. First, they note that many cases of 'typical' paternalism, especially in life-and-death cases, really do not deserve the title of 'paternalism' at all. Take, for example, the severely burned patient refusing whirlpool treatments and skin grafts so as to be allowed to die, because he does not wish to endure the pain of treatment merely to be able to live the life of a blind cripple as he is destined to do if the treatment works. If the physician insists on keeping this patient alive, despite the fact that the patient's rational faculties are all intact (upon evaluation by a consulting psychiatrist), we may seem to have a clear case of placing the benefit to the patient over the value of respect for patient autonomy. But

Beauchamp and McCullough argue that, if one really presses this physician, we are likely to learn that the physician believes strongly (the psychiatric evaluation to the contrary) that no patient in his right mind would have made the choice that this patient has made. Thus the physician is not really justifying paternalism; he is denying that any patient autonomy really exists for him to respect. Since paternalism entails interference with autonomy, to show that the patient is not acting autonomously is to show that paternalism is not at issue in the case at all. The benefit principle operates unopposed.

If paternalism is present much less often than had been thought in these dramatic, life-and-death cases, Beauchamp and McCullough suggest that it is present much more often than had been thought in the humdrum, day-to-day cases. They characterize as paternalistic the vast majority of ambulatory, primary-care encounters. The patient presents with a cough; the physician diagnoses bronchitis and prescribes an antibiotic; the patient departs, prescription in hand, with a minimum of questioning and discussion. This, the authors say, is paternalism; the physician ignores the patient as a freely choosing moral agent and simply uses his own judgment to decide what will benefit the patient. The paternalism, they go on to say, is justified on two grounds: the fact that the benefit is real and harm is rare; and the fact that the degree of interference with the patient's liberty is so slight.

One may join with Beauchamp and McCullough in thinking that perhaps the benefit principle has been given too short shrift in our recent fascination with autonomy, and that our enchantment with the dramatic, life-and-death cases may have blinded us to the lessons that can be learned from the more usual office practice. And one should note that Beauchamp and McCullough agree with Miller in seeing autonomy as a sliding-scale rather than as a simple all-or-none phenomenon. Yet I believe that an alternative account of the usual office encounter can be given which avoids the necessity of justifying paternalism on a grand scale.

The notion of implied consent is a generally accepted concept both in law and ethics. If I walk up to a woman at a cocktail party, disarrange her clothing, and place my hand in a suitable position to palpate the precordial impulses, my behaviour is ethically and legally outrageous. The same act, in the medical examining room, is routine and unproblematic; the difference is implied consent. Reasonably informed and understanding adults in our society realize that voluntarily entering the physician's office and requesting an examination constitutes granting one's consent to certain actions. The patient who insists, 'I know that I gave my consent to be examined by the physician, but I never intended to permit him to place that cold metal thing on my bare breast', cannot get anyone to take her seriously. It is not necessary for the physician explicitly to obtain consent for each step in the routine examination procedure.

By similar logic, when a patient who is not seriously ill presents for an examination and is given a diagnosis and a prescription for some commonplace and relatively low-risk remedy, it seems mistaken to me to contend that he has been treated paternalistically and that he has been thwarted in the effective exercise of his autonomy. It seems rather to me (and indeed the patient, if asked, would probably say precisely the same thing) that the entire episode was an exercise in his autonomy. He knew exactly what sort of thing to expect when going to a physician with those sorts of symptoms; had he not wanted those things, he could easily have stayed at home, or consulted a chiropractor, or done something else again. And we have no evidence to conclude that, if the patient has disagreed with the diagnosis or the treatment, he would not have freely spoken up and said so. We know from experience that some patients are too cowed by the physician's authority to speak up or object; indeed we can often predict who those patients are going to be, since they often come from the less educated and lower-class populations. Toward that particular population of patients, the medical profession owes increased efforts to improve education and communication (Waitzkin 1984). But we also know that many patients are all too ready to voice objections, sometimes at considerable length. Without more information we cannot conclude that this patient's failure to ask questions or raise difficulties represents an absence of autonomy; it may just as easily represent adequate autonomy, full satisfaction with the outcome, and a reasonable desire to get the business concluded expeditiously. In short, the paternalism may rest less with the physician

in this encounter, and more with the observer who concludes that the patient's freedom of action is such a fragile thing that it is totally crushed by the presence of a stethoscope and a prescription pad. (I speak here of the typical ambulatory patient and do not intend to include in this judgment the seriously ill patient or the patient undergoing a major emotional crisis. And I further assume that the physician proposes some commonplace remedy, not some invasive procedure or some intervention outside the realm of experience of the average person.)

We may thus disagree with Beauchamp and McCullough and see the typical ambulatory encounter as a case of implied consent rather than as a case of justified paternalism. This is not merely a semantic quibble so long as we hold – as we should – that interference with one's exercise of autonomy in matters of significance is of grave moral concern. If we see paternalism everywhere, we are going to find commonplace and commonsense ways of justifying it, and those justifications of the relatively harmless cases will slide over imperceptibly into justifications of more and more egregious cases. If, on the other hand, we encounter paternalism only rarely, the label 'paternalism' will itself serve as a signal that a special and strong mode of justification is required. Further, even if we disagree with Beauchamp and McCullough and hold that autonomy is maintained in the typical ambulatory encounter, we might still find on analysis that the autonomy is present only minimally and that it is within the physician's power to expand and enhance it. Once again, the sense of autonomy most likely to be missing is effective deliberation, and the physician can encourage this through patient education and more active stimulation of dialogue. Why the physician should take the time to do this is a matter beyond the scope of this paper. I will assume that considerations of enhanced adherence to therapeutic regimens, greater responsibility for one's own maintenance of health, and fewer inappropriate emergency uses of the health care system will all recommend themselves to physicians who are unimpressed with autonomy as a bare-bones argument in its own right.

Conclusion: a positive view of autonomy

In the process of reviewing some of the important philosophical contributions to the concept of autonomy in the past few years, I have sketched a transition from the older and unsatisfactory negative view of patient autonomy to a clinically more sensible, positive view of patient autonomy. Callahan (1984) is referring to the older negative view when he asserts, 'My autonomy, I have discovered, is an inarticulate bore, good as a bodyguard against moral bullies, but useless and vapid as a friendly, wise, and insightful companion'. The positive view holds that autonomy is complex and varies along a sliding scale (or scales). The physician can be a barrier to patient autonomy, but the actively intervening physician can also remove other barriers to patient autonomy. Doing so requires clinical skill and judgment in assessing the multiple dimensions of autonomous behaviour in a particular patient at a particular time, and in identifying the factors that obstruct an increase in autonomy in each relevant sense. The medical interventions that enhance patient autonomy for the future may be as various as lowering an acutely increased blood urea nitrogen level; providing emotional support and counselling for a life crisis; educating the patient about the alternative treatments for primary breast cancer; and helping the patient to identify unresolved anger at a previous physician, the after effects of which have interfered with productive relationships with all later physicians.

I contend that this positive view of patient autonomy constitutes a significant advance in medical ethics. It has arisen in part from philosophers doing the sorts of things philosophers do well – clarifying terms and engaging in logical analysis of concepts. But in part it has been dependent upon philosophers entering the clinical world and taking seriously some of the day-to-day concerns of clinicians. Philosophers have not been content to settle for a notion of autonomy that achieves theoretical clarity and simplicity. Instead they have insisted upon a notion of autonomy that does some useful work for them when applied to the real activities of practitioners and patients. I view this as a constructive and mutually illuminating interplay between the two disciplines of medicine and philosophy, and one that sets a good example for future advances in medical ethics.

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