Philosophical Medical Ethics

Where respect for autonomy is not the answer

RAANAN GILLON

In several of my articles in this series I have emphasised the centrality of the principle of respect for autonomy to many areas of medical ethics, as indeed to ethics in general, and I have shown how this centrality is a feature of both utilitarian and deontological theories of ethics. Undoubtedly, readers will have thought of counterexample after counterexample deriving from their clinical practice when respect for autonomy does not seem to be the most important or relevant moral principle. In this article I shall outline several categories of clinical circumstances in which, so I shall argue, respect for autonomy is not the central moral issue. They include examples in which patients have given prior consent for their doctors to make decisions on their behalf; in which respect for the autonomy of a particular patient conflicts with respect for the autonomy of others or causes harm to others or conflicts with considerations of justice; in which the patient has either no autonomy or too little autonomy for the principle of respect for autonomy to apply; and of emergencies in which it is not possible to find out what the patient himself would wish to happen.

I have already discussed the fact that often patients positively and deliberately delegate doctors to make decisions and manage their case. Provided the patients have made an autonomous choice then the doctor who accedes to their request and makes the decisions is indeed respecting their autonomy. In these circumstances the Hippocratic principles of medical beneficence and non-maleficence to the patient are the main moral determinants, though, as I have argued, they may have to be constrained by considerations of justice. Let me recall that the principle of respect for autonomy—whether in the utilitarian model of Mill or in the deontological model of Kant—has built into it the need to consider the autonomy of others: a point too often forgotten by overenthusiastic libertarians. I have also argued against any moral principle being taken as absolute—the principle of respect for autonomy may conflict with the principles of beneficence, non-maleficence, and justice (though I have also argued from both deontological and utilitarian standpoints that where others will not be harmed such conflicts usually require respect for the patient's autonomy).

Impaired autonomy

The most obvious counterexamples to the primacy of respect for autonomy arise either when the patient has no autonomy—for example, a baby has no autonomy—or, more difficult still, when patients have considerably impaired or otherwise inadequate autonomy—for example, when they are young and immature or severely mentally handicapped or disordered, from whatever cause. One of the complicating features of medical practice is that disease and disability tend precisely to impair people's autonomy to a greater or lesser extent.[1 2 3] The crucial question then arises, How much autonomy does a person need to have for his autonomy to require respect?

It is perhaps worth distinguishing between impairments of the three types of autonomy I discussed in my article on autonomy: of action, of will (or intention), and of thought. Impairment of autonomy of action, however gross, does not in itself justify overriding the principle of respect for autonomy. This becomes immediately obvious if severely physically handicapped people are considered; their impaired autonomy of action in no way reduces our moral obligation to respect their autonomy of thought and of will, though respect for their autonomy must as usual be balanced against respect for the autonomy of others. Physically handicapped people, especially those needing wheelchairs, often complain, however, that they are treated as though their autonomy is generally impaired and typically as though they are children ("Does he take sugar?").

When autonomy of thought or will, or both, are sufficiently impaired medical intervention without consent that will benefit the person concerned—that is, paternalistic intervention—often seems to be justified, and indeed morally imperative, even when the person concerned rejects such help. A child with meningitis should surely be given her antibiotic injections even if she hates injections and volubly refuses them; a severely mentally handicapped adult should surely be operated on for appendicitis even if he does not want an operation. The most plausible justification for overriding such decisions is that (*a*) it is in the patient's best interests to do so and (*b*) such patients do not have sufficient autonomy of thought for their self damaging decisions to require the respect due to autonomous agents (though, as the American president's commission on medical ethics concluded in a useful report, this should in no way stop doctors from consulting such people and, as far as is consistent with their best interests, acceding to their opinions and preferences[4]).

Impaired autonomy of thought is not necessarily a matter of impaired reasoning; reasoning may be fairly unimpaired but based on an information substrate that is grossly distorted by, for example, delusions, false perceptions or hallucinations, or both. Even that apostle of individual liberty, J S Mill, argued that paternalistic interference was justified to benefit the mad or delirious, children, and the immature and that in general "those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury."[5]

Impaired volitional autonomy

Not only may autonomy of thought, including reasoning and cognition, be grossly impaired but so too can volitional autonomy—that is, impaired autonomy of will or intention (a point approached from a different perspective in an excellent analysis of these issues by Professors C M Culver and B Gert, one a psychiatrist, the other a philosopher[6]). Such impairment of volition may be intrinsic or extrinsic. The case of extrinsic impairment raises the interesting

Imperial College of Science and Technology, London SW7 1NA

RAANAN GILLON, MB, MRCP, director, Imperial College health service, editor, *Journal of Medical Ethics*, and associate director, Institute of Medical Ethics

issue of duress. Clearly, an agreement to participate in some clinical trial would hardly be voluntary if the "volunteer" and his family were threatened with death if he refused. But what about an offer of payment? Most of our decisions are subject to some degree of external pressure. At one end of the spectrum such pressures are clearly powerful enough grossly to impair our autonomy of will or intention; at the other end they are equally clearly within the normal range of "pros and cons," consideration of which necessarily plays a part in voluntary choice.

Similarly, the mere presence of intrinsic pressures such as stress, neurosis, and grief, although they may diminish a person's autonomy, does not justify overriding what is left. On the other hand, gross intrinsic impairment of volitional autonomy may also occur and is especially obvious in certain psychiatric conditions, including severe depression and certain phobias. Dr Pamela Taylor, in a symposium on putatively "irrational" yet "competently made" decisions to refuse electroconvulsive therapy, graphically recalls that some psychiatric patients are simply not able to make voluntary decisions of any kind.[7] As well as psychiatric illnesses various severe "physical" illnesses and toxic agents can cause grossly impaired autonomy of will (alcohol and barbiturates are used by seducers and interrogators for precisely this purpose). When people's autonomy of volition is sufficiently diminished by such impediments, though not when it is merely diminished,[8] then the autonomy that remains may justifiably be overridden not only if it threatens others but also if it threatens them.

Such examples from psychiatric practice are entirely consistent with the obvious claims that: (*a*) autonomy is not an all or nothing affair and (*b*) a basic minimum of autonomy is required for the principle of respect for autonomy to be applicable. They do not alas give answers to the major question that I started with, How much autonomy is "sufficient" for a person to be respected as an autonomous agent? Nor do they answer the questions, Who is to decide how much autonomy a particular person possesses and on what basis, and Who is to make decisions (such as giving or withholding consent by proxy to medical intervention) on behalf of those judged non-autonomous or "incompetent," and according to what criteria?

I can do no more than outline a few points here in the context of these important questions. Although there are no clear cut answers to the question of how much autonomy a person must have to have it respected, I have argued previously (in my article on autonomy) that at least in democratic, and hence in principle autonomy respecting, societies there seems no good reason for doctors to establish any higher (or lower) standards of requisite autonomy than those set democratically. In our society these standards are not high, and little autonomy is required to be allowed by law to make legally valid contracts, marry, consent to sexual intercourse, vote, make a will, go motor racing, hang gliding, horse riding, and mountaineering, join the army, drive and motor cycle, smoke, drink alcohol, and generally participate in risk taking and risk inflicting occupations and in general take responsibility for one's own decisions. It seems reasonable for doctors, unless they are required by the democratic process to do otherwise, to accept that people possessing similarly minimal standards of autonomy should none the less have that autonomy respected in the context of medical care (in so far as such respect is compatible with respect for the autonomy of others).

Dialogue between the profession and society

This seems pre-eminently an area in which far more dialogue is needed between the profession and society. It may be that were non-professionals to have a better awareness of the depredations of severe disease, both physical and mental, on a person's autonomy of thought or will, or both, they would wish to raise the threshold required for autonomy to be respected. People in our society might agree with those like Professor J F Drane who proposes that required standards of "competence" to make decisions on medical care for oneself should vary with the seriousness of those decisions. Thus to be respected as competent to make decisions that are "very dangerous and run counter to both professional and public rationality"—for example, a decision to refuse lifesaving treatment —would require a far higher standard of manifest competence to make informed, voluntary, deliberated, and thus autonomous decisions than would less dangerous decisions, including a decision to accept the same treatment.[9,10]

Dialogue between the profession and society seems necessary to decide on the two other problems mentioned: who should decide how much autonomy a person possesses, and on what criteria, and who should make decisions by proxy, and by what criteria, for those patients classified as inadequately autonomous or incompetent? Reasonable arguments could be offered for those with special training, such as forensic psychiatrists and psychologists, to make the assessments of patients' autonomy, and doing so in relation to the particular decisions that need to be made; reports on methodology abound.[6,11-15]

Similarly, reasonable arguments can be offered in favour of people previously designated by the patient, or their next of kin or other loved ones being proxies for inadequately autonomous patients (except in emergencies where delay would be dangerous), these proxies having an option to delegate part or all of their proxy decision making to doctors if they believe this to be in the patient's interests. I would, however, agree with Professor Kennedy that such proposals are not the prerogative of doctors to implement without social agreement.[16] After all, it is fairly uncontroversial to assert that the source of any authority or rights that we as a profession have to make decisions about other people's medical care, notably the source of our right to be beneficent to any patient, is either that person's own autonomous desire that we do so or something simplistically but most easily summarised as "the will of society." In cases where the patient does not have such an autonomous desire, including a previously expressed prospective desire,[17] it follows that the source of our authority to behave paternalistically towards him must be society. Hence our obligation to lay the ground rules for such beneficent medical paternalism in consultation with that society of which we form a part.

References

1 Pellegrino ED. Toward a reconstruction of medical morality: the primacy of the act of profession and the fact of illness. *J Med Philos* 1979;**4**:32-56.
2 Freud A. The doctor-patient relationship. In: Gorovitz S, ed. *Moral problems in medicine*. 2nd ed. Englewood Cliffs, London: Prentice-Hall, 1983:108-10.
3 Perry C. Paternalism as a supererogatory act. Cited by: Jones GE. The doctor-patient relationship and euthanasia. *J Med Ethics* 1982;**8**:195-8.
4 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. *Making health care decisions*. Washington: US Government Printing Office, 1982:181.
5 Mill JS. On liberty. In: Warnock M, ed. *Utilitarianism*. 11th ed. Glasgow: Collins/Fontana, 1974:135-6,229.
6 Culver CM, Gert B. *Philosophy in medicine*. Oxford, New York: Oxford University Press, 1982:109-25. (See also chapters 3, 7, 8.)
7 Taylor PJ. Consent, competency and ECT: a psychiatrist's view. *J Med Ethics* 1983;**9**:146-51.
8 Anonymous. Impaired autonomy and rejection of treatment [Editorial]. *J Med Ethics* 1983;**9**: 131-2.
9 Drane JF. *The many faces of competency*. *Hastings Center Report* 1985;**15**:17-21.
10 Eth S. Competency and consent to treatment. *JAMA* 1985;**253**:778-9.
11 Bloch S, Chodoff P, eds. *Psychiatric ethics*. Oxford, New York: Oxford University Press, 1981:203-94.
12 Edwards RB, ed. *Psychiatry and ethics*. Buffalo: Prometheus Books, 1982:68-82,189-346,496-605.
13 Roth LH, Meisel A, Lidz CW. Tests of competency to consent to treatment. *Am J Psychiatry* 1977;**134**:279-84.
14 Roth LH, Lidz CW, Meisel A, *et al*. Competency to decide about treatment or research: an overview of some empirical data. *Int J Law Psychiatry* 1982;5:29-50.
15 Bluglass R. *A guide to the Mental Health Act 1983*. Edinburgh: Churchill Livingstone, 1983:75-88.
16 Kennedy I. *The unmasking of medicine*. London: George Allen and Unwin, 1981:76-98.
17 Robertson GS. Dealing with the brain damaged old—dignity before sanctity. *J Med Ethics* 1982;**8**:173-9.

Occupationless Health

Richard Smith's series on unemployment will resume on 25 January.