DAVID C. THOMASMA

AUTONOMY IN THE DOCTOR-PATIENT RELATION

ABSTRACT. As an introduction to this issue, I argue that the concept of autonomy is clearly important for many of the freedoms we enjoy. The problem in medicine with its use lies in interpreting the concept with respect to the impact of disease on persons, the models of medicine we employ, and the settings in which the problems arise. A short statement about the major points of the authors collected in this issue concludes the editorial.

Key words: Philosophy of medicine, Autonomy, Medical ethics, Doctor-patient relation, Hermeneutics, Metaphysics of persons, Health care setting, Models of medicine, Disease, Self-determination.

This issue on autonomy in the doctor-patient relation is designed to complement the previous issue of Theoretical Medicine devoted to paternalism. Over the past eleven years working in the clinical setting, I have found that no other philosophical concept has been more genuinely puzzling to physicians, even disturbing, than that of patient autonomy. The reasons are many. Three stand out.

First, there has been a transition from medical paternalism toward unlettered and uneducated patients to new forms of doctor-patient relations. This transition is due to the general improved level of health education of the populace and patients' rights movements [1]. Physicians' perception of a basic moral principle of medicine, caring for the patient, must therefore be violently separated from its recent, historical context. Distinguishing care for the patient from its historical context of paternalism is difficult.

Second, autonomy presents a puzzle because, whether justified or not, it connotes independence. But the experience of physicians is that both doctor and patient establish a mutual relationship less sacred than a religious bond, but more 'sacred' than legal contracts of plumbing repairs or bonds with animals. However hard it is to correctly describe this bond [2], it is nonetheless perceived by doctors and patients as 'special'. Witness patient reaction against uncaring doctors and scornful descriptions of some specialists as mechanics. These negative judgments flow from a respectful vision of what the bond or relationship ought to be. With respect to autonomy, therefore, physicians find it hard to conceive of either the doctor or the patient being 'independent' in such a relationship. In other words, the relation seems to demand much more than a friendly handclasp between two autonomous beings.

Thus the puzzlement about patient autonomy utterances moves beyond mere verbal misunderstanding. Even if philosophers make it clear that by 'autonomy' is meant 'self-determination', the confusion remains — how can one be self-determined within a relationship? More effort must be spent on

discussing the impact of the bond between doctor and patient on both concepts of autonomy and paternalism. As it is, the concept of autonomy and its defense are rarely sufficiently related to the circumstances of the bond between doctor and patient.

With respect to this problem, Paul Ramsey’s view of the conscience of physicians within the relationship leads him to remark: “Treatment refusal (by patients) is a relative right, contrary to what is believed today by those who would reduce medical ethics to patient autonomy and a ‘right to die’” [3]. Contrast this view with that of Robert Veatch, about whom Ramsey surely must have been writing: “There is a clear right of the competent patient to refuse treatment for any reason, but the right not to be declared incompetent while exercising that refusal is only beginning to emerge” [4].

The third reason autonomy presents difficulties for medicine is closely related to the second. While it has never been fully articulated, sufficient evidence exists that disease has a negative impact on personal autonomy [5]. It does so because disease or a serious accident contributes to the dissolution of the self. Personal existence is threatened. A re-evaluation of life and its worth, of things and their place, and of others and our relationships takes place. The body is objectified, as, indeed, is the disease itself [6]. And dependency on healers for continued existence replaces the normal status of self-determination persons enjoy. These primary characteristics of disease greatly contribute to a lack of autonomy in the patient. That is why Pellegrino and I called being a patient a “state of wounded humanity”.

I think clinicians and patients instinctively realize that autonomy is not to be presumed in many cases. By contrast, ethicists unfamiliar with the clinical setting do make this presumption. An example of the difference in approaches can be gained by considering Dworkin’s now-classic argument that autonomy entails authenticity and independence, Annas’ description of a hospital as a human rights wasteland, and the use two clinicians, Eric Cassell and Mark Siegler, make of these arguments.

As Dworkin [7] makes clear, autonomy means a mode of self rule, of not being subject to the will of another [8]. But it also means that the subject makes laws for itself. This is the view of Kant [9]. Therefore, an autonomous person is one who is not subject to the will of others and who is not subject to his social and biological circumstances. The emphasis is on one’s rational nature. Dworkin encapsulates the concept of autonomy as one which entails authenticity and independence. Authenticity is meant to describe a person’s motivation. Independence describes ownership of that motivation. Using this analysis, Dworkin then develops a list of principles for preserving autonomy.

Throughout the article cited, Dworkin assumes that persons are essentially independent of their relations to others, to society, and to the vicissitudes
of their own body [10]. There is no recognition that being a person is a social state of existence [11]. Of course, his concerns do not lie in this metaphysical arena. Rather, he is concerned about the general characteristics of policy toward behavior control, choosing those means of influence that do not detract from a person’s ability to rationally reflect on choices. Nevertheless, the assumption of a Kantian definition of personhood lies behind his entire approach.

To be sure this approach is responsible for many gains in personal freedom, not only political ones over the centuries, but also with respect to any number of moral health care problems, especially those arising in research and hospitalization. The philosophical strength of the approach lies in two assertions: First, the recognition that modern medical care hardly ever parallels the traditional one-to-one relation of doctor and patient. Care in the hospital separates a person from normal and usual supports — clothing, familiar surroundings, self-movement, job, family, and children. These losses, which George Annas views as non-essential, lead to a second assertion. It is that losses such as these are failures to recognize that “The American medical consumer possesses certain interests, many of which may properly be described as rights” that are not forfeited in the doctor-patient and patient-hospital relation [12].

Whether or not these assertions have been proven, there is little doubt that the autonomy emphasis in medical ethics and legal literature has gained many adherents. We thus applaud drama in which patients, through strength of character and heroic resolve, assert their rights as persons. The classic example is Brian Clark’s drama “Whose Life Is It Anyway?” in which the paralyzed hero wins recognition of his right to stop treatment and presumably to die [13]. The drama is centered around the consulting physician’s strongly felt duty to preserve life and the patient’s claims to autonomy.

Despite our cheers for autonomy, however, a reassessment of the metaphysics upon which it is based is due. If, indeed, we are autonomous entities only accidentally related to others and our own bodies, then assertions of autonomy in the doctor-patient relation have philosophical as well as legal strength. The relation of patient to doctor would then be characterized by the three contracts described by Veatch in his effort to ground the principles of professional-medical ethics [14]. All of the relations described by his contract theory are external to persons.

An inkling of the unacceptability of philosophical ‘externalism’ upon which assertions of autonomy have been based stems from the instinct of physicians who must work with impaired persons. Thus Patricia Bradley, an English physician, says of Veatch’s contract theory mentioned above:

Veatch argues that the relationship between patient and doctor is an equal one, ignoring what Pellegrino calls the fact of illness which places the patient in a potentially vulnerable
relationship with his physician. He suggests that an appropriate source of medical morality would be the ethic of the triple contract. Based as it is on a wrong assumption, this model must be rejected when applied to the traditional doctor-patient relationship [15].

She does suggest that the model of what can be called externally grounded contracts might possibly apply to preventive and community medicine, an arena in which persons are not properly considered patients, that is, not suffering some assault on their normal status as persons.

Both Cassell and Siegler, physicians who maintain their clinical practice, take the description of autonomy presented by Dworkin, but apply it in a way which suggests the same medical instinct as Bradley's: that persons who are ill are impaired as persons. Cassell argues that disease directly destroys the authenticity and independence of patients, not only with respect to choices, but also with respect to sufficient knowledge and impaired reasoning. As he says: "When philosophers and lawyers . . . talk about rights, they often speak as though the body does not exist. When they discuss the rights of patients, they act as if a sick person is simply a well person with an illness appended . . . That is simply a wrong view of the sick" [16].

Given this fact of illness, Cassell then argues that the real function of medicine is to restore autonomy, to preserve the person as he defines himself. The preservation of life is, therefore, seen as subservient to the primary goal. Note that Cassell does not assume that the patient already possesses the authenticity and independence Dworkin uses to describe autonomy.

Similarly, Mark Siegler's discussion of a case in which he respects the wishes of a critically ill patient to die, details the "particularities of clinical circumstances" which contribute to clinical ethics [17]. Objecting to Veatch's (and Cassell's) opinions about respect for the competent patient's wish to die, because neither take into account medical and morally relevant factors, Siegler proposes the following clinical guidelines: (1) The patient's ability to make rational choices about care; (2) The nature of the person making the choice; (3) Age of the patient; (4) Nature of the illness; (5) Values of the physician responsible; and (6) The clinical setting. Each of these has an impact on the decision to respect the autonomy of the patient. Siegler asks, given the nature of critical illness and the narrow time-frame in making decisions, whether a person's choice actually reflects his normal personality, that is, are the wishes once established by autonomous acts? In the case he discusses, the patient's character and values were interpreted in the absence of family, and were judged consistent with his wish to establish limits for medical care.

It is very important to note that the inadequacy of the autonomy model in the doctor-patient relation does not lie in disagreements about the concept of autonomy, Bruce Miller's more recent attempt to resolve this problem notwithstanding [18]. Even though Miller attempts to resolve four cases based on
four concepts of autonomy, in actuality it is the decision about \textit{applicability} of autonomy to patients that is the governing factor. It is a hermeneutical problem, a problem of interpreting principles of ethics in the clinical setting.

At the root of moral hermeneutics about the degree of autonomy possessed by a patient are metaphysical assumptions about the patient as person, the degree autonomy is and ought to be a characteristic of persons, and the role and scope of relations with others and with one's body. In this regard, Engelhardt recognized the weakness of Dworkin's effort to argue that moral autonomy is essential to persons. The weakness lies in neglecting the social and historical constraints on autonomy. While Engelhardt appeals to Hegel's objections to a Kantian universalist ethic on these grounds, he does not properly consider one's intrinsic relation to one's body as a major constraint on autonomy [19]. Perhaps Engelhardt's lapse was due to the general character of the discussion, i.e., the grounding of ethical principles. However, Cassell's point that moralists neglect the impact of disease on autonomy by neglecting the fact we have bodies is well-taken.

I have summarized the strengths and weaknesses of the autonomy and paternalism models of the doctor-patient relation elsewhere [20, 21]. These led me to propose the theme of this issue, and to invite shorter papers from physicians as well as and conjointly with philosophers on the theme of autonomy in the doctor-patient relationship. Although I made no demands on topics the invitees submitted, the papers nonetheless fell into two groupings. The first was papers which examined the role of patient autonomy in descriptions of medicine. The second was the role of patient autonomy in specific medical settings.

In the introductory essay, a world-known internist and medical educator, Gene H. Stollerman, argues that autonomy ought to arise from within the doctor-patient relation as a function of the educational and persuasive skills of the clinician, rather than as a function of unilateral decision-making by either party. James Childress and Mark Siegler team up to explore the ways our models and metaphors either accurately describe or distort the many different kinds of doctor-patient relationships. The five models they find are subjected to a critique based on the differences between relations between intimates and strangers. David Ozar contributes an analysis of three additional models, the Guild Model, the Commercial Model, and the Interactive Model, under each of which the patient's autonomy may be enhanced or compromised.

Another internist, Alfred Beasley, combines his insights with a philosopher, Glenn Graber, to examine the range of autonomy which varies with different settings. Beasley and Graber suggest that new diagnostic tests will significantly alter our ideas about patient autonomy and social freedom as well as contribute to a metaphysics of human being. Continuing jointly authored articles, the
next one by a physician, David Smith, and a philosopher, Lisa Newton, sets up a Hegelian dialectic. As thesis, Newton explores the philosophical basis of rights, patient autonomy, and rules governing medical practice. As antithesis, Smith critiques these concepts from the standpoint of clinical reality. As synthesis both authors suggest a new era, a second generation of examining the doctor-patient relation, has begun. In it, concepts of loyalty, social responsibility, community integrity, and the uniqueness of intimate relations sketch our philosophical landscape.

In this regard, Terrence Ackerman questions two "dogmas of liberalism", namely that patients in a therapeutic setting have an ability to act autonomously and that physician non-intervention is the best strategy to protect the autonomy of patients. Paralleling Stollerman's suggestion, Ackerman argues that autonomy is best seen as a process of personal growth enabling the patient to overcome disruptive effects of illness.

The first essay to examine autonomy in a distinct setting is by the highly respected physician-educator, Edmund D. Pellegrino. In it, Pellegrino proposes that a moral use of coercion may lie in a socially desirable end if it stems from health as a value. John Sorenson and Garrett Bergman, a theologian and pediatrician, scrutinize the role quality-of-life decisions play in choosing particular clinical options in pediatrics. They argue that quality of life factors differ from quantitative longevity factors, and are essential to the determination of probable best self-interest choices physicians must make on behalf of children. As such they help distinguish between real paternalism and necessary medical paternalism. Carson Strong's essay on this distinction as it arises in the Newborn Intensive Care Unit presents a specific argument that some physician behavior thought to be paternalistic is not so.

If there is any one theme which emerges in these essays, it is this: the idea of patient autonomy must be recast with respect to social obligations, differences provoked by specific therapeutic and preventive settings, and distinctions among medical models.

ACKNOWLEDGEMENTS

I wish to thank Terrence Ackerman, Ph.D., Kenneth Micetich, M.D., and Andrew Griffin, M.D., for their assistance in preparing this issue.

DAVID C. THOMASMA

Stritch School of Medicine, Loyola University Medical Center, Medical Humanities Program, 2160 South First Avenue, Maywood, Illinois 60153, U.S.A.
REFERENCES