"An overemphasis on patient autonomy results in patients feeling abandoned and physicians feeling frustrated."

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"What would you do, doctor?" an 84-year-old lady asks the consultant, for the third time, in the outpatient clinic on a November morning of last year. She is faced with the choice of undergoing surgery for her worsening cataracts, which may also relieve some intraocular pressure to address her early glaucoma, or to proceed with medical management for the glaucoma alone. On receiving an identical measured response she turns to me. the medical student in the corner, as a last resort for decisive intervention. I avoid her gaze, and avoid the mounting conflict: a conflict not between a doctor and a patient, nor between their respective interests, but between two of the great ethical cornerstones of medical practice: autonomy and beneficence. As if to illustrate for the consultant and me the two extremes of moral standing on the much-debated matter of respect for autonomy, the very next patient to enter the consultation room is a 65-year-old man with diabetic retinopathy and an unfortunate host of co-morbidities. He thrusts

his hat on to the table and proclaims, before even a word of greeting, "Let me tell you now, you won't play God with me!"

The word autonomy derives from the Greek words for self-governance. It encompasses a capacity to decide and act without the constraints of controlling interferences by others or personal limitations, most notably a lack of adequate understanding, which prevent meaningful choice1. In the steady shift of medical practice from its paternalistic roots to patient-centrality, respect for patient autonomy has come to overshadow its fellow principles of beneficence, non-maleficence and justice. To quote the American bioethicist, Paul Wolpe: "for better or for worse, autonomy has emerged as the most powerful principle in bioethics, the basis of much theory and much regulation, and has become the 'default' principle"2. But what has triggered the emergence, and arguably the overemphasis, of autonomy as the primary governing principle in

medical ethics? Wolpe has suggested that as a result of the "erosion of trust" between the doctor and patient (a reflection of the documented widespread decline in social trust and trust in the medical profession since the 1960s), rituals of trust in the form of dialogues clearly establishing the patient's autonomy have emerged as a substitute for organic trust3. Furthermore, respect for patient autonomy may actually reinforce physician authority rather than impede professional privilege, as, in reality, autonomy tends to be limited to a right to refuse a particular treatment rather than to demand it. Others argue that by prioritizing patient autonomy, the doctor shifts the burden of decision-making to the patient and thus is relieved of some responsibility, as well as being less likely to be sued for malpractice4.

Regardless of the reasons, the unprecedented prominence ascribed to the respect for autonomy has led to momentous alterations in the dynamic of the doctor-patient relationship. The paternalistic model sees the doctor as being in a better position than the patient to decide what is in the patient's best interests, and thus allows the doctor to act accordingly even if this contradicts the expressed wishes of the patient5. Other models presented by Emanuel and Emanuel<sup>6</sup> involve respect for autonomy in varying degrees, ranging from the informative model, where the doctor acts only to provide medical facts, to the interpretive and distributive models, wherein discussion about management is encouraged and patient values can be challenged to an extent (in the latter)6. It is clear that patient autonomy only can be completely respected in the informative model. Thus, I believe it is the move towards incorporating this model in clinical practice with competent patients, to maximally distance ourselves from paternalism, which has left these patients feeling unsupported. It seems, in the case of patients like the 84-year-old lady above, that it is the unfulfilled want for reinstatement of the primacy of beneficence in the doctor-patient relationship that results in the frustration and abandonment experienced by doctors and patients, respectively. But surely accommodating this would

send us straight back to the dark era of unopposed paternalism? Not if we adopt an alternative model, as presented by Edmund Pellegrino (an avid defender of the prominence of beneficence), of autonomy incorporating rather than replacing beneficence. He argues that "the best interests of the patients are intimately linked with their preferences"; the patient's wishes alone determine the extent of the doctor's beneficent role, even if this wish involves a rational request for the doctor to choose for them.

Intrigued by the stark contrast of outlook and expectation between these two patients, I excuse myself from the clinic to find them in another room awaiting further tests. After some general discussion about their respective health issues, I ask them individually what the doctor's position should be in their decision-making. They unanimously maintain that one of the doctor's main roles is to fully inform them. However, the first patient feels that a doctor's experience warrants choosing for her, while the second patient comments that he is tired of having to do what doctors tell him to do. It became clear to me that there is no singular view of what autonomy means. One interpretation, as expressed by the second patient and championed by the philosopher Isaiah Berlin, incorporates a complete freedom from external constraint; an utter self-sufficiency and responsibility for all aspects of life. Notably, in upholding such a stance, autonomy simultaneously becomes a duty of sorts; a patient who chooses that they trust their doctor enough to make or strongly influence their decision for them cannot be viewed as autonomous4. Alternatively, a view of autonomy centred on freedom of choice rather than on complete independence allows a patient like the former to maintain her autonomy while passing some responsibility of the decisionmaking process to the doctor. The American philosopher Gerald Dworkin argues that autonomy does not require independence for its own sake: provided the patient is fully informed and engages actively in the decision-making process they may still be autonomous while being receptive to, or even reliant on, the opinion of the doctor<sup>4,7</sup>.

Therefore, for the doctor to respect this patient's autonomy, perhaps he/she has to accept that this patient does not wish to make the decision solely by themselves (provided they are fully informed and their judgement is a rational one), i.e. an autonomous delegation of choice. Furthermore, accepting this is also crucial for the doctor to act beneficently in this situation. To quote Dworkin: "autonomy is important, but so is the capacity for sympathetic identification with others. ... [A]lthough it is important to respect the autonomy of others, it is also important to respect their welfare, or their liberty, or their rationality"8.

In conclusion, I believe it is time to end the frustrating strife to abolish all the dwindling traces

of paternalism from modern medicine at the expense of our patients' welfare. It is time to stop sacrificing beneficence for the respect of a universal notion of what patient autonomy should be and instead to carefully determine each patient's view of what their autonomy entails, fully inform them so they are in a position to exercise this autonomy, and mould our relationship with them around this deepened understanding. If we can achieve this – a respect for autonomy tailored to each patient who walks through the clinic door, be it either of the two patients on that November morning or anyone in between – an "overemphasis" of autonomy can do nothing but good.

## References

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