

# BIOETHICS NOTES

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**"It were not best that we should all think alike; it is difference of opinion that makes horse races."**

-Mark Twain

## Patient Autonomy

by Robert Shabanowitz

In the last thirty to forty years clinical decision-making has evolved into a process of shared decision-making. Historically medical decision-making was mostly under the purview of the physician, a strongly paternalistic approach. Over time, however, our liberal democratic society evolved to ardently promote individual rights and freedoms; now we speak of and espouse "patient autonomy." However, patient autonomy is only one of several basic principles that inform medical decision-making. Advances in medical knowledge, technology and investigative tools have effected the progression of medical science to a higher standard of care and attendant high expectations. Accurate and factual information is pertinent to patients having to make personal health-care decisions. How well the patient understands and evaluates this information is at the heart of autonomous decision-making and physicians contribute to this process in a meaningful fashion beyond just being purveyors of facts; they contribute to a deliberative process that serves to promote and protect patient autonomy.

**Clinical Decision-making:** Clinical decision-making does not occur in a vacuum. At minimum, we can define three necessary components involved in the decision-making process. Decisions must be intentional, and made with understanding and without controlling influence. Multiple parties are often involved in this process, each playing a specific role, ascribed with certain responsibilities, duties and limitations.

**The Role of the Physician:** The doctor/patient relationship forms the foundation of patient decision-making, and physicians want patients to make decisions that benefit the patient's medical goals (the principle of beneficence). One of the fundamental roles of the physician is to facilitate informed decision-making. It is incumbent upon the physician to insure that the patient has all the available information to make an autonomous decision. The physician must adequately explain the risks/benefits, nature and

purpose, diagnosis and prognosis, expected outcomes and consequences, alternatives and risks/benefits of the alternatives. This basic transfer of information and decision-making is crucial to what we define as the process of informed consent. However, the physician is not just a provider of facts; the physician must present information in a manner consistent with the ability of the patient to comprehend. The presentation of information must be free from subtle influence or manipulation, free from false beliefs and free from the physicians own world view. In such a manner, the physician must balance protecting and promoting an individuals well-being and respecting the individuals right to self-determination. Effective communication, accurate information presented in a way the patient can understand, and non-control are all essential elements that empower a patient to make a truly informed, reasoned, and intentional decision. It is this complex and interactive process that ensures patient autonomy. Patient autonomy is not about making any decision but about making an informative and reasoned decision.

A physician must not only provide factual information, but must also evaluate the decision-making capacity of the patient. S/he must evaluate the patient's ability to reason as well as the possible influence of disease or medications on the decision-making process. Often a physician may have a long history of care for a patient, enabling her/him to understand the patient's values and goals. In situations where patient decisions may be at odds with previously stated goals, the physician should evaluate and discuss with the patient the underlying reasons for this change. This does not mean that every patient decision is suspect merely because it conflicts with physician recommendations. Where strong differences remain in treatment choices, the physician may use persuasion and appeal to reason. However, this must not entail undue influence, manipulation or coercion. Most appropriate is a sliding scale approach, where decision-making capacity is evaluated in context to increasing risks or harms. Greater evidence or standards for rational decision-making is expected when risks and harms are increased (the principle of nonmaleficence). Although patient, unrestrained paternalism by the physician is unacceptable, the

physician does have an obligation to his personal or professional set of values and he must balance these concerns against those of his patient. In extreme cases, this may require a transfer of the patient to the care of another physician.

**The Role of Family:** Individuals make many decisions that affect their family. We can consider family in a strict sense as only the immediate family, or we may define a more expanded view of family that includes friends, religious groups, or cultural/ethnic groups; some of us may even consider society as part of a universal family. Most individuals make decisions within the context of these groups and based upon expected or perceived responsibilities; we attach great responsibility to our immediate family and loved ones. Therefore, in making clinical treatment decisions, it is often with consideration to our families as well as ourselves. Family support and involvement strengthens a patient's ability to understand his/her treatment decisions. The role of the family is to assist the patient's decision-making. This is often described as either interpretive or deliberative in nature, and refers to how our values are either rediscovered or reordered during decision-making. Family is important in this process because not only are they usually the most knowledgeable about a patient's values and goals, but also care most for the patient and want what is in his/her best interests. There are limitations to family influence, however, because family may also have the greatest conflict of interest with the patient's treatment decisions. Similar to physician limitations, undue influence, manipulation or coercion is unacceptable. This requires a delicate balance between respect for patient autonomy and expected duties/responsibilities to family. In this sense, the physician must remain the agent of the patient, and although s/he may help clarify family issues, s/he can not represent family interests. Therefore, if informed consent is considered a process of shared decision-making with family as facilitators rather than competing interests, we would recognize both the right of an individual to make autonomous decisions within this larger context, and allow for consideration of what extent her/his decisions impact the duties/responsibilities and moral obligations of the patient to her/his family.

**The Role of Surrogates:** The role of surrogates in clinical decision-making occurs when patients are deemed not to have decision-making capacity. The surrogate decision maker is often designated in an advanced directive or medical power of attorney. Responsibilities and limitations of the surrogate decision maker are contingent upon accepted standards such as substituted judgment (subjective) or best

interests (objective) standards. These standards attempt to make decisions for the patient based upon the patient's vision of the good and consistent with the patient's aims and values. Through the use of advanced directives, instructions can be very specific. However, even advanced directives are open to scrutiny and do not assume absolute moral authority. One limitation of advanced directives is that they are not contemporaneous, and therefore the ideal of true informed consent is impossible; there is nuance to every medical situation and goals and values may change over time and in context to specific scenarios.

Protecting the ability for patients to act autonomously is at the heart of clinical decision-making. Physicians, family, or friends can facilitate this process by providing information and assisting the patient's understanding not only of the facts but the assimilation of those facts into the patient's global view of the good. Most of us have preferences and values that are not strictly autonomous in nature. We make decisions daily and because our lives intermingle with others, those decisions often involve balancing competing interests. Most of us compromise in hopes of attaining an overall good for ourselves as well as the loved ones in our lives. This compromise is not just utilitarian, but is a dynamic process that changes over time and with any given situation. This compromise also appreciates that we have responsibilities that place moral weight on the legitimate interests of other parties.

Respectfully Submitted,  
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## References

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