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MEDICINE AND SOCIETY
How Autonomous Is Medical Decision Making?
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Medical clinicians are bound by a universal ethical code first encapsulated within the so-called Hippocratic Oath and enshrined in professional codes of ethics in all specialties. The vast majority of patients that a clinician encounters over the course of his or her career will share the clinician's commitment to the moral ideals which underlie and derive from the oath. Most will agree, for example, that minimising their suffering and preventing avoidable death are of paramount importance. There are exceptions to this general phenomenon, however, and these instances raise fundamental questions for the ethical regulation of clinical practice.

The moral ideals of the Hippocratic Oath are not universally shared and espoused. For some patients, physical suffering or even dying from a medically preventable death is not the worst thing that can happen. Some patients have refused to consent to rudimentary medical treatment in full knowledge that the inevitable consequence of their refusal would be their premature and, in clinical terms, unnecessary death. The most commonly cited example of this phenomenon is the Jehovah's Witness refusal to receive a blood transfusion. U.S. courts have tended to uphold decisions made by competent adult patients in such instances and have denied medical authorities' requests to administer treatment against patients' wishes.

Thus, clinicians have been prevented from saving lives in the name of patient autonomy [1]. The application of life-saving medical expertise is refused in the name of patients' commitment to the tenets of their religion, recognising the will of their God. While the literature in this area of medical ethics might suggest otherwise, Jehovah's Witnesses by no means exhaust the list of religious and cultural communities who have, or are likely to, refuse medical treatment on moral grounds. The Church of Christ, Scientist has long prohibited the use of vaccinations and inoculations amongst its members. Similarly, a strict adherence to vegan ideals is incompatible with receiving medical treatment that involves or has fundamentally benefited from xenotransplantation technology.

Many societies are increasingly multicultural in character, an inevitable consequence of which is the exposure of medical clinicians to a diverse range of ethical ideals that are, in various ways, incompatible with the secular ethos upon which Western biomedical clinical practice is based. In the United States, one might cite Buddhist, Shinto, Confucian, Hindu, and even Muslim ideals that prohibit such practices as the transplantation of religiously sacred or taboo organs amongst their adherents. The more ethnically and religiously diverse a society becomes, the greater the likelihood

its medical clinicians will confront ethical ideals and commitments that restrict or prevent them from minimising harm and preventing unnecessary death [2].

Determining Patient Autonomy

The more severe the likely medical consequences of such patient refusals, the greater the challenge to clinicians. When refusals are not grounded in beliefs of a recognised religion, clinicians generally request that a determination of the patient's mental competence be made. Patients who have cognitive deficits are likely to be deemed incompetent to determine what is in their best interests and incapable of exercising genuine autonomy. Likewise, a patient with a history of schizophrenia, admitted to a hospital with a life-threatening but curable condition, who refuses treatment on the grounds that the voices in his head are telling him to reject the clinician's recommendations is unlikely to avoid treatment. Another patient with a similar condition, however, who refuses treatment on the grounds that his religion and his God strictly forbid any such action is, all things being equal, likely to prevail, even if this results in his death. Devout atheists and secularists might question whether a genuine distinction can be made between the clinically incompetent and the more conventionally irrational believer in a recognized religion. Medical ethicists would reply that the criterion for determining a patient's decision-making capacity is not so much what the patient avows and espouses but how he came to hold the commitments and beliefs he does: form prevails over the substance in this regard.

Conventional medical ethics tends to accept this source-based distinction and avoids challenging the ideals and practices of communities that in some cases have existed for millennia. This position takes its bearings from commitment to the thoroughly reasonable ideal of respecting religious and cultural beliefs that differ from one's own. A desire to avoid religious and cultural intolerance is a basic expectation of all citizens, irrespective of whether they happen to be medical clinicians or patients. But respecting another's religious and cultural beliefs does not, by itself, compel us to accept that those beliefs have been examined and are autonomously espoused. After all, we come to hold beliefs in a multitude of ways, not all of which necessarily satisfy philosophic criteria for being autonomous—that is, not all are fully informed and uncoerced. In fact, when it comes to some of our deepest and most fundamentally avowed beliefs and commitments, there are good reasons to question whether genuine autonomy has played a sufficient role.

The key criterion for the clinical determination of patient autonomy is the mental competence test, familiar to all practicing clinicians. As it stands, this criterion is straight-forward and uncontroversial enough. But from a more robust philosophical perspective, this test, while necessary, is not sufficient. To complete the picture we must add the condition of the individual's having the opportunity to exercise choice, which entails the existence of legitimate, known options. To exercise autonomy, one must have more than one option from which to choose. When this criterion—existence of known, available options—is combined with the criterion of sufficient mental competence; applying the principle of respect for patient autonomy to

patients who refuse treatment on grounds of their deepest ethical commitments gets philosophically complex.

Many religious and secular ethical commitments require fundamental and unequivocal adherence to a set of established tenets of faith on the part of all who wish to be recognised members of the faith community. To medical clinicians this set of required beliefs is most evident in those patients for whom death of the body is not the worst thing that can happen. In these instances patients might be said to have a *formal* choice, in so far as they can either repudiate their beliefs and undergo the treatment or comply with their beliefs and suffer the consequences. But viewing this situation in these terms undervalues and fails to fully appreciate what it means to espouse such fundamental beliefs.

On the other hand, it would be a mistake to dismiss such beliefs as *necessarily* incompatible with the exercise of autonomy, which must extend to include the avowal of both the deepest and even the most trivial beliefs and commitments. A commitment to morally absolutist beliefs should not be dismissed as necessarily binding the individual who adheres to them and thereby denying that individual's autonomy. Choice remains the principal element of acting autonomously, and therein lies the potential for re-evaluating the conventional bioethical understanding of patient autonomy.

Doubting the Determination

Many of the more devout amongst us do indeed choose to recognise the authority of a moral or cultural tradition. We can say that such individuals have chosen to enter into some community that is willing to accept them. The same cannot be said so easily of those born into a particular way of life who know little or nothing of the beliefs, traditions, and practices that constitute fundamental aspects of their adherents' identities. As some philosophers and social theorists have argued, certain forms of cultural identity can constitute their adherents' identities and sense of self [3]. In these instances, distinguishing the autonomous element of an individual's compliance with values and ideals that prevent life-saving medical treatment is a difficult task and one that lies beyond the expertise of medical and legal professionals.

Seeking to avoid allegations of religious and cultural intolerance, some medical ethicists and legal philosophers argue that everyone has an opportunity to leave his or her community and that a continuing adherence to a particular community, irrespective of how one came to be a member in the first place, may be construed as sufficient evidence of an individual's autonomous decision to accept its rules and practices, even if complying with them might result in a medically preventable death. The so-called 'right of exit' resolution is in some instances naive and complacent [4]. For many reasons an individual might find it extremely difficult, if not impossible, to repudiate his or her community—lack of sufficient resources, for example, geographic isolation, or the individual's inability to imagine himself or herself being any other way than that prescribed by the community. The more deeply an individual

is formed by religion or culture, the more difficult it will be to recreate his or her identity in an alternative existential setting. The depth of an individual's integration within some communities and the absoluteness of that community's ethical prescriptions can severely restrict the individual's capacity to exercise choice, particularly in matters of life and death. In cases such as these, an individual may have little real choice but to comply with a fundamental religious tenet, even if this might cause great suffering or even a premature death.

Lessons to Learn

In practice, the bioethical ideal of respect for patient autonomy is far messier than medical ethics textbooks suggest. One of the most fraught areas of the relationship between clinician and patient in this regard concerns a clash of ethical values that prevent clinicians from minimising suffering and preventing death. Typically, this conflict is resolved by appeal to the principle of patient autonomy. I have suggested, however, that both the formulation and the application of this principle require closer scrutiny and analysis. I do not, at this point, propose a clear solution. Clinicians should not simply ignore patients' beliefs because they are informed by deep and uncompromising religious or cultural commitments that differ from those underlying much professional medical ethics. On the other hand, the presumption that, subject to satisfying a mental competence test, such patients are to be simply considered as exercising autonomy is based upon a degree of philosophical complacency and sociological naivety. Recognising the problem is the first step towards developing an effective remedy.

References

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Further Reading

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