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PATIENT AND PHYSICIAN AUTONOMY: CONFLICTING RIGHTS AND OBLIGATIONS IN THE PHYSICIAN- PATIENT RELATIONSHIP*

*Edmund D. Pellegrino, M.D.***

For centuries, physician beneficence went unchallenged as the first principle of medical ethics. To be sure, some physicians had, at times, violated this principle. But no creditable ethical opposition was mounted until a quarter of a century ago when patient autonomy was asserted as a *prima facie* moral principle of equal or greater weight than beneficence.¹ Progressively since then, patient autonomy has become the dominant principle shaping physician-patient relationships.

Three serious moral conflicts have emerged as a result: first, beneficence and autonomy have been polarized against each other when they should be complementary; second, the physician's moral claim to autonomy has received little attention; and third, the "autonomy" of medical ethics, itself, has come under a serious threat. This essay will examine each of these three consequences resulting from the rise of patient autonomy. It shall do so from the point of view that the physician-patient relationship is a moral equation with rights and obligations on both sides and that it must be balanced so that physicians and patients act beneficently toward each other while respecting each other's autonomy. Effecting this balance is a morally mandatory and exacting exercise. The compass-points that might guide this balancing are to be found in a reflection on the concepts of autonomy and beneficence, the way the content of these abstract notions is provided by the clinical encounter, and the way conflicts may be resolved in particular clinical situations.

Out of this reflection, five conclusions will emerge: (1) in concept, au-

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1. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 67-119 (3rd ed. 1989).

tonomy and beneficence are complementary and not contradictory; (2) in theory and in practice, autonomy is a positive as well as a negative principle; (3) the actual content of the concepts of beneficence and autonomy is defined in specific actions and decisions in the light of which conflicts are best understood and resolved; (4) the physician's autonomy as a person and a professional must be factored into the equation; and (5) medical ethics, as an enterprise, must maintain a certain "autonomy" in the face of political and socio-economic pressures.

I. THE CONCEPT OF AUTONOMY

A. *Autonomy in General*

Autonomy is one of those widely applauded concepts which, on closer inspection, turns out to be difficult to define with precision.² This is not the place to review the range of construals of the term. Rather, I will limit myself to that construal which centers on the etymology of the word itself, which means "self-rule." What is common to most definitions is the notion that an autonomous person is one who, in his thoughts, words, and actions, is able to follow those norms he chooses as his own without external constraints or coercion by others.³

The history of the concept is complex, and its roots are political as well as moral. Politically, autonomy came into prominence during the Enlightenment as an assertion of the individual's right to be free from tyrannous government — not of law *per se*, but of unjust law.⁴ Morally, autonomy encompasses the right of persons to freedom of conscience and to respect as agents capable of making their own judgments in accord with universal moral principles,⁵ or in accord with freely arrived at decisions.⁶

Autonomy gets its status as a moral right of humans from the fact that human beings have the capacity to make rational judgments about their own lives, choices, and interests. Self-governance deserves respect because it is the way human beings actualize their powers of choice, and choice is a distinctly human activity. To obstruct the capacity for auton-

2. GERALD DWORKIN, *THE THEORY AND PRACTICE OF AUTONOMY* 3-6, 12-20 (1988).

3. This is a paraphrase of the essentials of Dworkin's use of the term. *Id.* at 7-12.

4. See JOHN LOCKE, *LOCKE'S SECOND TREATISE ON CIVIL GOVERNMENT* (Lester DeKoster ed., 1978).

5. See IMMANUEL KANT, *GROUNDING FOR THE METAPHYSICS OF MORALS* (James W. Ellington trans., 1981).

6. See JOHN STUART MILL, *ON LIBERTY* (Elizabeth Rapaport ed., 1978).

omy is to assault an essential part of a person's humanity, because the choices we make are so much an expression of our membership in the human community, of who we are or what we want to be as individual members of that community. Human beings are owed respect for their autonomy because they have an inherent dignity. They do not have dignity because they are autonomous. Human beings who lack or have lost the capacity for autonomous actions are nonetheless humans who retain their inherent dignity. Respect for persons comprises more than respect for autonomy.

Autonomy has taken on a distinctive negative connotation. Arising, as it did, as a moral claim against invasion of human rights by tyrannous government, it has come to mean a right of self-determination *against* those who would usurp that right. In medical ethics, it is conceived largely as a moral and legal defense against physician paternalism and against those who would impose their values — social, moral, or otherwise — on others.

But autonomy is also a positive concept. It implies an obligation to foster the human capacity for self-determination, to enhance it, and to remove the obstacles to its full operation. This is especially important in clinical medical ethics where pathophysiological, emotional, and social realities complicate the actualization of patient autonomy. If taken as a strictly negative concept of non-interference, autonomy can be self-defeating for patients and self-serving for physicians. This positive aspect of autonomy will become clearer as I fill in the content of the concept as it operates in the clinical situation.

B. Patient Autonomy and Physician Beneficence

Twenty-five years ago, the political and moral notion of autonomy was appropriated as one of the *prima facie* principles of medical ethics.⁷ There were good reasons for the emergence of patient autonomy at that time. The rights of patients to refuse unwanted treatment had been neglected for entirely too long. In the mid-sixties, these rights could no longer be denied as participatory democracy, better public education, and the civil rights movements became realities. All authority claims came under suspicion. The abuses of professional and bureaucratic power were widely publicized and no longer tolerable. Moreover, the unprecedented powers of medicine made the choice of medical treatments a far more significant matter than it had ever been in the past.

7. BEAUCHAMP & CHILDRESS, *supra* note 1.

The principle of patient autonomy was seen as the patient's protection against usurpation of his right to participate in decisions that affected his life. This amounted to a denial of the long tradition of medical paternalism (or parentalism), which considered the duty of physicians to decide what was best because the patient lacked medical knowledge and might lose hope if he knew the whole truth about his options or prognosis.

Since paternalists acted in the name of beneficence, beneficence was equated with paternalism and thereby came to be interpreted as a counter-principle to autonomy. Morally valid and invalid forms of beneficence and autonomy were not distinguished from each other. The dilemmas of medical decision-making soon were reduced to weighing the principles of autonomy and beneficence against each other.⁸

Medical paternalism and parentalism, however, are not to be equated with beneficence, conceptually or in practice. Paternalism does not account for the patient's preferences or values that are part and parcel of her good or best interests.⁹ Paternalism makes the medical good of the patient the only good and subverts other goods to that good. Paternalism violates the patient's autonomy in the name of the patient's best interests while ignoring or overriding some of the most vital of those interests. This cannot be a beneficent act because the patient's own choices are so much an expression of his or her own life story or personhood. To violate or ignore the patient's choices is, by definition, a maleficent act, an injury to the patient's humanity. Only when the patient's human capacity to act autonomously is impaired (i.e., when the patient is incompetent) may we resort to paternalism as a beneficent act to override objections to treatment.¹⁰

This is the negative aspect of autonomy. Important as it is, it is a distortion of the idea of autonomy to equate it with total independence from the physician or others in making treatment decisions. The cultural bias against dependence or even the semblance of dependence is strong in American life. However, total independence is unrealistic in any walk of life. Human beings live in community and personal association, especially when they are patients. Patients especially need the input of others if their own choices are to be genuine ones. Physicians are needed to

8. TOM L. BEAUCHAMP & LAWRENCE B. MCCULLOUGH, *MEDICAL ETHICS: THE MORAL RESPONSIBILITIES OF PHYSICIANS* 22-51 (1984).

9. See EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE* 23-25 (1988).

10. JAMES F. CHILDRESS, *WHO SHOULD DECIDE?: PATERNALISM IN HEALTH CARE* 102 (1982).

provide information and to discuss this information with patients to enable and empower them to use their autonomy wisely. Patients must compare their values with those of others in the context of some community of belief which they accept in whole or in part. Patients cannot identify with their current choices without reference to some structure of values which they formed in the past and which they reaffirm or reject at the moment of choice. This is part of knowing ourselves, and we know ourselves largely in relation to others.

As Dworkin points out, autonomy implies a "capacity to reflect upon one's motivational structure and make changes in that structure."¹¹ Without associating with others and drawing on their preferences and values, we lack the opportunity to alter or reaffirm our values because we do not know what alternatives are available and why they might be preferable. To move from the abstract realm of concept to actual decisions, autonomy needs content, and this comes from reflection not only on our own past values but on the values of others at the moment of choice. It is the physician's obligation to enhance, empower, and enrich the patient's capacity to be autonomous. An autonomous choice requires that we fill in, to the extent possible, the action or choice that maximizes realization of the patient's values. Thus, autonomy has a positive as well as a negative aspect. To become a reality, patient autonomy requires cooperation and assistance from the physician. In short, it requires the physician's beneficent attention to make the patient's autonomy an authentic, as well as an independent, reality.

C. Physician Autonomy

In all the current discussions about the moral status of patient autonomy, the autonomy of the physician is often neglected. This philosophy has serious defects. The physician-patient relationship is one of mutual obligation — like any truly ethical relationship. The physician as a human being has the same claim to respect for his or her capacity to make personal choices, to follow his or her conscience about what is good medicine and what is morally acceptable as a person. Personal and professional ethics are not fully separable from each other. Therefore, the patient's moral right of autonomy must be balanced with respect for the physician's autonomy. Autonomy cannot be a unilateral moral right for either patients or physicians.

Physician autonomy may be considered under three headings: (1) au-

11. DWORKIN, *supra* note 2, at 108.

tonomy as a person, which gives moral status to the physician's personal moral values and conscience; (2) autonomy as a physician, which gives moral status to the physician's knowledge and obligation to use it wisely and well; and (3) autonomy as a member of a profession, of a moral community with collective obligations to patients and society. I have written elsewhere¹² of the moral obligations and the autonomy of medicine as a moral community, and will confine myself here only to the first two construals of the physician's autonomy as an individual.

The autonomy of the physician as a person has its roots in the same ground as the autonomy of any other person (i.e., the physician's capacity as a person for rational judgment and expression of preference with respect to values and choices). The physician, therefore, cannot be expected to lay aside or ignore his deeper personal beliefs, values, or religious commitments. To be sure, patient autonomy requires that the physician not impose his values in his decisions for the patient. But patient autonomy cannot require the physician to sacrifice his personal moral integrity even for what the patient may believe to be a morally good purpose.

Respect for the physician's autonomy also derives from the fact that, under normal circumstances, the physician must write the orders that are carried out by others. The physician cannot avoid the fact that she is the focal point through which harm and benefit of a clinical decision will flow in a majority of cases. The physician therefore is a *de facto* moral accomplice in what happens to her patient. She cannot place responsibility on others for morally indefensible decisions or for cooperation in decisions that violate her conscience. This inescapable fact of the physician-patient relationship places unavoidable obligation on the physician to avoid action she deems harmful to her patient, even if that action is "required" by state regulation, policy, or law.¹³

The physician's autonomy as a physician is also grounded in the possession of expert knowledge needed by sick people and society. The power, itself, conferred *de facto* by the possession of such knowledge, demands that the physician be free to use it according to her best judgment.¹⁴ If the physician is to fulfill the moral requirement to make her knowledge

12. Edmund D. Pellegrino, *The Medical Profession as a Moral Community*, 66 BULL. N.Y. ACAD. MED. 221 (1990).

13. Edmund D. Pellegrino, *Societal Duty and Moral Complicity: The Physician's Dilemma of Divided Loyalty*, 16 INT'L J.L. & PSYCHIATRY 371 (1993).

14. See David M. Mirvis, *Physicians' Autonomy - The Relation Between Public and Professional Expectations*, 328 NEW ENG. J. MED. 1346 (1993).

available to those who need it, she must be allowed sufficient discretionary latitude to apply that knowledge as rationally, efficiently, and safely as possible. This is essential if physicians are to fulfill their part of the covenant with society and with individual patients. Physicians enter this covenant from the first day in medical school, when they accept the privileges and the obligations that go with the acquisition of medical knowledge and skill.¹⁵

Clearly, this third sense of physician autonomy can never be absolute. If the physician is incompetent, acts in his own self-interest, or acts paternalistically in the sense I defined earlier, he misuses his expertise and violates his covenant with both the patient and society. That covenant is based on trust in the doctor's Oath which commits him to use his knowledge primarily in the service of the sick.

The physician's autonomy as a physician is also limited when she mistakes medical expertise and authority for expertise in questions of values. The physician has no standing as an expert in human values and no authority to set the goals or priorities of public policy relative to the allocation or distribution of health care resources. To be sure, the physician's knowledge provides essential factual data on which rational social policy should be based. But the actual choices of values are not the prerogative of physicians or any other "experts" — politicians, economists, or even ethicists. Social value questions are a matter of concern for the whole of society. In this respect, the expert is like any other member of society with no authority over the values of other individual members of that society or over the society as a whole. The arguments of experts may have more cogency but no more authority than those of others.

II. AUTONOMY: ITS CONTENT IN THE CLINICAL CONTEXT

Autonomy in general, and physician and patient autonomy in particular, might conceivably be defined in the abstract in some general way congenial to a large number of people. However, when we begin to give it content in the context of illness, the problems with absolutism and abstraction become evident, as do the implications of autonomy as a solely negative moral right.

First of all, no two persons experience illness the same way. No two persons have the same way of expressing their capacity for autonomous choice. Very few patients demand only "the facts." Some will seek a

15. Edmund D. Pellegrino, *The Ethics of Medical Education*, in *THE ENCYCLOPEDIA OF BIOETHICS* (Warren T. Reich ed., forthcoming 1994).

wide variety of opinions before deciding on their own; some will not. Some patients will prefer to exercise their autonomy by giving it up to a surrogate (i.e., someone they trust to make the decision for them, or perhaps even the physician). The majority will want to express their own way of being autonomous by asking not only for facts, but also for the doctor's opinion and the opinions of family and friends.

Thus, the content of the idea of autonomy, when it is actualized, will vary with the patient's prior values and cultural, personal, and social relationships. These, in turn, condition a patient's response to illness. Sickness forces a confrontation with the self and with the need to adapt to *this* illness, here and now. Sickness is a test of our values. For each of us, our response to sickness is unique, and thus the way we express our autonomy is also unique.¹⁶ Patients will vary in the degree of dependence or independence they desire depending on their relationship with the physician, on their relationship to their society or community, and on the degree of trust they impute to others.

Second, no matter what degree and kind of autonomy a patient chooses, the very fact of illness physiologically or psychologically compromises the actual expression of autonomy to some degree. The sick person is dependent on the physician's knowledge and help; otherwise she would not need or seek medical help. In addition, in varying degrees, she is in pain, anxious, fearful, and vulnerable. Brain function may be temporarily or permanently compromised by fever, shock, medication, age, or dementia.

To restore autonomy, physicians must first attend to reversing these physiological and psychological impediments to the optimal exercise of autonomy. In such cases, medical treatment is essential to restore autonomy. This may require temporarily downplaying or overriding the patient's autonomy until normal sensorial states are attained, and then enhancing and empowering it as the capacity for self-determination returns. During this transition, beneficence (i.e., acting in the patient's best interest) modulates the physician's move from "weak" paternalism to enhancement of the patient's full autonomy.

Third, no matter what degree of autonomy a patient may want or in what way he wants to express it, the patient is vulnerable to deception in the information he receives. The patient is dependent on the physician's disclosure of diagnosis, prognosis, treatment options, side effects, effec-

16. George J. Agich, *Reassessing Autonomy in Long-Term Care*, HASTINGS CENTER REP., Nov.-Dec. 1990, at 12.

tiveness, outcomes, etc. Which facts the physician chooses, which she emphasizes, and which she represses are often subtly or frankly conditioned by her judgment of what she thinks is in the patient's best interests. As any clinician knows, she can get almost any decision she wants from most patients. Therefore, even the most conscientious physician must exert great care to avoid manipulating the patient's choices, even for good reasons. The fact that physicians can so easily influence the patient's choice makes the full operation of patient autonomy problematic. For that very reason, it is morally incumbent on the physician to protect patient autonomy as scrupulously as possible and to try to help the patient realize its positive content.

This cannot mean, as some erroneously argue, that autonomy in a sick person is a fiction, that to try to enhance it is a sham, and that we should return to the Hippocratic tradition of benign authoritarianism. Such a reversal would be an intolerable suppression of the patient's human right as a rational being to make uncoerced choices. Physicians and others, therefore, have an obligation not to take advantage of the patient's vulnerability. Informed consent is an empty notion or a charade if the information on which it is based is biased in favor of the physician's preferences.

None of this means that physicians cannot advise or persuade patients to do what they think is right. Not to do so is a species of moral abandonment. Patients are entitled to know what physicians think is "best," all things considered. Although the extremes of this spectrum are not difficult to identify, no one can draw precise lines between advice, persuasion, manipulation, and coercion. But the difficulty of drawing a line does not justify a presumption in favor of paternalism. Rather, it increases the physician's obligation in beneficence to protect autonomy by the most scrupulous self-examination of his own motives in obtaining consent.

Much, therefore, still depends on the physician's character and sensitivity and her possession of the virtue of benevolence. The physician's character may turn out to be the last safeguard of the patient's autonomy and well-being. But, ultimately, the physician and patient must decide together what is to be done. Only in this way can patient autonomy become a cooperative and beneficent enterprise, rather than an adversarial one.

All of this applies with special force to surrogate decisionmaking and to advance directives, which become operative when a competent patient loses the capacity to make his own decisions. Here, the patient's wishes

are represented by others or by a written document. The surrogate's wishes have the moral status we usually attribute to a competent patient and should be respected as such. However, family and friends can be in a financial or emotional conflict of interest with the welfare of an incompetent patient. They may even wish, consciously or subconsciously, to relieve themselves of the emotional and physical burdens of caring for a chronically ill person. Their representations of what the patient's autonomous decision would have been were he competent are open to serious question.

When "autonomy" is expressed in a living will or other advance directive, an assessment must be made of whether the decision executed in the past, when a person was competent, represents what the patient would want now, when the patient is no longer competent. Is *this* person, now in a persistent vegetative state, the same person who originally made out that living will? Is autonomy, in its full meaning, so absolute that it binds us to decisions the benefits and the import of which the patient could not possibly have anticipated, and which, in the actual context of a particular decision, may not be in his present interests?

In these circumstances, the patient is in need of a beneficent agent — one who can be trusted to protect him or her from the autonomous decisions of others, even those who might be legally, but not morally, valid surrogates. This agent may have to be the physician, nurse, or other health professional who acts under the principle of beneficence. Regardless of whether the surrogate is a family member, friend, or the health professional, when the patient's autonomy has been transferred to others, it must be held in trust. If that trust is violated, the surrogate loses her moral status as well as her "autonomy" to make choices for the patient.

Not enough attention has been given to the limitations placed on the "Western" notion of autonomy when applied to the care of patients from different cultural backgrounds. Even in the "West," as Surbone points out in the case of Italian culture, patients may not expect or want to make decisions, preferring to leave them to families or the physician.¹⁷ Is it a beneficent or maleficent act to insist on or offer autonomous decision-making in these circumstances? Is it morally wrong, or rather a legitimate compromise, to work within the patient's cultural confines? Are we compelled by the fundamental nature of the principle of "respect for persons" to impose our view of autonomy, or may we compromise it in the name of cultural integrity?

17. See Antonella Surbone, *Truth Telling to the Patient*, 268 JAMA 1661 (1992).

These nuances in the full expression of patient autonomy in clinical decisions underscore the fact that autonomy cannot function in actuality without beneficence. Beneficence, properly exercised, is the guarantor of autonomy, rather than its enemy. Enhancing autonomy, enabling and empowering the patient to make her own choices, and helping the patient to understand the choices before her in terms of her own past values are all acts of beneficence. These acts enhance the positive content of autonomy and are crucial to any comprehensive notion of the patient's welfare. On this view, the health professional holds the patient's autonomy in trust. While it must be protected, it cannot be divorced from beneficence. It requires the physician's involvement, not her disengagement. In short, if the positive content of the concept of autonomy is to be realized, it will require beneficent action on the part of the health professional.

I must emphasize this point because the current pressure to assure patient independence is eliciting two morally dangerous responses on the part of health professionals. One response is to emphasize the negative non-interference dimension of autonomy. This negative conception of autonomy reduces the ethics of the physician-patient encounter to procedure rather than substance. On this view, as long as the procedure allows for autonomy, all is well. Autonomy is absolutized in principle and practice. This may lead to the second response, namely, that physicians will accede to whatever the patient or valid surrogate wants. This prompts the physician to transfer all responsibility to patients, family or friends. This occurs with alarming frequency in the care of infants, the elderly, and demented patients who may be over- or under-treated because their surrogates demand it.

Indeed, one of the most important contributing factors to disagreement between family surrogates and health professionals is the psychological burden family surrogates carry when they must decide whether to discontinue life support measures. Here, the autonomy owed the patient is transferred to the valid surrogate. In such cases, families often feel they are being asked to sentence a loved one to death or, by their decision, are actually participating in the death of the patient. They need reassurance when the medical situation is one which, in the eyes of the physician, is "hopeless." Physicians cannot simply leave the entire burden to the surrogate or even the patient. They must share that burden.

Thus, detachment is not a beneficent act. Often, when families or patients ask that "everything" be done, they are seeking reassurance that everything that could be *effective* or *beneficial* be done, not that "everything" — irrespective of probabilities of success — be done. They also

want to share their responsibility for cessation of life-support with the doctor. The focus of ethical concern may well shift, however, from the substantive to the procedural when irreconcilable conflict about what constitutes beneficence or the patient's best interests occurs.

IV. CHALLENGES TO PHYSICIAN AUTONOMY

A seriously neglected facet of the growing dominance of patient autonomy is its impact on the physician's autonomy. The physician-patient relationship, like any ethical relationship, is a reciprocal one. In the justifiable concern for patient autonomy, it is easy to forget that the physician is a moral agent as well as the patient. As such, the physician's autonomy, as well as the patient's, is deserving of respect. When the two are in conflict, the patient's wish does not automatically trump the physician's. The physician's autonomy, like the patient's, has its negative and positive construals.

It may seem paradoxical to worry about physician autonomy when it is the patient who is vulnerable and the doctor who holds the knowledge and power the patient needs. This fact rightly imposes the heavier moral burden on the physician in the equilibration of the autonomy relationship. He cannot use his claim to autonomy to violate the patient's capacity to make self-governing choices. But the physician is, like the patient, a human being, entitled to respect for his capacity to reason, judge and make choices that are authentically "his." He cannot impose his values on the patient, just as the patient cannot impose hers on the physician. The physician-patient relationship is a moral equation with reciprocal rights and obligations.

Today, that equation is becoming unbalanced as patient autonomy is elevated to the status of a trumping principle, morally as well as legally. For some, this even implies or includes overriding the physician's values, his discretionary latitude in clinical decisions, and, in some cases, even his rights of conscience. As patient autonomy receives more and more legal sanction, the problem of preserving the physician's moral integrity will grow. This danger is accentuated by the deficiency of "conscience clauses," which could provide statutory protection for physicians who refuse to provide or participate in procedures they find repugnant on moral or religious grounds.¹⁸

In the United States, these threats to the physician's autonomy and

18. See Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177 (1993).

conscience derive from the evolution of autonomy from a negative to a positive right. The rights of patients to make decisions consistent with their own values was first noted as a right to refuse unwanted treatment in 1914.¹⁹ In 1976, it was extended to a right of valid surrogates to refuse life-saving measures over the physician's objections.²⁰ In 1983, the President's Commission extended autonomy to include the right of participation in "Do Not Resuscitate" orders. This meant that physicians should offer treatments (like resuscitation) that patients might want even if they were not judged medically indicated.²¹ As a result, the pristine right of refusal of unwanted treatment is now becoming, for some, a right to demand treatment — even over the doctor's best medical judgment.²² Elevating patients' demands for specific kinds of care to moral status under the rubric of autonomy poses several challenges to the physician's right to her own moral integrity.

First, there is the challenge to the physician's judgment of what is good medicine (i.e., medicine that is rationally sound in diagnosis, prognosis and therapeutics). For patients to claim a right to any procedures they wish is to challenge a conscientious physician's integrity as a physician. It depreciates his expertise, reduces his discretionary latitude in decision-making, and makes him a technical instrument of another person's wishes. What is more important is that this can pose a risk to the patient's well-being and subvert the healing purpose for which medicine is intended in the first place. What is demanded may not be indicated, effective or beneficial. Such demands violate the internal morality of medicine as a practice.²³ They can redound to the patient's harm by undermining the physician's moral obligation to provide sound advice and sound practice and to avoid medically useless or futile treatments.

This threat is especially pressing today in the debate over medical futility and who defines it. Some would do away with the concept entirely because they consider that defining "futility" is not, and cannot be, an

19. *Schloendorff v. Society of N.Y. Hosps.*, 105 N.E. 92, 93 (N.Y. 1914).

20. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

21. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT OF THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 241 (1983).

22. *In re Wanglie*, No. Px-91-283 (D. Minn. July, 1991).

23. For a further discussion of the morality issues in medicine, see John Ladd, *The Internal Morality of Medicine: An Essential Dimension of the Patient-Physician Relationship*, in *THE CLINICAL ENCOUNTER: THE MORAL FABRIC OF THE PATIENT-PHYSICIAN RELATIONSHIP* 209 (Earl E. Shelp ed., 1983).

objective determination. They argue that the idea of futility is so freighted with both the patient's and physician's values that it should be abandoned entirely.²⁴ Others would retain the concept only for obvious situations of total brain death, permanent vegetative state, far advanced malignant disease,²⁵ or when a treatment has failed in the last 100 cases.²⁶ Still others would institutionalize the criteria for futility in hospital policies that would bind the physician to compliance.²⁷ Underlying this debate is the challenge to the physician's expertise to determine when a treatment — or all treatment — is useless, ineffective or not indicated because the healing, caring, or curing ends of medicine can no longer be attained. One of the Hippocratic Authors made it an ethical obligation for the physician and the patient²⁸ to desist from treatment when the limits of medicine's power had been reached.

This limitation on the clinician's discretionary latitude in the use of medical knowledge and skills is especially dangerous when dealing with surrogate decisions for incompetent patients. Do patients or surrogates really know what doing "everything possible" means? Must we respect orders for "no tubes" or "extraordinary measures" when these may well be effective and beneficial and might have been desired if the patient were now competent? Did the previously competent patient really intend to forswear such measures? Is it ever possible in a living will or medical directive to anticipate what one would wish at the moment of actual decisionmaking? Must vigorous, ineffective, burdensome, and futile treatment be continued because the living will or surrogate requires it?

These difficulties do not vitiate living wills or surrogate decisions by those with a durable power of attorney for health. They do warrant caution about the content of autonomy and its actualization in particular cases in which there is doubt about what the patient wanted to be done. They alert us to the fact that the physician's discretion can be so restricted by advance directives that the patient's welfare is compromised. Moreover, a mistaken respect for autonomy or the physician's fear of violating

24. R.D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560 (1992).

25. Stuart J. Youngner, *Who Defines Futility?*, 260 JAMA 2094 (1988).

26. Nancy S. Jecker & Lawrence J. Schneiderman, *Medical Futility: The Duty Not to Treat*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 151 (1993).

27. Lance K. Stell, *Stopping Treatment on Grounds of Futility: A Role for Institutional Policy*, 11 ST. LOUIS U. PUB. L. REV. 481 (1992).

28. Hippocrates, *The Art*, in 2 HIPPOCRATES 185-217 (W.H.S. Jones trans., 1981).

autonomy becomes an excuse for moral detachment, which is actually moral abandonment.

The physician is accorded discretionary latitude in clinical decisions because medical knowledge must be applied to individual cases. The care of individual cases is not reduced to a set formula, but rather must be modulated by a host of clinical and personal factors peculiar to each patient. Without discretionary latitude, the physician cannot personalize and individualize care; she cannot fulfill her obligation to use her knowledge for the patient's best interests. Without constraints on discretionary latitude, the physician's decisions can violate the patient's values or produce physical harm. The balance between too narrow and too wide a definition of discretionary space is a delicate, but increasingly important, one to strike.

Another place where physician autonomy is endangered is in the sensitive realm of the physician's religious beliefs. In the future, the secular trend in our society and the drive for autonomy may converge to place constraints on the physician's religious convictions and values. Current legal literature already reflects instances of subtle, and sometimes not so subtle, coercion of the consciences of nurses and physicians who oppose or refuse to participate in abortion, sterilization, the use of abortifacient, or to carry out directives to withdraw feeding tubes.²⁹ Medical students and residents are under increasing pressure to learn and to participate in abortion training by practice. Applicants to medical schools are now frequently asked about their views on abortion. No solid data are available on whether their answers influence the admission committee's or interviewer's decision to accept or reject them. Nevertheless, the question is asked so often that it seems unlikely to be of only passing interest to interviewers.

Fortunately, the right of conscientious refusal on grounds of personal beliefs is currently protected.³⁰ However, past statements of official bodies like the American College of Obstetricians and Gynecologists with respect to training in abortion techniques as a condition of residency approval are worrisome, even though superseded at the present time.³¹

Another possible challenge to physician autonomy presents itself in the current debate about voluntary euthanasia and assisted suicide. It seems very likely, in view of the current drift of public and professional opinion,

29. Wardle, *supra* note 18.

30. Executive Board Minutes from the American College of Obstetrics and Gynecology at 12, Item 6.2 (Jan. 1992) (on file with organization).

31. See Barbara L. Lindheim & Maureen A. Cotterill, *Training in Induced Abortion by Obstetrics and Gynecology Residency Programs*, 10 FAM. PLAN. PERSP. 24 (1978).

that one or both of these practices will become legal. When this happens, these procedures will also very likely become "benefits" or entitlements in our future health care system. The Clinton Administration is likely to include abortion among "reproductive services" in its proposed Health Security Act. Pressures on physicians are then sure to mount to provide abortions as part of the "benefit package." We are promised that the rights of conscience of those who find abortion morally reprehensible are to be protected. However, in a climate of moral pluralism, self-determination, and consensus ethics, this could change.

I cite these examples not to provoke furious debates about the moral status of the procedures in question, but because whatever one's position may be, the moral problem of the integrity of the physician's autonomy and moral rights of expression of conscience cannot be ignored. If legal or societal sanction for a certain procedure becomes widespread, will this warrant violation of the physician's conscience? Some see these as matters of such societal benefit that the physician's private moral and religious beliefs should be dissociated from his professional life.³² This will pose an impossible situation for the morally conscientious Orthodox Jew, Roman Catholic, or Muslim in certain fields of medicine.

Another challenge to the physician's moral integrity and autonomy is one encountered by physicians in countries with "managed" health care systems. The political and economic pressures of health care policy and reform already place the physician in a position of moral conflict. The economic and fiscal drive behind such programs can make the physician a moral accomplice in practices he deems injurious to his patient's well-being. No matter what setting he is in — cost containment, rationing, acting as a gatekeeper, an institutional milieu of managed health care or managed competition, a publicly funded clinic adhering to clinical guidelines, etc. — all place the physician in the position of double or triple agency.

The physician's professional commitment to advocacy for her patient may put her at odds with an institution's or society's well-being. Exigency, expediency and economics, not ethics, drive such systems. Does the "autonomy" of the institution or health policy override the autonomy of either, or both, the patient and physician? How are "good" business, economic, political and fiscal policy, and the moral purpose of medicine to be reconciled? Which takes precedence when conflict is unavoidable?

32. This dissociation is one I have encountered already in private conversation with medical students, colleagues, and influential laypeople.

Such questions are sure to become more widespread in the future as the zeal for cost containment and managerial ideologies, rather than the welfare of patients, are enshrined in law and public policy.

IV. PROCEDURAL ETHICS AND CONFLICT RESOLUTION

The central moral issues in any attempt to balance patient and physician autonomy are substantive. But, when substantive moral issues are unresolvable, procedures for ethically dealing with the conflict are necessary. The autonomy of patients, their surrogates, and physicians all carry moral weight and, on that account, command respect. The ethical goal of any procedure aimed at conflict resolution should be to protect each agent's autonomy to the extent possible. To this end, a variety of procedural moves are morally plausible when a conflict in moral or professional values reaches an impasse.

To begin with, the patient or patient's valid surrogate can discharge the physician and engage one who will take care of the patient on his or her terms. Alternatively, the physician can withdraw, respectfully and without recrimination, on grounds of preservation of his moral integrity. However, these alternatives are possible only if another physician is willing to undertake the care of the patient. To withdraw without transferring care to another competent physician is morally and legally unacceptable and constitutes abandonment. Hence, the question about how the transfer should be made arises.

In both situations, patients or surrogates might claim a right to assistance in selection of another physician specifically congenial to their moral values. In cases that do not involve a fundamental moral principle (e.g., a patient's choice of a "lump" resection and radiation as against radial mastectomy for breast cancer, or the use of non-standard, but not harmful, medical treatment) such cooperation could be ethically appropriate. The issue may be more fundamental, however, when it involves voluntary euthanasia, abortion, physician-assisted suicide, or withdrawal of care from patients in a persistent vegetative state. In such instances, some would argue that the physician who withdraws has an obligation to find another physician to undertake the patient's care under the family's or patient's terms. For others, this would constitute an unacceptable degree of moral complicity by cooperation in an act one considers morally untenable.³³

The most difficult situation, for which there is no totally satisfactory solution, is when physicians and patients or their surrogates disagree on a

33. Pellegrino, *supra* note 12.

serious and fundamental ethical issue and the possibilities of physician withdrawal, or discharge of the physician by patient or surrogate, are foreclosed by external circumstances. There may be no physician willing to undertake care on the patient's or surrogate's terms. No other physician may be available for reasons of geography or urgency of the clinical situation or lack of the required expertise. Or, the physician may be employed in an institutional setting (i.e., prisons, the military, certain managed care plans, or residency training programs), in which physician choice is limited by virtue of his occupying a specific, socially defined role. In these settings, failure to perform the expected role (i.e., participation in state-ordered executions), could result in significant fiscal penalties, discharge from one's job, and legal or disciplinary action.

When there are irreconcilable differences in moral commitments and the physician cannot extricate herself by reasons of exigency or limitations imposed by patient or society, the physician must still be faithful to her conscience. This may mean acceptance of the attendant penalties for refusal to comply with institutional, legal, or socially defined goals (e.g., refusal to participate in state-ordered executions or in coerced interrogation of war prisoners). Just when and how individual physicians should refuse to comply with social conventions is not a matter of precise formulation. No one can enter the mind and heart of another and untangle the moral psychology of a particular moral choice, but this fact does not vitiate judgment about the ethical probity of the act in question.

Some of the most complex and difficult situations occur when surrogates are acting for infants whose future values cannot be known.³⁴ In such cases, the conflict will often be between the surrogate's and the physician's estimates of what is "best" for the infant. The vagaries of "quality of life" estimates complicate the issue because of the impossibility of assessing how the infant would make that evaluation when he or she becomes aware it must live with the infirmities the physicians prognosticate.

These infirmities are often complex, may result in a life of prolonged disability and discomfort, and constitute grave emotional, physical and fiscal burdens for parents and society. In a society propelled by economic constraint, reluctance to sacrifice material goods even for disabled children, and an obsession with physical beauty, it is not uncommon for even conscientious parents to decide to withhold or withdraw life-sustaining treatment in order to spare the infant a "life of suffering" or poor quality.

34. See Arthur E. Kopelman, *Dilemmas in the Neonatal Intensive Care Unit*, in *ETHICS AND MENTAL RETARDATION* 243 (Loretta Kopelman & John C. Moskop eds., 1984).

But "quality of life" and "value of life" are not synonymous terms. The modern tendency to use them synonymously is a serious point of discord between secular and religious perspectives on ethical decisions. What is right and good in these circumstances is problematic and may be interpreted in contradictory ways by physicians, nurses, parents, and even governmental regulation.³⁵ In these circumstances, we may search for procedures which will protect the autonomy of all participants, but the substantive ethical disagreement remains.

When the physician believes the parents' decision would constitute grave harm to the infant, she has several procedural alternatives. One alternative is to withdraw and ask the parents to engage another physician. This would be permissible if the physician did not think that withdrawal would result in grave moral and physical harm to the infant. Where the physician might judge otherwise, whether treatment is withheld or continued, then that is medically futile.³⁶ At such a time, the physician has an obligation to take whatever measures are available to avert harm, such as appeal to an ethics committee or, if necessary, to the courts.

A proponent of absolute parental autonomy might justifiably ask what moral claim a physician can have to judge, or even question, a parent's surrogacy rights. This point of view assumes that parents have absolute dominion over their children and that their decisions will invariably be benevolent and altruistic; it also ignores the covenantal trust relationship between the physician and the patient. For a variety of reasons — pride, shame, or unwillingness to confront the expense, financial and emotional, of caring for a disabled child — parents may decide to undertreat. On the other hand, they may opt for futile overtreatment out of lack of information, religious conviction, or fear of being in some way responsible for their infant's death.

Furthermore, the autonomy imputed to parents cannot be absolute. Physicians and nurses are obliged by virtue of their commitment to the well-being of their patients to act in the interests of the infant. They must, of course, appreciate that decisions surrounding the care of very sick and potentially disabled infants must involve the family. Indeed, in a

35. Child Abuse Amendments of 1984, Pub. L. No. 98-457, 98 Stat. 1749 (1984) (amending 42 U.S.C. § 5101 (1974)).

36. See Anne Bannon, *The Case of the Bloomington Baby*, HUM. LIFE REV., Fall 1982, at 63; Michael McCarthy, *Anencephalic Baby's Right to Life?*, 342 LANCET 919 (1993); John J. Paris et al., *Physicians' Refusal of Requested Treatment: The Case of Baby L*, 322 NEW ENG. J. MED. 1012 (1990).

real sense, the whole family becomes a "patient," whose collective interests must be safeguarded. The implications of the decision on the future lives of the whole family are, therefore, not to be denied; however, these considerations by themselves do not justify withholding or withdrawing treatment that is effective, beneficial and not disproportionately burdensome.

When there is obvious and overt conflict between the good seen by parents and the medical good of the infant, the obligation is greater to the most vulnerable person (in this case, the infant). Situations involving such irreconcilable conflicts of obligation are sometimes unavoidable. Still, we are obliged to do as much as possible to respect the physician's obligations as physician as well as the autonomy of surrogates or patients. Sometimes both cannot be respected without unacceptable compromises, on one side or the other.

Before such an impasse is reached, all other methods of conflict resolution should be exhausted. Ethics committees can serve to clarify the issues and perhaps suggest a way in which compromise could effectively be reached in a manner that preserves the moral integrity of all the participants. Appointment of legal guardians and appeals to the courts are far less satisfactory. In any case, all of these devices address only the procedural resolution of the practical conflict. They certainly do not resolve the ethical dilemma of conflicting claims to autonomous decisionmaking.

V. THE INTEGRITY OF MEDICAL ETHICS

Some would suggest that the problem is with medical ethics itself, with the insistence on universal rules of moral conduct on which physicians base their moral claim to autonomy as physicians. Why not change medical ethics, itself? Why not leave it to be negotiated between physician and patient? Perhaps medical ethics should be a changing, socially constructed contract varying from society to society, era to era, and patient to patient. Some argue that medicine and its ethics must be whatever is negotiated politically between the profession and government. Other socially and politically constructed forms of ethical justification are currently popular as well. They imply that there is no such thing as a universally binding medical ethic, only an ethic of political expediency or societal convention.

Some of us, however, think this would be disastrous for medicine, the physician, and the patient. The autonomy — that is really to say the moral integrity — of both physicians and patients must somehow be pre-

served. So, too, must the integrity of the ethics of medicine itself. Medical knowledge is too powerful a tool to become an instrument of governmental or social pressures, or private negotiation, however benign their motives may appear to be. Medicine is also too powerful to go wholly unregulated. There are too many examples of the subversion of the powers of medicine to evil purpose by unjust political regimes to make the ethics of medicine a subject for political negotiation.³⁷ There are too many examples of the way unregulated medical "entrepreneurs" or morally bankrupt physicians can exploit the vulnerability of the sick.

Medical ethics must maintain a degree of independence if it is to protect the sick person. It must remain subject to public criticism, but not be controlled by social convention. It must also be protected from subversion by the profession itself. This requires a much firmer philosophical grounding for medical ethics than we now possess. The possibility of achieving universal approbation for a commonly held ethic of the profession seems to be receding today in the face of the multi-cultural, morally pluralistic, and morally relativistic temper of the times. This climate, however, cannot justify abandoning the effort. Nothing less is called for than a reconstruction of the ethics of the relationship between patient and doctor. This will be difficult, indeed, because the "remarkable solidarity" and "singular beneficence," which Osler praised,³⁸ are rapidly disappearing in the worldwide questioning of the moral values that have traditionally undergirded medical ethics.

I have purposely said little about the principle of justice, which must also be factored into the equation. On the whole, this facet of the physician-patient relationship has been underdeveloped. It is now necessary to establish the conceptual relationships among justice, autonomy, and beneficence, as well as their actualization in the clinical context. Justice has the interesting facet of being both a principle and a virtue. The incorporation of justice into the autonomy-beneficence equation will require a prior clarification of how principles and virtues are conceptually and practically related.

Despite the difficulties, the effort to balance the autonomy equation is not futile. Its importance impels us to the effort to try to find the points of balance. Autonomy and beneficence are two principles so closely tied to the healing ends of medicine that to violate either is to imperil the

37. See Edmund D. Pellegrino, *Societal Duty and Moral Complicity: The Physician's Dilemma of Divided Loyalty*, 1 INT'L J.L. & ETHICS (forthcoming June 1994).

38. William Osler, *Chauvinism in Medicine*, in *AEQUANIMITAS: WITH OTHER ADDRESSES TO MEDICAL STUDENTS, NURSES AND PRACTITIONERS OF MEDICINE* 267 (1943).

moral integrity of both patients and physicians. Nevertheless, any comprehensive moral philosophy for the health professions must encompass more than these two principles. Justice must be included and account taken of both virtue and the moral psychological insights of non-principle based theories.

In any case, one step in the larger effort is to try to achieve a better balance between the two most powerful principles shaping physician-patient relations today. Several precepts need to be built into the current reexamination of the foundations of professional ethics:

- 1) Patient autonomy is a moral right of patients, and it is a duty of physicians to respect it.
- 2) Integrity of conscience and professional judgement are moral rights of physicians. Society and patients have an obligation to respect them.
- 3) Physician autonomy is limited by a competent patient's or valid surrogate's moral right to refuse proffered treatment. The physician is obliged, however, to help the patient arrive at an autonomous decision by enhancing or empowering the patient's capacity to make authentic, self-governing choices.
- 4) The patient's autonomy is limited when it becomes a demand for treatment the physician honestly believes is not medically indicated, is injurious to the patient, or is morally repugnant.
- 5) The physician's autonomy is limited on questions of value, e.g., on questions of the goals or purposes to which medical knowledge may be put for particular individuals or societies.
- 6) Societies and institutions must establish mechanisms, with only minimal recourse to law, for unilateral discontinuance of the relationship when either patient or physician feels personal integrity is being compromised.
- 7) The first principle of medical ethics is still beneficence. Beneficence is essential if autonomy is to be authentically expressed and actualized.

In sum, beneficence and autonomy must be mutually re-enforcing if the patient's good is to be served, if the physician's ability to serve that good is not to be compromised, and if the physician's moral claim to autonomy and the integrity of the whole enterprise of medical ethics are to be respected.