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INFORMED CONSENT AND RESPECT FOR AUTONOMY

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ABSTRACT In this thesis I examine the medical concept of informed consent and the philosophical concept of autonomy in conjunction with the relationship between them. This examination is complicated because autonomy can refer to decisions or persons. Further autonomy may have instrumental or intrinsic value. These differences mean autonomy may be respected in different ways. This examination is further complicated because whilst a vast wealth of medical literature exists on informed consent and mentions autonomy, very little of this literature does more than mention autonomy. As a result of my examination I argue for the following.

Firstly I argue the form of autonomy underlying informed consent should be personal autonomy and to respect autonomy means accepting autonomous decisions.

Secondly I show in certain contexts a surrogate decision maker cannot make a decision on behalf of an incompetent patient that would be generally agreed to be in his best interests. I will argue in such contexts a patient's decision should always be accepted as the concept of competence becomes detached from the concept of informed consent. Thirdly I show a patient may make an autonomous decision based only on understanding the purpose of the procedure he is consenting to. I will argue it follows a patient should not be required to understand details of the nature of the procedure he is consenting to for his consent to be accepted.

Fourthly I argue an autonomous decision must be one an agent identifies with and has some persistence. I will show these conditions are satisfied by an autonomous agent's absence of restlessness to change his decision. Lastly I argue informed consent decisions should be linked to a patient's ability to understand the risk involved in his decision and not directly linked to the degree of risk involved in his decision.

Contents

Preface	
Introduction	1
1 Informed consent in practice	7
1.1. Informed consent and medical guidelines	7
1.2 Informed consent and legal judgements	18
1.3 Informed consent and bioethics	27
2 Autonomy 1	31
2.1 Intuitive ideas of autonomy	32
2.2 Respect for autonomy	41
3 Concepts of autonomy	59
3.1 Mill and autonomy	59
3.1.1 Mill's concept of liberty	60
3.1.2 Mill's concept of liberty and respect for autonomy	63
3.2 Kant and autonomy	71
3.3 Dworkin and autonomy	77
3.3.1 Dworkin's first concept of autonomy	78
3.3.2 Dworkin's second concept of autonomy	82
3.3.3 Dworkin's second concept of autonomy and decisions	88
3.4 Christman and autonomy	96
3.4.1 Christman's historical account of autonomy	97
3.4.2 A comparison between Christman and Dworkin's concepts	

of autonomy	102
3.4.3 Christman’s concept of autonomy and our intuitive ideas of autonomy	108
3.5 Frankfurt and autonomy	111
3.5.1 The central features of Frankfurt’s concept of autonomy	112
3.5.2 The practical consequences of Frankfurt’s concept of autonomy	115
3.5.3 Frankfurt’s concept of autonomy and the problem of regress	124
3.5.4 Frankfurt’s concept of autonomy and our intuitive ideas of autonomy	130
4 Risk related competence	137
4.1 Internal, risk related symmetric and asymmetric competence assessment	137
4.2 Does the concept of asymmetric competence exist outside Informed consent	144
4.3 Asymmetric competence assessment and “yes decisions” or “no decisions	151
4.4 Asymmetric and a risk related symmetric assessments of competence in practice	156
4.4.1 The asymmetric triggering of competence assessments and risk related competence assessments	157

4.4.2 Symmetric or asymmetric risk-related competence assessments in practice	160
4.4.3 Risk-related assessments of competence and accepting a patient's consent in practice	166
4.5 Risk related competence assessments and personal autonomy	172
5 The purpose of informed consent decisions and the context in which these decisions are made	188
5.1 The patient's purpose when making informed consent decisions	188
5.2 The purpose of assessing a patient competence.	193
5.3 The domain in which informed consent decisions are meaningful	200
5.3.1 Useful competence assessments	200
5.3.2 Useful competence assessments and informed consent	205
5.4 Informed consent decisions requiring the patient's ongoing co-operation.	223
6 Competence, informed consent and personal autonomy	227
6.1 A competent patient's capacity to understand the information supplied to him	228
6.1.1 Must a competent patient actually understand the information provided?	229
6.1.2 How much information must a competent patient actually understand?	235

6.2 Must a competent patient believe the information supplied to him?	242
6.3 A competent patient's capacity to communicate	245
6.4 Patient rationality.	247
6.4.1 Instrumental Rationality	248
6.4.2 Beliefs, goals and values	254
Bibliography	264

Preface

This thesis grew out of an amateur interest in applied Philosophy. I am an unlikely candidate to write a thesis in applied philosophy having spent most of my life as a farmer. Whilst farming I completed an Open University degree concentrating mostly in mathematics. From this I developed an interest in the philosophy of mind. This led me to The Centre for Continuing Education at Newcastle University where over several years I developed my philosophical interests further. I am particularly grateful to Mike Bavidge and Ian Ground for helping me develop these interests. During these classes I developed a particular interest in applied philosophy. As a result of this I decided to do a MA in applied philosophy under Brenda Almond at The University of Hull. I completed this in 1995. On completing my MA my interest in philosophy continued purely as a hobby. This state of affairs might have continued except one of the partners in the farm died. I now found myself in my late fifties without a farm and time on my hands. It was purely through surfing the web that I contacted David Over at Sunderland University which at that time had a philosophy department. David suggested I should enrol to do a doctorate. I originally thought of myself as too old to commence such a serious piece of work but David persuaded me otherwise for which I am grateful. The subject of this thesis originated the dissertation for my MA at Hull. My dissertation concerned living wills or advance directives. Superficially advance directives appear to be a form of informed consent and concerned with personal autonomy. I questioned whether these connections are as clear-cut as it is usually assumed. These questions led to this thesis exploring the relationship between autonomy and informed consent. In conclusion I must thank my wife for her patience with me whilst researching and writing this thesis.

Introduction

The purpose of this thesis is to investigate the relationship between the philosophical concept of autonomy and the practical idea of informed consent. In medical practice a competent patient must give their consent before any treatment can lawfully take place. Historically a patient's consent was necessary in order to obtain her co-operation regarding some proposed treatment. However since the 1960s informed consent has been more concerned with respecting a patient's autonomy (Jackson, 2001, page 10). The General Medical Council expresses this concern for autonomy as follows.

Successful relationships between doctors and patients depend on trust. To establish that trust you must respect patients' autonomy - their right to decide whether or not to undergo any medical intervention even where a refusal may result in harm to themselves or their own death. (General medical Council, 2001, page 1)

This thesis is concerned with applied philosophy with the practical implications of basing informed consent on respect for autonomy. It will investigate whether informed consent as currently practised is fully compatible with respecting autonomy. It will conclude it is not fully compatible and make some practical recommendations.

This thesis assumes there is a lack of theoretical understanding about the concept of autonomy, practical ideas of competence and the relationship between autonomy and competence. Demarco supports this position.

This is especially true given the link between autonomy and well-being. Autonomy is too important, and paternalism too controversial, to be buried in the concept of competence. Nevertheless much about competence and autonomy is unclear. We do not have adequate notions of either. Developing adequate concepts and determining how informed consent should relate to paternalism requires more work (Demarco, 2002, page 244).

Consent applies to all medical interventions that involve touching a patient. For instance a patient's consent is required if a doctor wishes to take her blood pressure just as it is in the case of a proposed appendectomy. In practice if a patient consents they are usually presumed to be competent (General Medical Council, 1999, page 5). However in many cases if a patient refuses to consent to some proposed treatment her competence will not be assessed. For instance, if a patient refused to have her blood pressure taken, her competence would not be assessed. This is also true in more serious cases. Consider a patient, suffering from an arthritic knee, who is advised to have an operation to replace her knee joint. Let it be assumed that without this operation she will probably be confined to a wheelchair. In practice if this patient refused to consent her competence would not be assessed. The operation would simply be cancelled.

Nevertheless in some circumstances if a patient refuses to consent to treatment, her competence would be assessed. Moreover, in these circumstances if she is found to be incompetent she might be treated against her will. The case of Ms B [2002] illustrates this. Legal judgments consider that refusals of consent vary in importance depending on whether there is a risk to the patient's life or a risk of irreparable harm being done to her health see T, [1992]. This thesis is for the most part concerned with understanding the implications of

basing informed consent on respect for autonomy in these circumstances. The idea of patient competence is central to the practice of informed consent. Buchanan and Brock argue, that the central purpose in assessing competence is to determine whether the patient retains the right to accept or refuse a particular medical procedure. (Buchanan & Brock, 1989,page 28)

It follows that the way risk, to a patient's life or of irreparable harm being done to her health, affects the assessment of her competence must be central to this thesis. Intuitively a patient is competent to give or refuse informed consent to some proposed treatment if she possesses certain capacities. The risk to a patient's health might affect the degree to which a patient must possess these capacities in order to be considered competent in two ways. Firstly, risk might indirectly affect the degree to which a competent patient must possess these capacities. For instance a competent patient might need additional capacities to understand the risks involved in some proposed treatments. Secondly, risk might directly affect the capacities a patient must possess if she is to be regarded as competent. In this scenario a patient would need additional capacities in order to be considered competent when the risk to her life or irreparable harm occurring to her health increases irrespective of whether she needs these extra capacities to understand the risks involved. The major conclusion reached in this thesis is that connecting the capacities needed by a patient to be considered competent directly to the risk involved, rather than to the capacities needed to understand the risk involved, is incompatible with respecting patient autonomy.

It is implicit in British case law as set out by Lord Donaldson in the case of T that a competent patient's capacities should vary directly with risk [1992]. It appears to follow that British case law is incompatible with respecting patient autonomy. In order to reach the above major conclusion, three supplementary questions must be considered. Firstly what exactly is

meant by respecting autonomy? I will argue that respect for autonomy involves recognition of some persons as the kind of persons who can determine their own future. I will further argue that this recognition involves accepting autonomous decisions. Secondly, since there are various philosophical concepts of autonomy, as pointed out by Cuypers (2000,page 226) and Meyers (2004,page 106), the question as to which concept of autonomy should form the basis of informed consent must also be considered. I will argue for the use of Frankfurt's concept of autonomy as the basis of informed consent. Thirdly, the question of why a patient's competence is assessed will be raised. I will conclude that a patient's competence is not assessed simply to respect her autonomy. A patient's competence is assessed in order to respect her autonomy and to ensure that if she is non-autonomous she receives beneficent care. I will argue that in practice this means giving precedence to respecting autonomy over acting beneficently.

This thesis is divided into six chapters. Chapters 1, 2 and 3 are preparatory chapters that make it clear what is involved in the practice of informed consent. Chapter 1 examines the practice of informed consent from three separate but related points of view; official guidelines, a legal perspective and a bioethical perspective. Chapters 2 will examine autonomy. 2.1 will examine our intuitive ideas of autonomy. 2.2 will examine what it means to respect autonomy. Chapter 3 continues the consideration of autonomy, by questioning which concept of autonomy should form the basis for the practice of informed consent and why a patient's competence is assessed. These questions will continue to be examined in chapter 4. The main task in chapter 4 is to examine the relationship between risk and competence assessment. In order to complete this task it is necessary to examine the concept of asymmetric competence assessment. The concept of asymmetric competence assessment holds that different standards of competence are needed for a patient to be considered competent when she consents to

treatment as compared to when she refuses to consent. The standard varies with the expected harms or benefits associated with the outcome of her decision. It follows that a patient might be considered competent to choose a safe option but incompetent to choose a dangerous option.

Chapter 4 shows that any system of risk related competence assessment based directly on risk means that acting beneficently must be given precedence over respecting autonomous decisions. This result will be used to show that connecting the capacities needed by a patient to be considered competent directly to the risk involved, rather than simply to the capacities needed to understand the risk involved, is incompatible with respecting patient autonomy.

Chapter 5 examines the various circumstances in which informed consent decisions are made. The circumstances in which a patient consents or refuses to consent to an appendectomy seem very different to those in which a parent consents or refuses to consent to the retention of a child's organs for post mortem examination. It will be argued that these different circumstances have important implications for the practice of informed consent. I will conclude that in some circumstances assessing a patient's competence does not serve the purpose of informed consent if that purpose is to respect patient autonomy whilst also acting beneficently towards non-autonomous patients. It will be concluded in these circumstances it is not useful to assess a patient's competence and her decision should simply be accepted. The arguments used in chapter 4 to reach the major conclusion in this thesis that, connecting the capacities needed by a patient to be considered competent directly to the risk involved, rather than to understanding the risk involved, is incompatible with respecting patient autonomy, do not specify what capacities a competent patient requires.

Chapter 6 addresses this omission. This chapter assumes that, because informed consent is based on respecting autonomy and ensuring that non-autonomous patients receive

beneficent care by giving precedence to acting autonomously over acting beneficently, all autonomous decisions should be respected. It follows that the capacities a patient requires to make a competent informed consent decision cannot be greater than those someone requires to make an autonomous decision. Chapter 6 will examine how much information a patient must understand to enable her to make an autonomous consent decision. It will conclude that a patient must be informed about any changes to her lifestyle likely to be brought about by any proposed treatment. It will further conclude that a patient must also understand the purpose of the proposed treatment. This examination of how much information a patient must understand in order to make an autonomous consent decision leads to a minor conclusion of this thesis which is that a patient can make an autonomous decision to ask her doctors to make a decision on her behalf and that such a decision should be respected. Chapter 6 also examines the capacities for rationality a patient needs to make an autonomous consent decision. It will conclude that a patient must be able to use instrumental rationality in order to make an autonomous consent decision. It will further conclude that if a patient is to make an autonomous consent decision, then her goals and values must have some kind of simple structure.

Chapter 1

Informed consent in practice

The purpose of this thesis is to reach meaningful conclusions concerning the relationship between informed consent and respect for autonomy. To do this it must be clear what is entailed by both the practice of informed consent and respecting autonomy. The purpose of this chapter is to examine how informed consent works in practice, by providing a critique of the practice of informed consent, intended to enable us to fully understand the practice of informed consent prior to examining the relationship between informed consent and respect for autonomy. Chapter 1 will also highlight some inconsistencies in this practice which appear to vary depending on the idea of patient competence adopted. Whether a patient's consent is regarded as valid depends on whether she is regarded as competent or incompetent see (Buchanan & Brock, 1989, page 28). A patient is considered competent if she possesses certain capacities. Chapter 1 will examine informed consent in practice by examining these capacities. The chapter is divided into three subsections.

1.1. Informed consent and medical guidelines

The General Medical Council is a professional body set up as a result of the 1858 Medical Act. It has a duty to protect patients and is also responsible to the Privy Council for establishing a register of doctors. The Medical Act of 1983 confirmed these powers. The Council carries out these duties in three ways. Firstly, it sets the qualifications doctors must meet and appoints examiners to see these qualifications are met. Secondly, it provides guidance to doctors as to ethical standards they should employ by giving practical guidelines.

Lastly, it has the power to remove doctors from its register if they fail to meet its ethical or clinical standards. The ethical guidelines provided to doctors include guidelines on informed consent. These guidelines presume adult patients are competent to give consent:

“You must work on the presumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand the information presented in a clear way. If a patient’s choices appears irrational, or does not accord with your view of what is in the patient’s best interests, that is not evidence in itself that the patient lacks competence. In such circumstances it may be appropriate to review with the patient whether all reasonable steps have been taken to meet their information need.” (General Medical Council, 1999, section 19).

If informed consent is practised according to the General Medical Council’s guidelines then the following should hold.

Firstly, these guidelines make it clear that an adult patient making an informed consent decision must be fully informed and must understand the information supplied to her if she is to be regarded as competent. This thesis assumes informed consent is based on respect for autonomy. It follows that the question of how much information a patient needs to make an autonomous decision should be related to the question of how much information a patient needs to understand if she is to be regarded as competent according to the practice of informed consent. This relationship and how much information a patient needs to understand in order to make a competent decision will be dealt with in chapter 6. Secondly, these guidelines make it

clear that a patient's competence need not normally be assessed when taking consent from a fully informed adult patient because adults are presumed to be competent. This presumption mirrors criminal law in that just as a defendant is presumed to be innocent unless proved otherwise, so a patient is presumed to be competent unless it can be shown otherwise. It follows if an adult patient is to be regarded as incompetent according to the General Medical Council's guidelines then it must be possible to show the patient has either not been provided with enough information or fails to understand the information provided. Thirdly, the General Medical Council's guidelines do not consider that the outcome of a patient's decision should play any part in setting the standard by which her competence is judged. It is of course true that a patient's decision may trigger an assessment of her competence. However these guidelines make it clear that the standard a patient must meet if she is to be regarded as competent should be determined solely by the capacities deemed necessary to understand the information provided to enable her to make her consent decision. This requirement is important when the asymmetric assessment of competence is discussed in chapter 4. All that is explicitly required by the General Medical Council's guidelines for a patient to be considered competent is that she is fully informed and has the capacity to understand the information provided. The capacities to communicate, to reason and the possession of a set of beliefs and values are not mentioned explicitly. It will now be argued that these guidelines implicitly require that a patient possesses the above capacities and a set of beliefs and values if she is to be regarded as competent.

If a patient's decision is to be respected then she must be able to communicate this decision. It follows that it must be implicit in these guidelines that a competent patient has the capacity to communicate. The General Medical Council (1999, section 5) sets out the detailed

information which patients should be given and capable of understanding in order to give competent informed consent as follows.

- Details of the diagnosis and prognosis, and the likely prognosis if left untreated.
- Uncertainties about the diagnosis including options for further investigation prior to treatment.
- Options for treatment or management of the condition, including the option not to treat.
- The purpose of a proposed investigation or treatment, details of the procedures or therapies involved, including subsidiary treatment such as pain relief, how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects.
- For each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused or necessitated by, the treatment.
- Advice about whether the treatment is experimental.

This list is extensive and it would be pointless to provide the patient with this detailed information unless she could use it to reflect upon when making her informed consent decision. If a patient is capable of reflection then she must have some degree of rationality. The General Medical Council's guidelines (1999, section 13) also require a competent patient to be able to discuss any treatment. Discussion requires a patient's active participation which requires some degree of rationality. It follows therefore that the General Medical Council's

guidelines implicitly hold a competent patient must possess some degree of rationality. It further follows that the degree of rationality necessary for a patient to be considered competent is determined solely by the degree of rationality considered necessary for her to understand the information provided.

It has been shown above that the General Medical Council implicitly requires that a competent patient must have some degree of rationality. However there are different types of rationality as is made clear by Over (Over in Koehler & Harvey, 2004, page 12).

There is a distinction between what is often called epistemic rationality, on the one hand, and rationality of action, on the other. This distinction is between rational belief and rational inference, on the one hand, and rational action, on the other. A rational belief is based on a generally reliable mental process. A rational inference has a conclusion that is true, or at least probably true, given its premises. A rational action is a good one for us to perform, in a sense of “good” that has to be clarified.

In this thesis the rationality of action will be referred to as instrumental or practical rationality. The definition of practical rationality used in here is based on Baron (1994, page 29) and is defined as whatever kind of thinking best helps people to achieve their goals. It is important to be clear what form of rationality is required by the practice of informed consent for the following reasons. It seems clear that whether a belief is rational or an inference is logical can be assessed by a third party. However, if informed consent is based on purely practical rationality, it is not immediately clear how the rationality of a patient’s actions can be assessed

by a third party. This creates a problem for the assessment of a patient's competence to give informed consent. This problem will be examined in 5.4.1.

The General Medical Council's guidelines are concerned with a competent patient understanding the information provided rather than her goals and values. This might lead to the assumption that the type of rationality the General Medical Council requires competent patients to have is limited to instrumental rationality. However, it will be argued here that the above assumption is false. The General Medical Council's guidelines require that a competent patient understands the information supplied to her. Clearly if a patient believes her wound is not gangrenous, when she had been informed it is gangrenous then she does not fully understand the information supplied to her. It follows that the General Medical Council's guidelines are implicitly concerned with a patient's epistemic rationality to some degree. It can be concluded that these guidelines are concerned with a patient's instrumental rationality and her epistemic rationality. However the concern with a patient's epistemic rationality is restricted to the truth of her representation of the world.

It follows from above that the General Medical Council's guidelines are not concerned with the rationality of a patient's goals and values. However it will now be argued that these guidelines implicitly require that a competent patient must possess some goals and values. An agent's goals and values may be regarded as her ideals. Frankfurt (1999) argues any decision of an agent who has no ideals is based on mere impulse and inclination.

He can make whatever decision he likes and shape his will as he pleases. This does not mean that his will is free. It only means that his will is anarchic, moved by mere impulse and inclination. (quoted in Frankfurt, 1999, page 114, originally 1993.)

Let it be accepted that if a competent patient has no goals and values the decisions she makes are based on mere impulse and inclination. The General Medical Council's guidelines (1999, section 5) require that detailed information must be given to a competent patient. It can be concluded that these guidelines implicitly require that a competent patient must have a set of goals and values in order to be able to use this information. This conclusion follows because if a patient has no goals and values, then her decision would be based on mere impulse and inclination. If a patient's decision is based on mere impulse and inclination it seems pointless to supply the detailed information. Indeed if a patient bases her decision on mere impulse and inclination it might be questioned whether she has any need of practical rationality. To summarise, the above guidelines presume patients are competent unless it can be shown otherwise. These guidelines also require that a competent patient must understand the information relevant to her decision. It has also been argued these guidelines implicitly require that a competent patient must have the ability to communicate and possess a set of goals and values. In addition a competent patient must be able to use instrumental rationality and have no beliefs, relevant to her condition, that misrepresent the world.

The Department of Health is responsible for implementing health and social care policy in the United Kingdom. It issues sets of health guidelines, among which is one on patient consent (Department of Health, 2001). This set of guidelines is more explicit than that of the General Medical Council. The Department's guidelines, like those of the General Medical Council presume adult patients are competent unless it can be shown otherwise.

Adults are presumed to have capacity, but where any doubts exist the health professional should assess the capacity of the patient to take the decision in question. (Department of Health, 2001, Paragraph 2.1.)

The Department of Health's guidelines set out the capacities a patient must have in order to be considered competent as follows:

For a person to have capacity, he or she must be able to comprehend and retain the information material to the decision, especially as to the consequences of having or not having the intervention in question, and must be able to weigh this information in the decision-making process. (Department of Health, 2001, section 2.1)

These guidelines also explicitly require that a competent patient must be able to communicate her decision (Department of Health, 2001, section 2.5).

It has been argued above that it is implicit in The General Medical Council's guidelines that a competent patient must possess a set of goals and values. The Department of Health's guidelines do not explicitly state a competent patient must possess a set of beliefs and values. However these guidelines seem to implicitly presume a competent patient has a set of beliefs and values.

Capacity should not be confused with a health professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision that is based on their own

religious beliefs or value system, even if it is perceived by others to be irrational, as long as the patient understands what is entailed in the decision. An irrational decision has been defined as one which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who applied his or her mind to the question could have arrived at it (Department of Health, 2001, section 2.5).

It follows according to the Department of Health's guidelines that a patient is competent when she has the following capacities; the capacities to understand and retain the information provided, to weigh and communicate her decision. In addition these guidelines also presume that a competent patient has a set of beliefs goals and values. This set of beliefs and values is necessary to enable the patient to weigh the information provided.

The Department of Health and The General Medical Council's guidelines appear to be similar but there are two significant differences. Firstly, the General Medical Council's guidelines seem to treat rationality in a Humean way. This means rationality is purely the slave of the passions (Hume 1978, Book II, Section III, originally published 1739 - 1740). However this is not the position adopted by the Department of Health's guidelines, see above. The General Medical Council's guidelines hold a competent patient must be able to use instrumental rationality and have no beliefs, relevant to her condition, that misrepresent the world. However the Department of Health's guidelines seem to require that competent patients have a greater capacity for epistemic rationality. This follows because these guidelines connect irrationality with the outrageous defiance of accepted moral standards. Beliefs about accepted moral standards are not restricted to beliefs that misrepresent the world. It can be concluded these two sets of guidelines differ somewhat with regard to the type of rationality a

competent patient requires. This difference is important. Let it be assumed that informed consent is based on respect for autonomy. Let it be further assumed that an autonomous decision requires some form of rationality. It appears to follow that the capacity for rationality needed by a patient to make a competent consent decision should be identical with the capacity for rationality needed to make an autonomous decision. The following question then arises. Is connecting the capacity for rationality a patient needs to make a competent decision with logic and accepted moral standards compatible with respecting patient autonomy? This thesis will attempt to resolve this important question in section 5.4.1.

The second difference in the guidelines issued by the Department of Health and The General Medical Council is connected to the first. This difference concerns the content of a patient's goals and values. It was argued above that the General Medical Council's guidelines implicitly require that a competent patient must possess a set of goals and values. However it seems unambiguous that these guidelines only require the existence of a set of goals and values and are not concerned with the content of these goals and values. The Department of Health's guidelines hold the following,

The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others as irrational, as long as the patient understands what is entailed by their decision. (Department of Health, 2001, section 2.3).

However, the Department of Health's guidelines also hold a decision may be irrational because it defies logic or accepted moral standards (Department of Health, 2001, section 2.3). It follows that if a patient bases her consent decision on her goals and values and these are not

based on accepted moral standards then her decision might be regarded as incompetent according to the Department of Health's guidelines. It would seem that the Department of Health's guidelines are ambiguous about whether the contents of a patient's beliefs and values matters as far as her competence to give informed consent is concerned. In practice it might be argued that some patients are intuitively considered to be incompetent due to their beliefs, goals and values rather than a failure of understanding or an inability to use practical rationality. This thesis will use the fact that informed consent is based on respect for autonomy to investigate this ambiguity in section 6.4.2. In this section I will argue that some simple structure must be placed on an autonomous agent's beliefs, goals and values. I will further argue that this structure resolves any ambiguity about whether the content of a patient's beliefs, goals and values matter when assessing her competence to give informed consent. The guidelines of the Department of Health and the General Medical Council agree about the following. Adult patients should be presumed to be competent unless there are reasons to doubt this. It is not up to the patient to show she is competent. If her competence is doubted then the health professionals involved in her treatment must show why she is incompetent. A patient can be shown to be incompetent if she lacks one of the following.

- 1) The capacity to understand and retain information provided.
- 2) The capacity to communicate.
- 3) The capacity to reason.
- 4) A set of beliefs, goals and values.

However these guidelines appear to differ concerning the importance of the content of a patient's goals and values when assessing her competence to give informed consent. The General Medical Council's guidelines only require that a patient possesses a set of goals and

values. The Department of Health's guidelines seem to be slightly ambiguous about whether the content of a patient's goals and values matter when assessing her competence to give informed consent.

1.2. Informed consent and legal guidelines

The legal position in the United Kingdom concerning informed consent has been developed over many years by case law. There are no specific statutes concerning informed consent Jones (1999, 105). Legal judgements presume every adult capable of making a choice is competent to consent unless it can be shown to be otherwise, see T [1992]. Legal judgements also hold that if a doctor treats a competent patient without her consent then the doctor commits an assault, see Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985]. Judge Cardozo classically expressed these positions as follows.

Every human being of adult years and sound mind has a right to determine what shall be done to his own body; and a surgeon who performs an operation without the patient's consent commits an assault for which he is liable in damages. [Schloendorff v Society of New York Hospitals, 1914]

This American judgement is important because it is usually quoted with approval in legal judgments and academic texts in The United Kingdom; see for instance Airedale NHS Trust v Bland [1992] and MB [1997]. This presumption of a patient's competence concurs with the guidelines issued by the General Medical Council and the Department of Health. Legal judgements also require that a competent patient possesses certain capacities. Justice Thorpe

set out the capacities legally required by a patient if she is to be considered competent in the case of C [1994]. If a patient possesses these capacities she is said to fulfil the conditions of the C test. According to the C test a competent patient needs these capacities to enable her to

Comprehend and retain the information as to the proposed treatment, had believed it and had weighed it in the balance when making a choice. [C, 1994]

It follows that if a patient is to be considered legally competent she must understand the information provided, believe it and be able to weigh it. This thesis assumes that to “weigh the information” means the patient can use reason to reflect on her decision.

The same arguments which were used in 1.1 can again be employed to show that legal judgements implicitly require a competent patient must possess the capacity to communicate her decision and the set of goals and values on which her decision is based. It follows legal judgments for the most part concur with the guidelines issued by both the Department of Health and the General Medical Council. However legal judgments go further than the above guidelines because not only do they require that a competent patient must understand the information provided, but they also require that she must believe it [C, 1994]. In section 5.2 I will question whether a patient must believe the information provided. The C test requires that a competent patient must be capable of weighing the information provided. However it is not immediately clear what sort of balance between instrumental and epistemic rationality this test requires. Indeed in the case of Sidaway it might appear there is no legal requirement at all that a competent patient must be rational.

If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons that are rational, or irrational, or for no reason. [Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital, 1985]

It seems improbable that there is no legal requirements concerning the rationality a patient is expected to possess in order give competent consent. If indeed patients had no need to possess rationality when giving competent consent then perhaps children or even the insane might be considered capable of giving consent. Further it would seem if Templeman's judgment given in Sidaway had no requirement for competent patients to be rational, then legal judgments are inconsistent. Thorpe stated in the case of C [1994] that a competent patient must be able to weigh the information supplied. Prima facie it seems Thorpe's judgment is inconsistent with that of Templeman.

This apparent inconsistency can be explained if the following holds. When Templeman referred to reasons in the case of Sidaway he was referring to a patient's goals and values, and Thorpe, in the case of C, regarded a patient as competent if she was able to use instrumental rationality and had no beliefs, relevant to her condition, that misrepresent her condition. If the above is accepted, then legal judgments do not require the goals and values on which competent patients base their decisions must be rational. However they do require that a competent patient must be able to use instrumental rationality in order to weigh the information provided and that she has no false beliefs concerning her condition. It follows that legal guidelines restrict the epistemic rationality a competent patient requires to beliefs concerning her condition. It can be concluded that the capacities a patient must have in order

to be considered legally competent concur with the capacities required by the General Medical Council's guidelines with one exception. Legal judgements require not only that a patient must understand the information provided but also that she believes it [C, 1994]. It can be further concluded that the capacities considered necessary for a patient to be considered competent by the Department of Health's guidelines exceed those considered necessary by legal judgments. The Department's guidelines hold that a patient's goals or values may sometimes be considered as irrational. It follows that the Department's guidelines place greater importance on epistemic rationality than do legal judgements.

These differences concerning the rationality of a patient's goals and values matter when assessing her competence, and can be illustrated in practice by considering the case of B [2002]. Ms B was a tetraplegic patient who was kept alive by a ventilator and who decided she wished to have the ventilator switched off. Ms B had not consented to being placed on this machine. There was disagreement as to whether Ms B's decision was competent. Ms B believed she would be better dead rather than continue to live on the ventilator. This belief concerned what Ms B cared about and was not a belief concerning the facts of her condition. It follows according to legal judgments and the General Medical Council's guidelines that the rationality of this belief would be irrelevant when assessing her competence to give informed consent. Further, according to legal judgments and the above guidelines, if Ms B had a preference to die rather than to continue living on the ventilator then she would be instrumentally rational in wanting the ventilator switched off because this action would deliver the "good" she desired. It can be concluded that provided Ms B understood the information relevant to her decision to be removed from the ventilator, then her decision should have been regarded competent according to legal judgements and the General Medical Council's

guidelines. However Ms B might not have been regarded as competent using the Department of Health's guidelines because these place greater emphasis on epistemic rationality. The Department's guidelines might agree that Ms B was instrumentally rational if she wanted the ventilator switched off when the "good" Ms B sought was to die. However, using these guidelines it might be argued that Ms B's belief that she would rather die than continue on the ventilator was irrational as it was in defiance of generally accepted moral standards. It follows that even though Ms B was instrumentally rational, and had no false beliefs concerning her condition, that she might still have been regarded as incompetent using the Department of Health's guidelines. In practice it might be argued that a patient's belief that she would be better dead rather than continuing to live on a ventilator would not be assessed for rationality and that the differences concerning the scope of epistemic rationality outlined above are of purely theoretical interest.

However such an argument would be unsound. These differences concerning the scope of epistemic rationality will be shown to be of practical importance by considering anorexic patients. An anorexic patient can be judged to be incompetent due to irrationality for two main reasons. Draper (2000) sets out these reasons as follows:

There are two justifications for associating irrationality with incompetence in the case of anorexia. One is the desire to not to eat undermines an even stronger desire not to die. Another is that the desire not to eat may be an involuntary one, grounded in some deeply held, but false, belief about their body image – usually that they are fat. (Draper, 2000, page 129)

Firstly, an anorexic patient may have no clear conception of her own “good” because of her conflicting desires. It follows if she has no clear conception of her own “good” she will be unable to use instrumental rationality and hence is incompetent. Secondly, an anorexic patient may also be regarded as incompetent because she has an untrue belief concerning her condition. However, a sufferer from anorexia might be able to fully understand her condition. Further, she might prefer to die and see death as a “good” rather than continue to live the way she does now. It follows that such a patient would be capable of using instrumental rationality and she would have no false beliefs concerning her condition. It further follows that such a patient might be regarded as competent according to legal judgements and the General Medical Council’s guidelines. Draper supports this position and argues that

It was noted earlier that many sufferers are not broadly incompetent. Granted that broad competence is intact we should be open to the possibility that the sufferers are actually as competent as anyone else to make decisions about the quality of their lives, and to assess the relative value of these lives in the light of this quality. For this reason, it is proposed that it may be wrong as well as unlawful, to force patients to comply with therapy just because they are anorexic. (Draper, 2000, page 133).

It should be noted in this context that when Draper uses the term unlawful she is referring to the current law in the United Kingdom and is not just making a moral point. It might be argued that in practice an anorexic cannot unambiguously hold the belief that death is a “good” and so should not be considered competent (Giordao, 2003). The Department of Health’s guidelines would seem to hold that an anorexic’s goals and values are in defiance of

generally accepted moral standards and hence are irrational. It follows that even the possibility that a limited number of anorexic patients might be regarded as competent could not occur under the Department of Health's guidelines. The example of anorexic patients clearly shows that the differences outlined above concerning the rationality of a patient's goals and values are not purely theoretical but matter in practice.

There is one further important legal judgment that must be considered in any examination of informed consent. Lord Donaldson stated in the case of T that

What matters at the time was whether at the time the patient's capacity was reduced below the level needed in a case of that importance, for refusals can vary in importance, some may involve a risk to life or irreparable damage to health, others may not [T, 1992]

This judgment has two important consequences. Firstly, risk must be considered **directly** in any assessment of a patient's competence. It follows that a patient will need greater capacities to be considered competent when giving informed consent to some treatment carrying a high risk as opposed to giving informed consent to some treatment carrying a lesser risk. It also follows that this increase in the capacities a patient needs in order to be considered competent occurs irrespective of whether these increased capacities are needed by the patient to understand the risk in question. Secondly, refusals of consent seem to require that a patient has greater capacities to be considered competent than when she consents. The General Medical Council's guidelines consider risk to be important. However, these guidelines do not consider risk to be important in the way required by Donaldson. These guidelines only hold it is

important for a patient to understand the risks she faces (The General Medical Council, 1999, section 4). However, if a patient has the capacities to understand the risks she faces, then risk plays no further part in the assessment of her competence. It follows that considerations of risk only **indirectly** affect the capacities a patient needs to be considered competent. Legal judgements also require that a competent patient understands the risks associated with any proposed treatment [C, 1992]. However, according to Donaldson's judgement in T, it is not sufficient that a patient merely understands the risks involved in order to be considered competent. Donaldson's judgement means risk is somehow connected **directly** to the standard of competence and this standard increases automatically as risk increases.

In order to make these issues clear, two examples will be used to show how the General Medical Council's guidelines and legal judgements treat risk differently. The first example concerns a patient who needs an emergency appendectomy and the second a patient who needs a hip replacement. The General Medical Council's guidelines require that a competent patient has the capacity to understand the information provided. This understanding includes both the risks involved in the procedure and in leaving the condition untreated. Let it be assumed that the capacities required by a competent patient to understand the details of each of these procedures are roughly equivalent. It follows, using the above guidelines, that a patient needs roughly the same degree of capacity to give competent consent for each of these procedures. However, this would not be the position according to Donaldson's judgement. Using this judgement a patient giving competent consent to a hip replacement would need the capacity to understand details of the procedure and the risks involved. However, if a patient refused to consent to an emergency appendectomy then she would need additional capacities, above those needed to understand details of the procedure and the risks involved, in order to be

considered competent. Further the patient requires these additional capacities in order to be considered competent irrespective of whether these additional capacities are needed to understand the risk involved. This follows because Donaldson's judgment means the capacities a patient needs in order to be considered competent increase **directly** with risk. It can be concluded that legal judgments and the above guidelines sometimes differ over the capacities a patient needs to be considered competent when making dangerous decisions.

The fact that some treatment carries a great risk does not of necessity mean that the patient needs any additional capacities to understand this risk as shown by the example above and as pointed out by Buller (2001, page 100) and Wicclair (1991, page 96). This raises the following question. Is it always possible to justify requiring a patient to have additional capacities when making dangerous decisions in order to be considered competent, irrespective of whether these additional capacities are needed by her to understand the risk involved? Clearly if a patient's decision seems likely to lead to harm then these additional capacities can be justified by beneficence. However, informed consent is based on respect for patient autonomy. It has been argued above that Donaldson's judgment means the capacities a patient needs to be considered competent in a risky situation are directly tied to risk in some way. It will be argued in chapter 4 that this means giving precedence to acting beneficently over respecting autonomy. This will lead to the major conclusion of this thesis. It will be concluded that requiring patients to have additional capacities when making dangerous decisions in order to be considered competent, when these capacities are not needed to understand the decision, is incompatible with respect for autonomy.

The second consequence of Donaldson's judgement means that a patient's refusal of consent is of greater importance when assessing her competence than her consent. It follows

that this judgement requires that the capacities a patient needs to be considered competent are not tied directly to the capacities she needs to her decision but are tied directly to the risk attached to the outcome her decision. It follows therefore that a patient's competence may be assessed asymmetrically. This means that a patient may be considered competent to consent but incompetent if she refuses to consent. Chapter 4 will argue that the idea of asymmetric competence assessment is conceptually coherent. However it will also argue that the concept of asymmetric competence depends on giving precedence to acting beneficently over respecting autonomy. For the above reason it will be conclude that the concept of asymmetric competence assessment is incompatible with respect for autonomy.

It can be concluded that in general, legal judgements concur with the guidelines of the Department of Health and the General Medical Council. However, there are two differences. Firstly, legal judgements additionally require that a competent patient must believe the information provided. Secondly legal judgements treat the way risk affects the assessment of a patient's competence differently. The above guidelines only make it clear that a competent patient must have the capacity to understand the risks involved in her treatment. It follows that the capacities a patient needs to be considered competent only vary indirectly with the risk involved with her decision. Legal judgements mean the capacities a patient needs to be considered competent vary directly with the risk involved with the outcome of her decision.

1.3. Informed consent and bioethics

Most bio-ethicists adopt a similar approach to the assessment of patient competence to those outlined above. Bio-ethicists usually agree that adults should normally be presumed to be

competent, see Buchanan and Brock (1989, page 21). Buchanan and Brock outline the capacities they believe are needed for a patient to be considered competent.

Two may be distinguished, the capacity for understanding and communication, and the capacity for reasoning and deliberation. Although these capacities are not entirely distinct, significant deficiencies in any of them can result in diminished decision-making competence. A third important element of competence is that the individual must have a set of values or conception of the good (Buchanan & Brock, 1989, page 25).

Wicclair (1991) agrees.

According to the standard analysis decision making capacity requires; (1) a capacity to understand and communicate, (2) a capacity to reason and deliberate, and (3) possession of a set of values and goals. (Wicclair, 1991, page 91)

Among bio-ethicists there is general agreement that in order to be considered competent a patient must be able to understand the information provided, be able to communicate, be able to reason and have a set of goals and values. However, there is no detailed agreement in two important areas. It was shown above that while legal judgements require the risk a patient faces to be linked directly to the standards she must meet in order to be considered competent, the official guidelines suggest the standards a competent patient must meet should only be indirectly connected to the risk she faces. There is a vigorous debate in bioethics as to whether

the risk a patient faces should be directly or indirectly involved in setting the standard she needs to meet in order to be considered competent. Buchanan and Brock (1989), (Drane, 1985) and Wilks (1997, 1999) argue that risk should be directly connected to the standard of competence employed. Whilst Buller (2001), Cale (1999), Demarco (2002) and Wicclair, (1991) argue that risk should only be indirectly connected to the standard of competence employed.

This disagreement concerning risk and the standards employed to assess patient competence extends into the debate about how much and what sort of rationality a competent patient requires. Wilks (1999) believes safety is a normative value and if a patient is to be considered competent she must be capable of recognising this value. If this position is accepted, then this has implications for the rationality required by a competent patient. A competent patient cannot simply be someone who is capable of practical rationality with no false beliefs about her condition. Others such as Wicclair (1991) believe the rationality needed by a competent patient should simply be as defined above. Both of these disagreements represent disagreements that seem to be part of the wider practice of informed consent.

This chapter's survey of different definitions of informed consent in practice makes it clear there is general agreement that a competent patient must be able to understand the information relevant to her condition, to communicate her decision and that she must have a set of goals and values. These specific details of these conditions will be examined in chapter 5. In practice this definition of patient competency reaches incomplete agreement in two areas. Firstly, it is generally agreed that risk can affect the capacities a patient needs to be considered competent but there is disagreement as to whether risk should affect these capacities directly or indirectly. Secondly, it is generally agreed that a patient must be capable of reasoning but

there is a disagreement about the scope of this rationality. How far should rationality extend to a patient's beliefs and values? It might be argued that the case of Ms B [2002] arose because of this disagreement. It might appear that with a little effort these disagreements could be resolved and a more complete definition of informed consent arrived at.

In practice it is difficult to see how these disagreements could be resolved without resorting to an arbitrary definition. One way to avoid this difficulty might be to resolve these disagreements simply by considering these disagreements in the light of the health interests of patients. However accepting this proposal would mean informed consent becomes merely a means to ensure a patient's co-operation with beneficent care. It should be noted that in the past this was indeed the purpose of consent, see Jackson (2001, page 10). Let it be accepted that informed consent is based on respect for autonomy. It follows that these disagreements can only be resolved, and a more complete definition of informed consent given, by examining both the concept of autonomy and the connection between informed consent and autonomy. This examination will take place in the following two chapters.

Chapter 2

Autonomy 1

The concept of autonomy must be examined for two reasons. The first is simply because informed consent is based on respect for autonomy. The second comes from the disagreements concerning the way informed consent is practised which I argued might be resolved by examining the concept of autonomy and the connection between informed consent and respect for autonomy. Unfortunately, as remarked in the introduction, there are various philosophical concepts of autonomy (see, e.g. Cuypers 2000, page 226 and Meyers 2004, page 106) which must be examined. This examination will involve three steps. Firstly, a concept of autonomy will be outlined. Secondly, the domain in which this concept of autonomy is applicable will be examined and thirdly the compatibility of this concept with our intuitive ideas of autonomy will be considered.

The justification for the first step in the above examination of autonomy is self-explanatory. The second and third steps in this examination may be justified as follows. The concept of autonomy originated in the idea that certain city-states in classical Greece were self-governing and the concept of personal autonomy is an extension of the concept of self-governing states according to Beauchamp and Childress (1989, page 68). This thesis will examine the extension of the domain of autonomy from the political, to the moral, to personal government and in doing so attempt to resolve some of the conflicts between various concepts of autonomy in relation to informed consent. It will be argued that some concepts of autonomy cannot be extended to cover the sort of decisions involved in informed consent. This is because the domain in which some concepts are meaningful is limited and should not be extended too far. In this thesis I will argue that any concept of autonomy underlying informed

consent must account to some degree for our intuitive ideas of what it means to be self-governing. Wittgenstein (1953, proposition 43) asserted that the meaning of a word is given by its use in language. If a patient believes the idea of autonomy being respected when he gives informed consent bears little resemblance to his intuitive ideas of self-government, then he may question whether his autonomy is indeed being respected. Chapter 3 will examine different concepts of autonomy in conjunction with our intuitive ideas. This chapter will clarify our intuitive ideas of autonomy and examine what it means to respect autonomy.

2.1. Intuitive ideas of autonomy

This section will set out the three conditions which seem to be necessary for our intuitive ideas of autonomy. In this section intuitive ideas of autonomy and self-government will be held to be equivalent. It will be argued that intuitively self-government means an agent has the freedom necessary to make choices, he identifies with his choice and any choice he makes must have some persistence.

Intuitively, autonomy can refer to either autonomous persons or to autonomous decisions. The first intuitive condition can refer to either an autonomous person or an autonomous decision. The second and third intuitive conditions refer only to an agent's autonomous decisions. Autonomous decisions are important for two reasons. Firstly, the idea of autonomous persons seems to be partly parasitic on the idea of autonomous decisions (see Christman, 1991, page 3). Secondly, the concept of informed consent is concerned with a patient's decisions. This does not of necessity mean informed consent is based on respect for autonomous decisions. However, it seems probable it will be easier to connect informed consent decisions to autonomous decisions rather than autonomous persons.

Intuitively, if someone is unable to make decisions about his future due to a lack of ability then he is incapable of self-government. Further, it seems intuitively that even if someone is able to make decisions about his future but is incapable of implementing his decisions, then he is incapable of self-government. It follows that an intuitively self-governing agent must of necessity have both the ability to make decisions and the ability to act on them. Waller (2001) argues that genuine autonomy is simply the ability of an agent to choose among various options and act on his choice.

Genuine autonomy requires options available within our actual environment, options chosen on the basis of our conditional preferences and changing circumstances; not mysterious alternatives that transcend all causal and environmental influences. This natural biological view of autonomy with its mundane alternatives, has special value in the medical environment. (Waller, 2001, page 585).

Let it be accepted that Waller is right and intuitively autonomy requires that autonomous agents have options. Implicitly it follows that autonomous agents must be able to make decisions about these options and have the ability to act on them. Waller gives a naturalistic account of autonomy. This naturalistic account requires that an autonomous agent has choices available to him and that he can choose and act on his choices. Furthermore he seems to believe this naturalistic account defines genuine autonomy.

Intuitively, it seems Waller is correct to believe that an autonomous agent must have choices available to him and must be able to choose and act on his choices. However, it seems he is wrong to believe this naturalistic account is sufficient to account for even our intuitive ideas of autonomy. If autonomy is simply the ability to choose among various options and act

without any further conditions then even wild animals might be regarded as autonomous. Intuitively, wild animals are free but this does not mean they are intuitively autonomous. Waller appears to be committed to this position because he believes autonomy is a product of biological evolution (Waller, 2001, page 585). Let it be accepted that intuitively autonomy is equivalent to self-government. Let it be accepted that wild animals make choices. However such choices do not seem to be acts of self-government and hence are not intuitively autonomous. It must be pointed out in fairness to Waller that his position appears to be ambiguous because in a later paper he argues that dumping responsibility onto a patient who cannot act *purposely* is not an example of respecting autonomy (2002, page 259). This might be because there are other intuitive ideas connected to self-government.

Intuitively if someone fails to identify with his decision then his decision is non-autonomous. This follows because if someone fails to identify with his decisions it appears the self has gone out of his self-government. Let it be assumed that someone makes a decision on a mere whim without reflection. Let it be further assumed that this is a freely made decision. However such an unreflective decision does not seem to be an act of self-government. In making such an unreflective decision the self seems detached from the decision. Intuitively, self-government is not simply the agent deciding, but deciding what is best for him. It follows that if someone decides what is best for him then he is deciding with reference to what he cares about. It is argued by Frankfurt (1988, page 83, originally 1982) if someone cares about something, then he must identify with what he cares about. If Frankfurt is right then intuitively self-government is about decisions an agent thinks are good for him, decisions he cares about, and these must be decisions he identifies with.

It is important not to confuse intuitions concerning autonomy that apply to persons with intuitions concerning autonomy that apply to decisions. Let it be accepted that self-government intuitively means the agent's decisions are freely made decisions, decisions in which the decision-maker has meaningful choices and the power to implement his decisions. It would appear to follow that children and the mentally ill might be intuitively autonomous. Buller (2001, page 101) argues that someone suffering from mild dementia might be intuitively self-governing to a degree that enables him to choose how to spend his day even if intuitively he would be incapable of self-government regarding his medical treatment. It seems clear that children and the mentally ill can make some autonomous decisions. Legal judgments seem to support this position. C was a schizophrenic confined to a mental institution. However, Justice Thorpe ruled that because C understood his situation he was competent to give consent [C, 1994]. The case of children is illustrated by *Gillick v West Norfolk and Wisbech Area Health Authority* [1986]. However, it seems intuitively apparent that children and the mentally ill are not always autonomous. The reason for this becomes apparent if we focus on autonomous decisions rather than autonomous persons. Intuitively a decision is only autonomous if an agent identifies with his decision. Children and the mentally can identify themselves with some decisions but they cannot identify themselves with these other decisions if they cannot understand the background and consequences of these decisions. This follows because when they cannot understand the consequences of their decision it is impossible for them to fully relate any decisions they make to what they care about. It can be concluded that intuitively an autonomous decision is a decision an agent must identify himself with.

The importance of agents identifying with their choices can be illustrated in practice. Consider a survey of women's attitude to consenting to screening for BRAC 1 and 2 gene

mutations which predispose them to breast and ovarian cancers (Hallowell, Foster, Arden-Jones, Murray and Watson, 2003). All the women involved in this survey had or were suspected to have cancer. It follows that the screening made no clinical difference to them. However this screening might alert their relatives to the need to be screened themselves and perhaps to take preventative action. The participants had the choice to consent to the screening and could also choose whether or not to pass the results of the screening on to their female relatives. The authors of the survey found the women felt they had no choice.

Thus, as far as most women concerned, they did not make an explicit decision whether they went to mutation screening, because, in a fundamental sense they felt that they had no real choice – in practice their actions are constrained by their need to care for other family members. (Hallowell, Foster, Arden-Jones, Murray and Watson. 2003, page 81)

These women's choice was constrained and it appears they had only one meaningful option. Clearly these women made an intuitively autonomous decision. This example raises the question of how autonomous agents may make intuitively autonomous decisions which may be in some way constrained.

Constraints may be imposed internally or externally. Let it be accepted that someone cannot be intuitively regarded as autonomous if his decisions are externally constrained. In the survey used above the women felt their actions were constrained by a need to care for other family members. Their feeling that they must care for others was an internal constraint. Intuitively these women's decisions were autonomous. It follows the internally constrained decisions of some agents are also intuitively autonomous. Clearly not all decisions that are

internally constrained are intuitively autonomous; consider for instance an unwilling drug addict. The question that must now be asked is this. Why are some internal constraints compatible with our intuitive ideas of autonomy whilst others are not? The women consenting to gene mutation screening clearly identified with their internally constrained choice. The unwilling drug addict does not identify with his internally constrained choice to take drugs. Intuitively, if someone's decision is subject to internal constraints and he identifies himself with these internal constraints then these particular constraints do not give reason to believe his decision is non-autonomous.

It been argued above an agent's identification with a decision is a necessary condition for that decision to be regarded as intuitively autonomous. The example used above demonstrates that in practice an agent's ability to identify with his decisions sometimes might be more important to him than the range of options open to him. Indeed, sometimes identification means an agent's decision is constrained from his viewpoint. The case of the women consenting to screening for gene mutations clearly illustrates this. However, from the viewpoint of a third party these women had the option of not consenting. This leads to the following conclusion. Intuitively an autonomous decision must be one in which the agent has options. However, internal constraints, with which the agent identifies might mean these options are reduced to a single option from the agent's viewpoint.

It has been argued that an agent's identification with a decision is a necessary condition for this decision to be regarded as intuitively autonomous. Unfortunately it is by no means clear what it means for an agent to identify with his decision. Identification might simply be thought to mean an agent has some desire and acts rationally to achieve his desire. Clearly this would be an insufficient condition for identification because the desire might be one the agent

wishes he did not have. The example of a drug addict used above clearly illustrates this. The addict might act quite rationally to obtain money to serve his desire to buy drugs, however this is not an autonomous act. It follows that even if an agent acts rationally to serve his desires this does not mean he identifies himself with these desires. The above position might be modified. Identification meant an agent had some desire and acts to achieve his desire. In addition the agent must also approve of this desire. This idea was developed by Dworkin, (1988, page 15) but later rejected by him. If such a definition were accepted then there are theoretical problems connected to regress or circularity which appear to be an intrinsic part of such a definition. The problem of how an agent identifies with his decisions is important. This problem will be examined in greater detail in chapters 3 and 5. However, even if there are theoretical problems associated with an agent identifying with his decisions, it still seems an agent's identification with his decisions is part of what it means to be intuitively autonomous.

It has been argued above that an intuitively autonomous decision only makes sense when the agent identifies with this decision. It was then pointed out that exactly what is meant by an agent's identification with his decision is not clear. However, it was suggested that an agent's identification with his decision must depend on what the agent cares about and cannot be based merely on impulse or inclination. If this was not so, wild animals might be thought to be autonomous. Let it be accepted that an intuitively autonomous decision must be a decision the agent cares about. It will now be argued that if someone cares about something then what he cares about must have persistence over time. Frankfurt (1988 originally 1982) argues the notion of "caring about" something requires persistence.

Desires and beliefs have no inherent persistence; nothing in the nature of wanting or of believing, requires that a desire or a belief must endure. But the notion of guidance, and hence

the notion of caring, implies a certain consistency or steadiness of behaviour, and this presupposes some degree of persistence. (quoted in Frankfurt, 1988, page 84 originally 1982)

Frankfurt's concept of "caring about" something will be discussed in detail in section 3.5. If someone fails to persist with a decision and continually changes his mind when his circumstances remain constant, then intuitively he either does not care about or is unable to care about his decision. It follows that the persistence of a decision seems to be intuitively a necessary condition for that decision to be regarded as autonomous. Indeed, without even introducing ideas of "caring about", intuitively such a decision does not seem to be an act of self-government. Governance of any sort requires some persistence of purpose.

The case of MB [1997] can be used to illustrate the importance of the persistence of a decision if that decision is to be regarded as an act of self-government. MB was twenty-three years old and was thirty-three weeks pregnant. She visited her local health clinic twice and on each occasion was asked for a sample of blood. On both occasions she refused consent saying she was frightened of needles. At a later visit to the health clinic it was suspected that her baby was in a breech position and this was later confirmed by ultrasound. Breech position carries the risk of prolapse. If prolapse occurs there is a risk that the baby's umbilical cord might get entangled in the membranes after they have ruptured causing the baby's blood supply to be obstructed during birth. This obstruction might cause death or brain damage to the baby due to lack of oxygen. The above was explained to MB and she was admitted to hospital where she consented to a caesarean section but she again refused to consent to a venepuncture to provide blood samples. However, when she was taken to operating theatre and the anaesthetist wished to insert a veneflon, MB refused consent and was returned to the ward. Later, when her GP visited her, she again consented to the caesarean section. However she again refused consent

when taken to operating theatre. The Hospital trust applied to the courts and MB was found to be of unsound mind due to her ambivalence caused by her needle phobia and hence was considered incompetent to give consent.

The purpose of using this case is not to consider this particular legal judgement but to illustrate the need for persistence in decision-making if someone's decision is to be considered intuitively self-governing. MB kept changing her mind and as result her decisions had no persistence. It has been argued we would not intuitively regard someone's decision as part of his self-government if he did not care about or was unable to care about his decision. It was further argued that someone does not care about or was unable to care about with his decision unless he persists with the decision. It is of course quite compatible with our intuitive ideas of self-government for someone to change his mind when the circumstances change. However MB kept changing her decision whilst her situation remained unaltered. If the above is accepted then she could not identify with her decisions and so was intuitively not self-governing. It might be suggested that the ideas of an agent identifying with his decision and persisting with that decision are connected. This thesis will examine this connection in chapter 5. However, at an intuitive level the concepts seem distinct and will be treated as such in the examination of more philosophical concepts of autonomy which occurs in chapter 3.

To summarise it seems someone is intuitively self-governing, autonomous only if he fulfils all of the following conditions.

- 1) The agent has the capacity to choose and there are no external constraints affecting his choice.
- 2) The agent identifies with his decisions.
- 3) A self-governing decision must have a degree of persistence unless the circumstances in which the decision was made change.

2.2 Respect for autonomy

It is generally agreed that the concept of informed consent is based on respect for autonomy (see the General medical Council's guidelines to doctors, 2001, introduction 1). It follows that prior to examining, in detail the manner in which informed consent is based on respect for autonomy, what it means to respect autonomy should be examined. This examination is complicated by two factors. Firstly there are some concepts of autonomy that refer to autonomous persons (see Dworkin, 1988, page 15), and some concepts that refer to autonomous decisions (see Christman, 1991, page 3). It seems clear that the ways in which an autonomous person and an autonomous decision are respected might differ. Secondly, autonomous decisions possess both instrumental and intrinsic value (see Dworkin, 1988, pages 111). The way in which these different values are respected might also differ. In this section I will firstly examine what it means to respect an autonomous person and secondly what it means to respect an autonomous decision.

However, prior to carrying out this examination of respect for autonomy the idea of respect must be clarified. This idea entails there is something which is respected and there is a respecifier who does this respecting. It will be assumed in this thesis a respecifier is always a human being. Respect entails if a respecifier respects something then his behaviour is in some way constrained with regard to what he respects. All sorts of things may be respected such as the countryside or a person. Clearly respecting the countryside places different constraints on someone to those placed on him when he respects a person. This thesis is only concerned with respecting persons. Not all persons are respected in the same way. For instance someone's behaviour towards the Prime Minister may be constrained by a feeling of awe. Someone's

behaviour towards a gangster may be constrained by a feeling of fear. This thesis is not concerned with respecting a particular person. It is only concerned with respecting persons in general irrespective of their particular character or station in life. In particular it is concerned with what constraints are placed on us when we respect an autonomous person.

An autonomous person is someone who is self governing. The concept of an autonomous person will be dealt with in greater detail in sections 3.3 and 3.5. It has been argued above that intuitively an autonomous person must be free, within the law, from external constraints. He must identify with his decisions and these decisions must have persistence. The question now that must now be answered is this. What constraints are placed on someone when he respects an autonomous person? In order to facilitate answering this question, two subsidiary questions must be answered. Firstly, why do we respect autonomous persons in general? It seems clear we do not respect autonomous persons because we are in awe of them as might be possible in the case of the Prime Minister or fear someone as might happen in the case of a gangster. In this section I will argue that we respect autonomous persons because we believe the exercise of autonomy has value. However, it seems clear that we should also respect non-autonomous persons such as children and the mentally incapacitated because we believe they have intrinsic value. This leads to the second question. How does respecting autonomous persons differ from respecting persons in general? In order to answer this second question I will examine the constraints imposed on someone when he respects autonomous and non-autonomous persons. I will conclude that the *intrinsic value* of autonomy imposes an additional *type* of constraint on someone when he respects an autonomous person as opposed to respecting a non-autonomous person.

Respect for persons is usually considered with reference to Kant's ideas. Kant's practical imperative requires we should always treat a person as an end in himself (Kant, 1948, page 91, originally 1785). Let it be accepted that to respect any person, autonomous or non-autonomous, means we must at least treat him as an end in himself. Accepting this leads to a further question. What constraints are imposed on our behaviour by treating someone as an end in himself? Buss (1999, page 536) argues treating someone as an end in himself means we must take that person's ends into account. However, before we can answer how we take someone's ends into account, a further question must be answered. What is meant by a person's ends? In the context of medicine a limited definition of someone's ends must include their health needs, goals and values. If this limited but diverse definition of someone's ends is accepted then we can try to answer the question of what is entailed by taking these ends into account? Let it be accepted that someone's ends include his health needs and we have a duty to take these ends into account. Accepting the above does not mean our behaviour is constrained by a duty to provide for all his health needs. This clearly follows because our resources are finite. However, if treating someone as an end in himself means we must take that person's ends into account and that we cannot ignore these ends by simply acting beneficently with regard to what we perceive to be his interests, it follows that to take someone's ends into account means we are constrained to act beneficently with regard to these ends. This means promoting these ends provided we are able. O'Neill expresses this position as follows.

However the Kantian conception of beneficence is from the start antipaternalistic. The duty to seek others' happiness is always a duty to promote and share others' ends without taking them

over, rather than a duty to provide determinate goods and services to meet others' needs, or to see that their ends are achieved. Beneficence of this sort presupposes others who are at least partly agents and have their own ends. (O'Neill, 1989, page 116)

It is important to be clear about what is meant by beneficence. O'Neill is referring to acting beneficently with regard to the ends of others, as perceived by these others. Acting beneficently in this sense means promoting the ends of others. However it is possible to act beneficently with regard to other's interests. Acting beneficently with regard to the ends of others, as perceived by these others, might be incompatible with acting beneficently with regard to other's interests. This can be clearly seen by considering children. Moreover there is nothing intrinsic to the nature of either acting beneficently to the ends of others or with regard to other's interests which would give priority to acting beneficently in one of these ways. In spite of this difficulty it can be concluded that to respect a person means we should promote his ends provided this is possible.

The above definition is a definition of what it means to respect persons. This definition applies to all persons, including children and the mentally incapacitated, and not just to autonomous persons. It follows that we are constrained to promote the ends of children and the mentally incapacitated in our dealings with them. It does not automatically follow of course that we have a duty to meet these ends as pointed out above. The question now arises what additional constraints does respecting an autonomous person place on the respecer as opposed to when he respects a non-autonomous person? Let it be assumed that respecting autonomous and non-autonomous persons places the same type of constraint on the respecer. He must consider and promote if possible the ends of both kinds of person. However, whilst the type of constraint may remain the same for both kinds of person, it may be harder for the respecer to

satisfy this constraint in the case of an autonomous person. It might be argued that this position is analogous to medical practice. A doctor is constrained to promote the health of all his patients. However differences in the degree of a patients' condition might make it harder to satisfy this constraint in some cases.

It might be argued that the above assumption, that respecting autonomous and non-autonomous persons imposes the same type of constraint on a respector, is unsound. Dworkin (1988, page 20) regards autonomy as the capacity of persons to reflect critically upon their first-order desires. It might then be argued that the possession of this capacity for autonomy places an additional type of constraint on someone respecting autonomous persons as opposed to someone simply respecting persons. Let it be accepted that respecting this capacity of autonomous persons does impose an additional constraint on someone respecting autonomous persons. A patient's recently diagnosed angina may place an additional constraint on a doctor. However, even if this is so it does not automatically follow that this is an additional type of constraint. The doctor is still only constrained to promote the health of his patient. It might then be argued, by analogy, that even if it is accepted that autonomous persons possess additional capacities compared to non-autonomous persons, this does not of itself mean an extra type of constraint is imposed on someone respecting autonomous persons. Respecting this extra capacity might still be simply regarded as requiring the promotion of the autonomous person's extended ends. It would appear to follow the promotion of this capacity does not impose an additional type of constraint on someone respecting an autonomous person. It might be argued that respecting autonomous and non-autonomous persons places the same type of constraint on the respector. It might of course be harder for someone to promote the ends of an autonomous person in practice. When considering autonomy, Buller (2001,

page 101), Beauchamp and Childress (1989, page 69) and the judgement in *Gillick v West Norfolk and Wisbech Area Health Authority*, [1986] believe self-government can be graduated. If the above assumption were accepted then this would provide an explanation of how it is possible to respect graduated autonomy.

In this thesis I will accept that to respect autonomous persons means accepting the same type of constraints needed to respect persons. However, I will also conclude that the assumption, that respecting autonomous and non-autonomous persons only places the same type of constraint on the respecer, is unsound. Rejecting this assumption means accepting that respecting an autonomous person places an additional type of constraint on a respecer to those imposed when he respects a non-autonomous person. I will present two arguments to justify my conclusion. Firstly, I will argue that if respecting autonomous and non-autonomous persons imposes the same type of constraints on respecers then this would mean specifically respecting autonomous persons has only a limited usefulness. Secondly, I will argue that if respect for autonomous and non-autonomous persons imposes the same type of constraints on respecers, then the intrinsic value of autonomy is ignored.

Let it be assumed that respect for both autonomous and non-autonomous persons imposes the same type of constraints on the respecer. I will now examine the usefulness of the idea of respecting autonomous persons in the specific context of informed consent. I will then apply the result of this examination to respecting autonomous persons in other contexts. Let it be accepted that informed consent is based on respect for autonomy. This places various constraints on health professionals in that they must seek to promote a patient's ends if possible. The details of these constraints need not be fully developed here for the following argument to be valid. Among these constraints must be some requiring that health

professionals do not deceive or coerce patients. In addition, health professionals must be constrained to supply a patient with sufficient information to enable him to understand his situation when this is possible. These constraints apply equally to respecting autonomous and non-autonomous persons because it has been assumed respect for both autonomous and non-autonomous persons imposes the same type of constraints on the respecer. These constraints also form an important part of the practice of informed consent. However, the idea of assessing a patient's competence is also part of the practice of informed consent (see Buchanan and Brock, 1989, page 28). Respecting the above constraints alone is unconnected to the idea of assessing a patient's competence. It can be concluded that if respect for a patient only requires promoting his ends, then the requirement to respect a patient seems unconnected to any assessment of his competence

Let it be accepted that informed consent is based on respect for patient autonomy. Let it be further assumed that respect for patient autonomy means a decision made by an autonomous patient must be accepted. It follows that an autonomous patient should not be treated against his will. However, it has been assumed that respecting autonomous and non-autonomous persons places the same type of constraint on the respecer. It has also been previously assumed that all persons should be respected irrespective of whether they are autonomous or non-autonomous. Using these assumptions leads to my second conclusion. If it is accepted that an autonomous person should not be treated against his will then a non-autonomous person also should not be treated against his will. This further conclusion seems to concur with Law (2003, page 54) who doubts the fact, that a patient is not autonomous can be used to justify treating him against his will. Accepting the above conclusion leads to my third conclusion. If informed consent is based solely on respect for autonomy and neither

autonomous nor non-autonomous patients should be treated against their will, then informed consent should not be concerned with the assessment of a patient's competence. It is still of course true that informed consent is necessary to enable patients to make competent decisions. If my arguments are accepted then in practice in difficult decisions, like that faced by Ms B [2002], the patient's decision should simply be accepted. My arguments appear to show a patient's autonomy has very little connection, if any, to the idea of informed consent. Accepting the above leads to two further conclusions. If an autonomous or non-autonomous patient is capable of understanding his situation and he is fully informed about his situation then his decision should always be accepted. It might then be further concluded that informed consent might be better based on respect for persons rather than respect for autonomy.

The above conclusions mean it is difficult to justify basing the practice of informed consent on respect for patient autonomy. It might be thought this difficulty could be resolved if informed consent was based on respect for autonomy but not solely on respect for autonomy. It might be argued this is the current position as far as informed consent is concerned (see O'Neill 2002, page 26). If the above proposal was accepted, then informed consent might be concerned with enabling a patient to make a competent decision in order to respect his autonomy. In addition, informed consent would be concerned with assessing a patient's competence for some other reason. In section 3.1 and chapter 4 I will argue that informed consent is designed to respect patient autonomy whilst at the same time ensuring beneficent care is given to non-autonomous patients. However, even if the above proposal is accepted, it gives no reason as to why informed consent should be partially based on respect for autonomy as opposed to being partially based on respect for persons. I have argued in the context of informed consent that, if it is accepted that respecting autonomous and non-

autonomous persons places the same type of constraints on the respecer, then there is no difference except perhaps in degree between respecting autonomous and non-autonomous persons. It follows in the context of informed consent that respect for an autonomous person appears to be an unnecessary additional concept. Furthermore if, in all contexts, there is no difference in the type of constraints imposed when respecting autonomous and non-autonomous persons, that respect for autonomous persons is an unnecessary concept in all contexts.

I will now argue the above conclusions are unsound. I believe the above arguments are valid. However, I believe the premise on which all of these arguments depend is false. This premise holds that respect for both autonomous and non-autonomous persons imposes the same type of constraints on someone. This premise is compatible with accepting that respect for an autonomous person may impose these constraints to a greater degree than in the case of a non-autonomous person. I will now argue that the intrinsic value of autonomy imposes an additional type of constraint on someone when he respects an autonomous person as opposed to when he respects a non-autonomous person. However, I will still argue in chapter 5 that decisions such as that made by *Ms B* [2002] should simply be accepted in certain contexts. It is widely accepted there are different concepts of autonomy (see Beauchamp and Childress, 1989, page 68). Two of the reasons underlying the existence of these different concepts are as follows. Firstly, the concept autonomy is applied in different domains. I believe the domain in which the concept of autonomy is applied has ramifications for the concept itself. I will deal with some of these ramifications in the next chapter. The second reason for the different concepts of autonomy is that the value of autonomy has two distinct sources.

Dworkin (1988,page 112) argues autonomy has both instrumental value and intrinsic value.

But there is a value connected with being self-determining that is not a matter of either of bringing about good results or the pleasure of the process itself. This is the intrinsic desirability of exercising the capacity for self-determination. We desire to be recognized as the kind of creature capable of determining our own destiny. (1988, page 112)

Frankfurt (1999, page 163) believes that the basis of autonomy is caring about something. He regards caring about something as having intrinsic value due to its essential role in making us the distinctive kind of creatures we are. It seems that any complete account of respect for autonomy must consider respect for both of these two sources of the value of autonomy. In what follows I will argue that the constraints, imposed on someone respecting the intrinsic value of autonomy, are of a different type to the constraints involved with respecting persons. This will lead me to conclude that it is simply not enough just to promote a patient's ends in order to respect his autonomy.

I have shown above that both Dworkin and Frankfurt believe autonomy gains its intrinsic value because it makes us the distinctive kind of people we are. Dworkin (1988, page 112) also believes the intrinsic value of autonomy is connected to us exercising our capacity for self-determination when determining our own destiny. This involves us in making decisions. I have shown above Frankfurt believes autonomy is concerned with us caring about something. Frankfurt (1988, page 83 originally 1982) further believes caring about something consists in guiding oneself along a distinctive path. This also involves us in making decisions. It follows that according to Dworkin and Frankfurt autonomy only gains its intrinsic value by the

autonomous agent exercising his capacities to make and implement decisions concerning his future.

Clearly, if someone respects the intrinsic value of someone else's autonomy, this places various constraints on the respecter. For instance it seems clear that if I deceive or coerce someone I will damage his capacity to make and implement decisions concerning his future. It follows that if I respect the intrinsic value of someone's autonomy I am constrained from behaving in such a way. However, observing such constraints alone is insufficient to respect the intrinsic value of someone's autonomy if Dworkin and Frankfurt are correct in their belief that autonomy only gains its intrinsic value by being exercised. Let it be accepted that the intrinsic value of autonomy is only realised by an autonomous agent making and implementing decisions concerning his future. It follows that if I stop someone from implementing such decisions I fail to respect the intrinsic value of his autonomy. This leads to two important conclusions. If I respect the intrinsic value of someone's autonomy I have a duty to *accept* the decisions with which he determines his future. Let it be further accepted that to respect an autonomous decision means accepting autonomous decisions. Accepting this leads to my second conclusion. If respecting autonomous persons means respecting the intrinsic value of their autonomy then respecting autonomous persons is identical with respecting autonomous decisions. In the following discussion, for clarity of expression, an autonomous decision will simply be defined as a decision with which an agent determines his future. A more precise definition of an autonomous decision will be given in the next chapter. I have argued respecting a person means we have a duty to promote his ends if possible. This promotion might be roughly characterised as a duty to *act beneficently* towards ends undetermined by us. The duty to *accept* the autonomous decisions of a person is a different

type of constraint to those outlined above. I assumed above that there is no difference in the type of constraints imposed when respecting autonomous and non-autonomous persons. This assumption points to the conclusion that respect for autonomous persons is an unnecessary concept. I have now shown both this assumption and the resulting conclusion are unsound.

Even if the above is accepted, it might still be questioned whether we have a duty to accept all of an agent's autonomous decisions? After all Dworkin(1988, page 114) believes the promotion of autonomy in the long run might require sacrificing autonomy in the short term. Furthermore he also believes that autonomy is a concept that can only be assessed over an extended portion of a person's life (1988, page 15). I have shown above that Dworkin believes the intrinsic value of someone's autonomy is linked to him exercising his capacity for self-determination. Someone exercises his capacity for self-determination by the decisions he makes which help to determine his future. It appears to follow that when Dworkin refers to autonomy in the short term, he must be referring to decisions which might be loosely defined as autonomous decisions. It might be argued that my interpretation of Dworkin is incorrect and he is not committed to the idea of autonomous decisions. However, I believe that when he refers to autonomy in the short term he must be referring to decisions by which an agent helps determine his future. Such decisions are intuitively autonomous and in the rest of this section will be referred to as autonomous decisions. It seems at least plausible to assume that respecting someone's autonomy in the long term might require not accepting some of his autonomous decisions. It might be tentatively concluded that provided some of the agent's decisions are accepted, the above assumption is perfectly compatible with respecting the intrinsic value of his autonomy.

The above conclusion is true in a trivial sense. Respect for the intrinsic value of someone's autonomy does not mean all his autonomous decisions must be accepted. If I respect the intrinsic value of someone's autonomy I do not have to accept any of his autonomous decisions which might harm myself or others. Clearly not all the autonomous decisions of a serial killer need be accepted. Let it be accepted that the domain of autonomous decisions in which all autonomous decisions might need to be respected is limited to autonomous decisions doing no harm to others. In the following discussion the meaning of an autonomous decision will be limited to this domain. The question posed above might now be asked again in our modified domain. If we respect the intrinsic value of autonomy, do we have a duty to accept all autonomous decisions?

It will now be argued that in order to respect the intrinsic value of someone's autonomy all of his autonomous decisions must be accepted. Dworkin (1988, page 112) believes that the intrinsic value of autonomy is connected to the desire to be recognised as the kind of creature capable of determining his own destiny. Frankfurt (1999, page 163) adopts a similar position because he believes "caring about" has intrinsic value due to its role in making us the distinctive kind of creatures we are. Let it be assumed that Dworkin and Frankfurt are correct in believing that the exercise of autonomy gains its intrinsic value by allowing us to be recognised as the kind of creatures capable of determining their own destiny. Let it also be assumed that some of an agent's autonomous decisions are respected and some are not. It follows that the agent is not recognised as someone who determines his own destiny. The above appears to lead to the conclusion that if only some of an agent's autonomous decisions are respected, then none of his autonomous decisions possess any intrinsic value. It might be argued that my conclusion is too simplistic. However, let it be accepted that if someone is to

be regarded as autonomous, at least some of his decisions must be accepted. However we cannot completely determine our future. In reality we can at best only partially determine our future or incompletely guide it. It might then be argued that if some of an agent's autonomous decisions are accepted and others are not then the agent is recognised as someone who partly determines his future. Accepting this would lead to the following conclusion. If others accept some of an agent's decisions, by which he partly determines his future, then the intrinsic value of his autonomy is partly respected. This conclusion would concur with the belief of Buller (2001, page 101) and Beauchamp and Childress (1989, page 69) that autonomy can be graduated.

I believe the above conclusion is unsound for the following reasons. Let it be accepted that Dworkin and Frankfurt are correct when they argue that the intrinsic value of autonomy is connected to the desire to be recognised as the kind of creature capable of determining his own destiny. I will now argue that if only some of an agent's autonomous decisions are respected, then none of his autonomous decisions possess any intrinsic value. My argument depends on exactly what is meant by "the kind of creature capable of determining his own destiny". If it is accepted that some persons are more capable of self-government than others, it follows persons have varying degrees of ability to determine their own destiny. I will now show that this partial ability of an agent to determine his own future is on its own insufficient to give an agent's autonomous decisions any intrinsic value. It has been accepted that the intrinsic value of autonomy is connected to someone being recognised as the kind of creature capable of partially determining his own destiny. However, it would appear both that Dworkin and Frankfurt believe that what matters as far as the intrinsic value of autonomy is concerned is not simply someone's ability to partially determine his own future. Dworkin and Frankfurt believe that what matters is the recognition that someone is the *kind of creature* capable of

determining his own destiny. It is interesting to note that they both use the word creature in this context. The recognition that someone is the kind of creature capable of determining his own future cannot be graduated. Clearly someone is either recognised as the kind of creature who is capable of determining his own future or as someone who is not. Let it be assumed that some of an agent's autonomous decisions are accepted and others are not. It follows that the agent's autonomous decisions are subject to additional constraints. It would appear that these additional constraints on accepting his decisions are applied precisely because he is not recognised as the kind of creature capable of determining his own future. It can be concluded that if the intrinsic value of autonomy is connected to someone being recognised as the kind of creature capable of determining his own destiny, then subjecting the acceptance of someone's decisions to additional constraints means that even his autonomous decisions, which are accepted, do not confer any intrinsic value on him.

I have argued that the reason we respect autonomy is not arbitrary. We respect autonomy because we value it. I have further argued that autonomy has two sources of value, intrinsic and instrumental. I have argued above that in order to respect the intrinsic value of someone's autonomy we must accept all of his autonomous decisions. It follows that respecting the intrinsic value of someone's autonomy means we cannot promote his autonomy in the long term, provided the promotion of his autonomy in the long term means not accepting some of his autonomous decisions as seems to be required by Dworkin (1988, page 114). One solution to this problem might be to argue that respect for autonomy means only respecting someone's instrumental autonomy.

At the beginning of this section I posed the following question are there any real differences between respecting autonomous and non-autonomous patients, (see Law 2003,

page 54)? I argued that a different type of constraint is imposed on someone when he respects autonomous as opposed to non-autonomous persons. The need for this different type of constraint was dictated by the need to respect the intrinsic value of autonomy. However, if respecting autonomy, simply means respecting instrumental autonomy this question could again be posed. I will now argue that if we simply respect someone's instrumental autonomy we would fail to account for the importance of autonomy in his life.

Let it be assumed that respecting autonomy simply means respecting the instrumental value of autonomy. Baron (1988, page 29) defines instrumental rationality as the kind of thinking that best helps an agent to achieve his goals including heuristics. Let it be accepted that autonomy is connected to the capacity of persons to reflect on and change their desires together with the ability to implement at least some of these changed desires (see Dworkin, 1988, page 20) and (Frankfurt, 1988, page 83 originally 1982). It might now be argued that an agent's use of his capacity for autonomy is of instrumental value to him. However accepting this would seem to mean that there is little point in simply respecting the instrumental value of an agent's autonomy. The goods obtained by respecting an agent's instrumental autonomy might be more simply obtained by respecting his instrumental rationality. If the above argument is accepted, and respecting an agent's autonomy simply means respecting the value of his instrumental autonomy, then respecting an agent's autonomy seems at best unimportant and at the worst pointless. However autonomy is not unimportant but central to our lives according to both Dworkin (1988) and Frankfurt (1999).

What makes an individual the particular person he is his life-plan, his projects. In pursuing autonomy, one shapes one's life, one constructs its meaning. The autonomous person gives meaning to his life. (Dworkin, 1988, page 31)

Caring is important to us for its own sake, insofar as it is the indispensably foundational activity through which we provide continuity and coherence to our volitional lives. (Frankfurt 1999, page 162)

The instrumental value of autonomy is not is not foundational to our lives by giving us a life-plan. The value of autonomy that is central to our lives is intrinsic autonomy. It can therefore be concluded that respecting the value of autonomy must include respecting the intrinsic value of autonomy cannot simply mean to respect the value of someone's instrumental autonomy.

I have argued that to respect the intrinsic value of an agent's autonomy, his autonomous decisions must be accepted. It might be argued by some such as O'Neill (2002, page 26) this is an impoverished view of the value of autonomy. This criticism would be true if the value of autonomy is considered alone. However the idea of personal autonomy does not exist in vacuum. The idea of personal autonomy is of necessity connected to persons. I also argued above that to respect persons means we must act beneficently towards other's perceived ends. It follows that when considered in context, the idea of personal autonomy becomes a richer concept. However, even if this is accepted it is still true, because respecting autonomy fundamentally depends on respecting the intrinsic value of autonomy, giving priority to accepting the decisions by which an agent partially determines his future over acting beneficently towards him. I will deal with this in greater detail in section 4.5. This does not of course mean that I must accept all of an agent's decisions in order to respect his autonomy. Someone's choice of ice cream flavour is not a decision by which he determines his future for example. It follows that if I am to respect someone's autonomy I must be able to determine

which of an agent's decisions are decisions by which he determines his future. This will be one of the main topics of the next chapter.

Chapter 3

Concepts of autonomy

The purpose of my thesis is to investigate the relationship between informed consent and respect for autonomy. In chapter 1 I examined the practice of informed consent. In chapter 2 I examined our intuitive ideas of autonomy and what it means to respect autonomy. Chapter 3 examines what is entailed by different concepts of autonomy. This chapter completes my preparation for the detailed investigation of the relationship between informed consent and respect for autonomy which will be carried out in chapters 4, 5, and 6. This examination is necessary because there are different philosophical concepts of autonomy and these different concepts might yield different results when applied to the practice of informed consent. I argued in section 2.1 that any meaningful concept of autonomy must account for our intuitive ideas of autonomy. For this reason my examination will be carried out by comparing these different concepts of autonomy with our intuitive ideas. This comparison will take place against the background of informed consent in practice. Chapter 3 will be divided into five subsections.

3.1. Mill and autonomy

Modern ideas of respect for autonomy in the practice of informed consent have their philosophical origins in the works of Kant and Mill, see (Beauchamp and Childress, 1989, page 71), (see Gauthier, 1993, page 25 and 2002, page 273) and (Mathews, 2000, page 62). Mill wrote about liberty rather than autonomy. This creates difficulties if his ideas are to be applied directly to respecting autonomy. For this reason, in this section I will not examine

Mill's concept of autonomy, for such a concept does not exist but I will examine autonomy in conjunction with the philosophy of Mill. It is clear from Mill's writing that he was concerned with self-government.

Over himself, over his own body and mind, the individual is sovereign" (Mill, 1974, page 68)

To be sovereign over oneself means to be self-governing. Intuitively self-government is at the heart of what it means to be autonomous. In what follows, autonomy and self-government will be held to be equivalent. I will argue that if Mill's ideas concerning liberty are used to define a concept of autonomy, then this concept of autonomy is incomplete. I will also argue that Mill's ideas concerning liberty define conditions in which respect for autonomous decisions is possible. This section will be divided into two sub-sections.

3.1.1. Mill's concept of liberty

Mill wrote about liberty not autonomy. In this subsection I will examine how an account of autonomy might be based on Mill's ideas on liberty. Mill believed people should be free to act as they please provided their actions do not harm others and

That the only purpose for which power can be rightfully exercised over any member of a civilised community against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant (Mill, 1974, page 69).

I argued in section 2.1 that freedom from external constraints is a necessary condition for self-government but that it is not a sufficient condition. I will not repeat this argument here but assume liberty is a necessary but not a sufficient condition for self-government.

Mill believed his idea of liberty should not apply to all and placed a restriction on to whom it should apply by saying

It is, perhaps hardly necessary to say that this doctrine is meant only to apply only to human beings in the maturity of their faculties (Mill, 1974, page 69).

I have argued that liberty alone is an insufficient condition to define autonomy. It seems possible that an adequate account of autonomy based on the work of Mill might utilise the above restriction. It follows that we must ask what Mill meant by “human beings in the maturity of their faculties” in order to consider the above restriction. One possible answer to this question might be that Mill was simply referring to adults. However this possibility must be rejected as too simplistic because it would include the mentally ill. Another possibility is that Mill was referring to adults capable of self-government. It might then be argued the social condition of self-government is the ground on which the right to liberty is based. If this possibility is accepted then it would seem the idea of liberty cannot be used to define autonomy. Another possibility would be Mill was defining the domain of liberty. Liberty should only apply adults capable of self-government. Once again if this possibility is accepted it would seem the idea of liberty cannot be used to define autonomy.

It is clearly difficult to define exactly what Mill meant by persons in the maturity of their faculties. However, it seems clear that Mill would not have regarded someone suffering from

mental illness as a person in the maturity of her faculties. This being so I will assume the fact that someone is a sane adult can safely be considered to be the minimum requirement for her to be regarded as a human being in the maturity of her faculties. This assumption would mean that any adult would be presumed to be free to choose unless she could be shown to be insane. This position concurs with the practice of informed consent. An adult patient's consent decision cannot simply be overruled because she is deemed incompetent, but only because she is incompetent due to insanity under the Mental Health Act of 1983 (Department of Health, 2001, section 2.3). However, even if freedom is restricted to sane adults a question remains. Are all freely made decisions by sane adults, autonomous decisions or does freedom only create the conditions in which sane adults can make autonomous decisions? I will argue that only the latter is true.

Mill believed that the freedom to choose creates the conditions necessary for self-government in mature adults. He also believed that this condition alone was insufficient to guarantee self-government. If someone is to be self-governing Mill believed she must use her faculties:

He who lets the world, or his own portion of it, choose his plan of life for him has no need of any faculty other than the ape-like one of imitation. He who chooses his plan for himself employs all his faculties (Mill, 1974, page 123).

It seems Mill would have believed that if a sane adult was free to choose, and used her reason and other faculties when choosing, then she would have been self-governing. However, the fact, that someone is a sane adult and free to choose does not automatically mean she must use

her reason and other faculties to choose her life plans. It follows that the fact that someone is a sane adult free to make her own decisions, does not of necessity mean that all her decisions are autonomous. This conclusion concurs with our intuitive ideas of autonomy. A sane adult does not of necessity have to identify with her freely made decisions. Nor do her decisions have to have persistence. It follows that the fact that an adult is free to choose and sane are necessary conditions for self-government, autonomy. However these conditions alone are insufficient to guarantee self-government. It can be concluded that any account of autonomy based on sane adults freely choosing their life plans, permits autonomy, promotes autonomy, but is an incomplete account of autonomy.

3.1.2. Mill's concept of liberty and respect for autonomy

Mill never defined when a decision freely made by a person in the maturity of her faculties was autonomous. The reason for this might simply be that he was only concerned with liberty. I argued in section 3.3.1 that freedom is a necessary but not a sufficient condition for a sane adult to be regarded as autonomous. I will now argue that Mill provides an answer as to why freedom matters to individuals as well as to society. I will then argue that this answer means it is possible to respect autonomous decisions by respecting Mill's concept of liberty.

Mill was a utilitarian and believed freedom maximised benefits to society.

Each is the proper guardian of his own health, whether bodily or mental and spiritual.

Mankind are greater gainers by suffering each to live as seems good to themselves, than by compelling each to live as seems good to the rest (Mill, 1974, page 72).

The following discussion will be based on utilitarian principles. Let my contention be accepted that Mill believed all decisions freely made by sane adults should be respected. Let it also be accepted that these decisions are justified because they benefit society. In the following discussion a “freely made decision” will specifically refer to a member of the set of all decisions *freely made by sane adults* unless stated otherwise. However caution is needed with this definition. Consider the case of MB introduced on page 39. It seems unlikely Mill would have believed MB’s refusal of consent should have been accepted even if made freely because he would not have regarded her as a sane adult. It would appear to follow a sane adult must be regarded as someone free from some internal controlling influences. If the above is accepted it might then be argued that the *set of all autonomous decisions is a subset of the set of all “freely made decisions” as defined above*. I will further examine the relationship between autonomous decisions and “freely made decisions” when considering the purpose of informed consent on page 174. I also argued in section 2.2 that to respect an autonomous decision simply means to accept that decision. It then appears to follow that if all “freely made decisions” are accepted in order to benefit society, then the set of all autonomous decisions would be automatically respected. It might then be concluded that there is no need to understand which conditions are sufficient to define autonomous decisions in order to respect autonomous decisions. Autonomous decisions could be respected automatically and efficiently by simply respecting the set of all “freely made decisions”.

Such a conclusion would be attractive in practice because it seems difficult to ascertain whether a particular decision is autonomous. I argued in section 2.1 that intuitively an autonomous decision is a freely made decision the agent identifies with and which has persistence. It should be relatively easy to determine when an agent’s decision is “freely

made” and has persistence. I further argued in section 2.1 that it is difficult in practice to determine which internal controlling influences are compatible with a patient identifying with her decision and which are not. It follows that it is difficult to ascertain whether an agent identifies with her decision in difficult cases. It further follows that it is not always easy to determine precisely if an agent’s decision is an autonomous decision. It might be concluded that in practice it would be advantageous if autonomous decisions could be respected by simply respecting the set of all freely made decisions. I will now examine the implications of the above conclusion before arguing such a conclusion would not truly respect autonomy.

Let it be accepted that respecting all freely made decisions is justified by its utility to society. It follows that a patient’s freely made decision should be respected because doing so is good for society, even if this decision damages her. For example, the freely made decision of an adult to refuse to give consent to an emergency appendectomy without which she will probably die should be respected in order to benefit society. Mill would have accepted this position (1974, page 69). Let it be accepted that, in general utilitarianism based purely on the utility of actions to society is wrong. However, accepting this does not mean that if informed consent is based purely on respect for autonomy, that it would be wrong to automatically accept all freely made decisions in the practice of informed consent. Indeed, in the context of informed, consent such a practice would seem to be the most efficient way to respect autonomy. Prima facie it might be concluded that the freely made decision of an adult to refuse consent to treatment without which she might be harmed should be respected in order to respect autonomy.

One way to counter the above conclusion might be to argue that respecting autonomy cannot simply be reduced to accepting autonomous decisions. Let it be accepted that

respecting the set of all freely made decisions automatically entails respect for autonomous decisions. It might then be argued that if autonomy is considered to be a global concept, such as the second-order capacity of persons to reflect critically on their desires, as suggested by Dworkin (1988, page 20), that respecting the set of all freely made decisions fails to respect autonomy. It might be further argued that sometimes respecting someone's freely made decision might damage her as an autonomous person. The following example appears to support this argument. Firstly consider a battered wife who has the freedom to decide whether or not to prosecute her abusive husband. Secondly let it be assumed that this freedom is removed and her husband will be automatically prosecuted if he abuses her. In the first scenario the freedom she has to decide whether to prosecute or not might leave her open to coercion at a later date hence damaging her capacity for autonomy. However in the second scenario her capacity for autonomy would be unchanged.

I accept the argument that respecting autonomy cannot simply be reduced to accepting autonomous decisions. However, accepting this argument does not entail accepting that not all autonomous decisions should be respected. In section 2.2 I argued that respecting an autonomous person places a different type of constraint on someone compared to respecting a non-autonomous person. I further argued that respecting someone as an autonomous person involves respecting the intrinsic value of her autonomy. It follows that to *treat* someone in a certain way is insufficient to respect her as an autonomous person. Respecting the intrinsic value of autonomy is of necessity connected to the *recognition* that someone is the kind of creature capable of determining her own future. If I do not accept someone's autonomous decisions then I do not recognise her as the kind of creature capable of determining her own

future. It follows that by not accepting her autonomous decisions, I do not respect her as an autonomous person.

I have argued that respecting someone's autonomy of necessity means respecting all of her autonomous decisions. This might be efficiently achieved by accepting all of her freely made decisions. It does not of course follow that simply respecting someone's freely made decisions is sufficient to fully respect her autonomy. For instance, in the context of informed consent, a patient may need to be fully informed about her condition in order to make an autonomous choice. However, it still follows that if informed consent is based purely on respect for autonomy the prima facie conclusion, that the freely made decision of an adult to refuse consent to treatment without which he might be harmed should be respected in order to benefit society also respect autonomy, is true. I do not believe that informed consent is based purely on respect for autonomy. I believe the purpose of informed consent is to respect autonomy whilst at the same time ensuring that beneficent care can be given to non-autonomous patients. If this was not so, then the idea of assessing a patient's competence seems pointless and all of a patient's consent decisions should simply be accepted.

Let it be accepted that the purpose of informed consent is to respect autonomy whilst at the same time ensuring beneficent care can be given to non-autonomous patients. It follows that if autonomy is to be respected one of the following options must be possible. Firstly, if autonomy is to be respected by respecting the set of all freely made decisions, then these decisions must benefit individuals in addition to society. Provided that respecting the set of all freely made decisions benefits individuals, then the above prima facie conclusion would be true. Secondly, autonomy could be directly respected. The latter will only be possible if autonomous decisions can be adequately defined.

Gauthier argues that the consequences of accepting Mill's ideas on liberty are good for individuals as well as society:

Mill's argument then is primarily based on consequentialist reasoning. Allowing each person in society to action his or her opinion of what is right is necessary for both human development and happiness. The individuality that results from respecting this kind of liberty is good both for each member of a society and for the society as a whole (Gauthier, 1993, page 23).

If Gauthier is correct then it might be argued that the set of all freely made decisions should be respected on the grounds of personal utility. It appears to follow that if all freely made decisions are respected then autonomy would also be respected automatically because autonomous decisions form a subset of the set of freely made decisions. It might be concluded that provided Gauthier is correct, respecting the set of all freely made decisions is perfectly compatible with the purpose of informed consent being to respect autonomy whilst ensuring beneficent care can be given to non-autonomous persons.

However, I believe the above conclusion is unsound for two reasons. Firstly I have argued above that respect for autonomy means accepting autonomous decisions. I accept that respecting an autonomous decision means to accept that decision. However I do not accept that respect for autonomy simply means accepting autonomous decisions. In certain contexts respect for autonomy means enabling agents to make autonomous decisions by providing them with information. This provision of information is particularly important in the context of informed consent, as I will argue in section 5.1. Secondly, I believe the premise on which the above argument is based is false. This premise states that all freely made decisions should be

respected because by so doing we benefit individuals. Consider again the patient facing an emergency appendectomy. Without this operation she will probably die. It follows that in almost all circumstances any calculation of her individual utility would conclude that accepting her refusal of consent would not benefit her. It follows that the premise that the set of freely made decisions should be respected because it benefits individuals cannot always be justified on the grounds of personal utility.

It might be possible to justify respecting the set of all freely made decisions on non-utilitarian grounds. For instance it might be argued that all freely made decisions, like all autonomous decisions, have intrinsic value. It might then be further argued that this value should be given preference over other values. However exactly why all freely made decisions should have intrinsic value is not immediately clear. Frankfurt (1999, page 106 originally 1992) points out that someone who merely chooses without any reasons, is a wanton and his decisions are wanton decisions. It would seem to be hard to attach any intrinsic value to a wanton decision. Moreover a wanton decision might be a freely made decision. It follows that the set of all freely made decisions contains some decisions which prima facie appear to have no intrinsic value.

If a decision is not a wantonly made decision then the agent must either care about the decision or how it affects the things he cares about. This appears to mean that an agent's freely made decision can only have intrinsic value if she cares about her decision. If someone cares about her decision it follows she identifies with her decision according to Frankfurt (1988, page 83 originally 1982). I argued in section 2.1 that if an agent identifies herself with her a freely made persistent decision then intuitively this is an autonomous decision. The above seems to suggest that the only reason why the set of all freely made decisions is intrinsically valuable to

persons, is not simply because they are freely made but rather because respecting this set respects autonomous decisions.

Let it be accepted that the set of all freely made decisions only gains its value because it contains autonomous decisions. Respecting this set means some non-autonomous decisions will also be respected. It follows that respecting this set in the context of informed consent means some non-autonomous decisions would be respected even if these decisions have no intrinsic value and harm patients. It can be concluded that even though it is possible to indirectly respect autonomous decisions by respecting all freely made decisions it would be preferable if autonomous decisions could be directly respected. This conclusion would be impossible to implement with autonomous decisions in general. However it might be possible to implement it in some contexts like that of informed consent. This would permit patient autonomy to be respected whilst permitting non-autonomous patients to receive beneficent care.

This section outlining Mill's work on liberty has reached the following conclusions.

- 1) Mill does not define a concept of autonomy.
- 2) Respecting Mill's concept of liberty would allow us to respect autonomous decisions indirectly without the need to precisely define autonomy.
- 3) Respecting Mill's concept of liberty would allow us to respect autonomous decisions but respecting Mill's concept of liberty does not necessarily mean we respect autonomy.
- 4) Respecting autonomous decisions by respecting Mill's concept of liberty in the context of informed consent might mean some non-autonomous patients are denied beneficent care.

3.2. Kant and autonomy

Kant based his concept of autonomous action on his idea of the Categorical Imperative.

Act only according to that maxim through which you can at the same time will that it should become a universal law. (Kant, 1948, page 84, originally 1785)

This principle is central to Kant's concept of autonomy. Kant gave several formulations of the Categorical Imperative all of which he regarded as equivalent. This equivalence might be questioned according to Beauchamp and Childress (1989, page 28). However in this section it will be accepted that Kant was correct and all of his formulations are at least roughly equivalent. It follows that any conclusions reached using the above formulation of the Categorical Imperative also applies to all Kant's other formulations.

Kant's Categorical Imperative means that when an agent makes an autonomous decision she ought to base her decision on laws she has chosen for herself. These laws must be applicable to all and based on reason. This reason should be pure reason untouched by what the agent cares about or desires as pointed out by Mathews (2000):

For Kant, then, a person is choosing autonomously when he or she chooses something, not on the basis of its attractiveness (appeal to the person's own desires and wishes), but as an act of pure will, on the basis of impersonal general laws (Mathews, 2000, page 60).

According to Kant an autonomous action cannot be a purely instrumental action serving the agent's personal interests. Kant of course believed someone could make decisions based

purely on what he desired or cared about. However he would not have regarded these decisions as autonomous decisions. This was because he believed the domain of autonomy was strictly limited to what an individual ought to do morally as pointed out by Secker (1999):

Kant's conception is not of individual or personal autonomy, where the central question is, "what do I really want, and is it best for me?"; rather, it is of moral autonomy which applies universally, and asks the question "Is this what I ought to do ?", morally speaking (Secker, 1999, page 48).

It will be accepted here that Kant's concept of autonomy is concerned *only* with decisions that have moral implications. It is of course true that what an individual desires and what an individual ought to do morally are sometimes connected. However there is part of an individual's life in which his desires are purely personal.

Kant's concept of autonomy raises a problem when applied to informed consent. Accepting this fact does not mean that Kant's concept of autonomy is unimportant in other areas of bioethics. It seems to me that Kant's concept might be particularly relevant to issues concerning reproduction. The problem concerning informed consent is linked to the domain of Kant's autonomy. Autonomy originally referred to self-governing city-states in ancient Greece. The domain of autonomy was extended by Kant to include all rational beings making moral decisions. Self-government in moral matters means the agent choosing laws to govern herself by using pure will untainted by her personal preferences. However, if the domain of autonomy is extended still further to include personal self-government unconnected to moral concerns, then the agent's personal preferences seem to matter. It might then be argued that Kant's insistence that autonomous actions cannot be purely instrumental actions serving an

agent's personal desires or wishes makes it impossible to extend the domain of his concept of autonomy to personal autonomy. This point is made by Frankfurt (1999):

The will can only be one that incorporates what Kant calls a 'pure' will. ... Now this pure will is a very peculiar and unlikely place in which to locate an indispensable condition of individual autonomy. After all its purity consists precisely in the fact that it is wholly untouched by any of the personal features that make people distinctive and characterize their specific identities (quoted in Frankfurt, 1999, page 132, originally 1994.)

These difficulties in extending the domain of Kant's concept of autonomy can be illustrated by the use of an example.

Mathews (2000) uses an end of life example to illustrate the difficulties involved in extending the domain of Kant's autonomy. He considers a terminally ill cancer patient whose life might be extended slightly by the use of chemotherapy. Let it be assumed that this patient decides on a shorter life with only palliative care rather than a longer life with the discomfort of chemotherapy. Mathews (2000) argues that if a patient made such a decision then she would not be acting autonomously according to Kant's concept of autonomy:

The patient in our example would thus not be acting 'autonomously' in the Kantian sense, but simply expressing the way she happened to feel about pain and death. There would thus, on Kantian principles, be no morally compelling reasons for those caring for this patient to accede to her wishes: indeed, if the maxim that doctors should seek to prolong life wherever

possible is universalisable, then they would have compelling Kantian reasons for acting paternalistically (Mathews, 2000, pages 61, 62)

Intuitively, it seems in this case that the patient should be able to make a choice about how to spend the rest of her life. Intuitively it further seems such a decision about whether to prolong her life or enjoy a shorter but higher standard of life concerns is about self-government.

It is probable that Kant (1948, page 67, originally 1785). would have approved of a maxim prohibiting the shortening of life because he believed it was possible to have a maxim prohibiting suicide. It follows that Kant would not have regarded the request to the courts by Mrs Pretty [2002] to permit her husband to assist her to die as an autonomous request. However, not prolonging life is different to shortening life, and there is no clear reason why a maxim requiring us to seek to prolong life wherever possible would be universalisable. It follows that Mathews is correct and Kant's concept of autonomy would have nothing to say about his example. Let it be accepted that many informed consent decisions are personal decisions unconnected to the domain of Kant's concept of autonomy. Prima facie it might be concluded if informed consent is based on respect for autonomy then it cannot be based on respect for Kant's concept of autonomy.

The above conclusion results from Kant's concept of autonomy being applied to a set of decisions Kant did not intend it being used on. Kant believed rational beings should use the Categorical Imperative when deciding what they ought to do. It follows that Kant's concept of autonomy only refers to moral decisions, as pointed out by Secker (1999) above. However, as Frankfurt (1988, originally 1982) points out, ethics is not the only thing people care about:

It can hardly be disputed that, for most of us the requirements of ethics are not the only thing we care about. Even people who care a great deal about morality generally care still more about other things. They may care more, for instance, about their own personal projects, about certain individuals and groups, and perhaps about various ideals (quoted in Frankfurt, 1988, page 81, originally 1982).

Decisions about personal projects, which career to follow, and what we value are decisions by which we govern ourselves. Intuitively, these decisions are autonomous decisions. Kant's concept of autonomy cannot be extended to cover these decisions because the Categorical Imperative excludes such personal interests. It might be argued that informed consent is only concerned with moral decisions. It would follow then that even if some personal decisions are autonomous decisions, and these decisions fall outside the domain of Kant's autonomy, this does not apply to informed consent decisions. The example of Mathew (2000) clearly shows this argument is unsound. Further, it would seem that the basis for almost all informed consent decisions concerns what the patient personally cares about. It seems that the prima facie conclusion that Kant's concept of autonomy cannot be used as the basis of informed consent should be accepted because to do so would extend the domain of Kant's concept of autonomy too far.

I have argued that the domain of Kant's concept of autonomy cannot be extended to cover all informed consent decisions. However, accepting the above does not necessarily mean the above prima facie conclusion is true. This conclusion will only be true if it is also accepted that all informed consent decisions must be autonomous decisions. Let it be accepted that if informed consent is based on respect for autonomy, then all autonomous decisions must be respected. However the acceptance of this fact does not of necessity mean that only

autonomous decisions should always be respected. I pointed out in section 2.2 that Law (2003, page 54) doubts the justification of treating a non-autonomous person against her will. In chapter 5 I will examine whether some decisions made by non-autonomous persons should always be accepted. I will conclude that some such decisions *should* always be accepted and set out the contexts in which this should occur. Let it be accepted that in some contexts of informed consent all of a patient's consent decisions should be accepted while in all other contexts only autonomous decisions should of necessity be accepted. It follows that if all personal decisions, such as that used by Mathews, fall into the first set of contexts then theoretically it is still possible for informed consent to be based on respect for Kant's concept of autonomy.

I will now argue that it is impossible to base informed consent on respect for Kant's concept of autonomy. I will present two arguments. Firstly let it be accepted that not all informed consent decisions need be autonomous decisions but some must be. I argued in section 2.2 respecting autonomous decisions means accepting autonomous decisions. I also argued in section 3.1 that the purpose of informed consent is to respect autonomy whilst at the same time ensuring beneficent care can be given to non-autonomous patients. It follows that it must be possible to ascertain whether certain decisions are autonomous or not. Because Kant's concept of autonomy is based on the Categorical Imperative it is difficult to see how this could be achieved in practice. The Categorical Imperative requires an autonomous agent to act on maxims she has chosen for herself and which are universalisable. However Secker (1999, page 55) points out an agent's maxims are not observable. It follows we cannot evaluate an agent's maxims except by what she tells us and observation of her actions. It might be concluded that Kant's concept of autonomy gives us reasons for why we should respect patient autonomy but

does not give us effective means to do so. It follows that it is impossible to base informed consent on respect for Kant's concept of autonomy.

A second reason might be advanced as to why informed consent cannot be based on respect for Kant's concept of autonomy. Let it be accepted that Secker (1999, page 48) is correct and Kant's concept of autonomy is concerned with moral decisions. It follows that if informed consent is to be based on respect for Kant's autonomy, then at least some meaningful proportion informed consent decisions must be moral decisions. However this does not seem to be true except in a limited number of cases such as women consenting to an abortion. Informed consent is usually concerned with a patient deciding what is in his best personal interest. It follows that informed consent and autonomous decisions, based on Kant's concept of autonomy, have little in common. It can again be concluded that it is impossible to base informed consent on respect for Kant's concept of autonomy.

3.3 Dworkin and autonomy

In this section I will examine the two concepts of autonomy developed by Dworkin. Kant and Mill's works were completed before the idea of informed consent existed, see (Jackson, 2001, page 10). However Dworkin's ideas on autonomy were developed concurrently with the growth of this idea. Dworkin (1988, chapter 5) also specifically linked autonomy to informed consent. It is important to note that Dworkin developed two different concepts of autonomy, both of which will be examined here. My examination of Dworkin's concepts of autonomy will take place in three subsections.

3.3.1. Dworkin's first concept of autonomy

Dworkin's first concept of autonomy is defined solely by two conditions (Dworkin, 1976). Dworkin's first condition requires that an autonomous agent's second order desires must concur in some way with her first order desires for these first order desires to be regarded as autonomous. Dworkin (1988, page 15) defined this concurrence as follows. Someone's first order desires are autonomous if her second order identifications are congruent with her first order motivations. Dworkin defined congruence as follows. Let it be assumed that an agent has a first order desire *x* and a second order desire *y*. If the desire *y* desires that the agent has the first order desire *x* then these desires are congruent. Second order identifications are desires about desires. First order motivations are simply desires for action and are not concerned with other desires. Dworkin's second necessary condition for a desire to be regarded as autonomous requires that the agent acquired his second order desires in a procedurally independent way. The purpose of procedural independence is to eliminate the possibility that forces external to the agent, using means such as coercion or manipulation, could influence her second order desires. Procedural independence is of particular importance if respect for Dworkin's first concept of autonomy forms the basis of informed consent. This follows because a patient may be in a weakened state whilst her doctors proposing treatment for her consent may be seen as figures of authority.

Dworkin's first concept of autonomy has three important properties. Firstly Dworkin's first concept is concerned with autonomous decisions rather than autonomous persons. Secondly it is a hierarchical account of autonomy. Lastly it is a purely structural account of autonomy. It is a structural account due to the two conditions that define it. Firstly there is

congruence between the agent's autonomous decisions and her second order desires. Secondly her second order desires must be acquired in a procedurally independent way. It follows any autonomous decision need have no particular content.

Dworkin (1988) rejected his first concept of autonomy because he regarded identification as being an insufficient reason to consider a desire autonomous:

It is not the identification or the lack of identification that is crucial to being autonomous, but the capacity to raise the question of whether I identify with or reject the reasons for which I now act (Dworkin, 1988, page 15).

The "identification" Dworkin is rejecting is clearly identification defined simply as the congruence between first and second order desires. It is important to note this idea of "identification" is not the same as our intuitive idea of identification outlined in section 2.1 in connection with our intuitive ideas of self-government. I will now examine why "identification" defined simply as meaning congruence is insufficient to guarantee that a decision is autonomous. I argued in section 2.1 that any meaningful concept of autonomy must be able to account for our intuitive ideas of what it means to be self-governing. I will argue that "identification" fails to define autonomous decisions because it fails to account for our intuitive ideas of autonomy. These intuitive ideas include the idea that an agent must identify with her autonomous decisions and these decisions must have some persistence.

It is possible according to Dworkin's first concept of autonomy that even if an agent is not autonomous, she could become so by altering her second order desires. I will argue that this means a decision may be autonomous according to Dworkin's first concept even if the

agent does not identify with her decision in the intuitive sense outlined in section 2.1.

Secondly I will argue because desires can change rapidly, any decision based purely on desires need have no persistence. It follows that an agent's autonomous decisions as defined by Dworkin's first concept can also change rapidly counter to our intuitive ideas of autonomy. Each these arguments will be made by using an example.

Consider a young woman who is about to commence a sexual relationship and desires to use contraception in the form of the birth control pill. This example is not directly concerned with the young woman's competence to give consent. It will only consider the conditions under which her decision to use this means of contraception would be considered autonomous using Dworkin's first concept of autonomy. Let it be assumed that the young woman has this first order desire simply because of the proved efficacy of this method of contraception. Let it be further assumed that she also has a second order desire wishing she did not have the first order desire to use this method of contraception. Perhaps this second order desire is due to the beliefs and values she acquired during her catholic upbringing. These beliefs and values hold that using this method of contraception is wrong. According to Dworkin's first concept of autonomy, if this young woman decides to take the birth control pill then her decision is not an autonomous decision. This follows because her first and second order desires are incongruent.

However it appears that this young woman could make her first order decision autonomous simply by changing her second order desires according to Dworkin's first concept of autonomy. Let it be assumed she is in a quandary about whether to implement her first order desire due to her conflicting second order desire. Let it be further assumed she has an additional desire to resolve this quandary. Let it be still further assumed that she changes her second order desire in order to satisfy this additional desire. According to Dworkin's first

concept of autonomy, because this young woman now “identifies” with her first order desires, due to her first and second order desires being congruent, her decision to take the birth control pill is now autonomous.

However Dworkin’s definition of “identification” seems to be an insufficient definition because it does not explain our intuitive ideas of identification. Intuitively an autonomous decision is one, with which an agent identifies herself, because it reflects what she cares about. This identification of necessity involves an agent’s values. An agent’s values are things she cares about and values cannot be changed at will (Frankfurt, 1988, page 84 originally 1982). It follows that if this young woman changes her second order desires at will then she does not identify herself with her decision to choose this method of contraception in the intuitive sense, and so her decision is still intuitively non-autonomous. The above leads to two conclusions. Firstly, if identification is simply defined as congruence between first and second order desires then this definition is inadequate to account for our intuitive ideas of autonomy. It follows that because Dworkin’s first concept of autonomy fails to account for our intuitive ideas of autonomy that this concept is not a meaningful concept of autonomy. Secondly, it might be concluded that Dworkin is wrong to believe identification is not crucial to a decision being autonomous. What is crucial is what is meant by identification.

Consider again the young woman who desires to use contraception by taking the birth control pill. Let it be assumed that she decides to take this pill for a month and then changes her mind the next month even though her circumstances remain unchanged. Let it be further assumed this process is repeated several times, as in the case of MB [1997]. Let it be still further assumed when she makes these decisions there is always congruence between her first and second order desires. It follows according to Dworkin’s first concept of autonomy that all

of these decisions would be autonomous. However these decisions are not decisions that form part of her self-government. Clearly any child she conceived could not be called a planned child. I argued in section 2.1 that any meaningful concept of autonomy must account for our intuitive ideas of autonomy. I further argued in section 2.1 that our intuitive ideas of autonomy require that an autonomous decision must have persistence unless the circumstances in which that decision is made change. The young woman's decisions in my example do not have persistence and hence would not be regarded as intuitively autonomous. It can be concluded from the above that Dworkin's first concept of autonomy does not concur with our intuitive ideas of autonomy and so is not a meaningful concept of autonomy. It can be further concluded that this concept could not form a useful basis for the practice of informed consent.

3.3.2 Dworkin's second account of autonomy

Dworkin (1988) abandoned his first concept of autonomy. He redefined autonomy as the second-order capacity of a person to reflect on her first order desires:

Autonomy is conceived as a second-order capacity of persons to reflect critically upon their first-order, desires, and so forth and the capacity to accept or attempt to change these in the light of higher-order preferences and values (Dworkin, 1988, page 20).

In addition to an autonomous agent's need for second-order capacities to reflect on her first order desires and the ability to change these desires, Dworkin (1988) also retained the need for procedural independence:

Spelling out the conditions of procedural independence involves distinguishing those ways of influencing people's reflective and critical faculties which subvert them from those which promote and improve them. It involves distinguishing those influences such as hypnotic suggestion, manipulation, coercive persuasion, subliminal influence, and so forth and doing so in a non ad hoc fashion. (Dworkin, 1988, page 18)

Law (1998, page 54) points out that this is an excellent list of factors that might inhibit procedural independence. However he argues it fails to suggest how procedural independence might be defined.

I argued in section 3.2 that it is impossible to base a concept of personal autonomy on pure reason because any concept of personal autonomy based on pure reason cannot account for our intuitive idea that an agent must identify herself with her autonomous decisions. It follows that any concept of personal autonomy must involve an agent's desires or values. It further follows that the question of how an agent acquires her desires or values is of critical importance in any investigation of personal autonomy. This means that the problem of whether it is possible to define procedural independence is critical to all concepts of personal autonomy. Indeed if it is impossible to define procedural independence it would seem to be impossible to define any concept of personal autonomy. I believe this problem can be overcome. For instance it is hard to define innocence positively. However it can be defined negatively by defining guilt. Procedural independence might also be defined negatively. If procedural independence is defined negatively then someone would be presumed to have acquired his second order desires in a procedurally independent way unless it can be shown that the acquisition of these second order desires was influenced by factors on a specific list. Such a list must include coercive persuasion, lying and any form of manipulation of the

agent's desires and values which she actively resists. It might be argued such a solution to the problem of procedural independence is an ad hoc solution. This would not be the sort of solution Dworkin would favour. However, if the concept of personal autonomy is to be useful in applying philosophy then perhaps sometimes such solutions must be employed. In what follows I will assume procedural independence is possible in practice.

Dworkin's second concept of autonomy differs from his first because it is concerned with a person's capacity to reflect on the decisions she makes rather than congruence between her first and second order desires. It follows that Dworkin's (1988) second concept of autonomy also differs from his first because it seems to be applicable to persons rather than decisions:

First, autonomy seems intuitively to be a global rather than a local concept. It is a feature that evaluates a whole way of living one's life and can only be assessed over an extended portion of a person's life, whereas identification is something that may be pinpointed over short periods of time (Dworkin, 1988, page 15).

In the rest of this thesis global autonomy will refer to autonomous persons, as defined by Dworkin above, unless stated otherwise. Dworkin's second concept of autonomy raises two important questions because it is concerned with autonomous persons. Firstly, what does it mean to respect this concept of autonomy? It seems clear it must be possible to respect any meaningful concept of autonomy. Secondly, how are informed consent decisions connected to respecting autonomy? These questions are vital if Dworkin's second concept of autonomy is to form the basis of informed consent. These questions will be examined in section 3.3.3.

I argued in section 3.3.1 that Dworkin's first concept of autonomy could not form a meaningful basis for the practice of informed consent. It would be pointless to investigate the above questions without first examining whether it is at least possible that Dworkin's second concept of autonomy might form a meaningful basis for the practice of informed consent. I will now compare Dworkin's two concepts of autonomy. I will then use this comparison to examine whether Dworkin's second concept of autonomy might form a meaningful basis for informed consent. This will be done by examining the examples used in section 3.3.1, in conjunction with Dworkin's second concept.

Both of Dworkin's concepts of autonomy are hierarchical and structural. However, second order desires in his first concept have become higher-order preferences and values in his second concept. Secondly, the relationship between the hierarchies has changed from congruence in his first concept to the capacity to reflect critically in his second. Lastly, in Dworkin's first concept all that mattered for a desire to be autonomous was congruence between this desire and second-order desires together with procedural independence. It follows that it would be possible for someone to have an autonomous desire under Dworkin's first concept even if she was unable to satisfy her desire. For instance, using Dworkin's first concept, a slave's decision could be fully autonomous even if she was unable to implement her decision. This is not the position Dworkin (1988) adopts in his second concept where

The idea of autonomy is not merely an evaluative or reflective notion, but includes as well some ability both to alter one's preferences and make them effective in one's actions (Dworkin, 1988, page 17).

According to Dworkin's second concept, an autonomous agent must have both the capacity to reflect on his desires and the possibility of satisfying these desires.

In section 3.3.1 I argued that Dworkin's first concept of autonomy fails to concur with our intuitive ideas of autonomy. This failure was due to two reasons. Firstly his first concept fails to account for our intuitive ideas about the need for an autonomous agent to identify with her autonomous decisions. Secondly his first concept is concerned purely with desires. It follows that this concept does not require that autonomous decisions have persistence counter to our intuitive ideas of autonomy. I will now examine Dworkin's second concept of autonomy to see if these problems remain.

In my examination of Dworkin's first concept of autonomy I used the example of a young woman who desires to use contraception by taking the birth control pill. I argued that if autonomy was defined by using Dworkin's first concept of autonomy, then this young woman's desire was non-autonomous because it was not congruent with her second order desires. I argued that she could make this desire autonomous by changing her second order desires and that such a change runs counter to our intuitive ideas of autonomy. Such a change would be impossible using Dworkin's second concept of autonomy. Using this concept the young woman could only reflect on and change her first-order desires. She would be unable to change her preferences and values at will. It is of course true that she could change her preferences and values over time or if her circumstances change. However such a change could not be arbitrary. If she arbitrarily changed her preferences and values it might be questioned whether what she was changing were indeed preferences and values. It follows, because she is unable to change her preferences and values at will, she is unable to make her desire to use contraception by taking the birth control pill autonomous. Prima facie it can be concluded that Dworkin's second concept of autonomy concurs better with our intuitive ideas

of autonomy than his first. However it is not clear from this example how his second concept deals with the intuitive idea that an agent must identify with her autonomous decisions.

I will now examine Dworkin's second concept of autonomy in conjunction with our intuitive idea that autonomous decisions must have some persistence. In this examination I will use the example of MB [1997] previously used in section 2.1. I argued in section 3.3.1 that any decision, which was repeatedly changed when the circumstances of the decision-maker remained unchanged, could not be considered to be intuitively autonomous. MB repeatedly changed her consent decisions and intuitively not all her decisions to refuse consent could be considered autonomous (see section 2.1). If, after reflection, some of MB's consent decisions did not reflect her preferences and values, then these decisions would be non-autonomous according to Dworkin's second concept of autonomy. However, let it be assumed that after reflection all MB's consent decisions reflected her preferences and values. It follows that because her consent decision changed repeatedly, then her preferences and values must also have changed repeatedly. I have argued above that an agent's preferences and values cannot be arbitrarily changed if the agent's circumstances remain constant. It follows that if an agent's preferences and values cannot be arbitrarily changed that the above assumption is false. It further follows after reflection that not all MB's consent decisions reflected her preferences and values. It still further follows that not all of MB's decisions would have been considered autonomous using Dworkin's second concept of autonomy. It can again be concluded that Dworkin's second concept of autonomy concurs better with our intuitive concepts of autonomy than his first.

However the above conclusion must be treated with caution. Dworkin's second concept of autonomy is primarily concerned with autonomous persons. It is far from clear how an

autonomous agent is related to and identifies with his decisions using Dworkin's concept. It is also unclear what it means to respect autonomy.

3.3.3. Dworkin's second concept of autonomy and decisions

If Dworkin's concept of global autonomy can only be evaluated over an extended portion of a person's life, as he proposed, then two key questions must be answered. Firstly what does it mean to respect global autonomy and secondly how are decisions connected to global autonomy? These questions are of particular importance if respect for informed consent is based on respect for global autonomy.

Dworkin (1988, page 20) believes autonomy is the second-order capacity of someone to reflect critically on her first-order desires together with the ability to act on these desires. He further believes whether someone is autonomous can only be assessed over an extended portion of her life (Dworkin, 1988, page 15). It follows that Dworkin's second concept of autonomy is a global concept. In the rest of this thesis global autonomy will always refer to Dworkin's second concept of autonomy unless stated otherwise. Global autonomy is concerned with persons rather than individual decisions. In other concepts of autonomy I have examined so far it is reasonably clear what is required of someone if she is to respect someone else's autonomy. However it is not immediately obvious what it means to respect global autonomy. Moreover if Dworkin's concept of global autonomy is to be a useful concept, it must be clear what it means to respect this concept. In this section I will examine what is meant by respect for global autonomy.

I argued in section 2.2 that to respect autonomy means accepting all autonomous decisions. However if autonomy is defined *solely* in terms of autonomous persons, this option is unavailable. There are no autonomous decisions only autonomous persons. I argued in section 2.2 that if someone respects something or someone then this means accepting constraints are imposed on her behaviour. It might be asked what constraints are imposed on someone who respects an autonomous person when autonomy is defined by Dworkin's second concept? There seem to be two possible answers to this question. Firstly, respecting an autonomous person might mean to respect her capacity for autonomy. Respecting this capacity could mean acting in a way to protect or promote this capacity. Respect in this sense would include constraining the respecifier to be truthful and non-coercive. Secondly, respecting an autonomous person might mean simply accepting her decisions.

Let it be assumed that to respect someone's global autonomy means to respect her capacity for autonomy. Respecting this capacity could mean acting in a way to protect or promote her capacities to reflect critically on her first-order desires and to implement the results of her reflections. If the above assumption is accepted, then it follows that when a decision does not affect someone's capacity for autonomy there is no reason based directly on respect for autonomy to respect her decision. Of course there may be other reasons why someone's decisions should be respected. In practice the exercise of decision-making should enhance an agent's capacity to make reflective decisions and hence promote her autonomy. It follows that there is a prima facie case to respect someone's decisions.

I have argued that the above assumption means no decisions made by an autonomous person should be respected when they damage her capacity for autonomy. I will now present two arguments to show that the assumption that to respect someone's global autonomy solely

means to protect or promote her capacity for autonomy, should be rejected. Firstly in section 2.2 I argued that respect for an autonomous person means some of her decisions must be accepted even if these decisions damage her capacity for autonomy. These decisions are decisions the agent governs herself by. The reason for this is that it seems impossible to respect the intrinsic value of someone's autonomy without accepting such decisions. It follows that respecting an agent's autonomy, by protecting and promoting her capacity for autonomous action, fails to respect the intrinsic value of her autonomy. Such behaviour would however respect the instrumental value of her autonomy. Secondly, let it be assumed that I respect someone's rationality. I do not respect her rationality by protecting or promoting her capacity for rationality. I do so by respecting the decisions she makes. It might then be argued, by analogy, that the same should hold for respecting someone's autonomy.

I have suggested that one way of respecting a person's global autonomy might simply be to accept her decisions. I argued in my introduction that if informed consent is based on respect for autonomy as required by the General Medical Council (2001, introduction 1), then the concept of autonomy adopted and what it means to respect that concept has important ramifications for the practice of informed consent. Let it be assumed that Dworkin's concept of global autonomy forms the basis of informed consent. It follows that a patient can only be assessed as autonomous over an extended portion of her life as required by Dworkin (1988, page 15). Let it be further assumed that to respect someone's global autonomy simply means accepting all her decisions. Accepting both of these assumptions would mean major changes would need to be made to the current practice of informed consent. In informed consent, as it is currently practiced, a patient's competence is judged by her ability to make an autonomous decision. This practice seems to be based on the assumption that only autonomous decisions

must always be accepted. However, if informed consent is based on respect for global autonomy and respecting someone's global autonomy entails accepting her decisions, it follows that provided a patient has led a normal life, then it might be concluded that all her consent decisions should simply be accepted in order to respect her autonomy. Accepting this conclusion would cause major problems for the practice of informed consent for it would mean accepting intuitively non-autonomous decisions such as that of MB to refuse a caesarean section.

It might be argued, again by analogy, that the above conclusion is false. If I respect someone's rationality I do not have to accept all her decisions. However, it does seem that if I respect her rationality I am committed to accepting her rational decisions. Dworkin believes autonomy may be sacrificed in some circumstances:

It is also possible that the promotion of autonomy in the long run requires sacrificing autonomy in the short run (Dworkin, 1988, page 114).

Accepting that it is possible to sacrifice autonomy in the short term seems incompatible with simply accepting all of an autonomous agent's decisions. It might be argued that my second assumption above should be modified as follows. Respect for global autonomy would now mean accepting all of an autonomous person's decisions provided these decisions are the product of reflection and reached in a procedurally independent way. In this way respecting someone's autonomy would be analogous to respecting her rationality. In addition such a modified conclusion would concur with the ideas developed in section 2.2 concerning what it means to respect autonomy. It would also mean that intuitively non-autonomous decisions,

such as that of MB to refuse a caesarean section, would not have to be automatically accepted in order to respect autonomy. However, it seems that Dworkin would not accept this modified conclusion. If it is possible to sacrifice autonomy in the short term then this is incompatible with simply accepting all of an autonomous person's decisions made in a certain way even if these decisions are the product of reflection and reached in a procedurally independent way. It might be concluded that Dworkin holds it would be wrong to respect global autonomy by either respecting an agent's autonomy, or by protecting or promoting her capacity for autonomy or automatically accepting any of her decisions.

It might be argued that the difficulties with what it means to respect global autonomy are caused because Dworkin defines his concept of global autonomy solely in terms of autonomous persons. Prima facie Dworkin's (1988, page 114) assertion that the promotion of autonomy in the long term may require sacrificing autonomy in the short term appears to be completely plausible. However, as has been shown above this apparently straightforward assertion causes great difficulties. It would be clear what Dworkin meant if he argued decisions might be sacrificed in order to promote autonomy in the long term. It would also be clear what Dworkin meant if he argued autonomous decisions might be sacrificed to promote global autonomy. I will argue below that the latter is impossible if autonomy is to be fully respected. However it is not immediately clear what Dworkin means by sacrificing autonomy in the short term to promote autonomy in the long term if autonomy is seen *solely* as the capacity of someone to reflect critically on her desires and her capacity to accept or attempt to change these desires in line with her preferences and values.

It might be argued that even if Dworkin does not explicitly believe there are autonomous decisions, his assertion that autonomy may be sacrificed in the short term implicitly requires

that there are autonomous decisions. Let it be assumed that autonomy *solely* refers to someone's capacity to reflect critically on her desires and her ability to satisfy at least some of her desires resulting from this reflection. Clearly it is possible to promote one decision at the expense of another. It is also possible to promote one capacity at the expense of another. For instance it might be possible to promote someone's capacity for intellectual excellence whilst failing to promote her capacity for sporting prowess. However if the above assumption is accepted it seems that Dworkin believes it is possible to promote someone's capacity for autonomy whilst at the same time attempting to sacrifice the same capacity. This appears to cause difficulties. However it seems possible to promote someone's long-term happiness by denying her short-term happiness. It follows it might be possible to respect someone's autonomy in the long-term by sacrificing her autonomy in the short-term. Whatever Dworkin's exact position it is clear an agent's decisions matter when they affect her capacity for autonomy.

Dworkin never defines autonomous decisions with reference to his concept of global autonomy. If Dworkin implicitly believes autonomous decisions exist these might simply be defined as any decision made by an autonomous person. It would follow that the concept of an autonomous decision is parasitic on the concept of an autonomous person. This reverses the position adopted by Christman (1991, page 3) with which I will deal in section 3.4. Secondly, an autonomous decision might be defined as any decision based on reflection and reached in a procedurally independent way. Each of these definitions means it would be possible to promote autonomy in the long term and sacrifice some autonomous decisions.

I argued in section 2.2 that if someone's autonomous decisions are not respected then the intrinsic value of her autonomy is not respected. I further argued that it is impossible to respect

some of an agent's autonomous decisions and fail to respect others whilst respecting the intrinsic value of her autonomy. I argued that the above holds because the intrinsic value of autonomy is based on the recognition of someone as the kind of person capable of determining her own future. It seems to be impossible to recognise someone as the kind of person capable of determining her own future whilst failing to respect all decisions she makes concerning her future. It might of course be argued that it is wrong to tie the intrinsic value of autonomy to the recognition of someone as the kind of person capable of determining her own future. However it would appear that this position is not open to Dworkin. Frankfurt (1999, page 163) ties the intrinsic value of autonomy to the recognition of someone as the kind of creature capable of determining her own destiny. I still further argued in section 2.2 that respect for autonomy must include respect for the intrinsic value of autonomy. It might be concluded that because Dworkin's concept of global autonomy permits autonomous decisions to be sacrificed in order to promote global autonomy in the long term that his concept fails to respect the intrinsic value of autonomy. It might then be further concluded that Dworkin's concept of global autonomy is an incomplete account of autonomy.

It might be argued that I am wrong to suppose Dworkin implicitly believes in autonomous decisions. Dworkin might believe there are no real autonomous decisions. It might be concluded that he believes there are only intuitively autonomous decisions and it is these decisions that might be sacrificed in order to promote autonomy in the long term. I argued in section 2.1 that any meaningful concept of personal autonomy must be able to account for our intuitive ideas of autonomy. This is of particular importance in the context of informed consent. Autonomous decisions are part of our intuitive ideas of autonomy. It can be concluded even if even if my supposition is incorrect that because Dworkin's concept of

global autonomy is unable to account for intuitively autonomous decisions, his concept is an incomplete account.

In order to make clear the importance of the value of intrinsic autonomy, consider the case of a young woman who is told she has leukaemia. She had wished to have a child of her own in the future. Her best medical option is to have radiotherapy to destroy her bone marrow followed by a bone marrow transplant provided a suitable donor can be found. This option will render her infertile. A second option is to take drugs which will hopefully hold her leukaemia in remission for a period. If she chooses this second option she may try to have a child and the possibility of a bone marrow transplant later. This is a dangerous option. A donor becomes available and she must decide which option to choose. Let it be assumed that this young woman chooses the second option. Her decision is clearly a decision by which she determines her future. Let it be further assumed that she fully understands the risks involved and still chooses the second option. Intuitively her decision is an autonomous decision. However, Dworkin believes autonomy in the short term may be sacrificed to promote autonomy in the long term. It seems possible that irrespective of whether Dworkin regarded this young woman's decision as autonomous or not he might believe her decision should not be respected. Intuitively decisions about how much risk a patient is prepared to accept seem to be the patient's responsibility. I will deal with the topic of risk in greater detail in the next chapter. It can be concluded that Dworkin's second concept of autonomy is unable to account for our ideas concerning respect for autonomy developed in section 2.2 or our intuitive ideas of informed consent.

3.4. Christman and autonomy

In sections 3.3.2 and 3.3.3 I examined Dworkin's concept of global autonomy and showed that there are differences between his concept and our intuitive ideas of autonomy. These differences would raise difficulties if informed consent were based on respect for Dworkin's concept. Many of these difficulties arise because Dworkin sees autonomy as a global concept that can only be assessed over an extended portion of someone's life. I argued that this concept makes it difficult to respect the intrinsic value of autonomy. In this section I will consider the concept of autonomy as proposed by Christman, (1991). Christman specifically proposed his concept to answer some of the other problems raised by Dworkin's concept, namely problems of regress and procedural independence.

Hierarchical theories of autonomy such as those of Dworkin and Frankfurt are concerned with the relationship between an autonomous agent's first order desires and her higher order desires or values. Christman's concept of autonomy, as pointed out by Jennings (2000) is concerned with an agent's attitude to the way she acquires her desires:

However, there is a significant difference between Christman's view and subjective theories in that for Christman it is not the agent's attitude to their *desires* that confers autonomy. Rather it is the agent's attitude to the *process* that led them to having the desires they do. (Jennings, 2000, page 159)

It follows that Christman's account of autonomy is a historical account. This history is the history of how the agent acquired her desires. The important thing as far as his concept of autonomy is concerned is not whether the agent identifies with her desires or has certain capacities, but the way she acquired her desires. This section will split into three subsections.

3.4.1. Christman's historical concept of autonomy

Dworkin's (1988) account of autonomy is concerned with an autonomous agent's capacity for critical reflection based on her higher-order preferences and values. Dworkin also specifies that these higher-order preferences and values must be procedurally independent. It follows that Dworkin's account of autonomy is also partly a historical account because it is concerned with how an agent acquired her higher-order preferences and values. The main concern of Christman's (1991) account of autonomy is how an agent acquires his desires and his account is not concerned with the content of these desires nor does it differentiate between first and second order desires:

- 1) Christman's concept of autonomy is defined by the following three conditions.
- 2) A person P is autonomous relative to some desire D if it is the case that P did not resist the development of D when attending to this process of development, or P would not have resisted the that development had P attended to the process.
- 3) The lack of resistance to the development of D did not take place (or would not have) under the influence of factors that inhibit self-reflection.

- 4) And the self-reflection involved in condition (1) is (minimally) rational and involves no self-deception. (Christman, 1991, page 11)

In what follows it will be assumed that if an agent has an autonomous desire then any action or decision flowing from this autonomous desire is an autonomous action or decision.

Christman's account of autonomy can be illustrated by two related examples. Let it be assumed that two patients are involved in accidents and each patient requires a blood transfusion. Let it be further assumed that both patients refuse to give consent to the transfusion. Let it be still further assumed that the first patient is a Jehovah's Witness who did not resist the development of her desire not to have the transfusion. Christman would regard her decision as autonomous. However let it be assumed that the second patient's desire not to have the transfusion is based on an irrational phobia of needles, as in the case of MB [1997]. In this case if the patient unsuccessfully resisted the development of this desire not to have the transfusion, Christman would regard her decision as non-autonomous.

I will now examine and comment on each of Christman's three conditions. Christman's first condition requires the following. An agent is autonomous relative to some desire if he did not resist the development of this desire or would not have resisted the development of this desire. The hypothetical lack of resistance is a necessary part of the condition. Consider a man who is HIV positive and engages in unprotected intercourse. Clearly if such a man was aware of the consequences of his actions, and did not consciously resist the development of his desire for unprotected intercourse, Christman would regard his desire as autonomous. Let it be assumed this man did not consciously attend to the development of this desire. In this scenario there are two possibilities. Firstly, had he attended to the development of his desire, he would not have resisted its development. Once again Christman would have regarded his desire for

unprotected intercourse as autonomous. Secondly, had he attended to the development of his desire, he would have resisted its development. In this case Christman would have regarded his desire as non-autonomous.

Christman's second condition for a desire to be autonomous is that the lack of resistance to the development of this desire did not take or would not have taken place under the influence of factors that inhibit self-reflection. It is important to distinguish between desires which are non-autonomous due to Christman's first condition and those that are non-autonomous due to his second condition. Christman's first condition refers to whether an agent resisted the formation of a desire. This resistance or lack of resistance concerns the agent. Christman's second condition refers to the conditions in which this resistance or lack of resistance took place. These conditions must be ones in which the agent is able to reflect on the formation of her desires. This reflection must be rational in some sense because Christman's third condition requires reflection must be minimally rational. However, it must be noted that Christman (1991, page 13) only requires the conditions are such that an agent is able to reflect on the formation of her desires. He does not require that the agent actually reflects on her desires in line with the second part of his first condition.

Christman's third condition for the formation of autonomous desires requires that any self-reflection involved is minimally rational and involves no self-deception. This condition has two parts. Part one is concerned with rationality, and part two is concerned with self-deception. Hierarchical accounts of autonomy, such as the first concept of Dworkin and that of Frankfurt, appear to be purely structural definitions of autonomy. It follows that whether a decision is autonomous according to some hierarchical account of autonomy can be solely determined by examining the relationship between this decision and some other elements

required by the concept. The content of the agent's desires, preferences or values plays no part in determining her autonomy. I will argue below that minimal rationality as defined by Christman is also a purely structural definition. However I will argue that the second part of Christman's third condition for the formation of autonomous desires requiring that any self-reflection involves no self-deception must consider the contents of an agent's desires, preferences or values. It follows that Christman's account of autonomy is not a purely structural account.

Christman regards minimal rationality as having two conditions. Firstly, minimal rationality requires internal consistency. According to Christman this means that an agent's beliefs and desires form a consistent set:

I would defend the claim that only minimal 'internal' conditions for rationality (like consistency of beliefs and desires) would be plausible conditions for autonomy (Christman, 1991, page 14)

Minimal rationality as defined above is a structural requirement only requiring that an agent's beliefs and desires be internally consistent. It would appear that this requirement is not concerned with any externally imposed standards which might be concerned with the contents of an agent's beliefs and desires. People have a great many beliefs and desires and in practice do not check these for consistency. For this reason Christman only requires an agent's beliefs and desires are not manifestly inconsistent.

What this requirement must capture, though, is the necessity that an autonomous person is not being guided by manifestly inconsistent desires or beliefs (Christman, 1991, page 16).

It should be noted here that Christman considers an autonomous person in addition to autonomous desires without previously defining autonomous persons. Dworkin believes autonomy is a global concept, and I have argued that the concept of an autonomous decision is dependent on the concept of an autonomous person. Christman (1991, page 3) reverses this dependence believing the idea of an autonomous person is parasitic on the idea of autonomous decisions. It might be presumed that Christman implicitly believes that an autonomous person is simply someone who has autonomous desires. However, if this is accepted, it is difficult to see how the concept of an autonomous person does any useful work. The second condition Christman (1991) believes is necessary for minimal rationality requires that an autonomous agent must be capable of calculating the utility of her decisions and maximising this utility:

These conditions should not be seen as less stringent than, for example, the axioms of standard decision theory, wherein the agent is rational if she chooses the action that will maximise her expected utility (Christman, 1991, page 15).

If an agent maximises her utility any calculation she uses is based on her internal preferences and values. It might be concluded that minimal rationality is not concerned with any externally imposed standards which might be concerned with the contents of an agent's beliefs and desires.

The second part of Christman's third condition necessary for autonomous desire acquisition concerns self-deception. This condition is connected to the idea that a person's set of beliefs and values are transparent to her:

If the 'self' doing the 'governing' is dissociated, fragmented, or insufficiently transparent to itself, then the process of self-determination sought for in a concept of autonomy is absent or incomplete (Christman, 1991, page 17).

It might appear that this condition follows directly from the first part of Christman's third condition requiring the agent is not manifestly inconsistent. Clearly, if an agent has a manifestly inconsistent set of beliefs and desires, her self may not be transparent to her. However the fact that someone does not have a manifestly inconsistent set of beliefs and desires not mean she is not deceiving herself. Consider a gambler who has had a run of bad luck. Let it be assumed that she convinces herself that her luck is about to change and she is about to win a large amount of money. Because of this conviction she gambles a large amount of money she cannot afford. It would appear to be conceivable that once the gambler has convinced herself that her luck is about to change she does not have a manifestly inconsistent set of beliefs and desires. Moreover it is quite possible to imagine circumstances in which a gambler might welcome rather than resist the development of such a belief. The example of the gambler shows that it is not enough that an agent's beliefs and desires are not manifestly inconsistent for her not to be self-deceiving.

3.4.2. A comparison between Christman and Dworkin's concept of autonomy

In this section I will compare Christman and Dworkin's accounts of autonomy in the context of informed consent. Firstly I will argue that both Christman and Dworkin hold that a patient should be able to base an autonomous decision on a restricted amount of information.

Secondly I will argue that due to the problem of infinite regress, Christman's account of

autonomy might form a better basis for the practice of informed consent than hierarchical accounts of autonomy. Thirdly Christman believes his concept eliminates the need for procedural independence which is needed in both of Dworkin's concepts. I will argue that this belief might be false. Lastly I will argue that because Dworkin is concerned with autonomous persons and Christman with autonomous desires, then Christman's concept of autonomy concurs better with both our intuitive ideas of autonomy and informed consent.

Christman's concept of autonomy means it is possible for a patient to make an autonomous decision requesting that she is not to be fully informed about her course of treatment. This is possible because what matters as far as his concept of autonomy is concerned is how and in what conditions an agent acquires her desires. It seems possible to imagine a patient not resisting the acquisition of such a desire. She might be squeamish about hearing details of her medical condition for instance. It also seems possible to imagine the acquisition of this desire taking place in conditions which do not inhibit reflection and in which the patient is minimally rational. Dworkin (1988, page 118) also holds that it is possible for a patient to make an autonomous decision requesting she is not to be fully informed or consulted about her course of treatment. Such a request seems unlikely to damage a patient's capacity for autonomy. However a request by a patient that she is not to be fully informed about her condition runs counter to the ethos of informed consent. One of the main purposes of informed consent, as the name implies, is to inform a patient about her condition. It follows if informed consent is based on respect for either of these concepts of autonomy the practice of informed consent might need to be revised. It is argued by some that a patient should be able to make a request that she is not fully informed about her condition (see Clarke, 2001). Section 5.1.1 will examine this question in detail.

Most concepts of personal autonomy have a hierarchical structure. This means an agent's first order desires must be endorsed at a higher level if these first order desires are to be considered autonomous. It might be argued that this might not be true of Dworkin's concept of global autonomy as this concept is primarily concerned with an agent's capacity for autonomy. However, I argued in section 3.3.3 that Dworkin's concept of global autonomy is still implicitly committed to the idea of autonomous decisions. This means that his concept might still have a hierarchical structure. The question may be asked what makes these higher-order desires, beliefs or values autonomous? Law (1998) states the problem as follows:

Chief among these is the thought that if it is appropriate to ask of any first order-desire whether it is endorsed by the agent's second-order desires, then it seems equally correct to ask of those second order desires whether they themselves are desires that the agent is happy to have and act on... For instance, I might have a desire for chocolate and a second-order desire not to have this first-order desire. But I may also have a third order desire to be rid of this annoying second-order desire (Law, 1998, page 52).

The problems associated with regress may seem to be trivial in the case of chocolate. However this would not be true in the case of chemotherapy. Consider again the case of a patient facing a decision whether to extend her life slightly by chemotherapy or to opt for shorter life with palliative care (Mathews, 2000, pages 61, 62). Let it be assumed that this patient's first order desire is to avoid discomfort and to do so she feels she should not consent to chemotherapy. On reflection this patient decides it is her best option to undergo treatment and as a result of this reflection she consents to chemotherapy. Let it be further assumed that

this patient has the capacity for critical reflection and the ability to change her first-order desires. It follows under most hierarchical accounts of autonomy that, without the problem of regress, the above patient's decision would be considered autonomous. However, it is possible to imagine that this patient has a still higher order desire that she does not have the second order desire to undergo chemotherapy. This appears to lead to an infinite regress. If the above is accepted it follows that hierarchical concepts of autonomy offer incomplete accounts of autonomy. Theoretically this might mean that if informed consent were based on respect for a hierarchical concept of autonomy, then in practice it would be hard to decide whether a patient's consent decision was truly autonomous. Christman's concept of autonomy avoids the problem created by regress because he concentrates solely on the way an agent acquires her desires, rather than the way she identifies with her desires. Prima facie it might be concluded that Christman's concept of autonomy would form a better basis for the practice of informed consent than hierarchical concepts of autonomy.

A problem related to infinite regress is procedural independence. Procedural independence is a requirement in both of Dworkin's concepts of autonomy. Procedural independence requires that an agent acquires her second order desires, beliefs or values without being unduly influenced by outside forces. Dworkin (1988, page 18) believes this can be achieved but does not specify how. I suggested in section 3.3.2 that it might not be necessary to specify all the conditions necessary for procedural independence. I argued that it might be better to define procedural independence negatively by assuming procedural independence is possible in some circumstances and listing all the circumstances which make procedural impossible. Christman (1991, page 19) claims his concept of autonomy eliminates the need for procedural independence.

It might be argued that Christman is wrong and that the way someone acquires his autonomous desires might be manipulated, and that this gives rise to the need for procedural independence to be part of his concept of autonomy. I believe such an argument would be wrong. Christman's second condition, that reflection takes place in circumstances that do not inhibit self-reflection, appears to rule out the manipulation of an agent's desires. However if Christman's concept of autonomy is to be meaningful it must be possible to specify the factors that inhibit self-reflection. It might then be argued that specifying the conditions that inhibit reflection is identical to specifying the conditions needed to define procedural independence negatively. It might then be concluded that Christman's concept of autonomy only eliminates the need for procedural independence if this is defined positively. It might be further concluded that if procedural independence is defined negatively then Christman's concept of autonomy does not eliminate the need for procedural independence. It might be still further concluded that if the idea of procedural independence is defined negatively then this idea is built into Christman's concept of autonomy.

Christman's concept of autonomy also differs from that of Dworkin because Christman is concerned with how desires are acquired and Dworkin is concerned with the capacities of autonomous persons. I argued in section 3.3.3 that because Dworkin's concept of global autonomy is primarily concerned with an agent's capacity for reflection that this gives rise to a problem with respecting the intrinsic value of autonomy. I argued in sections 2.2 and 3.3 that this problem occurs because the intrinsic value of autonomy is tied to the recognition of someone as the kind of creature that can determine her own future. However this problem does not occur when autonomy is associated with autonomous desires as required by Christman. If autonomous decisions are respected by simply accepting these decisions then the makers of

these decisions are automatically accepted as the kind of creatures that can determine their own future.

In section 3.3 I used the example of a young woman who is told she has leukaemia and wishes to delay treatment in order to try to have a child of her own. I suggested that if informed consent is based on respect for Dworkin's concept of global autonomy then the above patient's decision to postpone treatment in order to have a child might be considered non-autonomous. I argued that if this suggestion were true, it would be at variance with both our intuitive ideas of autonomy and informed consent. However, if Christman's concept of autonomy was applied in the above case, these difficulties do not occur. According to Christman's concept of autonomy whether a decision is autonomous depends on the conditions in which the agent acquired her desires and whether she resisted the development of the desires underlying her decision. It is quite clear in the above case that the young woman did not resist the development of her desire to postpone treatment in order to try to have a child. The development of her desire did not take place in conditions that inhibited her self-reflection. Further she had a manifestly consistent set of beliefs and was not deceiving herself. It is clear then that Christman would regard this young woman's decision as autonomous. It can be concluded that Christman's concept of autonomy appears to concur better with our intuitive ideas of autonomy than that of Dworkin in some difficult cases.

3.4.3. Christman's concept of autonomy and our intuitive ideas of autonomy

Christman's concept of autonomy concerns personal autonomy. It is not primarily concerned with the good of society, as was Mill, or with what someone ought to do morally, as was Kant.

Informed consent decisions are personal decisions. It follows that Christman's concept of autonomy can be directly connected to informed consent decisions. In practice this direct connection would seem to be preferable to an indirect connection through the concept of an autonomous person. Prima facie it follows that Christman's historical account of autonomy would appear to form a better basis for informed consent than Dworkin's global concept of autonomy. I argued in section 2.1 that any meaningful concept of autonomy must concur to some degree with our intuitive ideas of autonomy. In this section I will compare Christman's concept of autonomy with the intuitive ideas of autonomy developed in section 2.1.

In section 2.1 I argued that an intuitively autonomous decision is subject to three conditions. Firstly an autonomous agent must have the capacity to choose and there must be no external constraints controlling his choice. Secondly he must identify with his autonomous decisions. Lastly his autonomous decisions must have a degree of persistence unless there are changes in the circumstances in which the decision was made. It seems clear that Christman's concept of autonomy meets the first of these conditions. Clearly, if an agent's decision is constrained then this decision was made under the influence of factors that inhibit self-reflection. It follows, according to Christman's second condition, that such a decision is non-autonomous.

In section 2.1 I argued that the idea of an agent identifying with his desires is important because it allows us to identify which internal constraints are compatible with autonomy and which are not. Consider again the case of MB [1997]. Recall that MB was twenty-three years old with a needle phobia and was expecting her second child. It seems clear that, according to Christman's historical account of autonomy, MB's decisions to consent to the caesarean section would be autonomous. This follows because she did not resist the formation of her preference for the section, there were no reflection inhibiting factors and she appeared to be

minimally rational. However, according to Christman's historical account of autonomy, MB's decisions would not be autonomous when she refused consent because in these circumstances her phobia of needles inhibited her self-reflection. This follows because her desire to refuse consent originated in conditions that would be incompatible with Christman's second condition.

In section 2.1 I also considered the attitude of women consenting to screening for BRAC 1 and 2 gene mutations (Hallowell, Foster, Arden-Jones, Murday and Watson, 2003, page 81). Intuitively these women's decisions were autonomous even if these decisions were internally constrained by a desire to care for other family members. Christman would regard these women's choices as autonomous because they did not resist the formation of their preferences for screening, there were no factors inhibiting reflection, and they appeared to be minimally rational. It seems that Christman's concept of autonomy is able to differentiate between internal constraints that are intuitively compatible and incompatible with autonomy. However this ability to differentiate between internal constraints does not mean that Christman's concept of autonomy automatically concurs fully with regard to our intuitive ideas about the need for an agent to identify with his autonomous desires.

It would seem, according to Christman, that *any* desire acquired by an agent without him resisting the acquisition of this desire, and subject to Christman's two further conditions would be autonomous. It follows that an agent might acquire a great many autonomous desires he does not believe are important. The question then may be asked whether a desire that an agent does not believe is important to him can be a decision an agent identifies himself with. For instance, someone may have a desire for ice cream. It is perfectly possible he did not resist the formation of this desire, there were no factors inhibiting reflection, and he was minimally rational. It follows according to Christman that the agent's desire for ice cream would be an

autonomous desire. Such a desire is a freely made desire and as such should normally be respected. However, intuitively it would seem to be absurd to argue that an agent identifies himself with a desire for ice cream. Even if the above is accepted it would be wrong to base philosophical arguments solely on our intuitions, although these intuitions may of course guide our arguments.

Let it be assumed for the sake of argument that an agent can identify himself with a trivial desire such as the desire for ice cream. Such a desire need have no persistence. For instance a diner might substitute his desire for ice cream with a desire for an alternative sweet. I will now argue that if an agent has a desire and this desire has no persistence then he does not identify himself with this desire. Let it be accepted that if a person identifies himself with something this identification forms part of the definition of that person as a particular person. Let it also be accepted definitions must have some persistence. It follows that a particular person cannot be defined by reference to mere whims because these whims have no persistence. It can be concluded that if an agent's desire has no persistence then the agent does not identify himself with this desire. I argued in 2.1 that intuitively an autonomous decision is one with which the agent identifies and which has persistence. The above conclusion suggests that these two conditions are linked. I will further explore this linkage in section 5.4.2.

The above conclusion would create a problem if informed consent were based on respect for Christman's concept of autonomy because then some desires which a patient neither cares about nor identifies himself with would be regarded as autonomous. Furthermore these desires should be respected even if respecting these desires harms the patient. It follows that Christman's concept of autonomy leads to a similar position to that which would occur if Mill's ideas on liberty were to form the basis of informed consent (see section 3.1.2). It might

be concluded that if informed consent was based on either Mill's account of liberty or Christman's historical account of autonomy then some decisions that an agent neither cares about nor identifies with should be respected. It might be further concluded that Christman's concept of autonomy, like that of Dworkin, cannot deal adequately with the problem of identification. I will now argue that an agent identifying with his decisions is central to any meaningful concept of autonomy.

3.5. Frankfurt and autonomy

I concluded in section 3.4.3 that the way an agent identifies with his autonomous decisions must be accounted for in any meaningful account of personal autonomy. In this section I will examine an account of autonomy as envisioned by Frankfurt in which an agent's identification with his desires is central to the account. Crucial to Frankfurt's account of autonomy is an agent caring about something. Frankfurt believes caring about something depends on reflection:

Caring insofar as it consists in guiding oneself along a distinctive or in a particular manner, presupposes both agency and self-consciousness. It is a matter of being active in a certain way, and the activity is essentially a reflexive one (quoted in Frankfurt, 1988, page 83, originally 1982).

It follows that Frankfurt's account of autonomy is in some ways related to that of Dworkin(1988, page 20) who sees autonomy as the second order capacity of persons to reflect

on their first order desires. Both Frankfurt and Dworkin's accounts of autonomy concerning personal autonomy are hierarchical and purely structural. I will examine Frankfurt's concept of autonomy in four sub-sections.

3.5.1. The central features of Frankfurt's concept of autonomy

The defining feature of autonomy according to Frankfurt is how an agent relates to his autonomous concerns by caring about them.

The formation of a person's will is most fundamentally a matter of his coming to care about certain things, and of his coming to care about some of them more than others (quoted in Frankfurt, 1988, page 91, originally 1982).

It must be made clear exactly what Frankfurt means by "to care about". He does not simply mean to take care of something. Someone can take care of something without caring about what he is taking care of. For example a shepherd must take care of his sheep but this does not of necessity mean he must *care about them* in the way Frankfurt means. Perhaps he only cares about making a living. An agent's taking care of something may be purely instrumental in obtaining some other good he seeks. The shepherd's identity need not be tied to his taking care of his sheep. For instance the shepherd may become a tractor driver and make his living by this means and need never take care of sheep again. However *caring about* something according to Frankfurt cannot be a purely instrumental means used in order to obtain some other good. Caring about something means the agent cares about the thing for its own sake.

Furthermore the good of what the carer cares about is tied to the carer's own good, and if what he cares about is harmed then he is harmed too.

A person who cares about something is, as it were invested in it. He *identifies* himself with what he cares about in the sense that he makes himself vulnerable to losses and susceptible to benefits depending upon whether what he cares about is diminished or enhanced (quoted in Frankfurt, 1988, page 83, originally 1982).

It is argued by Zimmerman (2000) that Frankfurt's idea of caring about something can be passive. I believe that any such argument is unsound because caring about something by its nature involves activity (see Frankfurt, 1988, page 83, originally 1982). Intuitively it seems that Frankfurt is correct and "caring about something" is connected to autonomy. If this was not so, it would be hard to imagine anyone ever being self-governing in personal matters because he would have no consistent means of decision-making.

Frankfurt believes that by caring about something we act autonomously. Frankfurt also believes that autonomy can be defined in terms of what we love (Frankfurt, 1999, page 132, originally 1994). Frankfurt's ideas concerning both caring about and loving differ from our intuitive ideas. Both caring about and loving are not concerned with emotions according to Frankfurt but are concerned with an agent's volitional structure.

That a person cares about something or that he loves something has less to do with how things make him feel, or his opinions about them, than the more or less stable motivational structures

that shape his preferences and guide his conduct (quoted in Frankfurt, 1999, page 129, originally 1994).

In the above quotation Frankfurt defines caring about as being based on an agent's stable motivational structure rather than his desires. An agent's desires are of course part of her motivational structures. However because her desires need have no persistence these may not form part of any stable motivational structure by which she guides her life. It follows that Frankfurt believes an autonomous action is an action which flows from this stable motivational structure. It follows from this that if an autonomous agent has a stable motivational structure then he must be able to prioritise what he cares about (Frankfurt, 1988, page 91, originally 1982). Sometimes Frankfurt seems to treat caring about something and loving something as equivalent, as in the above quotation. However, elsewhere Frankfurt (1999, page 155) speaks of loving as being a particular mode of caring. Frankfurt sees autonomy as the formation of a person's will being based on caring about (1988, page 91, originally 1982) and on loving (1999, page 129, originally 1994). In what follows it will be held that to care about something and to love something are roughly equivalent and that either can form a basis for personal autonomy. To be autonomous according to Frankfurt means the following. Firstly an autonomous decision or action flows from what the agent cares about or loves. Secondly this caring about something requires her to identify with his decision or action. Thirdly an autonomous agent must be able to prioritise the things she cares about.

3.5.2. The practical consequences of Frankfurt's concept of autonomy

Frankfurt defines autonomy in terms of what a person cares about. In the rest of this thesis “to care about” will be taken to mean what Frankfurt means by caring about as outlined in section 3.5.1, unless stated otherwise. This section will examine the practical consequences of Frankfurt's ideas on caring. In order to make these consequences clear, I will examine them in connection with the idea of informed consent.

Let it be assumed that informed consent is based on respect for Frankfurt's concept of autonomy. I argued in section 2.2 that to respect personal autonomy means accepting an agent's autonomous decisions provided these decisions do not harm others. It follows that to respect Frankfurt's concept of autonomy means to accept all decisions the agent cares about provided these decisions do not harm others. Medicine is a practical discipline and prima facie it is difficult to see how the idea of informed consent could be of much practical use if it were based purely on Frankfurt's ideas on caring about as outlined in section 3.5.1. The reason for this is that the idea of caring about appears to be too vague a concept to be of much practical use. However the use of Frankfurt's ideas on caring about would have three major consequences in practice. These consequences might permit his concept of autonomy to form the basis of informed consent. In this section I will examine these consequences. Firstly I will argue that Frankfurt's ideas on autonomy mean an autonomous decision can only be made by an agent who has some values. Secondly I will argue that Frankfurt's ideas on autonomy require that if someone cares about something this caring about must have persistence. Lastly I will argue that Frankfurt's ideas on autonomy means that only an agent who is wholehearted can make an autonomous decision.

The first consequence of adopting Frankfurt's ideas on autonomy is that only an agent with values can make an autonomous decision. Frankfurt (1999) argues if someone has no ideals then his decisions are moved by mere impulse and inclination.

He can make whatever decision he likes and shape his will as he pleases. This does not mean that his will is free. It only means that his will is anarchic, moved by mere impulse and inclination. For a person without ideals, there are no volitional laws he has bound himself to respect and to which he unconditionally submits. He has no inviolable boundaries. Thus he is amorphous with no fixed shape or identity. (quoted in Frankfurt, 1999, page 114, originally 1994)

Intuitively personal autonomy concerns self-government and if someone's decisions are based purely on impulse and inclination then these decisions are not normally part of his self-government. It follows that Frankfurt is correct and if a decision is autonomous then the agent making this decision must have some ideals. It will be assumed here that ideals means values and that values must be something the agent cares about. Let it be accepted that if informed consent is based on respect for autonomy, then a competent decision must be an autonomous decision. It then further follows that if informed consent is based on Frankfurt's concept of autonomy that only a patient with a set of values can make a competent decision. This concurs with informed consent in practice. The General Medical Council, the Department of Health and legal guidelines all require that a competent patient must have a set of values (see sections 1.1 and 1.2). In bioethics it is also generally agreed that a competent patient must have a set of values (for example see Wicclair, 1991, page 91); (Buchanan and Brock, 1989, page 25).

The second consequence of adopting Frankfurt's ideas on caring about something as the basis for defining autonomy is that autonomous decisions must have some persistence. Frankfurt argues that someone can only care about something over time.

Desires and beliefs have no inherent persistence; nothing in the nature of wanting or of believing, requires that a desire or a belief must endure. But the notion of guidance, and hence the notion of caring, implies a certain consistency or steadiness of behaviour, and this presupposes some degree of persistence (quoted in Frankfurt, 1988, page 84, originally 1982).

Prima facie it might be concluded that autonomous decisions must also have some persistence. Dworkin (1988, page 15) believes that autonomy is a feature defining a whole way of living one's life and can only be evaluated over an extended portion of a person's life. It follows that Dworkin's ideas on autonomy concur with those of Frankfurt by holding autonomy must have some persistence. Dworkin is primarily concerned with an autonomous agent's capacity for autonomy. According to Frankfurt (1999, page 129 originally 1994) considering someone's stable motivational structure is important when considering his autonomy. It might then be assumed that an agent's capacity for autonomy and his stable motivational structure are roughly equivalent. It might then be further assumed that Dworkin and Frankfurt's concerns about the persistence of autonomy are similar. This second assumption would be false. It is true that Frankfurt is concerned with an agent's stable motivational structure but his primary concern is with the actions that flow from this structure. These actions are partly reflexive (Frankfurt 1988, page 83, originally 1982) but it would be wrong to assume that Frankfurt believes autonomous actions can be wholly reflexive.

No one can properly be said to care about something unless, at least to some degree, he guides his conduct in accordance with the implications of his interest in it. This means paying attention to it and to what concerns it; it means making decisions; it means taking steps. Thus, with respect to those things of whose importance to him derives from the fact that he cares about them, the person is necessarily active (quoted in Frankfurt, 1999, page 87, originally 1982).

It follows that Frankfurt believes autonomy is concerned with decisions flowing from what the agent cares about. What an agent cares about defines his stable motivational structure which by definition must have some persistence. It can be concluded that the prima facie conclusion reached above is true and if a decision is autonomous, then this decision must have some persistence.

The importance of the persistence of autonomy can be illustrated in practice by considering the case MB [1997]. Recall that MB had a needle phobia and was pregnant. Due to complications expected in her delivery she was advised to have a caesarean section. MB consented to the section but later withdrew her consent due to her phobia. This process of consenting and then refusing to consent was repeated several times. MB's consent decisions were not persistent. It follows that MB's decisions would not have been considered as autonomous decisions according to Frankfurt's concept of autonomy. It further follows that if informed consent was based on respect for Frankfurt's concept of autonomy, and a competent decision must be an autonomous decision, then MB's decisions would not have been considered as competent decisions.

The third consequence of adopting Frankfurt's concept of autonomy is that an autonomous agent's volitional structure must be wholehearted. Frankfurt (1988, page 91, originally 1982) believes caring about things means coming to care about some things more than others. He believes caring about some things more than others unites an autonomous agent's will making him wholehearted. This property is defined by Cuypers (2000) as follows;

If a person's will is wholehearted, then it is true of him that his will has a particular unity of attitude, preference and goal. His personality is coherently organised around such a volitional unity. Hence the wholehearted person has a will with a pattern of his own. (Cuypers, 2000, page 236)

It is important to note that the fact that a wholehearted person must care about things and care about some things more than others, only means he has stability in what he cares about. The fact that an agent's will is wholehearted does not mean he must have unity in his desires. For example, someone may have a stable volitional structure and care about not smoking. However he might be unable to overcome his desire for a cigarette. This smoker would still be wholehearted because he has a stable volitional structure even though he does not have unity of desires. Wholeheartedness only refers to an agent's volitional structure and is concerned solely with what the agent cares about. However it would be a mistake to believe that Frankfurt would regard someone who wholehearted and persistent in what he cares about, but is unable to act on what he cares about, as autonomous. Frankfurt (1999, page 87, originally 1992) regards autonomy as being connected to action.

This thesis is concerned with applying philosophy in the context of informed consent. It follows that if the idea of wholeheartedness is to be a useful idea in this context it must be possible to determine in practice whether an agent is wholehearted. Frankfurt defines wholeheartedness as follows;

In what does his wholeheartedness with respect to these physic elements consist? It consists in his being fully satisfied that they, rather than others that inherently (i.e., non contingently) conflict with them, should be among the causes and considerations that determine his cognitive, affective, attitudinal and behavioral processes (Frankfurt, 1999, page 103, originally 1992).

If wholeheartedness is to be a useful idea, we might ask exactly what is meant by satisfaction. Frankfurt defines satisfaction as follows:

What satisfaction does entail is an absence of restlessness or resistance. A satisfied person may be willing to accept a change in his condition, but he has no active interest in bringing about a change (quoted in Frankfurt, 1999, page 103,).

Frankfurt believes an autonomous agent must be wholehearted. He also connects an agent's wholeheartedness with an absence of restlessness or resistance to his volitions. It might then be argued that because Frankfurt's ideas on wholeheartedness are connected to a lack of resistance, these ideas are similar to Christman's ideas on autonomy. Recall that Christman would regard an agent's desire as autonomous provided that the agent did not or would not

have resisted the development of the desire had he attended to the desire's formation, subject to his two other conditions. However it is important to be aware of the differences between Christman's and Frankfurt's ideas. Firstly the lack of resistance applies in different domains. Christman is concerned with an agent's lack of resistance to the acquisition of his desires. Frankfurt is concerned with an agent's lack of resistance to what he cares about. This lack of resistance applies to an agent's volitional or stable motivational structure which may be distinct from his desires, see page 114. It might be argued Christman is concerned with how an agent acquires his motivations whilst Frankfurt is concerned with an agent's stable motivational structure. Secondly, Frankfurt would regard an autonomous agent's lack of resistance to what he cares about as actually occurring. Christman connects an agent's lack of resistance to his desire acquisition as either occurring or possibly occurring if he attended to his desire acquisition. It might be concluded that in practice it should be possible to determine if an agent is wholehearted about some decision by asking two questions. Firstly, does the agent care about his decision? Secondly, is he satisfied with his decision? His satisfaction would be indicated by a persistent absence of restlessness to accepting his decision.

Frankfurt's idea of wholeheartedness is connected to the idea of ambivalence. Cuypers (2000) defines a volitionally ambivalent person as follows:

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He is torn in two opposite directions and thus suffers from volitional division, the ambivalent person is threatened by disintegration and personality disorder (Cuypers, 2000, page 236).

It must be noted that in the above context, ambivalence like wholeheartedness only refers to an agent's volitional structure and not to his desires in general. In order to avoid confusion, when

it only concerns an agent's volitional structure, ambivalence will in future be referred to as volitional ambivalence and, when it concerns an agent's desires will be referred to as psychological ambivalence. It seems clear that if someone is not satisfied with what he cares about he must suffer from volitional division. It follows if someone is not satisfied with what he cares about he must be volitionally ambivalent. Let it be accepted that Cuypers is right and a person who is volitionally ambivalent is threatened by disintegration and personality disorder. Intuitively such a person is non-autonomous. It can be concluded that if a decision is autonomous, then this decision must be wholehearted.

If the ideas of wholeheartedness and ambivalence are to be meaningful in the context of informed consent then the implications of applying these ideas in this context must be clear. I will now use three examples based on the case of Ms B [2002] to make these implications clear. Recall that Ms B was a tetraplegic patient being kept alive on a ventilator which she wished to have switched off. Ms B had no desire to continue living on the ventilator. It follows that Ms B's wish to have the ventilator switched off was not psychologically ambivalent. In addition Ms B cared about her wish to have the ventilator switched off and was not restless with, or did not resist the formation of, this wish. Because of this it further follows that Ms B's wish to have the ventilator switched off was not volitionally ambivalent and hence she was wholehearted. It still further follows that Frankfurt would have regarded Ms B's wish as autonomous. It can be concluded that in the context of informed consent, because respect for autonomy means accepting autonomous decisions as argued in section 2.2, Ms B's wish to have her ventilator switched off should have been accepted.

Secondly, consider an imaginary Mr B. Mr B's medical condition is identical to that of Ms B. However his volitional structure is different. Mr B cares about both continuing to live

and not wanting to spend the rest of his life on the ventilator. Mr B's caring about continuing to live and having the ventilator switched off are both elements of his volitional structure and not simply desires. Let it be assumed that Mr B is unable to give priority to either wanting to continue to live or not wanting to spend the rest of his life on the ventilator. It follows that Mr B's volitional structure is split and hence he is volitionally ambivalent. It further follows that he is non-autonomous. It still further follows that because, like MB, Mr B is unable to make a persistent decision he is incompetent to give informed consent. In this situation a surrogate decision maker must make a decision on Mr B's behalf. It can be argued that the fact that someone is non-autonomous does not mean his decisions should simply be ignored (see Law, 2003, page 54). It can also be argued that just because a patient is incompetent his decisions can simply be ignored (see Buller, 2001, page 109). However, in this context, because Mr B is volitionally ambivalent there are no clear-cut decisions made by Mr B to which a surrogate decision maker can give additional weight. It follows that in this situation a surrogate decision maker should make a decision based purely on what he believes to be in Mr B's best interests.

Thirdly consider Mrs B who is in an identical situation. Mrs B cares about having the ventilator switched off and sometimes desires to continue living. Mrs B persistently cares about not living the rest of her life on a ventilator and wishes to have it switched off. It follows that she is not volitionally ambivalent. However, when the time comes to switch the ventilator off, even though Mrs B continues to care about having it switched off, she is frightened and has a temporary desire to continue living. This desire overwhelms her continuing volition. It follows that Mrs B is psychologically ambivalent. It seems clear that because, like MB, Mrs B is unable to make a persistent decision, she is incompetent to give informed consent and a surrogate decision maker must make a decision on her behalf. However Mrs B's wish to have

the ventilator switched off is volitionally un-ambivalent. In section 5.4.2 I will argue that the persistence of an autonomous agent's volitions are of greater importance than the strength of his desires as far as self-government is concerned. It follows that in this situation Law and Buller's concerns can be addressed. It further follows that a surrogate decision maker should give special weight to Mrs B's wishes when deciding on her behalf.

If it is accepted that informed consent is based on respect for autonomy and wholeheartedness is an integral part of any meaningful concept of autonomy, then this leads to three conclusions. Firstly, if a patient's decision is both volitionally and psychologically un-ambivalent, then this decision must be accepted. Secondly, if a patient's consent decision is both volitionally and psychologically ambivalent, then a surrogate decision maker should make a decision on behalf of the patient based purely on the surrogate's view of the patient's best interests. In this situation, the surrogate decision maker acts purely as a patient's representative. Lastly, if a patient's consent decision is volitionally un-ambivalent and psychologically ambivalent, then a surrogate decision maker should make a decision on behalf of the patient giving special weight to the patient's wholehearted decision. In this scenario a surrogate decision maker should act as the patient's agent rather than his representative as far as possible.

3.5.3. Frankfurt's concept of autonomy and the problem of regress

Frankfurt's concept of autonomy raises three major theoretical problems. Firstly, Frankfurt's concept would seem to regard some non-voluntaristic acts as autonomous. Secondly, it might be argued that by concentrating solely on what an autonomous agent cares about as opposed to

other features such as his desires Frankfurt is dealing with an “ideal self” as opposed to the real person. Both of these problems are directly connected to our intuitive ideas on autonomy. I will consider these problems in conjunction with our intuitive ideas on autonomy in section 3.5.4. This section will only deal with the third problem, that of regress. The problem of regress is a theoretical problem. It might be assumed that theoretical problems have no place in this thesis as it primarily concerned with the relationship between autonomy and informed consent. However, I will show that this assumption is false. I will argue that it would be futile to base informed consent on respect for any concept of autonomy that has irresolvable problems limiting the usefulness of the concept. Two solutions will be offered to the problem of regress. Firstly, I will argue that the problem of regress dissolves away in practice. Secondly, I will argue that Frankfurt’s concept of autonomy is a hybrid concept and this blocks the path to regress.

Frankfurt’s concept of autonomy appears to suffer from a problem associated with infinite regress. Cuypers (2000) summarises part of Frankfurt’s concept of autonomy as follows:

The harmonious mesh between a person’s second-order volitions and his first order desires is, then wholly sufficient for the autonomy of his first-order psychology. In short, autonomy consists of self-identification and volitional harmony (Cuypers, 2000, page 229).

Accepting the above appears to lead to the problem of infinite regress:

First-order desires are made autonomous by acts of identification, but what, in turn makes these second-order acts autonomous? (Cuypers, 2000, page 229)

It follows that if the above explanation of Frankfurt's concept of autonomy is accepted as a complete explanation of his concept then this concept has a problem connected with infinite regress.

I will now show that if informed consent is based on respect for Frankfurt's concept of autonomy, then the problem of regress appears to be of practical importance. Consider someone donating a kidney to a relative. This process has no medical benefit to the donor. It follows that it is especially important to be certain that the donor's decision is autonomous. The donor may have an initial first order desire not to donate her kidney perhaps because of fear. However let it be assumed on reflection she decides it would be altruistic to donate her kidney and as a result of this reflection modifies his first order desire. She decides to donate one of her kidneys. It follows that there is now a harmonious mesh between the donor's second order volitions and her first order desires. It further follows that without the problem of regress the donor's desire to donate one of her kidneys might be called autonomous. However it seems perfectly possible for the donor to have a third-order volition wishing she did not have the altruistic second-order volition to donate one of her kidneys. This leads to the conclusion that Frankfurt's concept of autonomy is an incomplete account of autonomy. Let it be accepted that informed consent is based on respect for Frankfurt's concept of autonomy. Let it also be accepted, as argued in section 2.2, that to respect autonomy means accepting autonomous decisions. It might be concluded in this context that it would be impossible to decide whether to accept the patient's decision to donate one of his kidneys. This points to a

second conclusion, namely that it is wrong to base informed consent on respect for Frankfurt's concept of autonomy unless the problem of regress can be solved.

The problem associated with basing informed consent on respect for Frankfurt's concept of autonomy must be specified. Let it be accepted that Frankfurt's concept of autonomy has a theoretical problem associated with infinite regress. However, the problem to be addressed here is whether this theoretical problem means Frankfurt's concept of autonomy cannot form a *useful* basis for informed consent. I will now argue by analogy that in practice this problem associated with infinite regress does not limit the concept's usefulness. If someone makes a calculation it is sensible for him to check his calculation, perhaps even double-check it. However is it sensible for him to triple-check the calculation or perhaps check it a hundred times? Theoretically someone may make a mistake in some calculation ninety-nine times. However, in practice, someone would not usually check his calculation a hundred times if he always obtained the same answer. Checking loses its point after many checks have been carried out because the checker becomes convinced his answer is correct. It follows that while theoretically it is possible to check a calculation an infinite number of times, in practice this checking becomes pointless.

It might be argued that, by analogy, the same is true of all hierarchical accounts of autonomy including Frankfurt's concept. Theoretically it is possible for an agent to endorse his reflection at one level by reflection at a higher level an infinite number of times. However, in practice, this also becomes pointless because the agent becomes committed to his choice as pointed out by Frankfurt:

For a commitment is decisive if and only if it is made without reservation, and making a commitment without reservation means that the person who makes it does so in the belief that no further accurate inquiry would require him to change his mind. It is therefore pointless to pursue the inquiry any further. This is precisely the resonance effect (quoted in Frankfurt, 1988, page 168, originally 1987).

It might be objected that my analogy is a poor analogy for two reasons. Someone might argue that each calculation is identical whilst each reflection reflects on a different previous reflection. I believe this objection is unsound. I accept that the procedure used in each calculation check is identical. However, the purpose of each check is different. Consider the second calculation check in a series. This is simply a calculation. However the purpose of this calculation is to check the previous result. Secondly, it might be objected that higher order reflections are not connected directly to an agent's original decision and hence are not analogous to calculation checks. I believe this second objection is also unsound. It is hard to see any useful purpose to an agent's higher order reflections unless these reflections are in some way checks on the agent's original decision. It follows that the purpose of each of these higher order reflections is to check on the correctness of the agent's decision. Let it be assumed that all an agent's reflections endorse his decision. It follows that at some stage the agent becomes committed to his decision. When this stage is reached, the resonance effect means it becomes pointless to reflect further. The kidney donor may question whether his higher order desire is endorsed at a still higher level. However, if his questioning always endorses his original decision, then eventually he will become committed to this decision and further questioning becomes pointless. This thesis is concerned with applied philosophy and,

even if the theoretical problem of regress exists, it seems in practice that the problem of regress does not limit the *usefulness* of Frankfurt's concept of autonomy.

I have argued that even if Frankfurt's concept of autonomy suffers from the theoretical problem of regress, this does not affect the usefulness of his concept. Let it be assumed for the sake of argument that all purely hierarchical accounts of autonomy suffer from the theoretical problem of regress. I will now argue that because Frankfurt's concept of autonomy is not a purely hierarchical concept, it does not suffer from the problem of regress. Kristinsson (2000, page 270) notes that Frankfurt's concept of autonomy can be interpreted in two ways. Firstly, Frankfurt's concept may be seen as a reflective process by which an agent identifies with his first order desires. This would seem to be a hierarchical account of autonomy and open to the problem of regress. Secondly, Frankfurt's concept is defined by what an agent cares about. Cuypers (2000, page 226) concurs with Kristinsson's view and expands on it by arguing that Frankfurt's concept of autonomy is a hybrid concept. He defines this hybrid as a combination of voluntaristic and non-voluntaristic components (Cuypers, 2000, page 247). He argues that the harmonious agreement between a person's second-order volitions and his first order desires defines the voluntaristic component. He then further argues that the non-voluntaristic component consists of what the agent cares about. The agent's second order volitions are autonomous not because they are endorsed at some higher-level, but because the agent cares about them wholeheartedly. This means that the agent is satisfied with his volitions, and has no desire to reflect further on these volitions:

When a person is fully satisfied with his motivational energies there is no need whatsoever that he should also adopt a higher-order attitude towards his self-satisfaction. The state of self-

satisfaction does not require the adoption of a higher-order attitude to make that state self-satisfactory (Cuypers, 2000, page 238).

It can be concluded that if it is accepted Frankfurt's concept of autonomy is indeed a hybrid concept that the way to infinite regress is blocked. It can be further concluded that the theoretical problem connected to regress does not mean that Frankfurt's concept of autonomy cannot form the basis for informed consent.

3.5.4. Frankfurt's concept of autonomy and our intuitive ideas of autonomy

This section is concerned with two potential problems connected to Frankfurt's concept of autonomy. These problems are related to our intuitive ideas of autonomy and were outlined at the start of section 3.5.3. Firstly, Frankfurt's concept of autonomy contains a non-voluntaristic component. If this was not so, his concept might indeed be open to the theoretical problem of regress as argued in section 3.5.3. However, it might be suggested that even if this non-voluntaristic component helps solve the problem of regress, it clashes with both our intuitive ideas of autonomy and informed consent. Secondly, it might be suggested that Frankfurt's concept of autonomy is based on ideas concerning "ideal persons" rather than "real persons". If this is true, it would follow that his concept of autonomy should not be used as a basis for informed consent as informed consent deals with real rather than ideal patients. I will accept that Frankfurt's concept of autonomy contains a non-voluntaristic component but I will argue that this does not clash with either our intuitive ideas of autonomy or informed consent. I will not accept that Frankfurt's concept of autonomy depends on the idea of an ideal person.

Frankfurt believes autonomy is based on caring about (1988, page 91, originally 1982) or loving something (1999, page 129, originally 1994). Frankfurt's ideas on caring about and loving something may not be identical, however in this thesis I regard them as roughly equivalent when they form the basis for his concept of autonomy (see section 3.5.1). Frankfurt believes loving is volitionally constrained to some degree:

Roughly speaking, then, when I refer to love I am referring to a concern for the well-being or flourishing of a beloved object – a concern that is more or less volitionally constrained so that it is not a matter of entirely free choice or under full voluntary control, and that is more or less *disinterested* (Frankfurt, 1999, page 165).

Frankfurt also holds that to love something regardless of any benefits it brings to the agent is what it means to be disinterested. If someone loves something, and his desires and interests do not affect this loving with respect to what he loves, then he is not free:

In this respect, he is not free. On the contrary, he is in the very nature of the case captivated by his beloved and his love. The will of the lover is rigorously constrained. Love is not a matter of choice (quoted in Frankfurt, 1999, page 135, originally 1994).

It follows that if informed consent is based on respect for Frankfurt's concept of autonomy, then it is possible for a patient facing some decision to feel he has no real choice concerning this decision. It might then be suggested that if someone is faced by some decision and feels

he has no real choice, then intuitively his decision is non-autonomous and he is unable to give genuine informed consent.

I believe that the above suggestion is too simplistic and what it means to have no choice must be better defined. Someone may have no choice due to either internal or external constraints. Frankfurt (1999, page 131, originally 1994) believes an autonomous agent must be free from external constraints. Let it be accepted without further argument if a patient's choice is constrained by external constraints his choice is non-autonomous and he is unable to give informed consent. but that he may be constrained internally. The question that must be addressed is this, are some of an agent's internal constraints compatible with him making autonomous decisions? Wolf (1990) seems to believe a truly autonomous agent must have no internal constraints including reason:

A truly autonomous agent would be no more bound by Reason than Desire. Thus a truly autonomous agent must have a freedom more radical than that which the ability to act in accordance with Reason automatically affords (Wolf, 1990, page 53).

The above position may not completely represent Wolf's view. Wolf's reason view of action seems very akin to some concepts of autonomy (Wolf, 1990, chapter 4). However she does also mention moving from the autonomy view to the reason view (Wolf, 1990, page 71).

Whatever Wolf's exact view of autonomy is, the above position seems to be untenable for two reasons. Firstly, if this position was accepted, it means children and even the insane might be regarded as fully autonomous. It follows that such a radical concept of autonomy cannot account for our intuitive ideas of self-government and should be rejected. Secondly, Frankfurt

(1999, page 114, originally 1993) argues that if someone has no ideals or values his will is anarchic. It might be objected that Frankfurt is wrong and someone's will is not purely anarchic if it is guided by his impulses and desires. Let it be accepted for the sake of argument that someone's will need not be anarchic in these circumstances. However, it does not automatically follow from accepting the above, that if someone's will is guided by his impulses and desires, then his will is autonomous. Consider MB and her needle phobia [1997]. It follows that if someone's will is autonomous he must have some ideals. Frankfurt believes someone's ideals are internal constraints:

Now an ideal is a limit. A person's ideals are concerns that he cannot bring himself to betray. They entail constraints that, for him it is unthinkable to violate (quoted in Frankfurt 1999, page 114, originally 1993).

It seems clear that Frankfurt is correct to believe an agent's ideals or values impose internal constraints on his actions. If this were not so in practice his ideals would be indistinguishable from his impulses and desires. It can be concluded that an agent's ideals act as internal constraints on his will and compel him to act in a certain manner.

It might then be further concluded by some such as Wolf that, because these ideals mean an agent's choice is not totally free, he is non-autonomous. I will now argue that such a conclusion would be false because these ideals are constitutive of an autonomous agent's will. This means that they are liberating rather than coercive and hence supporting the agent's autonomy rather than opposing it see Frankfurt (1988, page 88). I will argue that these ideals not only support an agent's will but that they also define it. This can explain why MB's internally imposed needle phobia with which she did not identify was coercive whilst

internally imposed constraints with which an agent identifies himself support and define his autonomous actions. In section 2.1 I argued that any meaningful concept of autonomy must be able to distinguish between those internal controlling influences, which are compatible with autonomy, and those influences, which are not. I further argued that this distinction can be made by distinguishing between those internal controlling influences an agent identifies himself with and those he does not. Frankfurt (1988, page 83, originally 1982) asserts that if someone cares about something then he must of necessity identify himself with what he cares about (see section 3.5.1). The truth of this assertion depends on what is meant by someone identifying himself with something. In order to clarify this, it is important to be clear about the differences between being identified with and identifying with something. Certain attributes or dispositions might be identified with me. For instance I may be identified as small and bad tempered. I possess these attributes and dispositions and am essentially passive with regard to them. However, I believe that it would be wrong to hold I am passive with regard to the things I identify with. If this were not so there would be no essential difference between being identified with something and identifying with something. It follows that identifying with something must be connected to action. However, I do not identify myself with all my actions. For instance, consider someone who suffers from Tourette's syndrome. I only identify myself with all my reflective actions. Furthermore, it seems that the basis for all my reflective action is what I care about. It can be concluded that Frankfurt's assertion, that if someone cares about something then he must of necessity identify himself with what he cares about, is true.

Accepting Frankfurt's assertion leads to two further conclusions. Firstly, his concept of autonomy is able to distinguish between internal controlling influences which are compatible with autonomy, and internal controlling influences, which are not. Secondly an autonomous agent's will must of necessity be subject to some internal controlling influences with which

the agent identifies herself. It follows that even though an agent has some ideals and these ideals mean she is not free from internal constraints, this does not mean the agent is non-autonomous.

It would also seem internal constraints with which a patient identifies herself are compatible with informed consent. Consider again the women who were offered screening for the BRAC 1 and 2 gene mutations. These women were subject to no external force requiring them to consent to the screening. However, they felt they had an internal constraint compelling them to consent because their will was constrained by a need to *care about* other family members (Hallowell, Foster, Arden-Jones, Murday and Watson. 2003, page 81). It is clear that these women were constrained by what they cared about. Intuitively these women were autonomous and in practice informed consent would consider their decisions as competent. It also seems that Frankfurt would regard their decisions as autonomous because these decisions were based on their ideals. It can be concluded that in this case the practice of informed consent, our intuitive ideas of autonomy, and Frankfurt's concept of autonomy all concur in agreeing that some internal constraints with which the agent identifies herself are compatible with autonomous decision-making. It can be further concluded that, because Frankfurt's concept of autonomy is based on caring about, it concurs in general with our intuitive ideas of autonomy that an agent must identify herself with her autonomous actions.

The second objection to Frankfurt's concept of autonomy forming the basis of informed consent is that it is too far removed from our intuitive ideas of self-government and decision-making to be meaningful. It might be argued that an autonomous decision should just be any naturally made decision, as suggested by Waller (2001, page 585). It might be further argued that by linking the way a person cares about something with autonomy, we are linking the

making of autonomous decisions to ideal rather than actual persons. This danger was expounded by Berlin (1969, page 132). He argued that some exponents of autonomy regard autonomy as a property of my “real self” as opposed to my empirical or actual self. This might lead to the position where someone might think it right to ignore an agent’s intuitively autonomous decision because he believes it does not reflect his real self.

Such a paternalistic position might be particularly easy to adopt in medical practice. Let it be assumed that a patient refuses to consent to some proposed treatment. His medical team might believe that if the patient truly understood his situation, his “real self” would consent and accept the proposed treatment. This belief might cause the medical team to override the patient’s refusal of consent in the interests of his “real self”. Let it be accepted that it is wrong to base autonomy on some concept of an ideal self. However, accepting this does not mean that autonomy as proposed by Frankfurt is based on some ideal self. I have argued above that what we care about, our ideals, is constitutive of us as being the particular persons we are. Frankfurt (1999, page 162) also regards caring about something as defining us the distinctive kind of creatures we are. If caring about something makes all of us the particular persons we are, and defines us as the distinctive kind of creatures we are, then it does not follow that Frankfurt’s concept of autonomy leads only to some ideal kind of person being regarded as autonomous. It follows that Frankfurt’s concept is not based on “ideal persons” but actual persons. It can be concluded that Frankfurt’s concept of autonomy is not too far removed from our intuitive concepts of self-government and decision-making to be a useful concept, and might form the basis of informed consent.

To summarise, Frankfurt’s ideas on autonomy are based on ideas of caring about. Frankfurt’s ideas of caring about differ from some of our intuitive ideas of caring because caring about is defined as being disinterested. However, caring about has two important

consequences connected to our intuitive ideas of autonomy. Firstly, caring about must be in some sense persistent. Secondly, caring about of necessity requires that an agent must identify with his actions. I have examined three possible objections to Frankfurt's concept of autonomy being the basis for informed consent. I have concluded that each of these objections can be overcome and that Frankfurt's concept of autonomy could possibly form the basis for informed consent.

Chapter 4

Risk related competence

Chapter 4 will consider how risk affects the standard a patient needs to meet in order to be considered competent. I will consider the concepts of risk related symmetric and asymmetric assessment of patient competence in conjunction with the ideas of personal autonomy developed in chapter 3. This chapter will be split into five sub-sections.

4.1 Internal, risk related symmetric and asymmetric competence assessment

Before examining risk related competence assessments, the different ways in which risk and competence assessment can be linked must be clearly set out. This requires defining simple internal competence, risk related symmetric and risk related asymmetric competence assessments. In most cases of competence assessment *the triggering of the assessment is asymmetric with regard to the risks associated with the decision*. This means a patient is usually presumed to be competent when her consent decision does not endanger her health. However, if the outcome of her decision involves danger, then an assessment of her competence would be triggered. For example when a patient consents to a routine appendectomy she would usually be presumed to be competent because the dangers connected to her decision are low. If however she refused to give consent to an appendectomy then, because this decision endangers her life, her competence to give consent would be assessed. This position is generally accepted (e.g. by the Department of Health, 2001, Paragraph 2.1), (the General Medical Council, 1999, page 5), and (Buchanan and Brock, 1989, page 21). However this generally accepted presumption of competence has led some to conclude that

not only is an assessment of a patient's competence *triggered* asymmetrically, but her competence should be *assessed* using asymmetric standards, or even that the decision she makes should be asymmetric in some way.

British legal judgments hold the standard required for a patient to be considered competent should vary with risk. Lord Donaldson [1992] set out this position in the case of :

What matters at the time was whether at the time the patient's capacity was reduced below the level needed in a case of that importance, for refusals can vary in importance, some may involve a risk to life or irreparable damage to health, others may not [1992].

Lord Donaldson's judgment means that in practice the capacities a patient requires to be considered competent vary with the risks connected to her treatment. However, there are two ways in which the capacities a patient requires to be considered competent can vary with risk. Firstly, a patient might need extra capacities to understand and evaluate the risks involved in her treatment. This definition means that the capacities a patient needs to be considered competent vary directly with the capacities she needs to understand the risks involved. However, these capacities do not of necessity vary directly with the risks themselves (see Buller, 2001, page 101). In the rest of this thesis when I refer to a patient's capacities varying indirectly with risk, I am referring to the above definition. Secondly, the capacities a patient needs to be considered competent might not vary with the capacities needed to understand the risks involved but vary directly with the risks themselves. Similarly, when I refer to a patient's capacities varying directly with the risks involved in her treatment, I am referring to this second definition.

Using the first definition it is clear that increased risk does not automatically mean that informed consent decisions are more difficult to make. Buller (2001, page 100) accepts that some informed consent decisions may involve a greater risk to a patient's life and well being than others. But he argues that just because these decisions involve a greater risk does not of *necessity* make them more difficult to understand than less risky decisions. Indeed, in certain situations Buller argues increased risk may actually make a decision easier. In order to make this clear consider two examples. Firstly, consider a patient with breast cancer. She is given a choice between a mastectomy and a lumpectomy, each being followed by chemotherapy. This patient might find it difficult to decide which option to choose because she has difficulty in evaluating the risks involved with each option. Because of this difficulty it follows that the patient requires increased capacities in order to understand the risks involved. Secondly, consider a patient advised to undergo an emergency appendectomy without which she is expected to die. This second patient faces a similar risk to her life but the information she needs to understand the risk involved in order to make her decision is simple to understand. It follows that this patient needs no increased capacities to understand the risks involved.

In chapter 1 I that showed it was generally agreed that a competent patient must have the capacities needed to understand and weigh the information relevant to her condition including the risks involved. She must also have the capacity to communicate and a set of goals and values. Any patient who has these capacities will be defined as internally competent. There are two important characteristics of this definition of competence. Firstly, internal competence assessment requires the same capacities from a competent patient whether she consents or refuses to consent. It follows that the outcome of a patient's decision makes no difference in any internal assessment of her competence. It further follows that using an internal competence assessment a patient cannot be assessed as competent to consent to some

proposed treatment but assessed as incompetent to refuse consent to the same treatment (see Wilks, 1997, page 419). However, an assessment of these capacities may be triggered asymmetrically. This means that whether a patient's competence is actually assessed rather than presumed may depend on the risk involved with the outcome of her decision. Secondly, a patient's internal competence to make a decision is assessed purely on whether she has the capacities needed to understand the decision she faces and the risks connected to this decision. It follows that any internal assessment of a patient's competence is only indirectly linked to the risks involved. The capacities a patient needs to be considered competent only increase with the risks involved if the patient needs these extra capacities to understand the extra risks. The appendectomy example I have used above clearly demonstrates that increased risks associated with a particular procedure do not automatically mean increased capacities are required by a patient to understand and evaluate these increased risks. It also seems that an assessment of a patient's competence based only on assessing her internal capacities to understand her condition can deal perfectly adequately with the risks associated with any treatment. This follows because a patient must understand her condition if she is to be regarded as competent and this understanding must include the risks involved (see the General Medical Council's guidelines, 1999, page 5). It follows that if the standard required for a patient to be considered competent *automatically* increases with increased risk, this increase cannot be solely related to the capacities needed by a competent patient to understand and evaluate the risk involved. This increase must be related directly to the increased risk itself. A risk related standard of competence assessment is defined as follows. A competent patient must have the capacities needed to understand and weigh the information relevant to her decision, to communicate and have a set of values and goals. In addition, if the risk associated with one decision is greater than the risk associated with a second decision, then the patient

must have increased capacities to understand and weigh the information relevant to the first decision as opposed to the second decision. Moreover, this increase in capacities occurs irrespective of whether these increased capacities are needed by the patient to understand her decision. It follows that the capacities needed by a patient who is advised to have an emergency appendectomy and whose competence is assessed using a risk related standard would be high if she is to be considered competent. These high capacities are not required because they are needed by the patient to understand the risk involved in the appendectomy, but simply because of the high risk attached to her decision.

Others argue that the capacities a patient requires in order for her to be assessed as competent in a risky situation should not vary directly with the risk connected to the outcome of the decision she makes. These capacities may be greater than the capacities the patient needs to understand the information provided. This gives rise to the idea of asymmetric competence assessment:

If we consider a safe, routine treatment for an acute and dangerous condition (as with an appendectomy for appendicitis), it is clear that the risk in accepting the treatment is small, the benefit great, while the risk in refusing it is great and the benefit in most cases non-existent. This means that one confronted with this choice would require a higher level of competence to say no than to say yes, with, indeed, a very pronounced difference between the levels (Wilks, 1997, page 417).

Buchanan and Brock (1989, page 51) and Drane (1985, page 100) support Wilks' position. I believe that Lord Donaldson's judgment in the case of T [1992] also supports this position. It might be argued that I am wrong and Lord Donaldson's judgment only supports the

asymmetric triggering of competence assessment. However, such an argument would seem to be unsound. If Lord Donaldson was referring to the asymmetric triggering of an assessment of a patient's competence, he would surely have connected refusals of consent directly to the assessment of a patient's competence. He did not do this. He connected refusals of consent directly to the capacity a patient needs to be considered as competent [1992]. It follows that Lord Donaldson's judgment in the case of T means the capacities required for a patient to be considered competent should depend directly on the risk connected to the outcome of a patient's decision rather than the risk inherent in the decision. It follows that he considered the standard used in the assessment of a patient's competence should be asymmetric with regard to risk. Asymmetric competence assessment is defined as follows. A competent patient must have the capacities to understand and weigh the information relevant to her condition. She must be able to communicate and have a set of values and goals. In addition, asymmetric competence assessment requires that a competent patient must have the above capacities to a greater degree if she chooses a risky option as opposed to a less risky option. It follows that a patient might be considered competent to choose a safe option but incompetent to choose a risky option using an asymmetric competence assessment. In practice this usually means a higher standard of competence is required in refusals of consent and a lower standard in cases when the patient consents. It is important not to confuse asymmetric competence assessment with the asymmetric triggering of a competence assessment. In an asymmetric competence assessment the standards employed in actually assessing a patient's competence vary directly with the risks involved with the outcome of her decision. In an asymmetric triggering of a competence assessment whether, a patient's competence is actually assessed or just presumed depends on the risks involved with the outcome of her decision.

It is generally agreed that a patient must understand the risks she faces if she is to make a competent informed consent decision. However, as I have shown above, there is no agreement as to the way risk should play a part in the assessment of a patient's competence. There are three possible ways risk might be connected to the assessment of competence. Each of these leads to a different concept of competence assessment. These concepts are defined as follows.

- 1) ***Internal competence assessment*** requires that a competent patient must have the following capacities. She must be able to understand and weigh the information relevant to her condition including the risks involved. She must be able to communicate. In addition to these capacities she must also have a set of goals and values.
- 2) ***Risk related symmetric competence assessment*** requires that a competent patient must have the capacities considered necessary for internal competence together with a set of goals and values. In addition to possessing these capacities the degree to which a patient needs these capacities in order to be considered competent varies directly with the risks involved in the proposed treatment. A more risky treatment means a patient must have increased capacities in order to be considered competent.
- 3) ***Risk related asymmetric competence assessment*** requires that a competent patient must have the capacities considered necessary for internal competence together with a set of goals and values. In addition to possessing these capacities the degree to which a patient needs these capacities to be considered competent varies directly with the risks involved in the outcome of a patient's decision.

4.2. Does the concept of asymmetric competence exist outside informed consent?

Wilks (1997) contends not only are asymmetric competence assessments possible but someone may be asymmetrically competent regarding some decision outside the confines of informed consent. In this section I will examine whether Wilks' claim is true. If it is this will not of necessity show asymmetric competence assessment should be part of informed consent, but it will support the case for this. However, if his claim is false and the asymmetric assessment of competence only applies in the context of informed consent, then it will be necessary to show why asymmetric competence assessment should only apply in this context. Wilks (1997, page 419) backs up his claim by using two examples. The first example he uses is of two tightrope walkers of differing ability . This example though much discussed is unlikely to occur in normal life and will not be examined by me. His second example concerns a more everyday example of an investment decision:

Say someone offers me a stock deal, on the basis of which I could make, or lose, a great deal of money. But I simply do not know enough about this particular stock, or the market in general, to leave me convinced of the assurance that accompanies the offer-that my investment will yield generously. I am not competent to say yes to the offer because the risk involved is considerable, and I do not know enough to justify undergoing it. By contrast, saying no is the safe option; I stand to make no money by refusing the, but I stand to lose none either. And for precisely this reason I feel myself competent to say no (Wilks, 1997, page 421).

I will now examine this example by comparing it with the appendectomy example also used by Wilks (1997). The purpose of my comparison is to determine whether both of these examples are cases in which the agent is asymmetrically competent. I will conclude that Wilks' example of an investment decision is a case of asymmetric competence.

There are major differences between these two examples. Wilks believes that in some informed consent decisions, the decision a patient faces splits and he illustrates this split by using an appendectomy example:

Sometimes the task involves a simple-yes-or-no decision. But in the sort of case just considered that task essentially splits. There are in fact two tasks; the task of making a yes-decision, and the task of making a no-decision (Wilks, 1997, page 422).

Wilks also argues that the potential investor feels herself competent to say no to the investment opportunity but not competent enough to agree to invest. This leads to the first difference between these two examples. A potential investor implicitly or explicitly assesses her own competence whilst in the appendectomy example, others assess her competence. The second difference is that whilst the investment decision also splits, it does not split in the way Wilks envisages the appendectomy decision splitting. The investment decision splits into two separate decisions. Firstly, the investor implicitly or explicitly assesses her own competence prior to deciding whether or not to invest. Secondly, the potential investor decides whether or not to invest. However, according to Wilks, the appendectomy decisions simply splits into two tasks rather than decisions, the task of making a "yes-decision" and the task of making a "no-decision".

In the light of these clear differences I will now investigate whether the potential investor might be asymmetrically competent. I will present two arguments that seem to show that the investor cannot be asymmetrically competent. I believe both arguments fail. In rejecting the second of these arguments I use a counter argument to show that an investor may indeed be asymmetrically competent in accord with our intuitive ideas. Firstly it might be argued if an investor assesses her own competence to make an investment decision then this self-assessment means she cannot possibly be asymmetrically competent. This argument runs as follows. Let it be assumed that the investment decision faced by the potential investor splits into two separate decisions. The first decision made by the investor is whether she is competent enough to decide to invest. Her second decision is deciding whether or not to invest. The first decision the investor makes is symmetric because she can decide she is either competent or incompetent. This follows because if the investor decides she is competent she also automatically decides she is not incompetent. The same reasoning can be applied if she decides she is incompetent. Let it be further assumed that the investor assesses herself as competent to make the investment decision. She then makes the investment decision in which she is competent to choose either option. This decision is again symmetric. Let it be assumed the investor assesses herself incompetent. She then makes no further decision. It might then be concluded that the investor cannot only be asymmetrically competent to make her original investment decision. This follows because her original investment decision is composed of one or two decisions and the investor's competence is symmetric with regard to choosing the options in both of these decisions. The above conclusion is false.

The above conclusion depends on the following implicit premise. If an investor assesses herself as competent to make an investment decision then she must be competent to make that

decision. This premise is false. The fact that Wilks' investor feels competent to invest does not of necessity imply she is competent to invest. However, the fact that a competence assessment cannot be private does not mean it cannot be internal. It only means the criteria on which the assessment is based cannot be private. It follows that the standard of competence applied must be capable of being verified by others. It further follows that if an agent assesses her own competence this assessment must be capable of concurring with some generally accepted standard even if in practice this assessment does not take place. It follows that even though an investor assesses herself as competent to choose either option it is possible she might be mistaken. It further follows that if an investor makes an investment decision, the fact that she assesses herself as competent to make an investment decision does not guarantee she is in fact competent to make this decision. It can be concluded that she might only be competent to choose one option. It can be further concluded she might be asymmetrically competent with regard to her investment decision.

I will now present a second argument which seems to show that the potential investor's competence to make an investment decision cannot be asymmetric. In this argument, when referring to an agent's competence, I am referring to her being considered competent rather than being assessed as competent. I believe competence assessment should apply in the more formal setting of informed consent. However I will assume the capacities someone needs to be assessed or considered competent are equivalent. Let it be accepted that an agent can only be competent to make some decision if she has the capacities needed to understand which of the expected outcomes would best concur with her goals and values. It follows that the potential investor can only be competent if she has the capacities needed to understand whether investing or not investing would best concur with her goals and values. The following

argument is modified from one used by Buller (2001, page 106) who argues against the asymmetric assessment of patient competence. Firstly, let it be assumed that the investor fully understands the consequences of both investing and not investing. It follows that because the investor has the capacities needed to understand which of the expected outcomes would best concur with her goals and values, she might be competent to decide whether to invest or not.

Secondly, let it be assumed that the investor only has the capacities needed to understand the consequences of not investing and does not have the capacities needed to fully understand the consequences of investing. According to Wilks, it follows that she has asymmetric competence. However it has been assumed that a competent investor must have the capacities needed to understand the consequences of *both* investing and failing to invest. If this were not so she would be unable to know which decision would best concur with her goals and values. It follows that if the investor does not have the capacities needed to understand which option would best concur with her goals and values she cannot be competent to make *any* choice concerning the investment. It further follows that if the investor only has the capacities needed to understand the expected outcomes of not investing, she is not asymmetrically competent as claimed by Wilks but incompetent. This leads to the conclusion that depending on whether the investor has the capacities needed to understand the probable consequences of both investing and not investing, she is either possibly competent to choose either option or incompetent. It can be further concluded that Wilks' investment example is not an example of asymmetric competence. Furthermore it would seem that this argument based on (Buller, 2001, page 106) means that asymmetric competence is impossible in all circumstances including cases such as the appendectomy used above.

I believe this argument is unsound. Consider the example of the investor again. Let it be assumed that the potential investor is a complete novice as far as financial affairs are concerned. Let it also be assumed that the investment opportunity she is offered is highly complex. Finally let it be assumed that the potential investor decides that because she is unable to fully understand the investment opportunity, she should decline the offer to invest. According to the above argument, she is not asymmetrically competent but incompetent if she makes this choice. Intuitively the potential investor's choice not to invest seems to be a competent decision. Moreover, in this context if the investor chooses to invest, intuitively her choice would seem to be incompetent.

Intuitively it appears that Wilks is correct and the potential investor can be considered to be asymmetrically competent, however intuition can be misleading. I will now argue that whether our intuitive ideas are correct depends on the purpose of the investor's decision. The argument used above is dependent on the premise that an agent can only be considered competent to make some decision if she is capable of understanding which of the expected outcomes would best concur with her goals and values. If this premise is accepted then the argument is a valid argument and the potential investor cannot be considered as asymmetrically competent. However, this premise seems to depend on the assumption that the *purpose* of an investor's decision is to decide which of the expected outcomes would best concur with her goals and values. I believe this assumption cannot always be justified. Let it be accepted that an investor only understands the consequences of not investing and does not fully understand the consequences of investing. In this context it might be questioned whether the purpose of her decision is to choose the option that best concurs with her goals and values. Let it be accepted that one of the agent's primary goals is to make a lot of money. However, in

the above context the potential investor's naivety in financial affairs prevents her from deciding which option best concurs with her goals and values. It seems possible that in this context the potential investor's purpose when making her investment decision is to choose an option which *satisfies* her. It is important to be clear what is meant by satisfaction in this context. Usually someone is said to be satisfied if some state she desires obtains. In this context an agent being satisfied simply means her subjective state is such that he has no desire to alter her situation. It follows the potential investor might be satisfied with not investing because this is a safe option. It further follows that if her purpose is to choose an option that satisfies her, then she might be considered as having the requisite capacities she requires to be considered as competent, provided she decides not to invest. However, this would not be true if she decides to invest. It can be concluded that her decision might be asymmetrically competent. It can be further concluded that if agents are concerned with decisions that satisfy their goals and values, the concept of asymmetric competence can exist outside the practice of informed consent.

I have used an argument based on Buller (2001, page 106), which seems to show that the concept of asymmetric competence existing outside the practice of informed consent is nonsense. I then used a counter-argument based on the purpose of an agent's decision to show that this conclusion is false. This counter-argument was based on the idea that the purpose of an agent's decision is not always to choose the best outcome in the light of her goals and values but sometimes to choose an outcome that satisfies these goals and values. This idea has important ramifications, which I will develop in the rest of this thesis. It is objected by Veatch (1995, page 7) that the concept of informed consent is impossible. In section 5.1 I will show that the above idea of patients' satisfying their goals and values can be used to overcome

Veatch's objection. In section 6.4.2 I will use this idea to argue that a competent patient must be able to order her goals and values in some way. Finally, it must be noted that it seems possible to connect the idea that a patient makes a decision which satisfies her with Frankfurt's idea that an autonomous agent must be satisfied with her decisions developed in section 3.5.2.

4.3. Asymmetric competence assessment and "yes decisions" or "no decisions"

Wilks (1997, page 422) argues that risk sometimes causes informed consent decisions to split into two tasks, of making a "yes-decision" and making a "no-decision". This raises three questions. Firstly what is meant by the task of making a "yes-decision" or a "no decision"? Secondly whether if it is assumed that the making of "yes decisions" and "no decisions" are not real choices might these decisions be a part of medical practice. It might be questioned whether these "tasks" are compatible with either informed consent or personal autonomy. Lastly, are the tasks of making "yes-decisions" and "no-decisions" a necessary component of the asymmetric assessment of competence?

A patient making a consent decision may give consent or refuse to give consent to some proposed treatment by simply saying yes or no. A patient whose competence is asymmetrically assessed may also give consent or refuse to give consent in the same way. However, in this context when her competence is assessed, she might be found to be competent if she said yes and incompetent if she said no. However simple yes or no decisions as outlined above are not what Wilks means when he considers "yes decisions" and "no decisions". According to Wilks, these decisions do not just mean different standards of

assessment are being applied when a patient consents compared to when she refuses to give consent. These decisions are different tasks:

When a yes-or-no-decision divide in this way one can easily find oneself competent to perform one of the two resulting tasks but not the other (Wilks, 1997, page 417).

I will now question what sort of tasks the making of “yes decisions” and “no decisions” could be in the specific context of informed consent. Let it be assumed that a patient can give consent by making a “yes decision”. Let it be further assumed when she does so she has a real choice. It follows that she could have refused to give consent. Let it be still further assumed that a patient can refuse to give consent by making a “no decision”. It follows that if the patient has a real choice when she consents by making a “yes decision” she could also have made a “no decision”. However, Wilks (1997, page 417) argues that the making of “yes decisions” and “no decisions” are two different tasks. It can be concluded that the making of “yes decisions” and “no decisions” does not involve a patient making a real choice

In the following discussion only “yes decisions” will be considered and I will assume that all the conclusions reached are equally applicable to “no decisions”. Because the task of making a “yes decision” does not involve a real choice, one might ask what sort of task it is. If a “yes decision” is not a genuine decision then it might be considered to be something akin to authorising, permitting or assenting to treatment. However, even if a patient decides to authorise, permit or assent to treatment it might be argued that authorising, permitting or assenting to treatment are not genuine tasks. They are the products of a task. This task is the task of *deciding* whether to authorise, permit or assent to treatment. It might be argued that

Wilks, in his treatment of “yes decisions”, is equating giving consent with making consent decisions. However giving consent is the product of a consent decision. It can be concluded that if the making of “yes decisions” only means authorising, permitting or consenting to treatment, then it would be wrong to consider the making of a “yes decisions” as a task.

It is difficult to see what other sort of task the making of a “yes decision” might be. It might be argued that the term consent has a specialist meaning within the practice of informed consent, as Clarke (2001) argues:

Indeed, there is said to be a ‘doctrine of informed consent’ that is often discussed by medical ethicists as if it were mostly a product of the peculiarities of the context of medicine and as if it were only very loosely related to the common notion of consent, that permeates other aspects of western life (Clarke, 2001, page 174).

It might then be further argued that the task of making a “yes-decision” is a genuine task within the practice of informed consent and has a meaning peculiar to this context. Let it be still further assumed in this context that this task is related to the making of consent decisions. I will now argue that even if the task of making a “yes-decision” has a meaning peculiar to the practice of informed consent, this meaning is incompatible with both the ethos of informed consent and personal autonomy.

According to the General Medical Council (1999, introduction 1, a competent patient should be able to make a decision to consent or to refuse to consent to some proposed treatment. It follows that whatever way consent decisions are defined within the practice of informed consent, the ethos of informed consent is committed to allowing patients to make genuine decisions. It has been assumed above that in the context of the practice of informed

consent, the making of a “yes decision” is meaningful. I have also shown that above the task of making a “yes-decision” does not involve any genuine decision-making. It follows that it cannot be assumed on the basis of a patient’s “yes decision” that she has made a genuine decision to consent to some proposed treatment. It further follows that the fact that a patient has made a “yes decision” should not also be considered as her making an informed consent decision according to the ethos of the General Medical Council’s guidelines. The Department of Health’s (2001, introduction, 1) guidelines on consent state that a competent patient should determine what happens to her body. If she is to do so then she must have some genuine choice. It follows that if a patient makes a “yes decision”, then this should not be regarded as an informed consent decision according to the ethos of the Department of Health’s guidelines. It can be concluded that if “yes decisions” have a meaning peculiar to the practice of informed consent, and the making of these decisions is regarded as giving informed consent, then the practice of informed consent is incompatible with the ethos of informed consent.

I will now argue that the making of “yes decisions” instead of genuine decisions is incompatible with personal autonomy. Dworkin (1988, page 20) believes that autonomy is the second-order capacity of persons to reflect on their first-order desires together with the ability to accept or attempt to change these desires. Dworkin also believes that an autonomous agent must be able to exercise this capacity. However, if the making of a “yes decision” replaces genuine choice in the practice of informed consent, then a patient does not have the ability to exercise her choice by making a “yes decision”. It can be concluded that Dworkin would not regard the making of a “yes decision” as an autonomous choice. Frankfurt (1999, page 87, originally 1982) believes that if someone is autonomous then she must care about something and guide her conduct in accordance with this caring. It follows that if an agent guides her

conduct with regard to what she cares about, then this guidance must involve her in making decisions based on what she cares about. It also follows that if an agent guides her conduct with regard to what she cares about she must be able to implement her decisions. It might be possible for someone to reflect on her decisions passively but she cannot guide her conduct passively. It further follows that if a patient is unable to make a consent decision based on what she cares about, because she can only make a “yes decision”, Frankfurt would not regard her “yes decision” as autonomous. Consider a Jehovah’s Witness who is assessed only to be competent to make a “yes decision” about some procedure requiring a blood transfusion. Let it be assumed that she refuses to give consent to the transfusion because of her religious beliefs. This results in her being considered incompetent. It follows that because she is being prevented from implementing her decision made with regard to what she cares about, her autonomy is not being respected. It can be concluded that the making of “yes decisions” cannot be regarded as part of personal autonomy if this is based on what the agent cares about. I have shown above that if “yes decisions” are considered as consent decisions by the practice of informed consent, then the practice of informed consent is incompatible with the ethos of informed consent. Let it be accepted that the practice of informed consent should be based on respect for personal autonomy, as required by the General Medical Council (1999, introduction 1). It can be concluded that the replacement of genuine decision-making by “yes decisions” should play no part in the practice of informed consent.

Wilks connects the making of “yes decisions” to the asymmetric assessment of competence. I have argued that the making of “yes decisions” should play no part in the practice of informed consent. However, the asymmetric assessment of patient competence remains a coherent concept without the need for “yes decisions”. Let it be assumed that a

patient's competence is assessed asymmetrically. The patient in this situation can simply say yes or no to some proposed treatment. She will base her consent decision on what she perceives to be in her best interests or, as I have argued in section 4.2 on what satisfies her. It follows that she does not have to make a "yes decision". However, her competence to give consent to the proposed treatment might still be assessed asymmetrically. She might be assessed as competent if she consents, says yes, and incompetent if she refuses consent, says no. It can be concluded that the asymmetric assessment of a patient's competence does not depend on her ability to make "yes decisions" and "no decisions".

4.4. Asymmetric and a risk related symmetric competence assessment in practice

Asymmetric competence assessment means that a competent patient must possess the capacities needed to understand and weigh the information provided. In addition, the degree to which a competent patient must possess these capacities varies directly with the expected risk based on the outcome of her consent decision. This concept of asymmetric competence assessment is conceptually coherent. However, accepting this does not automatically mean it is a useful concept. Risk-related symmetric competence assessment also requires that a competent patient must possess the capacities needed to understand and weigh the information provided. However, the degree to which a competent patient must possess these capacities varies directly with the expected risks involved with the decision she faces rather than the outcome of this decision. In this section I will argue that in practice there is no meaningful difference between risk-related symmetric and asymmetric competence assessments. This section will be divided into three subsections.

4.4.1. The asymmetric triggering of competence assessment and risk related competence assessments

Before considering the question of whether there are any meaningful differences between symmetric and asymmetric risk-related competence assessments in practice, two things must be made clear. Firstly, the way the asymmetric triggering of a competence assessment differs from a risk-related competence assessment. Secondly, the differences in the capacities a patient requires to be considered competent under both symmetric and asymmetric risk-related competence assessments.

A patient's competence to give consent is not usually assessed in practice and in most cases an adult patient is presumed to be competent unless there are reasons not to do so (see the General Medical Council 1999, section 19) and the Department of Health, 2001, Paragraph 2.1). Doctors and medical staff are busy people and competence assessments are time consuming. It follows that this presumption of competence might be done for reasons of efficiency. Due to this presumption of competence a patient's competence, is usually only assessed in practice when the patient exhibits conditions that suggest she might be incompetent. Several conditions may trigger an investigation into a patient's competence (Wear, 1998, page38). For example, a patient might show a lack of understanding, an inability to weigh the information provided, or fail to communicate adequately.

A further reason why a competence assessment might be triggered would be when a patient refuses to give consent when the benefits of the procedure she is being asked to give

consent to are clear and her refusal to give consent threatens her well-being, as Drane (1985) points out:

These questions arise usually when the patient refuses treatment or chooses a course of action which, in the opinion of physician in charge, threatens his or her well-being. (Drane, 1985, quoted in Mappes & Zembaty, page 99)

It might be presumed that if a patient appears to act against her best interests then her ability to understand her situation is limited. It should be noted that this is only a presumption and may be false. However, if a patient appears to act against her best interests this indicates the possibility of limited understanding and should usually trigger an assessment of her competence. The General Medical Council's guidelines (1999 section 19) concur and hold that a presumption of incompetence should not automatically lead to an assumption of incompetence but rather to an assessment of the patient's competence. It follows in the practice of informed consent that a competence assessment may be triggered when a patient refuses to give consent and appears to have chosen a risky option which threatens her well-being.

Consider a patient who refuses to give informed consent when this refusal might cause her great harm. Let it be assumed that her refusal triggers an assessment of her competence. The trigger for this assessment is not the patient's capacities but the fact that harm might occur to her. This means that had the patient chosen a safer option this assessment of her competence would not have occurred. The triggering of this competence assessment is asymmetric. It is important to be clear about the difference between the asymmetric triggering

of a competence assessment and the asymmetric assessment of a patient's competence. The asymmetric triggering of a competence assessment simply means that a competence assessment actually takes place. However the asymmetric triggering of a competence assessment does not determine the standards employed in any subsequent competence assessment or the form of assessment employed. The asymmetric assessment of a patient's competence means the standard applied in any assessment of the patient's competence varies directly with the risk connected to the outcome of her decision. It follows that the asymmetric triggering of a competence assessment is conceptually distinct from the asymmetric assessment of competence.

It is assumed by Drane (1985) and Wilks (1997) that the increased risk associated with a refusal of consent, which would usually lead to the asymmetric triggering of a competence assessment, should lead to an asymmetric assessment of competence. However the asymmetric triggering of a competence assessment does not affect the capacities a patient needs to make her decision in any way. The form of competence assessment employed determines the standards used in this assessment. It follows that the asymmetric triggering of a competence assessment does not affect a patient's autonomous decisions. Let it be accepted that the asymmetric triggering of competence assessments would be useful. It further follows that the asymmetric triggering of a competence assessment is justified. I have shown above that the asymmetric triggering of a competence assessment is conceptually distinct from the asymmetric assessment of competence. It follows that the asymmetric assessment of competence cannot be justified simply because the asymmetric triggering of competence assessment is justified. Both the asymmetric triggering of competence assessments and the asymmetric assessment of competence are attempted solutions to the same problem, namely that associated with patients making risky decisions by refusing to consent. It further follows

that if the asymmetric assessment of competence is to be justified it must be justified by reference to this problem without reference to the asymmetric triggering of competence assessment. It can be concluded that it is coherent to hold that a competence assessment may be triggered asymmetrically and that any competence assessment should not be asymmetric.

4.4.2. Symmetric or asymmetric risk-related competence assessment in practice

Before examining symmetric or asymmetric risk-related competence assessments in practice, the relationship between the capacities required for a patient to be considered competent under these different forms of competence assessment must be set out. Consider a consent decision D such as the appendectomy example used by Wilks (1997, page 417). D has a marked asymmetry between the risks involved when the patient gives consent and refuses to give consent. It is accepted that a patient must have certain capacities in order to be regarded as competent. The degree to which a patient must possess these capacities may vary. The degree to which a patient requires these capacities in order to be considered competent will be referred to as the standard she must meet in order to be considered competent. Firstly, consider a patient's competence with regard to D using an asymmetric assessment of her competence. Let it be assumed that the patient must have these capacities to degree C1 in order for her consent decision to be simply accepted. C1 is a low standard because of the low risk involved in consenting with regard to D. I showed in section 2.2 that respecting autonomy means accepting autonomous decisions. Let it be accepted that informed consent is based on respect for autonomy. It follows that the practice of informed consent should respect autonomous decisions. I will assume here that the standard C1 is determined by the capacities a patient needs for her decision to be considered as autonomous. If a patient refuses to give consent

then she must meet a standard C2 for her refusal to be regarded as competent. This is a higher standard than C1. C2 is directly determined by the expected risks connected to the outcome of the patient's decision. The higher the expected risks connected to the outcome of the patient's decision the higher the standard C2 will set. Secondly, consider the same decision D, only this time the patient's competence is being assessed using a risk related symmetric competence assessment. If the patient is to be considered competent to give consent or to refuse to give consent with regard to D using a risk related symmetric competence assessment, then the degree of the capacities she needs in order to be considered competent is determined directly by the risk involved in the procedure. This standard cannot be C1 because this is the standard of competence appropriate for a decision involving little risk. The standard employed in a symmetric risk related competence assessment should be determined directly by the highest risk involved in the decision. It follows that in this context the standard C2 should be applied irrespective of whether the patient gives consent or refuses to give consent with regard to D.

I will now question whether there are any meaningful differences in practice between asymmetric and symmetric risk related competence assessment. This will be done in the four possible contexts listed below.

- 1) When a patient is competent and refuses to give consent to treatment.
- 2) When a patient is incompetent and refuses to give consent to treatment.
- 3) When a patient is competent and gives consent to treatment.
- 4) When a patient is incompetent and gives consent to treatment.

I will conclude that the treatment a patient receives is identical irrespective of whether her competence is assessed using an asymmetric or a symmetric risk related assessment.

Firstly, consider the outcomes when a competent patient refuses to give consent to some procedure and her competence is assessed using both asymmetric and symmetric risk related

competence assessments. Let it be assumed that if this procedure is not carried out her life is endangered. I will argue in section 5.3 that surrogate decision-making is only useful in circumstances in which irreparable harm may occur to a patient or her life is endangered. I will argue in all other circumstances if a patient refuses to consent, treatment should simply be abandoned. In practice an assessment of her competence will be asymmetrically triggered. Consider the outcome when this patient is assessed as competent using a symmetric risk related standard of competence assessment. Symmetric risk related competence assessments always use the higher standard C2 irrespective of whether the patient gives or refuses to give consent. It follows that in the above context the patient's competence would be assessed using the standard C2. It also follows that because she is competent, her refusal of consent would be accepted. Next consider the outcome when the same patient makes the same decision only this time her competence is assessed using an asymmetric risk related standard of competence. Because this patient chooses a risky option, the standard C2 will be applied. Once again because the patient is competent her refusal of consent would be accepted. It can be concluded that when a competent patient refuses to give consent to some procedure without which her well-being is threatened, the following holds. The standard of competence required and the treatment the patient receives are identical irrespective of whether an asymmetric or a symmetric risk related assessment of her competence is used

Secondly consider the outcomes when an incompetent patient refuses to consent and her competence is assessed by both asymmetric and symmetric risk related competence assessments. Let it again be assumed that the patient chooses an option which threatens her life. This means an assessment of her competence would be triggered. Consider the outcome when the patient's competence is assessed asymmetrically. It follows that because the patient

chooses a risky option, then the standard C2 will be used. It further follows that because the patient is incompetent a surrogate decision-maker should make the decision on her behalf. Next consider the outcome when this patient is assessed as incompetent using a symmetric risk related standard of competence. The standard C2 would again be applied. Once again, because the patient is incompetent a surrogate decision-maker should make the decision on her behalf. It can be concluded in this context the treatment the patient receives and the standards of competence applied are identical irrespective of whether her competence is assessed using an asymmetric or symmetric risk related competence assessment.

Thirdly, consider the outcomes when a competent patient consents to some proposed treatment using both asymmetric and symmetric risk related competence assessments. Because this patient is competent her consent would be accepted using both of these types of competence assessment. However, different standards would be applied when assessing her competence. If an asymmetric risk related assessment of her competence was employed, the standard C1 would be applied. If a symmetric risk related assessment of her competence was employed, then the standard C2 would be applied. It follows that in this context a patient assessed as competent using an asymmetric assessment of her competence might be assessed as incompetent using a symmetric risk related assessment of her competence.

I will now argue that when a patient consents to some proposed treatment, the treatment she receives will be the same irrespective of whether her competence is assessed using the standard C1 or C2. Let it be assumed a patient making a consent decision who is assessed as incompetent to do so using the standard C2 would be considered as competent using the standard C1. Consider the treatment this patient will receive if she is assessed as incompetent using the standard C2. In this case a surrogate decision-maker should make the decision on

behalf of the patient. Let it be accepted that surrogate decision-making is only meaningful if the patient's life is endangered and a surrogate decision-maker can choose a generally agreed best option. If there is no generally agreed best option then the surrogate decision-maker's decision becomes a personal decision. I will deal with the generally agreed best options in detail when discussing the domain of informed consent in section 5.3. Let it be accepted that surrogate decision-maker chooses this generally agreed best option. Because there is a generally agreed best treatment option, this should be the treatment offered to the patient for her consent. It follows that surrogate decision-maker should also choose this treatment offered to the patient. However if the same patient was assessed as competent using the standard C1 she would have her consent to the proposed treatment accepted and this treatment would take place. It can be concluded that if a patient is assessed as incompetent using the standard C2, and she would be considered as competent using the standard C1, she would receive identical treatment under both standards. It can be further concluded the fact that a patient assessed as competent using an asymmetric assessment of her competence might be assessed as incompetent using a symmetric risk related assessment of her competence would make no difference to the actual treatment she receives.

Lastly, consider the outcomes when an incompetent patient consents to an informed consent decision. In these circumstances, because the patient is incompetent, a decision should be made on her behalf by a surrogate decision-maker. This should occur irrespective of whether her competence is assessed using an asymmetric or a symmetric risk related assessment of her competence. However, the standards used to assess the patient as incompetent are not the same. Firstly, if the patient is assessed as incompetent using a symmetric risk related assessment of her competence, she fails to meet the standard C2.

Secondly, if the patient is assessed as incompetent using an asymmetric assessment of her competence, then she fails to meet the standard C1. It follows that because C2 is a higher standard than C1, that a patient who would be regarded as incompetent using a symmetric risk related competence assessment might be regarded as competent using an asymmetric risk related competence assessment.

I argued above that if a patient consents to some proposed treatment, the treatment she receives will be the same irrespective of whether her competence is assessed using the standard C1 or C2. This argument can be applied to show that whichever form of risk related competence assessment is used, an incompetent patient should always receive the same treatment. The above argument concluded that if a patient was assessed as incompetent using the standard C2 and she would be considered as competent using the standard C1, then she would receive the same treatment under both standards. This conclusion means that if a patient is assessed as incompetent using a symmetric risk related competence assessment, and she might be assessed as competent using an asymmetric risk related competence assessment, then this difference in her competence assessment would make no difference to the treatment she receives.

This section has shown that the treatment a patient receives is identical irrespective of whether an asymmetric or a symmetric risk related assessment of her competence is used. However, there is a difference between these two forms of competence assessment. The high standard C2 applied to assess a patient's competence by a symmetric risk related competence assessment might mean that in certain circumstances her autonomy would not be respected. Moreover had an asymmetric assessment of her competence been employed her autonomy

might have been respected because the lower standard C1 would have been applied. I will examine whether this difference is meaningful in practice in the next section.

4.4.3. Risk-related assessments of competence and accepting a patient's consent

It is clear that a patient who consents and who might be regarded as incompetent using a symmetric risk related assessment of her competence might sometimes be regarded as competent using an asymmetric risk related competence assessment. However, I have shown that the medical treatment provided to this patient would be identical irrespective of which of these two forms of competence assessment was used. This thesis is concerned with applied philosophy. It might then be questioned if the medical treatment provided is identical, irrespective of which form of risk related competence assessment is used, whether this difference is of any practical importance? In this section I will show that this difference matters. I will then argue that if a patient's consent decision should always be accepted. I will conclude that if a patient's consent decision is always accepted, then in practice there is no difference between asymmetric and symmetric risk related competence assessments.

I showed in section 4.4.2 that which of these two forms of competence assessment is employed might affect a patient's autonomy. I also showed in section 4.4.2 that the treatment the patient receives is identical irrespective of which type of risk related competence assessment is used. Let it be accepted that autonomy has instrumental value (see Dworkin, 1988, page 111). Let it be assumed that the value of autonomy is purely instrumental. It appears to follow that the fact that, a patient who consents and whose autonomy might not be respected using a risk related symmetric competence assessment might have her autonomy

respected using an asymmetric competence assessment, is of no importance. I will now argue that this conclusion is false. I will argue that whilst the treatment the patient receives using these different forms of competence assessment is identical, the outcome of the treatment might not be identical.

I will now argue that it is not only important what form of treatment a patient receives, but also the way this treatment was decided upon. The exercise of autonomy has therapeutic value according to Waller (2001, page 586). It follows that even if the treatment a consenting patient receives is identical under different types of risk-related competence assessment, the outcomes of this treatment might differ. Consider a consenting patient assessed as incompetent using the standard C2 employed by a symmetric risk-related competence assessment. Let it be assumed that this patient would have been assessed as competent using the standard C1 employed by an asymmetric risk-related competence assessment. In this situation this patient would only have her autonomy respected if she was assessed as competent by an asymmetric risk-related competence assessment. It follows that even though the treatment she receives is unaltered by the type of risk-related competence assessment employed, the efficiency of this treatment might be improved due to the therapeutic value of the patient exercising her autonomy if an asymmetric risk-related competence assessment was employed. It can be concluded that there is a meaningful difference between these two risk-related methods of assessing a patient's competence even if autonomy is regarded as purely instrumental.

It might be argued that the therapeutic value of autonomy would be automatically respected by simply accepting all of a patient's freely made informed consent decisions. In section 3.1.1 I argued that respecting all of a patient's freely made decisions meant respecting all her autonomous decisions. However, if autonomy only has instrumental value, it is by no

means clear why we should accept all of a patient's freely made informed consent decisions. Let it be accepted that autonomy only has instrumental value. It follows that autonomy only gains its value from the value of the goods it delivers. It further follows that these goods do not have any special value because they are the result of an autonomous action. It can be concluded the goods autonomy delivers must be balanced against other goods. In the context of informed consent, this means the therapeutic value delivered by a patient acting autonomously must be balanced against other goods such as her well-being, which might be delivered by non-autonomous means.

If it is accepted that autonomy only has instrumental value and the goods it delivers do not have any special value, then it seems there is no obvious reason why informed consent should respect autonomy. For it might be argued that if the goods a patient seeks can be delivered more efficiently by her doctors acting beneficently rather than respecting her autonomy, then her doctors should act beneficently rather than respect her autonomy. I believe such an argument fails because it fails to consider any connection between autonomy and beneficence. Beneficent care is concerned with a patient's interests. These interests are partly subjective (see Atkins, 2000, page 72; Veatch, 1995, page 7). Welie and Welie (2001, page 130) argue that because of this subjectivity truly beneficent health care should be tailored to the unique needs of each individual patient's life story, expectations and plans. It is of course true that in practice medical professionals can offer some beneficent care without the autonomous input of patients, but this care is restricted to the domain determined solely by the patient's physical condition. It follows that true beneficence is impossible without considering a patient's autonomous desires. Consider for instance the example used by Mathews (2000, pages 61, 62) of a terminally ill cancer patient whose life might be extended slightly by the use

of chemotherapy. This patient may choose a shorter life with only palliative care or a longer life with the discomfort of chemotherapy (see section 3.2.1). In order to act with true beneficence to such a patient, her autonomous desires must be considered. It can be concluded that even if autonomy only has instrumental value and the goods it delivers do not have any special value, there are still meaningful reasons why informed consent should respect autonomy.

I have shown that there are meaningful reasons why informed consent should respect a patient's autonomy even if autonomy only has instrumental value. However, the same reasons could be given as to why informed consent should respect a patient's freely made decisions. Moreover, these reasons for why instrumental autonomy should be respected do not explain why respecting autonomy is so central to the practice of informed consent. The reason is because autonomy does not only have instrumental value but also has intrinsic value (see Dworkin, 1988, page 112). Dworkin argues that the intrinsic value of autonomy is connected to an agent being recognised as the kind of person capable of determining her own destiny. Frankfurt (1999, page 163) agrees by arguing that regardless of whether autonomy delivers the goods we seek, it has intrinsic value because of its essential role in making us the distinctive kind of creatures we are. Consider again the patient who consents and is assessed as incompetent using the standard C2 employed by a symmetric risk related assessment of her competence. She might have been assessed as competent using the standard C1 employed by an asymmetric risk related assessment of her competence. It follows that if a symmetric risk-related competence assessment is employed to assess a patient's competence rather than an asymmetric risk-related competence assessment, then she may be denied the intrinsic value of her autonomy because she is not recognised as the kind of creature capable of determining her

own future. It can be concluded that the intrinsic value of autonomy means there is a meaningful difference between these two methods of assessing competence.

I have given three reasons to show that when a patient consents there are meaningful differences between asymmetric and symmetric risk related competence assessments in practice. These differences occur because asymmetric risk-related competence assessments respect a patient's autonomy better than symmetric risk-related competence assessments. I will now propose that the application of informed consent should be changed so that if *any* patient freely consents to some proposed treatment her consent should always be accepted. I will further argue that if this modification to the practice of informed consent is accepted, then these differences between asymmetric and symmetric risk related competence assessments vanish in practice.

In section 4.4.2 I argued that even if a consenting patient was assessed as incompetent using the standard C2 employed by a symmetric risk-related competence assessment and she would be considered as competent using the standard CI employed by an asymmetric risk-related competence assessment, then the treatment she would receive would be identical in both cases. I will now slightly amend this argument to show that if a patient's consent decision is always accepted, the treatment she receives is identical irrespective of which of these two forms of risk-related competence assessment is used to assess her competence.

Let it be assumed that a patient's competence should only be assessed when there is a generally agreed best option for her doctors to propose for her consent. I will argue in chapter 5 that the domain in which a patient's competence might be assessed should be restricted to contexts in which there is a generally agreed best option for a patient to consent to. Moreover, I will argue that the domain in which the practice of informed consent is meaningful is larger

than the domain in which competence assessment should apply. Let this generally agreed best option for a patient be designated T. The patient's doctors should propose treatment T for the patient's consent. Consider what happens when a competent patient consents. The patient's consent is accepted and she receives treatment T. Now consider what happens when an incompetent patient freely consents to treatment. A surrogate decision-maker should make a decision on the patient's behalf which is in the patient's best interests. In this context the surrogate decision-maker should choose treatment T. It follows that if a patient consents to treatment, the treatment she receives is identical irrespective of whether her decision to consent is accepted or rejected as incompetent. It further follows that if a consenting patient's consent is always accepted then her interests are not harmed. Let it be accepted that if all consent decisions are simply accepted, then the autonomy of all patients capable of making autonomous decisions, is respected. It can be concluded that if a patient's consent is always accepted, then her consent is in her best interests and her autonomy is respected. This conclusion is subject to the condition that the patient can and wants to take part in the consent process. For as Waller (2002, page 259) points out dumping responsibility onto a patient who cannot act purposely is not an example of respecting autonomy. In section 6.1.1 I will extend this argument to show a patient may make an autonomous decision to delegate her consent decision to her doctors that is compatible with the practice of informed consent. It can be further concluded that, in this context, and subject to the above condition, there is no reason why a consenting patient's decision should not always be accepted. I therefore propose that the practice of informed consent should be altered. If there is a generally agreed best option and a patient who wants to take part in the informed consent process consents, then her consent should automatically accepted

I showed in section 4.4.2 that the standards used by asymmetric and symmetric risk-related competence assessments are identical if a patient refuses to give consent. It follows that there is no difference to the treatment a patient receives when she refuses to give consent irrespective of whether her competence is assessed using either of these forms of risk-related competence assessment. Let it be accepted that treatment T is generally agreed to be in the patient's best interests. I showed above, in this context, that the treatment a patient receives is identical irrespective of whether her consent is accepted or rejected as incompetent. I also showed that in this context if a patient's consent was automatically accepted, then her autonomy would be respected. I proposed in this context that a patient's consent should be automatically accepted. If my proposal is accepted, it means in practice that there is no meaningful difference between asymmetric and symmetric risk-related competence assessments.

4.5. Risk related competence assessments and personal autonomy.

In section 4.4 I proposed that if a patient freely makes a decision consenting to some treatment proposed by her doctors, then her decision should simply be accepted without any further assessment of her competence. I concluded that if this proposal were adopted then in practice there would be no meaningful difference between asymmetric and risk related symmetric assessments of a patient's competence. As a result of this conclusion, in this section asymmetric and risk related symmetric assessments of a patient's competence will be referred to simply as risk related competence assessments. It must be noted that risk related assessments refers to assessments of competence in which the standard required by a patient in

order to be considered competent varies directly with the risk involved rather than the capacities the patient needs to understand this risk. In this section I will examine risk related competence assessments in conjunction with personal autonomy. I will conclude that a patient can make an autonomous decision which might be regarded as incompetent using a risk related competence assessment. This leads to the major conclusion of this thesis *that asymmetric and risk related symmetric assessments of a patient's competence are incompatible with respecting a patient's personal autonomy.*

When considering risk related competence assessments it is particularly important to be clear about the purpose of informed consent and the purpose of assessing a patient's competence. This importance is due to the way risk related competence assessments combine the concepts of autonomy and beneficence. The General Medical Council's guidelines (2001, introduction 1) state that informed consent is based on respect for patient autonomy. This position is generally accepted in bioethics (see, for instance Silver, 2002, page 458). I will now examine what this position involves for the practice of informed consent. Let it be assumed that the purpose of informed consent is *purely* to respect patient autonomy. Let it be further assumed that to respect autonomy simply means to accept autonomous decisions. In section 3.1.2 I argued that the set of autonomous decisions is a subset of the set of all decisions free from external constraints. It follows that a patient's autonomy might be respected by accepting all her freely made decisions. It further follows that even if the concept of risk related competence assessment is coherent, this concept seems to serve no useful purpose in the context of informed consent. However, it might be argued that respecting a patient's autonomy does not only consist of accepting her autonomous decisions. It might be further argued respecting a patient's autonomy means accepting all her autonomous decisions and enabling her to make these decisions. Even if the above is accepted, it does not mean that the

assessment of a patient's competence is meaningful within the context of informed consent. A patient's autonomy could be respected by fully informing her about her condition and simply accepting her decision provided it is free from external constraints. Medicine is a practical discipline and assessment of patient competence takes time. It can be concluded that if the purpose of informed consent is purely to respect a patient's autonomy, then this could be achieved more efficiently and quickly without the need to assess her competence.

I will now argue that the assumption that the purpose of informed consent is *purely* to respect patient autonomy is false. Not all patients are autonomous. I have shown above that a patient's autonomy can be respected by fully informing her about her condition and accepting her freely made decision. Let it be assumed that the practice of informed consent only requires that patients are fully informed and their freely made decisions accepted. Accepting this assumption would mean that some non-autonomous patients would be deprived of the medical help they need, for no benefit to themselves, in order to respect the autonomy of others. Consider the case of MB [1997]. MB was intuitively non-autonomous because of her needle phobia. MB also refused to give consent. MB was fully informed. If all fully informed and freely made consent decisions were simply accepted, then MB's non-autonomous consent decision would have been accepted. It follows that MB would have been deprived of the help she needed in order to respect the autonomy of others. MB's fully informed and freely made decisions were not accepted. This example suggests that the purpose of informed consent is not purely to respect patient autonomy. Silver (2003) defines the purpose of medicine as follows.

The proper ends of medicine are to use medical skills and training to maintain or improve the condition of the person affected, subject to her autonomous consent. (Silver, 2003, page 209)

Silver's definition combines autonomy and beneficence. It would seem that any meaningful definition of the purpose of informed consent should be concerned with the purpose of medicine and also combine autonomy and beneficence. I believe that in practice the purpose of informed consent is as follows. ***The purpose of informed consent is to respect patient autonomy and enable patients to make autonomous decisions whilst also allowing non-autonomous patients to receive the beneficent medical care they need.*** If this definition is accepted, then the assessment of a patient's competence becomes meaningful. A patient's competence is assessed to ensure her decision is autonomous. However, this does not mean that the purpose of assessing a patient's competence is to respect her autonomy. ***The purpose of assessing a patient's competence is to ensure non-autonomous patients receive the beneficent medical care they need.***

Before risk related competence assessment is examined further, the relationship between autonomy and beneficence in any competence assessment, must be made clear. Let it be accepted that the purpose of informed consent is to protect a patient's autonomy by means which are compatible with beneficent care being given to non-autonomous patients. Let it be further accepted that the purpose of medicine is to act beneficently to all patients subject to their consent as set out by Silver (2003, page 209). In practice the demands of autonomy and beneficence may clash. Silver's definition of the aims of medicine and my definition of the purpose of informed consent given above, resolve any clash between the demands of autonomy and beneficence in the same way. They give priority to respecting the autonomous decisions of patients over acting beneficently. For example, an autonomous decision made by

a Jehovah's Witness who refused to give consent for a blood transfusion which was in her best medical interests would be respected, because respecting autonomous decisions is given priority over acting beneficently. However, a patient who refused to give consent to a blood transfusion due to a needle phobia, would have her decision overruled so she could be treated beneficently, because her decision is non-autonomous.

The capacities a patient requires to make a competent decision using a risk related assessment of her competence are determined directly by the risks involved. It follows that the capacities a patient requires to make a competent decision are not directly linked to the capacities she needs to *understand* the risks involved. For example, the capacities a patient needs to make a competent decision about an emergency appendectomy are directly determined by the risk inherent in the procedure, rather than the capacities needed to understand the risks involved in the procedure. Moreover these capacities need not be identical. Let it be accepted that Dworkin (1988, page 20) and Frankfurt (1988, page 84, originally 1982) are correct and the exercise of autonomy is essentially a reflective process. Reflection requires certain capacities. Let it be assumed that the capacities needed by an agent to make an autonomous decision are in part directly determined by the risks involved in her decision rather than her need to understand the risks involved in her decision. It follows that an agent cannot make an autonomous decision about how much risk she is prepared to accept. It further follows she is not being treated as the kind of person who can determine her own future. However, both Dworkin (1988, page 112) and Frankfurt (1999, page 163) hold that the intrinsic value of autonomy is connected to someone being recognised as the kind of person who can determine her own future. In section 2.2 I argued that it is impossible for someone to completely respect an agent's autonomy if she does not respect the intrinsic value of the agent's autonomy. I further argued in section 2.2 that this involves recognising the agent as the

kind of person who can determine her own future. It can be concluded that the assumption that the capacities needed by an agent to make an autonomous decision are in part determined directly by the risks involved in the decision, is false. It can be further concluded that the capacities a patient needs to make an autonomous decision are solely determined by the nature of the decision and only *indirectly* by the risks involved in the decision. The capacities considered necessary for a patient to be considered competent under a risk related assessment of her competence are determined directly by the risks involved. It follows that a patient may have sufficient capacities to make an autonomous decision, but these capacities might be judged as insufficient for her decision to be assessed as competent using a risk related standard. ***This leads to the conclusion that if competence is assessed using a risk related standard, then priority is being given to acting beneficently over respecting autonomous decisions.***

In order to make clear the change of priorities involved by using a risk related assessment of competence, consider the following example used by Drane (1985 quoted in Mappes & Zembaty, 1986, page 104)). Bob is an outstanding eighteen-year-old athlete who is involved in a road accident which crushes his left foot. Attempts to curb infections in the limb do not succeed and these threaten Bob's life. Bob is asked to consent to the amputation of his leg below the knee. Since Bob is no longer a minor, his consent is required for the surgery. Bob refuses to consent because he considers that without sport, his life will be meaningless. Let it be assumed that Bob fully understands his condition including the probability of his own death, without the amputation. Let it also be assumed that Bob understands that in time he might find it possible to lead a meaningful life outside sport and he has the ability to reflect critically on these facts in the light of his own values. It follows that Bob has the degree of

understanding necessary to make his decision to refuse consent autonomous. However, if Bob's competence is assessed by a risk related standard, this standard is determined directly by the risk involved. In Bob's case, because his refusal of consent is extremely risky, the required standard will be extremely high. It is probable that this standard will be higher than the standard needed for his decision to be considered autonomous. It follows that if a risk-related standard of competence is applied in Bob's case, then priority is being given to acting beneficently rather than respecting his autonomous decision. It further follows that Bob can make an autonomous decision which would be regarded as an incompetent decision using a risk related assessment of his competence. It must be noted that Drane would disagree with my analysis, and would instead regard Bob's decision as non-autonomous.

Cases such as Bob's might intuitively lead to the conclusion that the priority given to respecting autonomous decisions over acting beneficently in informed consent as it is currently practiced is wrong. It might be argued that the purpose of assessing a patient's competence should be altered to ensuring that **beneficent care is given to patients whilst considering patient's autonomous decisions with priority being given to acting beneficently over respecting autonomous decisions**. The fact that priority would be given to beneficence over autonomy does not mean that autonomy would not be considered. If this were so informed consent would become pointless and doctors acting beneficently could simply decide upon the appropriate treatment for a patient.

However autonomy is central to our lives. Dworkin (1988, page 31) argues that autonomy defines the particular person someone is and that by shaping her life plans and projects she gives meaning to her life. Frankfurt (1999, page 163) believes that the basis of autonomy is caring about something. He regards caring about something as having intrinsic

value due to its essential role in making us the distinctive kind of creatures we are. The fact that autonomy is so central to our lives means it is simply not enough just to consider a patient's autonomous decisions when assessing her competence. It means that her autonomy should be respected as required by current medical guidelines. I have argued that the risk related assessment of competence requires that acting beneficently must be given precedence over respecting autonomy in some competence assessments. I have further argued that because autonomy is crucial to making us the kind of persons we are, it is not enough that autonomous decisions are simply considered. It can be concluded that because of the importance of autonomy in shaping our lives, respecting autonomy should be an essential part of the purpose of assessing competence to give valid consent. It can be further concluded that the risk related assessment of competence could only be compatible with the importance of autonomy if it is possible at the same time to respect autonomy whilst also giving priority to acting beneficently over respecting autonomy.

Dworkin (1988, page 15) considers autonomy to be a global concept which can only be assessed over an extended portion of a person's life. He also believes the promotion of autonomy in the long term may require sacrificing autonomy in the short term (Dworkin, 1988, page 114). It might then be argued that respecting autonomy should mean respecting a patient's capacity for autonomous action rather than her individual autonomous decisions. Let it be assumed that respecting an agent's autonomy in the long term could be achieved simply by the promotion or protection of her capacity for autonomy (see section 2.2). It might then be argued that giving priority to acting beneficently over accepting individual autonomous decisions is compatible with respecting autonomy in the long-term. If the above is accepted,

then it is possible that the risk-related assessment of a patient's competence is compatible with respecting autonomy.

Consider again the case of Bob. Let it be assumed that Bob's competence is assessed using a risk-related standard. Let it further be assumed that Bob makes an autonomous decision to refuse consent and there is a high probability that without treatment he will die. In this case because the risk involved with refusing consent is very high, the standard set for Bob to be considered competent would also be very high. This follows because acting beneficently has been given priority over respecting his autonomous decision. Let it also be assumed that this high standard means Bob's decision is assessed as incompetent. However, it might be argued that even though this standard is high, and dictated by the needs of beneficence, it still respects Bob's autonomy in the long term. This follows, because without the amputation, Bob will probably die and his capacity for autonomous action will be lost. However if Bob's autonomous decision is sacrificed in the short term for beneficent reasons, his capacity for autonomous action will be preserved and hence respected. This example seems to show that priority may be given to acting beneficently over respecting autonomous decisions whilst at the same time still respecting autonomy. The above is only true if respect for autonomy means the promotion or protection of a patient's capacity for autonomous action.

The example of Bob intuitively shows that the idea of risk-related competence assessment might be compatible with respecting patient autonomy. This possibility means priority may be given to acting beneficently over respecting individual autonomous decisions. It depends on the premise that respect for autonomy means the promotion or protection of a patient's capacity for autonomous action. I will now examine the example of Bob in greater detail to question this intuitive position. Let it be assumed that if Bob consents to the

amputation, his chances of dying are very small. It follows that the risk involved with his consenting is minimal. Let it also be assumed that if Bob refuses to consent to the amputation, his chance of dying is high with a probability of 80%. It follows that the risk involved with his refusing to consent is high. Let it be still further assumed Bob fully understands the prognosis for each option and the probabilities of his survival with both options. Lastly let it be assumed that Bob decides he is prepared to accept the 80% probability of his death in the 20% hope that attempts to save his limb will eventually succeed and that he refuses to consent. Bob's competence is then assessed using a risk related assessment of his competence. Because Bob has made a dangerous choice, acting beneficently will take priority over respecting his autonomous decision and a high standard of competence will be applied. Finally let it be assumed that Bob's decision is judged to be incompetent and his leg is amputated. It follows that Bob has had his autonomous decision overruled and this overruling has preserved his capacity for autonomous decision-making. However, our intuitive ideas are altered when Bob's case is examined in greater detail. The preservation of Bob's capacity for autonomous action seems intuitively insufficient to respect his autonomy.

It has been assumed that respect for autonomy might simply mean the promotion or protection of a patient's capacity for autonomous action. Bob has had his capacity for autonomous action protected. The following question may now be asked. Why does Bob intuitively appear not have had his autonomy respected even though his capacity for autonomous action appears to have been protected? The reason for this is that autonomy does not simply have instrumental value. Autonomy also has intrinsic value (see section 2.2). The instrumental value of autonomy is clearly respected in Bob's case. The intrinsic value of autonomy involves an autonomous agent being respected as the kind of person who can determine his own future. The intrinsic value of autonomy involves an autonomous agent

exercising her autonomy according to Dworkin (1988, page 112). This means respecting an agent's capacity for autonomy only partially respects her autonomy. In order to fully respect someone's autonomy, one also must respect her autonomous decisions. Intuitively Bob's autonomy was not respected because his autonomous decision was not respected.

Next, consider a mountaineer called Bobby. Bobby has a child and decides to continue climbing. This decision involves considerable dangers for Bobby. However, let it be assumed she fully understands the risks involved and that her partner can adequately care for their child. Let it be assumed that Bobby's decision is autonomous. Bobby's decision differs from Bob's decision because she assesses the risk she is prepared to take whilst others assess the risk Bob can take. Bobby's decision might be regarded as both uncaring and dangerous. Her friends, acting from beneficent motives, might seek to persuade Bobby to change her decision. However, if her friends fail in their attempt to change Bobby's autonomous decision they would have to respect this decision. It can be concluded that in this case Bobby's autonomous decision would be respected rather than her capacity to make autonomous decisions in the future. This conclusion would seem to apply to all autonomous decisions made by adults outside the practice of informed consent.

It has been argued by Clarke (2000, page 174) that some concepts connected to informed consent are only loosely related to the meaning of these concepts in contexts outside the practice of informed consent. It might then be argued that the meaning of "respect for autonomy" is different in the context of informed consent, to the meaning of "respect for autonomy" in contexts outside the practice of informed consent. However, even if the meaning of "respect for autonomy" is different in the context of informed consent compared to its meaning in other contexts, it should be possible to give a reason for this difference. Perhaps it

might be argued that in the context of informed consent, a patient's capacity to make autonomous decisions should be respected rather than her actual autonomous decisions because of the possibility of her death. However, the example of Bobby clearly shows the possibility of an agent's death is connected to her decisions in contexts outside the practice of informed consent. Moreover, in these contexts an agent's autonomous decision is respected rather than her capacity to make future autonomous decisions. It seems hard to advance further reasons why respect for autonomy in the context of informed consent should differ from respect for autonomy in other contexts.

It has been assumed that in the context of informed consent, respect for a patient's autonomy simply means respecting her capacity to make future autonomous decisions. Let it be accepted that respect for autonomy should have the same meaning in all contexts unless reasons can be advanced for why respect for autonomy should have different meanings in different contexts. I have argued above that it is hard to see any reason why respect for autonomy should have a different meaning in the context of informed consent compared to other contexts. It follows that one of the following two options should hold. Firstly, respecting autonomy should only mean respecting an agent's capacity to make future autonomous decisions. If this first option is adopted, then respecting autonomy, in all contexts, should mean respecting an agent's capacity to make future autonomous decisions even if this means sacrificing some of her autonomous decisions. Secondly, respecting autonomy should mean respecting an agent's autonomous decisions.

I will now present two arguments to show that if respect for autonomy should have the same meaning in all contexts then respecting autonomy should mean respecting an agent's autonomous decisions. Firstly adopting the first option would mean autonomous decisions

such as that of Bobby would not be respected. This option would seem to be impractical as it would change the entire ethos of western culture. However, accepting this argument does not mean that it would be wrong to respect autonomy by respecting an agent's capacity to make future autonomous decisions.

I will now present a second argument to show that respecting autonomy should mean, respecting an agent's autonomous decisions. My argument is based on the intrinsic value of autonomy. In section 2.2 I showed that the intrinsic value of autonomy is connected to respecting autonomous decisions. Let it be accepted happiness has intrinsic value. A utilitarian might argue it would be right to sacrifice some happiness in order to promote greater happiness. Moreover a utilitarian might justifiably argue such a sacrifice is perfectly compatible with respecting the intrinsic value of happiness. It might then be argued by analogy that respecting the intrinsic value of someone's autonomy might mean sacrificing some of her autonomous decisions. I believe such an argument by analogy is unsound due to the nature of the intrinsic value of autonomy. I argued on pages 53, 54 that in order to respect the intrinsic value of someone's autonomy all of his autonomous decisions must be accepted. In section 2.2 I showed both Dworkin (1988, page 112) and Frankfurt (1999, page 163) believe that the intrinsic value of autonomy is connected to the desire to be recognised as the kind of creature capable of determining her own destiny. I believe Dworkin and Frankfurt's position is essentially the correct one. It follows the recognition that someone is the kind of creature capable of determining her own future cannot be graduated. Clearly someone is either recognised as the kind of creature who is capable of determining her own future or as someone who is not. It further follows if I promote someone's capacity to make future autonomous decisions by sacrificing some of her autonomous decisions then I fail to respect the intrinsic

value of her autonomy. However if I promote someone's happiness by sacrificing some of her happiness it might still be argued I respect the intrinsic value of her happiness. It can be concluded the above argument by analogy is unsound. If these arguments are accepted then it can be concluded that it would be wrong to respect a patient's autonomy by simply respecting her capacity for autonomous action.

In this section I have argued that the risk-related assessment of a patient's competence can only be compatible with respecting his autonomy if the following premise is true. It is possible to respect autonomy whilst at the same time giving priority to acting beneficently over respecting autonomous decisions. I further argued that this is only possible if respecting autonomy means only respecting a patient's capacity for autonomous action. I still further argued that it is meaningless to only respect a patient's capacity for autonomous instrumental action. It follows the above premise is false and a risk-related assessment of a patient's competence to give consent is incompatible with respecting his autonomy. This also leads to one of the major conclusions of this thesis. *All competence assessments tied directly to risk of a procedure are incompatible with respecting patient autonomy because sometimes they must give priority to acting beneficently over respecting autonomous decisions. Giving priority to acting beneficently over respecting autonomous decisions is incompatible with respecting autonomy. It follows that if informed consent is based on respect for autonomy the concepts of asymmetric and risk related symmetric assessments of patient competence should play no part in the practice of informed consent.*

Accepting the above conclusion leads to the following further conclusion. British case law on informed consent is incompatible with respecting patient autonomy. Lord Donaldson in the case of T stated that a patient's capacities should vary with the risks involved in his case

[1992]. I have argued the capacities a patient needs to be considered competent may indeed vary with the risks involved. In some circumstances a patient may need higher or extra capacities to understand the risks involved in her treatment. However, in order to respect a patient's autonomy, I have shown the capacities a patient needs to be considered competent should only be linked indirectly to the risk involved in her treatment. Lord Donaldson's judgment in the case of T concentrated directly on risk because it concentrated on the risks concerned with refusals of consent. I have concluded above that if risk is linked directly to the standard of competence in any competence assessment, then this assessment of competence gives precedence to acting beneficently over respecting the patient's autonomous decision. I have further concluded that respecting autonomy is not compatible with giving precedence to acting beneficently over respecting autonomy decisions. These conclusions lead to the second major conclusion of this chapter. *Current medical law as set out by Lord Donaldson in the case of T on consent involving risk is incompatible with respecting patient autonomy.*

It is of course true that the risk involved in a procedure still plays a major part in the assessment of a patient's competence to give consent to that procedure. Firstly the risk involved in the outcome of a patient's decision is important in triggering any assessment of her competence. This triggering may be asymmetric with regard to risk. The asymmetric triggering of competence assessments is perfectly compatible with respecting a patient's autonomy. Secondly, a patient must understand certain information relevant to his condition in order to make an autonomous decision. This information should include the risks involved in his decision.

This chapter reached the following conclusions.

- 1) The asymmetric triggering of competence assessments is compatible with respecting patient autonomy.
- 2) Asymmetric and risk related symmetric assessments of a patient's competence are directly linked to risks involved in the procedure. This means that acting beneficently is given precedence over respecting patient's autonomous decisions.
- 3) In circumstances when there is a generally agreed best option for a patient to choose. A patient's freely made decision to consent to some proposed treatment should be accepted regardless of whether the patient is competent or incompetent.
- 4) Asymmetric and risk related symmetric assessments of competence should not used to assess patient competence because they do not respect patient autonomy.
- 5) Current law as set out in the case of T on consent involving risk is incompatible with respecting patient autonomy.

Chapter 5

The purpose of informed consent decisions and the context in which these decisions are made

This chapter will examine the purposes behind making informed consent decisions. Firstly I will examine the purpose of a patient when making an informed consent decision. Secondly I will examine the purpose of assessing a patient's competence to make an informed consent decision. This chapter will also examine the context in which assessing a patient's competence to make informed consent decisions is meaningful. This examination will be carried out against the background of what it means to be competent. I will argue that in some contexts, in which the assessment of patient competence appears to be a coherent concept, it would be wrong to automatically conclude that it is a useful concept. I will further argue that if the assessment of patient competence is to be a useful concept, then it must be linked to the ability of surrogate decision-makers to make good decisions on behalf of incompetent patients. This will lead to a major conclusion of my thesis. I will conclude that in certain contexts, when it is impossible for a surrogate decision-maker to choose a generally agreed best option on behalf of an incompetent patient, the idea of assessing the patient's competence to give informed consent is not a useful one and should be abandoned. I will argue that in these contexts a patient's decision should always be accepted. However, I will also show that in these contexts, even if the assessment of a patient's competence should be abandoned, this does not mean that the idea of informed consent should also be abandoned. This chapter is divided into four sub sections.

5.1

The patient's purpose when making informed consent decisions

Before I examine the relationship between personal autonomy and the practice of informed consent further, the purpose of a patient's decision when she gives informed consent must be made clear. This is important when considering the information requirements needed to enable patients to make informed consent decisions. I will discuss these requirements in detail in section 6.1. However, I will argue in section 5.2 that the purpose of a patient's decision when she gives informed consent, is unimportant when considering the purpose of assessing her decision for competence.

The informed consent decision a patient faces is not to decide which form of treatment is in her medical interests. Patients do not have sufficient expertise to make such decisions. Fortunately informed consent decisions are not medical decisions as pointed out by Dworkin (1988):

Decisions about what form of treatment to undergo, the probabilities of cure and the side effects, judgements about how the body will react after various forms of surgery, whether to spend one's last days in hospital or at home – these are not technical medical judgements (Dworkin, 1988, page 113).

Intuitively a patient's informed consent decision is concerned with whether consenting or refusing to consent to some proposed treatment is in her best interests. Veatch (1990) defines consent as follows:

Consent means approval or agreement with the actions or opinions of another; terms such as acquiescence and condoning appear in the dictionary definitions. In medicine, the physician or other health care provider will, after reviewing the facts of the case and attempting to determine what is in the best interests of the patient, propose a course of action for the patient's concurrence (Veatch, 1995, page 5).

Let it be assumed that Veatch is correct in his analysis. It follows that the purpose of a patient making an informed consent decision is to decide whether consenting or refusing to consent to some proposed treatment is in her best interests.

Veatch further concludes that if informed consent means a patient makes a decision based on her best interests, then the treatment her doctors propose must also be in her best interests. He argues that this is impossible. He argues that if it is possible for doctors to determine what is in the best interests of a patient, then they must be capable of the following:

First the clinician must be expected to determine what will best serve the patient's medical or health interests; second the clinician must be expected to determine how to trade off health interests with other interests; and third the clinician must be expected to determine how the patient should relate the pursuit of her best interests to other moral goals (Veatch, 1995, page 7).

If it is accepted that a patient's best interests are a combination of these three different elements then it follows that doctors might well be unable to determine what is in her best interests. It further follows that if Veatch's conclusion, that it is necessary for doctors to make

recommendations which are in the patient's best interests, is true then the process of informed consent cannot get started. Because of these reasons, Veatch rejects the concept of informed consent as meaningful. He argues that a patient should place her trust in doctors with whom she has paired herself on the basis of their mutual goals and values. These doctors would then make a decision on the patient's behalf. Veatch (1995, page 11) argues that this process, based on pairing and doctors deciding, should replace the practice of informed consent. However, I argued in section 4.2 that some intuitively competent decisions are made by agents deciding what would satisfy them rather than what is in their best interests. It follows that the conclusion, that the purpose of a patient making an informed consent decision is to decide whether consenting or refusing to consent to some proposed treatment is in her best interests, needs revising. It might be concluded that the purpose of a patient making an informed consent decision is to decide whether consenting or refusing to consent to some proposed treatment would satisfy her. It might then be argued, if this revised conclusion is accepted that a patient's doctors would only need to propose a treatment that will satisfy her rather than a treatment which is in her best interests. However, in most circumstances the problem remains because a patient will only be satisfied if she believes her decision is in her best interests.

Let it be accepted that a patient usually bases her informed consent decision on her best interests. Because of this Veatch concludes that a patient's doctors must be able to make a recommendation which is in her best interests. I will now argue that accepting the former does not mean Veatch's conclusion is true. Let it be further accepted that Veatch is correct to believe a patient's doctors cannot know what is in her best overall interests. However, a patient's doctors can make a recommendation which is in her best medical interests. Consider a patient giving consent. This patient might accept her doctors' recommendation that some form of treatment is in her best medical interests. According to Wear (1998) the patient should

integrate this recommendation with her other interests to decide whether her doctors' recommendation is in her best overall interests:

Evaluating the data presented seems much more difficult, for one must first prioritize and relativize it to one's own personal circumstance. The patient must then attempt to array all this as a coherent fabric from which a specific decision can be generated (Wear, 1998, page 20).

It seems to be impossible for a doctor to prioritise and relativise a patient's medical interests with her other interests. However, this is something a patient can do. It follows that Veatch is correct and a patient's doctors cannot make a recommendation which is in her best overall interests. However, he is wrong to conclude this makes informed consent impossible. Let it be accepted that it is possible for doctors to make a recommendation which is in a patient's best medical interests. Let it be further accepted that a patient may then make a consent decision based on what she believes to be in her best overall interests. These interests would be based on her best medical interests and what she cares about. It can be concluded the purpose of a patient making an informed consent decision is to decide whether consenting or refusing to consent to some proposed treatment would satisfy her. It can be further concluded that in most circumstances a patient will only be satisfied if she believes her decision is in her best overall interests.

5.2. The purpose of assessing patient competence

I argued in sections 2.1 and 4.5 the purpose of informed consent is to respect patient autonomy whilst also ensuring non-autonomous patients receive beneficent care. It is often assumed in medical ethics that the purpose of assessing a patient's competence is to determine whether her informed consent decision should be accepted (see, for instance, Buchanan & Brock, 1989, page 28). In this section I will firstly examine our intuitive ideas of what competence assessment means in conjunction with personal autonomy. After completing this examination I will question the purpose of assessing a patient's competence to give consent as outlined by Buchanan and Brock. I will conclude that the reason why a patient's competence is assessed should concur with the purpose of informed consent as defined in section 4.5. The purpose of assessing a patient's competence should be to respect her autonomy if she is autonomous, and to allow her to receive beneficent care if she is non-autonomous. I will use this conclusion in later sections of this chapter to show that in some circumstances, the assessment of a patient's competence serves no useful purpose.

There are some concepts of autonomy that refer to autonomous persons (see, for instance, Dworkin, 1988, page 15), and some concepts that refer to autonomous decisions (see, for instance, Christman, 1991, page 3). This division also applies to our intuitive ideas of competence. There can be global competence which refers to competent people. Competence can also refer to a specific task. For instance, someone may be competent to run her life as she sees fit (global competence) but she may be incompetent to drive a car (task related competence). Buller (2001) defines the relationship between global competence and someone's competence to do a particular task as follows:

On this usage, the judgement that a person is competent or not to perform a particular task is based not on the particular features of the task, but simply on the fact that the person is competent (or not) (Buller, 2001, page 92).

However it is also possible to assess someone's competence to do a particular task directly by questioning whether she has the capacities needed to undertake this particular task successfully. It follows that prior to examining the purpose of assessing a patient's competence to give informed consent, a further question must be answered. Does assessing a patient's competence to make an informed consent decision involve assessing her global competence, or directly assessing her competence to make a specific decision?

I will now argue that it would be wrong simply to assess a patient's global competence when assessing her competence to make an informed consent decision. Intuitively someone is competent if she is skilful, efficient, or capable of undertaking some task. Intuitively it follows that someone is globally competent if she is capable of running her own life. It has been assumed above the purpose of assessing a patient's competence is to decide if she should retain the right to accept or refuse treatment. Prima facie it might be concluded that provided a patient is competent to run her life, she should be competent to give informed consent and her decision should be accepted. However, just because a patient has the capacities needed to run her own life it does not automatically follow that she can run own her life. Her decisions may be constrained. These constraints include internal constraints as illustrated by the case of MB [1997] who had a needle phobia. It follows from this that prima facie conclusion needs amending. Prima facie it might now be concluded that if a patient is competent to run her life,

and the decisions she makes are not constrained, then she should be competent to give informed consent. I believe that this amended prima facie conclusion should also be rejected. Let it be accepted that if someone is competent to run her own life she must be capable of making reasonable decisions. Let it also be accepted the reason we respect any decisions she makes is because we expect these decisions to be reasonable. However, even if someone is competent to run her own life it does not automatically follow that all her decisions are reasonable decisions. Someone who is competent to run her own life may make bad decisions when faced by strange and unusual circumstances in which her understanding of issues is limited. The circumstances of giving informed consent are strange and unusual to most patients. It follows that in the context of informed consent, we do not have reason to respect the decisions of a patient who is competent to run her own life because we always expect these decisions to be reasonable decisions. It can be concluded that the amended prima facie conclusion that, if a patient is competent to run her own life and the decisions she makes are not constrained, then she should retain the right to accept or refuse treatment, is false.

However the above conclusion, concerning the amended prima facie conclusion, might not be true in all circumstances. Buller (2001) points out much that the same abilities are needed to make all decisions:

In fact there seems something odd in the notion of decision relative competence as a whole for although it is obvious that different tasks require different skills, it is far less obvious that different decisions do. Whereas it is clear that cooking a meal at least requires some different skills to composing an opera, one can make an argument that that exactly the same skills are

needed to financial decisions as educational ones, namely attention to detail, appropriate weighing of options, understanding the implications etc (Buller, 2001, page 96).

If Buller is correct, and the same skills are needed to make informed consent decisions as are needed to make other decisions, then it might be argued that competence should refer to decision making in general rather than to specific decisions. This would mean that even if the idea of global competence were rejected when applied to generally competent persons, a restricted form of global competence might apply to persons competent to make decisions. For instance, someone may be an incompetent driver but a competent decision-maker. It might be argued that if someone is competent to make important decisions, such as whether to marry or which career to follow, then she should be competent to make other important decisions which might affect her. Accepting the above leads to the conclusion that the amended prima facie conclusion should be further amended as follows. If a patient is a competent decision maker and the decisions she makes are not constrained, then she should automatically retain the right to accept or refuse treatment.

I will now present three arguments to show that this further amended prima facie conclusion is false. Wicclair (1991) points out that not all decisions require the same cognitive skills and capacities;

The requisite skills and abilities vary according to the specific decision, and the standard of decision-making capacity therefore should be decision or task related. It is unlikely, for example, that there are no significant differences between the cognitive skills and capacities required to make a reasoned decision concerning life sustaining medical treatment, on one

hand, and the cognitive skills and capacities that are required to make sound financial investments, on the other hand (Wicclair, 1991, page 92).

It might then be argued that the fact that a patient is a competent decision maker when generally running her life, does not of necessity mean she has the cognitive skills to make a reasonable informed consent decision. However, it is by no means clear that different cognitive skills are required for different types of decisions, as pointed out by Buller above (2001, page 96). What is different is the type of information needed by the decision maker in different situations. One purpose of informed consent is to supply enough information to enable a patient to make a reasonable decision. It follows that my first argument, to show the further amended prima facie conclusion is false, fails.

Secondly, I will argue by analogy that the further amended prima facie conclusion is false. This conclusion relies on the implicit premise that by providing someone who usually makes competent decisions with information, when she is in strange and unusual circumstances, we can enable her to understand her situation. It might be argued that this implicit premise is false because information can only be understood against a background of knowledge. It might then be argued that it is pointless to provide someone with information, pertinent to some decision she is making, unless she already has the background knowledge necessary to understand the information provided. For instance, a banker making an investment decision needs not only to understand the information specific to her particular investment decision, but she must also have a background knowledge of financial markets and institutions. It might then be argued by analogy that a patient making an informed consent decision must not only understand the information specific to her particular decision but also have a background of medical knowledge. However, as pointed out by Dworkin (1988, page 113) informed consent decisions are not medical decisions. Intuitively someone's competence

to make investment decisions requires both understanding the decision and a specialist background. However, someone's competence to make informed consent decisions only requires that the patient understands her condition against the background of her normal life. It can be concluded that this argument by analogy fails.

My third argument runs as follows. Let it be assumed that an unconstrained patient is competent to make decisions such as whether to marry or which career to follow. If the further amended prima facie conclusion is correct, and provided this patient is suitably informed about her medical condition, then she should also be competent to give informed consent. Let it be further assumed that all of these decisions require similar understanding and cognitive abilities. I argued above that the further amended prima facie conclusion is dependent on the implicit premise that by providing someone who usually makes competent decisions with information, when she is in strange and unusual circumstances, we can enable her to understand her situation. I believe that this implicit premise is false. Decisions such as those concerning marriage and careers are not generally made in the same circumstances as informed consent decisions. Patients making informed consent decisions are often in strange and unusual circumstances. These circumstances can affect both their cognitive abilities and understanding. It follows that the further amended prima facie conclusion that, if a patient is a competent decision maker and the decisions she makes are not constrained then she should automatically retain the right to accept or refuse treatment, is false. It is of course still true that a patient's past decisions may be a guide to her competence to make informed consent decisions. It can be concluded that when assessing a patient's competence to make an informed consent decision, her competence to make this specific decision should be assessed and not her global competence.

Let it be assumed Buchanan and Brock (1989) are correct and the purpose of assessing a patient's competence is to determine whether her informed consent decision should be respected. A further question then might be asked. Why is it necessary to assess whether a patient retains the right to accept or refuse to accept a particular medical procedure? Silver (2002) asks the same question and then provides an answer:

The ideal answer is rather obvious and uncontroversial: we value a patient's autonomy and if they are capable of exercising it, we want patients to make the ultimate decisions about their health care (Silver, 2002, page 458).

Silver argues that purpose of competence assessment is to allow autonomous patients to make autonomous decisions. The General Medical Council (2001, introduction 1) support Silver's position. However, as O'Neill (2002, page 26) points out the idea of patient competence was developed in conjunction with the concept of informed consent and is only loosely connected to the philosophical concept of autonomy. Moreover, as I showed in section 3.1.2 that all autonomous decisions are members of the set of all freely made decisions. In section 2.2 I argued that respecting an autonomous decision simply means accepting that decision. I concluded in section 3.1.2 that if all freely made decisions are simply accepted, then there is no need to assess a patient's competence in order to respect her autonomy. I further concluded that in practice autonomous decisions could be respected more efficiently by simply respecting all freely made decisions. However, let it be accepted for the sake of argument that if the purpose of assessing a patient's competence is to determine whether her informed consent decision should be respected, then this respects patient autonomy. Even if the above is accepted, it is by no means clear why the decisions of non-autonomous patients should not be

respected in all circumstances. It might be argued that some decisions by non-autonomous patients should be accepted (see Law, 2003, page 54). In the light of the above, I believe that the purpose of assessing a patient's competence should not be simply to determine whether she retains the right to accept or refuse a particular medical procedure. *The purpose of assessing a patient's competence should be to respect her autonomy whilst also allowing her to receive beneficent care if she is non-autonomous.*

5.3 The domain in which the assessment of informed consent decisions is meaningful

I concluded in section 5.1 that the purpose of a patient making an informed consent decision is to decide whether consenting or refusing to consent to some proposed treatment would satisfy her. I concluded in section 5.2 that the purpose of assessing a patient's competence should be to respect her autonomy whilst also allowing her to receive beneficent care if she is non-autonomous. In practice, informed consent tries to satisfy both of these purposes. These purposes are connected. However, I will argue that the conditions in which these different purposes may be meaningfully satisfied are not the same. The circumstances in which a patient may be meaningfully enabled to make an informed consent decision are broader than the circumstances in which her competence may be usefully assessed. In this section I will set out the circumstances in which it is useful to assess a patient's competence.

5.3.1. Useful competence assessments

In general, if the assessment of someone's competence to do a task is to be a useful concept, then it must be possible for a third party to assess her competence to do the task in question. The question now naturally arises of how a third party assesses someone's competence to do

some task well. In what follows I will argue that informed consent remains meaningful even if it is impossible to say one outcome is preferable to another. However, I will argue that if any assessment of a patient's competence to give informed consent is to be useful then it must be possible to say that one outcome is preferable to another.

The General Medical Council's (1999, page 5) guidelines hold that all that matters when assessing a patient's competence to give informed consent is her internal capacity to understand the information provided. The Department of Health's (2001, section 2.1) guidelines also hold that what matters when assessing a patient's competence is whether she has the capacities needed to make the decision in question and the outcome of her decision should play no part in this assessment. This position is also supported in law by the C test [C, 1992]. It follows that medical guidelines may regard the outcome of a patient's decision as important in triggering an assessment of her competence. These guidelines, however, hold that the outcome of a patient's decision should play no part in the actual assessment of her competence. Intuitively this seems to be a strange conclusion. Normally we assess someone's competence to do some task by how well she completes the task or similar tasks. I will argue that even if any account of competence based purely on a patient's internal abilities is a coherent account, it is not a useful one.

The methods used to assess patient competence, as outlined in the guidelines given by the General Medical Council and the Department of Health, do not apply when assessing someone's competence to drive. Someone's competence to drive is not assessed by whether she has the capacities required to drive but by the outcome of a driving test. The driver's capacity to drive is not assessed directly, her driving is. A driver is only presumed to have the capacities required to drive after successfully passing her driving test. Wilks (1999, page 157)

uses the example of a painter to intuitively argue that any assessment of her competence to paint can only be meaningful if it is possible to assess whether she has made a good job. He argues that in general we do not assess whether someone is competent to complete some task by inquiring whether she has the capacities necessary to do the task, but by how well she completes the task or a similar task. This is also true in medicine. A surgeon's competence is assessed by the results of her operations rather than by whether she has the capacities needed for surgery. However, according to medical guidelines on informed consent, in any assessment of a patient's competence to make an informed consent decision, all that matters is whether she has the capacities needed to make the decision in question. The actual outcome of her decision should play no part in the actual assessment of her competence. It might be argued that the standards applied in other forms of competence assessment should also be applied to the assessment of a patient's competence to give informed consent. If this argument is to be rebutted, then it must be possible to give reasons why the assessment of a patient's competence to give informed consent based purely on her capacities should differ from the assessment of competence to do other tasks such as driving, painting and surgery. However, it is possible to give a reason why the assessment of a patient's competence should differ from the assessment of competence in other fields. The circumstances in which a patient's competence is assessed differ from the circumstances in which someone's competence to perform these other types of action are assessed. The actions of drivers, surgeons and even painters, take place in circumstances in which other people may be harmed. Because of this it is right that the standard of competence of drivers, surgeons and painters should be assessed by how well they perform their task. It might then be argued that because a patient's informed consent decision, with some exceptions, does not harm others, it need not be assessed by how well she performs this task.

It might be argued that accepting the above does not mean a patient's competence can be assessed differently to other forms of competence assessment. It means there is not the same reason to assess a patient's competence. I have shown that the practice of informed consent requires that a patient's competence should be assessed purely on the basis of whether she possesses certain capacities. If the above is accepted, it follows that the practice of informed consent uses no standards based on the outcome of a patient's decision to assess her competence. However, Wilks (1999) argues that normative standards are usually an essential part of what it means to assess someone's competence to do some task:

The point is that whenever we call someone competent at any thing we do it with the thought in mind they do something well, and in doing so we will always have in mind some relevant standard of wellness. This sort of normativity is built into all assessment of competence, which is itself, in my view an irreducibly normative notion. A practice for which the issue of normative standards does not arise will have practitioners for whom the issue of competence does not arise (Wilks, 1999, page 157).

It appears to follow that Wilks believes that if the practice of informed consent bases the assessment of a patient's competence purely on whether she possesses certain capacities, then this assessment of her competence is meaningless. Whether this belief is correct depends on what Wilks means by "the issue of competence". If Wilks means by this that the assessment of someone's competence is a coherent concept, it would seem his belief is false. Assessing someone's competence to do some task by simply questioning if she possesses certain capacities is a coherent concept. However if he means it is not *useful* to assess someone's

competence to do some task without any agreement about what it means to do the task well, I will argue that Wilks is correct.

I will base my argument on an example I have previously used that derives from Mathews (2000, page 61). Consider a terminally ill cancer patient whose life might be extended slightly by the use of chemotherapy. However this patient might prefer a shorter life with only palliative care. For this patient there is no general agreement as to which of these options is preferable. The patient may of course subjectively believe one option is better than the other. Let it be assumed that the assessment of a patient's competence to give informed consent is based purely on whether she possesses the capacities needed to make the requisite decision. It follows that the idea of assessing this patient's competence is coherent. Let it be further assumed that this patient does not have the capacities needed to be considered competent and is assessed as incompetent. It follows that a surrogate decision-maker should make a decision on the patient's behalf. The surrogate decision maker will either be a parent or a court appointed guardian. In most cases the court appointed guardian would be the patient's doctor. The surrogate decision maker should usually make her decision in consultation with the patient and her relatives. She should act beneficently by choosing the option which is in the patient's best interests, according to the General Medical Council's guidelines (1999, section 25) and also take into account any previously expressed desires the patient has made (1999, section 22). In this particular case there is no generally agreed best option. It follows that a surrogate decision-maker cannot act truly beneficently by choosing an option which would be generally agreed to be the best option for the patient as required by the General Medical Council's guidelines. In these circumstances a patient's competence may be assessed. However, in these circumstances such an assessment is not linked to the ability of a surrogate decision-maker to make a truly beneficent decision. It can be concluded that in these

circumstances any assessment of the patient's competence fails to serve the purpose of assessing patient competence as set out in section 5.2. It can be further concluded that if the assessment of patient competence is to be a useful concept it must take place in circumstances in which a surrogate decision-maker has the ability to act beneficently by making a decision which is generally agreed to be in the patient's best interests. If this conclusion is not accepted, then the assessment of patient competence in these circumstances seems to be no more than a gesture. It can be still further concluded that in these circumstances the idea of assessing a patient's *competence* to give informed consent is not a useful concept and should be abandoned.

5.3.2. Useful competence assessments and informed consent

In this section I will examine the conclusions reached above in greater detail by examining what is meant by "a generally agreed best option" and the circumstances in which the above conclusions are true. It seems that "a generally agreed best option" cannot mean a particular option is in the best objective interests of the patient. One reason for this is that autonomous agents determine, at least in part, what is in their best interests (Frankfurt, 1988, page 92, originally 1982). Because of this I argued in section 5.1 that it is impossible for a third party to know what is in a patient's best objective interests. It follows that if "a generally agreed best option", means an option which is in the patient's best objective interests, then a surrogate decision-maker could never make a decision which is "generally agreed" to be in a patient's best interests. It further follows that Veatch (1995, page 11) might be correct (see section 5.1) and the idea of informed consent should be abandoned.

I will now argue that "a generally agreed best option" should be defined by some practice. This can be made clear by the use of an example. Consider the statement that Doctor

Jones is a competent surgeon. The truth of this statement cannot be simply validated by some objective fact connected to Doctor Jones. The truth of this statement can only be validated in some practice. The truth in the case of Doctor Jones depends on the criteria agreed to by medical practice. It might then be argued by analogy the truth of whether a surrogate decision-maker can choose “a generally agreed best option”, depends not on some objective fact but on the criteria agreed by some practice. In the case of Doctor Jones the practice that agrees the criteria on which her competence is assessed is clear. However, in the case of a patient giving informed consent, it is not so simple to see which practice validates whether some decision is the “generally agreed best option” for the patient. Moreover as Dworkin (1988, page 113) points out, the informed consent decisions patients face are not technical or medical judgements. It follows that the practice which agrees the criteria that define “a patient’s generally agreed best option” ought not to be medical practice. I argued in section 5.1 that a patient making an informed consent decision is deciding whether consenting or refusing to consent to some proposed treatment would satisfy her. I further argued that in most cases this means a patient is deciding whether some medical intervention is in her best overall interests. It follows that her decision is a decision about how she will lead her life. People usually make their own decisions about how they should lead their individual lives. It can be concluded that in the context of informed consent, the practice which agrees the criteria by which it is possible to decide if a patient’s decision is in her “generally agreed best interests” should be people in general deciding how to lead their lives.

It might be objected that the idea that people in general can decide if something is “a generally agreed best option” is nonsense because people in general never agree about anything. It would appear to follow, in the context of informed consent, that a surrogate

decision-maker could never choose “a generally agreed best option” on behalf of a patient. If the above is accepted and it is also accepted that, the assessment of a patient’s competence is only useful in circumstance in which a surrogate decision-maker can choose “a generally agreed best option” on behalf of an incompetent patient, then the assessment of a patient’s competence is never useful. However, it is not true that people in general can never choose “a generally agreed best option”. Consider the case of a patient in need of an emergency appendectomy. This operation carries very little risk. Without the appendectomy the patient will almost certainly die. In such a case people would generally agree that the patient’s best option would be to have the appendectomy. It follows that there are some circumstances in which people in general can choose a generally agreed best option. It further follows in these circumstances a surrogate decision-maker could choose “a generally agreed best option” on behalf of a patient. It still further follows that in these circumstances the assessment of a patient’s competence might be useful. Unfortunately it is also clear in certain other cases, such as that of the terminally ill cancer patient whose life might be extended slightly by the use of chemotherapy, that a surrogate decision-maker cannot choose an option which would be “generally agreed” to be in the patient’s best interests. It seems possible in certain circumstances for a surrogate decision-maker to know whether her choice would be “generally agreed” to be in the patient’s best interests. However a problem remains. How could it be possible for a surrogate decision-maker to know if her choice would be “generally agreed” to be in the patient’s best interests in less clear cut cases? Before I attempt to answer this question, it must be made clear the circumstances in which the practice of informed consent means surrogate decision-making would be useful.

Consent applies to all medical interventions involving touching a patient. For instance the need for a patient's consent applies equally to doctors taking blood pressure or performing an appendectomy, as pointed out in my introduction. In many cases the patient's consent is implicit. For instance a patient rolling up her sleeve to permit her blood pressure to be taken would be an implicit form of giving consent (see the Department of Health's guidelines, 2001, section 12). In practice, if a patient consents she is usually presumed to be competent (General Medical Council, 1999, page 5). Hence when a patient consents the question of surrogate decision-making usually does not arise. Moreover I argued in section 4.4.3 that when a patient consents it is pointless to assess her competence and her decision to consent should always be accepted. It follows that surrogate decision-making is only useful in circumstances when consent is refused. However, accepting the above does not automatically mean surrogate decision-making would be useful in all cases when a patient refuses consent. For example, if a patient refused to have her blood pressure taken her competence would not be assessed. This applies in more serious cases. Consider a patient suffering from back problems who is advised to have an operation on a damaged disc. Let it be assumed that without this operation she will probably be confined to a wheelchair. In practice if this patient refuses to consent, a surrogate decision maker would have no role to play. The operation would simply not go ahead. Legal judgments consider that refusals of consent vary in importance depending on the risk to the patient's life or irreparable harm being done to her health [T, 1992]. This distinction is mirrored in medical practice and a patient's competence is usually only assessed when her refusal of consent means there is a threat to her life or a danger of irreparable damage being done to health. It follows that a surrogate decision maker would only be useful in circumstances when the patient refuses to consent and there is threat to her life or of irreparable damage being done to her health. In addition surrogate decision-making would

only be useful in the above circumstances provided treatment is capable of removing the threat to the patient's life or irreparable harm being done to her health. In most medical interventions treatment is expected to be able to return a patient back to her normal life undamaged. An appendectomy would be an example of this. However in some cases treatment may alter a patient's condition permanently meaning she will be unable to return to her former life. An example of this would be a patient offered radiotherapy for a brain tumour. This treatment might affect her speech meaning the patient could not resume her former life. Bearing in mind these two possible outcomes I can now define the context in which a surrogate decision-maker can make a decision on behalf of a patient that would generally be accepted to be in the patient's best interests.

First, consider the circumstances in which a patient's condition threatens her life or will irreparably damage her health and in which treatment is expected to enable the patient to return to her former life. Let it be accepted here without further argument that it is generally agreed to be in someone's best interests if she can follow her own interests, provided these interests do not harm others. Let it be assumed that a patient, in the above circumstances, is offered treatment and refuses to give her consent. I have argued that if a surrogate decision-maker cannot make a decision which is generally agreed to be the best option for a patient, then the assessment of her competence becomes pointless. However, in the circumstances outlined above a surrogate decision-maker could choose a generally agreed best option. Treatment in these circumstances would enable the patient to follow her interests and a lack of treatment would mean she would be unable to do so. It can be concluded that if treatment is expected to enable a patient to return to her former life, then it would be generally agreed treatment is the best option for the patient and that the assessment of her competence would be

meaningful. It is important to note that accepting the above does not mean that the patient's decision is necessarily incompetent.

Secondly, consider the circumstances in which a patient's condition threatens her life or will irreparably damage her health. Let it be assumed that treatment is expected to save the patient's life or prevent irreparable damage being done to her health. Let it be further assumed that in these circumstances treatment is not expected to enable the patient to return to her former life. In section 5.1 I showed Veatch (1995, page 7) believes a doctor must be able to balance a patient's medical, moral and other interests when proposing treatment for the patient's consent. He argues this is impossible. I have argued above that if, after treatment a patient is expected to be able to return to her former life, it would be generally agreed that treatment is in her best interests. It follows that in the above context it is possible to choose a generally agreed best option on behalf of a patient without the need to balance the patient's medical, moral and other interests. However, in other contexts it would seem that Veatch is right to believe it would be necessary to balance these interests in order to choose a generally agreed best option. Moreover, it would seem to be impossible for someone to balance a patient's medical, moral and other interests in these other contexts. It might be objected that Veatch is wrong to believe a patient's best interests are defined by balancing these three elements. Even if this objection is accepted, it still seems the things a patient cares about must partly define her best interests. However, it might be argued that a surrogate decision maker could be made aware of what the patient cares about. Perhaps the patient simply informs the surrogate decision-maker. Even if this argument is accepted, it seems to remain impossible for a surrogate decision-maker to make a judgement that is in the patient's best interests if this decision conflicts with the patient's decision. This follows because the surrogate decision

maker has no means to balance what the patient cares about with the patient's other interests without accepting the patient's input on balance. If she accepts the patient's input on balance then she must accept that the patient's decision is in the patient's best interests. It can be concluded that if treatment is expected to alter a patient's condition, making it impossible for her to return to her former life, then there is no generally agreed best option for a surrogate decision maker to choose on behalf of the patient and the assessment of her competence is pointless.

In practice, treatment may be expected to damage some of a patient's interests whilst leaving others unaltered. This means that a patient in these circumstances may be able to make a partial return to her former life. The following question now arises. If treatment is expected to allow a patient to partially return to her former life, is it possible for a surrogate decision maker to make a decision which would be generally agreed to be in the patient's best interests? In section 4.5 I considered the case of Bob, an eighteen-year-old athlete who is involved in a road accident. Bob is asked to consent to the amputation of his leg below the knee. It is clear that amputation will mean Bob can only partially return to his former life and interests. However, it seems inconceivable that Bob has no interests outside athletics. Intuitively a surrogate decision-maker could decide that amputation would be Bob's best option and it would generally be agreed that this decision was in Bob's best interests. It seems it would generally be agreed to be better for someone to partially return to their former life allowing them to follow some of their interests rather than none. It can be concluded that if treatment is expected to allow a patient to partially return to their former life, then a surrogate decision-maker could make a decision which would be generally agreed to be in their best interests.

It is now possible to set out the circumstances in which surrogate decision-making would be useful.

- 1) Surrogate decision-making would only be useful in the circumstances in which the patient refuses to consent and her life is threatened or irreparable damage may be done to her health.
- 2) Surrogate decision-making is only useful in the circumstances in which treatment will leave the patient able to return to a substantial part of her former life.

However, medicine is a practical discipline and in many cases some decision must be made even when there is no generally agreed best option for the patient. It follows that even if the above conclusions are interesting, they appear to be of little practical consequence. I now will argue that this is not so.

Let it be accepted that in certain cases a surrogate decision-maker is unable to make a decision which would be generally agreed to be in a patient's best interests, as outlined above. Accepting the above does not mean, of course, that a surrogate decision maker, or even an entire medical team treating a patient, do not believe she or they cannot make a decision which she or they believe is in the patient's best interests. This can be illustrated by the case of Ms B [2002]. Recall Ms B wished to have her ventilator switched off. Ms B's medical team had become emotionally involved with her (Hale, 2003, page 143). They believed it was in Ms B best interests to continue on the ventilator. However, any decision made by a surrogate decision maker in this context would not be generally agreed to be in the patient's best interests, as outlined above. Consider a hypothetical Mr B whose condition is identical to that of Ms B with one exception. The courts found Ms B to be competent and let it be assumed that Mr B is incompetent. Mr B wishes to be removed from the ventilator and a decision must be made whether to comply with his wishes. Let it be assumed, in the case of Mr B, his medical

team also believe it would be best for him to continue on the ventilator. Once again their decision would not be generally agreed, as outlined above, to be in Mr B's best interests. A decision must be made. It might be assumed, in the above case, that a decision made by his medical team should not be given preference over any decision made by the incompetent Mr B. I will now argue that such an assumption would be false. Buller (2001, page 109) argues even if someone is incompetent to make a decision about her future welfare, it does not follow that her preferences count for nothing. The General Medical Council (1999, section 25) and Buchanan and Brock (1989, page 52) support Buller's position. Let it be accepted that a surrogate decision maker when making a decision on behalf of an incompetent patient should take into account the patient's preferences and values. However, even if this is accepted, it does not of necessity mean that a surrogate decision maker must accept these preferences when making her decision. A surrogate decision maker, when making a decision on behalf of Mr B, might seriously consider Mr B's desire to have his ventilator switched off but still decide Mr B should continue on the ventilator. She might genuinely believe her decision is in Mr B's best overall interests. It might be concluded that it might be right for a surrogate decision maker to make a decision contrary to a patient's preferences after carefully considering these preferences in circumstances when there is no generally agreed best option for the patient.

I will now argue that the above conclusion is false. I will argue that when there is no generally agreed best option for a patient, it would be wrong for a surrogate decision maker to make a decision contrary to the patient's preferences. Let it be accepted without further argument that it is generally agreed that respecting someone benefits her. In section 2.2 I showed that according to Kant's practical imperative respecting someone means to treat her as

an end in herself and not simply as a means. I further showed in section 2.2 that Buss (1999, page 536) believes that treating a person, any person not just an autonomous person, as an end in herself means taking that person's perceived ends into account. Accepting the above means that a surrogate decision maker must take into account any preferences the patient has expressed when making a decision on her behalf. It also means that respecting a patient's preferences has generally agreed value, irrespective of whether the patient is competent or not. However, as I have pointed out above, this does not automatically mean that a surrogate decision maker must always satisfy a patient's preferences if this is possible. Sometimes a patient's preferences might harm her and a surrogate decision maker, acting beneficently, might believe avoiding this harm outweighs the benefit of satisfying these preferences. Let it be assumed that there is no general agreement as to whether treatment or no treatment is in an incompetent patient's best interests. Let it also be assumed, in the above circumstances, that a surrogate decision maker making a decision on behalf of an incompetent patient, chooses an option other than the patient's preferred option. It follows in these circumstances that the surrogate decision maker has chosen an option, on the patient's behalf, when there is no general agreement that this option is in the patient's best interests. It has been accepted that it would be generally agreed that respecting someone benefits that person. It further follows, in the above circumstances, that if a surrogate decision maker chooses an option other than the patient's preferred option, then she denies the patient a generally agreed benefit for no generally agreed reason. It follows that if someone does not accept a person's decision, when there is no generally agreed reason why she should not do so, then she does not seriously take that person's ends into account. I have argued above that to respect someone means seriously taking her ends into account. It therefore further follows that in the above circumstances, the surrogate decision maker does not respect the patient. It can be concluded that in the context

of when there is no generally agreed best option for an incompetent patient, surrogate decision making is pointless and a patient's decision should always be respected. This conclusion would mean that the number of patients whose informed consent decisions might be overruled would be low, see page 221. See also my discussion on 225 and 234. It should be noted that the above conclusion differs from the Department of Health's (2001, Paragraph 2.1) guidelines. These guidelines state, that if there is any doubt about a patient's competence to make a particular decision, then the health professionals involved should assess her capacity to make the decision in question. If this conclusion is accepted, then in the case of the incompetent Mr B, his preference to be removed from the ventilator should be respected, even if other competent persons believe his decision is wrong. Moreover the above conclusion seems to suggest that in certain circumstances it might be right to respect an anorexic patient's refusal to eat and let her die. I will deal with the competence of anorexic patients on page 257 and pages 263 and 264 and examine the circumstances in which I believe the above suggestion might be true.

There are two exceptions to the above conclusion. Firstly, when the patient has conflicting preferences, and secondly when the patient's decision might harm others. Consider the case of someone, like MB [1997], who alternately consents to some proposed treatment and then refuses to give consent. In such a case, the patient is ambivalent about her choices and unable to make a clear decision. It follows that a surrogate decision maker cannot make a decision based on the patient's persistent preferences. It would seem that in such a case the patient's medical team, after giving serious consideration to all her preferences, should make a decision on her behalf. In such a case an application to High Court should be made through the Official Solicitor,(see Department of Health, 2001, page 14). Secondly, consider an

incompetent patient with an infectious disease who refuses to consent to treatment. Her condition threatens the life of others. A surrogate decision maker in this context should not be bound by this patient's preferences. She must balance any harm done to the patient against any harm done to society.

I have concluded above that when there is no generally agreed best option for an incompetent patient, then surrogate decision making becomes pointless and a patient's decision should always be respected. I will now examine the consequences of accepting this conclusion for the practice of informed consent. Buchanan and Brock (1989, page 28) hold that the purpose of assessing a patient's competence is to decide whether her informed consent decision must be respected. It follows that if a patient is competent, presumed or otherwise, to give informed consent, then she retains the right to accept or refuse a particular medical procedure. It also follows that if a patient is incompetent then her consent decision does not of necessity have to be accepted. However, I have shown that it is not true that the decisions of only competent patients should always be accepted. I argued that in circumstances in which a surrogate decision-maker cannot make a decision which would generally be accepted to be in the patient's best interests, a patient's persistent decision should always be accepted. In section 5.2 I argued that the purpose of assessing a patient's competence is to respect her autonomy whilst at the same time allowing her to receive beneficent care if she is non-autonomous. In the above circumstances there would be no general agreement as to which option should be chosen by a surrogate decision-maker acting beneficently on behalf of an incompetent patient. Autonomy can be respected by simply accepting the persistent consent decisions of all patients (see section 3.1.2). Moreover, I argued above that respecting a person benefits that person. I further argued, in the above circumstances, it is impossible to respect a person without

accepting her consent decision. It follows that, in these circumstances, acting beneficently towards any patient means accepting her persistent consent decision. It can be concluded that, in circumstances in which a surrogate decision maker cannot make a decision which would generally be accepted to be in the patient's best interests, the assessment of a patient's competence should play no part in the practice of informed consent. Accepting the above conclusion does not mean that the practice of informed consent becomes meaningless in these circumstances. Let it be accepted that there is no point in assessing the patient's competence to give informed consent in Mathew's (2000, page 61, 62.) example of someone deciding whether to extend her life slightly by chemotherapy or to accept palliative care. However, this patient has an important decision to make about balancing the quality and length of her life. In order to make a decision that satisfies her, she needs to be informed about how long her life might be extended by chemotherapy, together with details of the unpleasant side effects of this treatment. She must also give her consent for any treatment to be lawful. It can be further concluded that, in the above circumstances, the practice of informed consent is *useful* even if the assessment of the patient's competence is *not useful*.

This thesis is concerned with applied philosophy. I will now show that these issues are of practical importance by considering again the case of Ms B. The Hospital trust in question held the view Ms B did not have the capacity to decide whether her ventilator should be switched off. The Trust held this view because Ms B's medical team believed her to be incompetent. Subsequently Butler Schloss [2002] ruled that Ms B did have the capacity considered necessary to make this decision because she was competent. Both the Hospital Trust and the Courts seemed to concur with Buchanan and Brock (1989, page 28) by believing that whether or not Ms B's preference to have the ventilator switched off should be respected

depended solely on deciding whether Ms B was competent. Let it be accepted that if a patient is competent to give informed consent she retains the right to accept or refuse treatment. However, according to the argument I have developed in this chapter, whether Ms B should have retained the right to decide whether to have her ventilator switched off, should not have *only* depended on assessing her competence. If my argument is accepted, then what should have been questioned first was whether the assessment of Ms B's competence was useful in such circumstances.

It might be concluded from the above that, when a patient refuses to give consent to some treatment proposed by her medical team and her competence might be questioned, this team should first ask themselves the following questions to establish whether any competence assessment would be useful.

- 1) Does the patient's condition threaten her life or might it cause irreparable damage to her health?
- 2) Is it possible for a surrogate decision-maker to make a decision on behalf of the patient that would be generally accepted? This question might be answered by considering whether the proposed treatment would for the most part allow the patient to continue with her former life. If these questions cannot be answered affirmatively it is pointless to assess the patient's competence and her decision should simply be accepted.

I believe these questions are perfectly compatible with the purpose of assessing patient competence if this purpose is to respect autonomy and ensure non-autonomous patients receive beneficent care. I further believe that if these questions became part of the practice of informed consent, a great deal of time and money could be saved.

Law (2003, page 54) doubts that the fact that a patient is simply non-autonomous can be used to justify treating her against her will. I have shown that Law is correct and that a non-autonomous patient should not be treated against her will in circumstances when there no generally agreed best option for a surrogate decision maker to choose. In these circumstances acting beneficently means accepting a patient's decisions and doing so automatically respects her autonomy. Accepting this conclusion would permit a larger number of patient's decisions to be accepted in the above circumstances. However, in other circumstances, respecting autonomy might clash with acting beneficently. This clash might occur because, as Silver (2002, page 461) points out, autonomy is concerned with an agent identifying with her decision rather than whether her decision is a good decision. In section 2.2 I argued that respecting autonomy is central to an agent's life and this involves accepting her autonomous decisions. I further argued, in section 4.5, that the purpose of assessing a patient's competence is to respect her autonomy whilst at the same time ensuring that non-autonomous patients receive beneficent care. It follows that non-autonomous patients might be treated against their will for beneficent reasons. It would seem to be preferable that the number of patients, treated against their will should be as low as possible in all circumstances. This raises problems in circumstances where only autonomous consent decisions are automatically accepted according to Beauchamp and Childress (1989):

To chain informed consent to fully or completely to autonomous decision making stacks the deck of the argument and strips informed consent of any meaningful place in the practical world. (Beauchamp and Childress, 1989, page 69)

Let it be accepted that in circumstances other than when a surrogate decision maker is able to choose a generally agreed best option, Beauchamp and Childress's assertion may be correct. It follows that if informed consent is chained completely to autonomous decision making, very few patients would be judged as competent in these circumstances. However, there are different concepts of autonomy. Whether Beauchamp and Childress's assertion is correct depends on which concept of autonomy underlies the practice of informed consent. It might be argued that Beauchamp and Childress's assertion depends on equating fully autonomous decision-making with good decision-making. I agree with Silver (2001) when he argues that autonomy is concerned with an agent identifying with her decision rather than making a good decision. If Silver's position were accepted, then this would nullify Beauchamp and Childress's concerns. It might then be possible to choose a concept of autonomy to underlie the practice of informed consent which would permit as large a number of persons as possible to be considered as autonomous. This in turn would mean that the number of patients whose informed consent decisions might be overruled by the practice of informed consent would be low.

I argued in section 2.2 that autonomy has both instrumental and intrinsic value. Let it be accepted that the instrumental value of autonomy, like the value of rationality, is concerned with good decision-making. However I also argued in section 2.2 that respect for autonomy must mean respecting the intrinsic value of autonomy. I further argued that the intrinsic value of autonomy lies in the recognition of the agent as the kind of creature who is able and ought to decide her own future. It follows that the intrinsic value of autonomy is not directly concerned with good decision-making. It further follows respect for autonomy must be concerned with what an agent desires or cares about. Accepting the above suggests that a concept of autonomy, such as that of Christman or Frankfurt, should underlie the practice of

informed consent. Both of these concepts would permit a large number of informed consent decisions to be regarded as autonomous and hence accepted. Silver argues that an agent must regard an autonomous decision as her own. However I argued in section 3.4.3 that this might not necessarily be true using Christman's concept. Moreover, I argued in section 3.4.3 that problems connected to the way an agent identifies with her desires, means that Christman's concept does not concur with the intuitive notions of autonomy that I outlined in section 2.1. Because of these problems, Christman's concept of autonomy should not form the basis for the practice of informed consent. I believe it follows that Frankfurt's concept of autonomy should form the basis for informed consent. Adopting this concept I believe would minimise the number of patients whose informed consent decisions might be overruled.

Wicclair (1991) argues competent patients must be able to give reasons that would be accepted by others for their consent decisions:

The competent patient must be able to give reasons for the decision, which shows that he has thought through the medical issues and related this information to his personal values. The patient's reason need not be scientific or publicly accepted, but neither can they be purely private or idiosyncratic (Wicclair, 1991, page 92).

It follows that any patient who is unable to give such a reason should be regarded as incompetent. The guidelines on informed consent hold the following. Firstly, the fact that a patient's choice appears irrational is not evidence in itself that the patient is incompetent (General Medical Council, 1999, section 19). Secondly, a patient may refuse to give consent for reasons that are rational, or irrational, or for no reason [Sidaway v Board of Governors of

the Bethlem Royal Hospital and the Maudsley Hospital, 1985]. It follows that Wicclair's assertion conflicts with informed consent guidelines. I will now argue that in circumstances when there is a generally agreed best option for a patient to choose, if a patient does not choose this option and is unable to give a reason for her choice, then it would be accepted by others that she should be presumed to be incompetent.

Let it also be assumed that, in the above circumstances, a patient refuses to give her consent. Practical rationality is defined as the kind of thinking which best helps people to achieve their goals (Baron, 1988, page 29). Let it be accepted that practical rationality is the type of rationality that people use to run their lives. I will deal with patient rationality in detail in section 6.4. It follows that people normally govern their lives by following their goals as far as they are able. It further follows that, in these circumstances, treatment would enable the patient to follow her previous goals and a lack of treatment would mean she would be unable to do so. Prima facie it might be concluded that this patient's apparent lack of practical rationality is evidence that she is unable to govern herself and hence is non-autonomous. It is important to note that this prima facie conclusion is open to rebuttal. The patient in these circumstances must be able to give reasons for her refusal that others would agree with. However, these reasons need not be generally agreed by others including the patient's health team. For instance, a patient might give as the reason for her refusal of consent the fact that she is a Jehovah's Witness and the treatment offered involves a blood transfusion. I suggest that in these circumstances if a patient is unable to give any or any coherent, reason for her decision to refuse consent, then the above prima facie conclusion should be accepted. It might be argued that accepting this prima facie conclusion fails to respect the patient's autonomy. However simply saying no, or making no coherent response, does not seem to be part of a patient exercising her autonomy. Autonomy involves reflective activity according to Dworkin

(1988, page 17) and Frankfurt (1999, page 87, originally 1992). It can be concluded that, in circumstances when there is a generally agreed best option for a patient to choose, if a patient does not choose this option and is unable to give reasons that would be accepted by others, these reasons need not be generally accepted by others including the patient's health team and she should then be presumed to be incompetent. This conclusion highlights the need for good two way communication between the patient and her health team. I will deal with communication in detail in section 6.3.

In this section I concluded that if it is impossible for a surrogate decision-maker to make a decision on behalf of a patient that would be generally accepted, then the patient's decision should simply be accepted. In these circumstances I believe it is pointless to question whether the patient is autonomous. As a result of this conclusion I further concluded that if it is possible for a surrogate decision-maker to make a decision on behalf of a patient that would be generally accepted, the following should hold: If a patient refuses her consent and is unable to give a reason for her refusal that would be accepted by others, she should be presumed to be incompetent. This presumption should be open to rebuttal.

5.4. Informed consent decisions requiring the patient's ongoing co-operation

I argued in section 5.3 that in circumstances in which it is impossible for a surrogate decision-maker to choose a generally agreed best option on behalf of a patient, the assessment of her competence to give informed consent is not a useful concept and ought to be abandoned. In this section I will extend the circumstances in which the assessment of a patient's competence

is not a useful concept. I will argue that, in circumstances when treatment is an ongoing process requiring the patient's ongoing co-operation, the assessment of her competence is also not a useful concept.

Lidz, Appelbaum and Meisel (1991) see all informed consent decisions as an ongoing process:

This involves using the routine, ongoing discussion of patient's problems as an opportunity to discuss both sides' expectations and understanding of the illness, values and expectations for the treatment; and of course their views of the advantages and disadvantages of the various treatment options (Lidz, Appelbaum and Meisel, 1991, page 109).

The idea that informed consent decisions should be seen as a process is supported by Wear (1998). Let it be accepted that when a patient gives consent to any major medical procedure, she needs to understand the advantages and disadvantages of this procedure. Let it also be accepted that a patient's doctors seeking her consent should also try to understand her beliefs and culture when proposing treatment (see the General Medical Council, 1999, section 6). For instance, it would be pointless to propose the termination of a pregnancy to a woman whose beliefs preclude abortion. Understanding a patient's beliefs requires dialogue according to the General Medical Council (1999, section 3) and dialogue is a process. However, even if it is accepted that the giving of informed consent is a process, it does not of necessity mean that it is an ongoing process. For example the giving of informed consent for a heart valve replacement is a finite process. In this example the patient's ongoing co-operation is required in the consent process however when treatment begins this process ends. The process ends in

the patient making a consent decision and whether treatment does or does not take place depends on the outcome of her decision. However, some treatments, such as chemotherapy, are ongoing and require both the patient's ongoing consent and co-operation. This section is only concerned with the circumstances in which treatment is an ongoing process requiring the patient's ongoing co-operation. I will argue that in these circumstances, the idea of assessing a patient's competence to give informed consent is not a useful concept and should be abandoned.

Consider a patient suffering from lupus and who is advised to have chemotherapy. Lupus is a disease of the immune system. It is expected that if chemotherapy is carried out, the patient will have an excellent chance of continuing to lead a meaningful life. This prognosis is in contrast to the example of the terminally ill cancer patient used in section 5.3 who would only have her life extended slightly by the use of chemotherapy. In the case of the cancer patient, I argued that a surrogate decision maker could not make a choice which would be generally accepted to be in the patient's best interests. In the case of the patient suffering from lupus, she is expected to be able to continue to lead a meaningful life. It follows that in this case, a surrogate decision-maker could make a decision on behalf of the patient which would be generally accepted to be in her best interests. Let it be assumed that the patient suffering from lupus refuses to give consent to chemotherapy and her competence is assessed. Let it be further assumed this assessment finds the patient to be incompetent and a surrogate decision-maker decides that the patient should receive chemotherapy. However, such a competence assessment would seem to be a mere gesture. This follows because if the patient refuses to cooperate, it would be impossible to implement this treatment. It can be concluded that in practice the lupus patient's consent decision alone determines whether any proposed chemotherapy is given irrespective of her competence. It can be further concluded that even if

the assessment of the lupus patient's competence is a coherent concept, it is not a useful concept. These conclusions can be generalised to all treatments which are an ongoing process requiring the patient's ongoing co-operation. It follows that if a patient's doctors propose a course of treatment for her which requires her ongoing co-operation, then the outcome of the patient's consent decision should alone determines whether the proposed treatment can be given. It further follows that, in these circumstances, even if the assessment of a patient's competence to give informed consent is a coherent concept, it is not a useful concept and should be abandoned.

CHAPTER 6

Competence, informed consent and personal autonomy

It is usually assumed that a patient's competence determines whether he has the right to accept or refuse some proposed medical treatment (see Buchanan and Brock, 1989, page 28); (Beauchamp and Childress, 1989, page 80). I argued in chapter 5 that this assumption is not true in circumstances when a surrogate decision maker could not choose a generally agreed best option for the patient or when the patient's treatment requires his ongoing co-operation. However, I accept that in all other circumstances this assumption is true. Informed consent guidelines hold that a competent patient must possess certain capacities, (see for instance the Department of Health, 2001, section 2.1). In chapter 4 I argued that these capacities, provided the purpose of informed consent is to respect patient autonomy whilst ensuring non-autonomous patients can receive beneficent care, should be identical to the capacities a patient needs to make an autonomous decision. These capacities should not be determined directly by the risk involved in any procedure the patient is consenting to. In chapter 4 I did not specify what capacities a patient needs to make an autonomous consent decision. In this chapter I will rectify this omission by comparing the capacities a patient needs to be regarded as competent according to current informed consent guidelines and the capacities he requires to make an autonomous decision. This comparison will be made together with an examination of the beliefs and values of an autonomous patient in four sub-sections. Each sub-section will make recommendations for the practice of informed consent.

6.1. A competent patient's capacity to understand the information supplied to him

In practice if a patient is to be considered competent then he must understand the information provided to him concerning his condition. A patient clearly does not have to understand all the information on which his proposed treatment is based. If this was not so he would be being judged on his ability to make a medical decision and this is both impractical and unnecessary (see Dworkin, 1988, page 113). The amount of information considered necessary for a patient's consent to be considered as valid, from a legal perspective, is based on Bristow's judgment in *Chatterton v Gerson*:

In my judgement once the patient is informed in broad terms of the nature of the procedure which is intended and gives her consent, that consent is real. [1981]

The Department of Health's (2001, section 4) guidelines also require a competent patient understands the information provided in broad terms. Defining the information a competent patient must understand in broad terms is imprecise. This section will examine how much information a competent patient must understand in broad terms by examining how much information he needs to make an autonomous decision.. The Department of Health's guidelines also state that it is not enough for a patient to merely have the ability to understand the information provided in order to be considered competent. He must actually understand the information provided. In this section I will also question whether a competent patient only needs the capacity to understand this information provided or whether he must actually understand it.

6.1.1 Must a competent patient actually understand the information provided?

Patients for the most part have only a limited knowledge of medical matters and need information to enable them to make competent consent decisions. Part of the purpose of informed consent is to supply this information. It might also be argued that part of the purpose of informed consent is to ensure patients understand the risks involved in any treatment they are consenting to in order to minimise complaints. The following question might then be asked. Must a competent patient actually understand this information or need he only have the capacity and opportunity to understand it? Clarke (2001) points out that, in most circumstances outside the practice of informed consent, someone is usually considered to be competent to make a decision provided he has the capacity and opportunity to understand information relevant to this decision:

In the circumstances examined above, it is having the opportunity to base a decision to consent on sufficient relevant information that is important to the legitimate granting of consent, not the actual use of sufficient relevant information in a decision to consent (Clarke, 2001, page 176).

For example if someone agrees to a contract to buy a house he must be given the opportunity to fully understand any planning restrictions applicable to the property. In practice a buyer need not actually understand this information. For instance, he may pay no attention to this information or trust his solicitor to do so. However, he must be supplied with the relevant information if any agreement is to be regarded as valid. Moreover he must also have the capacity to understand this information. For instance, if the vendor of some house sold the

property to someone incapable of understanding any relevant planning restrictions, then the purchaser's agreement might not be regarded as valid. The above seems to be true of most agreements. It follows that Clark is correct when he points out that, in most circumstances, the validity of an agreement depends on two factors. Firstly, someone agreeing to a contract must be given the opportunity to understand the information relevant to this contract. Secondly, he must have the capacity to understand this information. It is not important whether the contracting party actually understands the information provided.

However this is not the position as far as informed consent is concerned according to Clarke (2001):

In medicine, however a patient is expected to submit to compulsory listening before her decision to consent is deemed to be legitimate (Clarke, 2001, page 176).

In addition to this compulsory listening the practice of informed consent requires that a competent patient must actually understand the information provided. The fact that a patient possesses the capacity needed to understand this information is insufficient to guarantee his competence (see the Department of Health, 2001, section, 2) and the case of C [1994]). It follows that the practice of informed consent differs from other types of consensual agreement by requiring that a competent patient actually understand the information relevant to his consent decision.

I will now question whether the requirement that, a competent patient must actually understand the information relevant to his consent decision is compatible with respecting his autonomy. Dworkin (1988, page 31) argues that someone's autonomy shapes his life and gives his life meaning. Let it be accepted that if someone's decision is a conscious decision to shape

his life, then this decision must be based on information relevant to that decision. Random choices wantonly made cannot be part of shaping someone's life. It would appear that in the context of informed consent unless a patient understands the information provided to him by his doctors he is inadequately informed for his consent decision to play a part in shaping his life. It further follows that if a patient's decision plays an inadequate part in him shaping his own life this decision is non-autonomous. In section 5.3 I argued Frankfurt's concept of autonomy should form the underlying basis for the practice of informed consent, in order to permit as large a number of patient's consent decisions to be accepted as autonomous as possible. It might then be questioned whether the requirement that a competent patient must understand the information pertinent to his condition is compatible with respecting Frankfurt's concept of autonomy. Frankfurt (1988, page 91, originally 1982) believes someone expresses his autonomy by caring about certain things more than others. Frankfurt also holds that if someone cares about something he must identify himself with what he cares about. One of the aims of informed consent is to provide information to patients to enable them to make their own decisions. Let it be assumed that when a patient consents or refuses to give consent to some proposed treatment he refuses to consider any information relevant to this decision. In section 5.1 I argued that a patient's purpose when making an informed consent decision is to make a decision that satisfies him. I further argued that this usually involves a patient making a decision about what is in his best interests. However, if someone makes a decision, about which choice will satisfy him with an inadequate basis for his choice, then it is difficult to see how he can identify with his choice. His decision again appears to be randomly made and that of a wanton (see Frankfurt, 1999, page 106, originally 1992). It follows that Frankfurt would regard such a decision as non-autonomous. It further follows that the requirement that a

competent patient must actually understand the information relevant to his condition when making his consent decision is compatible with respecting autonomy.

Let it be accepted that a patient's decision cannot be autonomous unless the patient is satisfied with his decision. Satisfaction in the context of autonomy means the agent has no restlessness to change his decision or resistance to his decision (see Frankfurt, 1999, page 103, originally 1992) and section 3.5.2. I argued above that a patient cannot make an autonomous consent decision without actually understanding the information relevant to his condition. This argument depends on the implicit premise that a patient cannot be satisfied with his decision without understanding this information. I will now argue that in some contexts, this premise is false. Dworkin (1988) makes the following assertion:

If a patient has knowingly and freely requested of the doctor that he is not to be informed or consulted about his course of treatment then to seek to obtain informed consent would itself be a violation of autonomy (Dworkin, 1988, page 118).

If Dworkin's assertion is accepted then it would appear to follow that the requirement that a competent patient must actually understand the information relevant to his decision is incompatible with respecting his autonomy. I will now argue that Dworkin's assertion is correct but only in certain circumstances. Firstly, I believe that Dworkin only meant his assertion to apply in circumstances when a patient decides to accept his doctor's recommendation. In these circumstances it would seem perfectly possible for a patient to freely make a decision to consent and have no restlessness to change this decision. It follows that such a decision would be an autonomous decision. However, if a patient refused to

consent to his doctor's recommendations it would seem to be impossible for a patient to be satisfied with rejecting his doctor's advice without understanding the basis of this advice. It follows that there must be some modification to the conclusion that, a competent patient must actually understand the information relevant to his condition when making his consent decision is compatible with respecting autonomy. This modification is as follows.

- 1) **The requirement that a competent patient must actually understand the information relevant to his condition is compatible with respecting his autonomy when he refuses to give consent.**
- 2) **The requirement that a competent patient must actually understand the information relevant to his condition is incompatible with respecting his autonomy when he consents.**

The second conclusion reached above does not mean that a patient may be treated against his will. However it does mean a badly informed patient's consent should be accepted. On page 230 I argued that part of the purpose of informed consent might be to ensure patients understand the risks involved in the treatment they are consenting to in order to minimise complaints. It would appear to follow my second conclusion is at odds with the purpose of informed consent. However I agree with Dworkin in believing that when a patient consents even if he is not fully informed his decision may nonetheless be autonomous. For instance a patient might make an autonomous decision on the basis of trusting his doctors. It follows if informed is primarily based on respect for autonomy my second conclusion should be accepted. I will set out the consequences for the practice of informed consent of accepting these two conclusions.

Consider the circumstances when a patient consents to some proposed treatment and does not understand the relevant information. I concluded above that when a patient gives consent his decision can be autonomous even if he does not understand the information relevant to his condition. I concluded in section 4.4.2 that in circumstances when a patient's life is threatened or irreparable damage might occur to his health, if he consents his competence need not be assessed because the outcome would be the same irrespective of whether he was assessed as competent or incompetent. ***It follows that when a patient consents without understanding the information relevant to his decision in circumstance, when his life is threatened or in which irreparable damage might occur to his health, the practice of informed consent should simply accept his decision.*** This practice would be compatible with the purpose of informed consent, as set out in chapter 4, to respect patient autonomy whilst ensuring non-autonomous patients can receive beneficent care. However, I do not believe this conclusion should apply in circumstances when a patient consents to some proposed treatment and does not understand the relevant information, and in which neither the patient's life is threatened nor will irreparable damage be done to his health. I accept that in these circumstances when a patient consents his decision may be autonomous even if he does not understand the information relevant to his decision. In situations when a patient's life is threatened or irreparable damage might occur to his health it seems inconceivable his doctors should refuse to offer him treatment for his condition provided this is possible. In situations in which neither the patient's life is threatened nor will irreparable damage be done to his health I believe that doctors can refuse to offer a patient some previously proposed treatment if he does not understand the information relevant to his condition. ***It follows that when a patient consents without understanding the information relevant to his decision and in circumstances in which neither his life is threatened nor irreparable damage might occur to his health the patient***

should not be offered the proposed treatment. Furthermore by refusing to offer a patient treatment his doctors do not fail to respect his autonomy. Lastly, consider the circumstances in which a patient refuses to consent to some proposed treatment and does not understand the relevant information. I have argued that in such cases the patient's decision is non-autonomous. *In circumstances in which the patient's life is threatened or irreparable damage might occur to his health I believe he should be treated beneficently and this could mean overriding his refusal of consent. In circumstances in which the patient's life is not threatened and irreparable damage will not occur to his health he should also be treated beneficently and this would usually mean accepting his refusal of consent.*

I argued above that if a patient consents to some proposed treatment without understanding the information relevant to his decision in circumstances when his life is threatened or irreparable damage might occur to his health, the practice of informed consent should simply accept his decision. However, a patient may consent to treatment without understanding the information relevant to his decision in circumstances when another's life is threatened or irreparable damage might occur to the other's health for altruistic reasons. This could occur for instance in the case of kidney donation to a close relative or someone the donor loves. Moreover, such a decision could be freely made, persistent and one the donor is satisfied with. It follows that such a decision might be autonomous. The question that now arises is whether one should accept such a decision. This question cannot be answered by arguing that in these circumstances such a decision should simply be accepted because if it was not a surrogate decision-maker would also choose the same treatment. This question can only be answered by considering whether truly beneficent treatment can be offered in such circumstances. I believe every effort should be made to encourage the donor to understand the relevant information. If the donor fails to try understand the relevant information, one might

question whether his motives are truly altruistic and hence autonomous. It can be concluded that in these circumstances the proposed treatment should not be offered.

6.1.2. How much information must a competent patient actually understand?

I argued in section 6.1.1 that if a patient consents without understanding the information relevant to his decision in circumstances when his life is threatened or irreparable damage might occur to his health, the practice of informed consent should simply accept his decision. In all other circumstances a patient must actually understand the information provided if he is to make an autonomous decision. In this section I will examine what information he must actually understand in these other circumstances. I will use an example used by Clarke (2001) to investigate the minimum amount of information a patient needs to understand in order to make an autonomous decision:

Consider the case of ‘Squeamish John’. Squeamish John cannot bear to hear the details of medical procedures; hearing these make him feel weak at the knees and dramatically diminishes his capacity to make sensible decisions. Nevertheless he does not wish to abrogate responsibility for his decision about whether or not to undergo an operation. Squeamish John wishes to participate in a restricted informed consent process in order to make his decision. He wishes to make a decision based only on the disclosure of the risks and benefits of the operation couched in cold, impersonal, statistical language. He does not wish to have any significant details of the procedure described to him (Clarke, 2001, page 177).

I argued in section 4.5 that the purpose of informed consent is to respect patient autonomy whilst ensuring non-autonomous patients can receive beneficent care. I further argued that this is achieved in practice by giving priority to respecting autonomy over acting beneficently. I still further argued that if some autonomous decisions were not respected then priority must have been given to acting beneficently over respecting autonomy. It follows that the minimum amount of information a patient must understand in order to make a competent informed consent decision must be identical to the amount of information he needs to make an autonomous decision. In section 2.2 I argued that our intuitive ideas of autonomy require that an autonomous decision is freely made, has persistence and is one with which the agent identifies. Let it be accepted that Squeamish John's decision is freely made and has persistence. It would also seem that Squeamish John could identify with such a decision if he only understands the risks and benefits of the operation. Indeed, it seems he might be better able to identify himself with a decision about which he has limited understanding rather than one with which he has greater understanding. Intuitively it follows that Squeamish John's decision seems autonomous.

Squeamish John wishes to make a consent decision based only on his understanding the risks and benefits of the operation couched in cold, impersonal, statistical language according to Clarke (2001, page 177). Let it be accepted that if Squeamish John understands the risks and benefits of the operation this means he must understand his doctors' prognosis and the likely prognosis if his condition is not treated. It might be questioned whether he can make an autonomous decision based on such limited information. This question can only be answered by considering the circumstances in which the decision is made. Consider again a patient consenting to an emergency appendectomy. In the light of my discussion in section 6.1.1, in these circumstances, if Squeamish John consents to treatment then his decision should simply

be accepted. However, the acceptance of his decision is not based on respect for his autonomy but is simply based on the fact that any decision by a surrogate decision-maker would result in the same treatment. The question that I am attempting to answer is this: Does Squeamish John understand enough information to retain the right to accept or refuse the proposed appendectomy? In this example the patient's doctors' prognosis is that with treatment he will be able to return to his normal life and without treatment he will probably die. In these circumstances, because the outcomes are so clear, Squeamish John could possibly identify himself with a consent decision because he could be satisfied with his decision. Moreover, if such a decision were also freely made and persistent it might possibly be autonomous. This example can be generalised to reach the following conclusion. **In circumstances in which treatment is expected to enable a patient to return to his former life, and in which without treatment he will probably die, it is possible for a patient to make an autonomous decision based only on him understanding his doctors' prognosis and the likely prognosis if he is not treated.**

In section 4.5 I used the example of Bob who was asked to consent to the amputation of his leg below the knee. In these circumstances treatment is not expected to enable Bob to fully return to his former life. The question may again be asked in these circumstances. What is the minimum amount of information needed, in these circumstances, to enable a patient to possibly make an autonomous decision? I have argued that a decision is autonomous if it is freely made, persistent and the agent identifies himself with it by having no restlessness to change his decision. It follows that the answer to this question depends on the minimum amount of information needed for it to be possible for a patient to be satisfied with his decision. A patient who understands that treatment will change his life cannot possibly be

satisfied with any decision which does not take into account the expected life changing consequences of this treatment. It follows that in these circumstances any decision he makes based purely on his understanding of his doctors' prognosis and the likely prognosis if his condition is not treated, cannot possibly satisfy him and hence is non-autonomous. It would seem to be possible for a patient to be satisfied with his decision in these circumstances if he can understand all the possible outcomes, resulting from both treatment and no treatment, together with the risks, benefits and probabilities of these possible outcomes. **It can be concluded that, in circumstances in which a patient is expected to be unable to fully return to his former life, the minimum amount of information he possibly needs to make an autonomous decision are as follows. A patient must understand all possible outcomes of treatment and the expected outcome if he refuses treatment together with the risks, benefits and probabilities of these possible outcomes.**

However, accepting this conclusion does not mean that any decision based on the patient only understanding all the possible outcomes of treatment and the expected outcome if he refuses treatment together with the risks, benefits and probabilities of these possible outcomes, is autonomous. For instance, a Jehovah's Witness might not be satisfied with any consent decision based solely on these criteria. He would also want to know that the proposed treatment would not involve a blood transfusion. It follows that the minimum possible amount of information some patient actually needs to understand in order to make a autonomous decision cannot, in all circumstances, be based on them only understanding all the possible outcomes of treatment and no treatment together with the risks, benefits and probabilities of these possible outcomes. However it does not automatically follow that the above is also the minimum possible amount of information a patient needs to understand in order to make a

good decision. I mention this conflict on page 234 and discuss how this conflict might be resolved on page 248.

It might be argued that a patient's autonomy has not been fully respected if on reflection he feels his decision would have been different had he been better informed. This idea is supported by the Royal Liverpool Hospital Children's Inquiry. This support occurs in the specialist context of parents giving consent to the post mortem examination of their deceased children:

A practical test for the clinician in considering whether he has given full information is to question whether any significant detail not mentioned could have lead to a different decision by the next of kin. If so the test for fully informed consent will not have been met. (The Royal Liverpool Children's Inquiry, 2001, chapter 11, section 1.4)

It might then be suggested that the minimum amount of information a patient actually needs to understand, in order to make a competent decision in all circumstances, should include all significant details, without which, a patient make might make a different decision. I will argue that the practical test mentioned by the Royal Liverpool Children's Inquiry should not be adopted by the practice of informed consent. If this test was adopted in practice it would be difficult for a patient's doctors to know what would be a significant detail. For instance, if a patient's treatment involved stem cells, how these cells were obtained might be an insignificant detail to some patients but of major concern to a fundamental Christian. It follows that if this test was adopted, then a patient's doctors might be inclined to include all relevant details irrespective of whether they personally regard them as significant or not. Such

a course of action would be wrong for three reasons. Firstly, adopting such a course would be costly in time and medical resources. Secondly, most patients neither want nor need to be so comprehensively informed. Thirdly, informing a patient, such as Squeamish John, comprehensively fails to respect his autonomy. Accepting the above suggests that a patient's doctors should attempt to tailor the information given to the patient's particular requirements.

I suggest that the tailoring of information to a particular patient's needs should be done as follows. All competent patients must always be informed about, and actually understand, the possible outcomes of both treatment and no treatment. Competent patients must also always be informed about and actually understand the risks, benefits and probabilities associated with these possible outcomes. I have argued above that without actually understanding this minimum amount of information no patient can make an autonomous decision. This understanding need include no details of the actual procedure or treatment the patient is consenting to. In addition, it must be made clear to all adult patients that if they require additional information in order to make autonomous choices, then they should request this information. For instance, most patients would be interested in the immediate short term effects of treatment. Any adult patient requesting such information should be supplied with the information. I believe that my suggestion would respect the autonomy of all patients.

Others might suggest that the tailoring of information to a particular patient's needs could be better achieved as follows. All patients should normally be automatically fully informed. Prior to being fully informed all patients must be made aware that they have the right to make a decision based on a restricted amount of information. If a patient requests that the information he receives is restricted, this should be done. However, if a patient is to make a competent decision, this information may not be restricted below the level needed to make an autonomous decision as outlined above. It might then be argued that this second way of

tailoring a patient's information needs, would enable patients' to make better decisions whilst also respecting their autonomy. I believe that this argument fails. It fails because, whilst it is possible to specify the minimum amount of information all patients require in order to possibly make autonomous decisions, it appears impossible to specify the amount of information all patients need to make autonomous decisions. The above leads to the conclusion that a patient should be informed as follows.

- 1) All competent patients must always be informed about and actually understand the possible outcomes of suggested treatments and the expected outcome if no treatment takes place.**
- 2) Competent patients must also always be informed about and actually understand the risks, benefits and probabilities associated with these possible outcomes.**
- 3) It must be made clear to all adult patients that if they require additional information in order to make autonomous choices concerning their treatment, then it is their right to request this additional information**
- 4) If a patient requests additional information about his treatment, this request should be satisfied.**

6.2. Must a competent patient believe the information supplied to him?

One of the conditions of Thorpe's [1994] C test is that the patient must not only understand but also believe the information provided to him by his doctors if his decision is to be regarded as competent. This requirement that a competent patient must believe the information provided was not mentioned when the "C test" was subsequently applied in the case of MB

[1997]. In this section I will argue that Thorpe was right and that a competent patient should believe the information provided by his medical doctors. I will also argue that in practice it is impractical to assess whether a patient actually believes the information supplied to him.

I have shown that the purpose of informed consent assessment means all autonomous decisions should be regarded as competent decisions. I will now argue that a patient should believe the information provided to him by his doctors in order to make an autonomous decision. Whether a patient believes the information provided is connected to him trusting the medical team who supply this information. Let it be accepted that if someone you trust provides you with information that you must also trust this information. Let it be further accepted if you trust some piece of information you must also believe it. O'Neill (2002) argues that if trust is impossible, normal decision-making becomes impossible:

Just as total scepticism would produce a total paralysis of belief, and is untenable in practice, so an inability to place trust would produce a total paralysis of action, and is untenable in practice. In practice we have to take a view and place our trust in others for some purposes” (O'Neill, 2002, page 12).

It is important to be clear about what sort of action O'Neill believes would be paralysed without trust in the context of informed consent. It is clear that even if a patient fails to believe the information provided and does not trust his doctors, he may still act and make a consent decision. He might act on other information for example, from friends, the internet, a hunch or at random. However, unless a patient has specialist medical knowledge he would seem to ignore the best information available to him in order make a good decision or, as will be

argued below, an autonomous decision. It follows that when O'Neill talks of actions being paralysed without trust, she is referring to good or autonomous actions.

I will now question whether O'Neill's assertion that, an inability to place trust results in a paralysis of action is true when the actions in question are autonomous decisions made in the context of informed consent. Let it be assumed that, in the context of informed consent, a patient actually understands the information provided to him by his medical team. Let it be further assumed that he does not believe this information. It follows that, in this context, the patient is deprived of the information he needs to make a good decision. On page 120 I argued that an autonomous agent must be wholehearted concerning an autonomous decision and this must be reflected by his satisfaction with his decision, see Frankfurt (1999, page 103, originally 1992). It might then be questioned if a patient is aware he is deprived of the information he needs to make a good decision whether he can be satisfied with his decision. It might then be argued any such decision was not an autonomous decision. It might then be further argued that, in the context of informed consent, a competent patient must of necessity trust the information provided by his medical team if he is to make an autonomous consent decision.

I will now show that any assessment of a patient's competence should not include any assessment of whether he believes the information supplied to him by his medical team. Any assessment of whether a patient actually understands the information supplied to him cannot simply depend on asking him if he understands this information. Similarly, assessing whether a patient actually believes the information supplied cannot depend on asking him if he believes this information. However, there are problems with directly assessing whether a patient believes the information supplied because this assessment seems to depend on evaluating

unobservable mental processes, as pointed out by Maclean (2000, page 280). It might be argued that assessing whether a patient believes the information supplied might be done indirectly by considering the outcome of his decision. For instance, if a patient chooses a good outcome, then it might be assumed that he believed the information provided. Similarly, if a patient chooses a bad outcome, then it might be assumed he did not believe this information. I believe that such an argument is unsound. Accepting the above argument would mean that a patient's competence would be partly assessed on the outcome of his actual decision rather than on his ability to make this decision, contrary to the Department of Health (2001, section 2.3) and the General Medical Council (1999, section 19) guidelines. The purpose of these guidelines is to respect patient autonomy. In section 2.2 I showed that respecting autonomy means accepting autonomous decisions. Let it be assumed that the assessment of whether a patient believes the information supplied to him depends on the quality of the outcome of his decision. It follows that what is being assessed is whether a patient is making a good decision. I have argued throughout this thesis that autonomous decisions need not be good decisions, (see Silver, 2002, page 461). It can be concluded that any attempt by this method to indirectly assess whether a patient believes the information supplied to him is incompatible with respecting his autonomy. Moreover, because whether a patient believes the information supplied cannot be assessed directly, it can be further concluded that any assessment of whether a patient actually believes the information supplied to him should not form part of the practice of informed consent.

6.3. The patient's capacity to communicate

Informed consent is concerned with a patient's decisions and it follows that unless a patient is able to communicate his decisions the concept of informed consent is meaningless. This means that a competent patient must have the capacity to communicate his decision. However, the practice of informed consent means that a competent patient needs a greater capacity to communicate than that required to concur or refuse to concur to some proposed treatment. Firstly, a patient might need to communicate with his medical team in order to enable him to make an autonomous decision. Secondly, a patient may sometimes need to communicate the reasons for his decision in order to demonstrate his competence.

I argued in section 6.1.2 that a patient should only be automatically supplied with the minimum amount of information with which it might be possible for someone to make an autonomous decision. I further argued that, in some circumstances, a patient might require more information than this minimum amount in order to make an autonomous decision. I still further argued that if a patient requires additional information, then this information should be supplied through dialogue. This dialogue should concern how treatment, or lack of treatment, will impinge on what the patient cares about. It follows that in some circumstances a competent patient's capacity to communicate must include an ability to express what he cares about. A patient's medical team must then be able to explain in the dialogue how treatment is expected to affect his concerns.

Breier- Mackie (2001) points out patients often cannot verbalise their needs:

Patients who are confronted with the autonomy/paternalism dichotomy are often unable to verbalize their needs and wants to their doctors either because they are intimidated by the doctors' perceived power, or because the doctors lack the time to listen to their concerns (Breier- Mackie 2001, Page 513).

Because of this Breier- Mackie argues that nurses might assist a patient to clarify his concerns and needs. The provider of treatment has a duty to obtain a patient's consent (see the General Medical Council's guidelines,1999, section 14 and the Department of Health, 2001, section 9). The provider of treatment will in many cases be a medical team and the leader of this team will ultimately be responsible for obtaining a patient's consent. Both of these sets of guidelines agree that this duty may be delegated to a suitably qualified person. It follows that Breier-Mackie's suggestion that suitably qualified nurses might play a part in some consent processes is compatible with current guidelines. I believe that Breier-Mackie's suggestion is a sensible one. However, the exact role of suitably qualified nurses in the consent process must be made more explicit. I have argued that in some circumstances informed consent requires a dialogue. I further argued that a patient's primary role in this dialogue is to express what he cares about with respect to the proposed treatment. I believe that a suitably qualified nurse's role must be limited to acting as a patient's agent by helping him to communicate what he cares about. An agent does not make decisions for the person she acts for but must attempt to ensure that person's decisions are acted on. A representative may make decisions which she believes are in the interests of the person she acts for. It follows because a suitably qualified nurse's role is simply to help a patient to make an autonomous decision, she should **not act as his representative** by vocalising what she believes to be in his best interests. It can be concluded that a competent patient must have the capacity to communicate both his decision

and in some circumstances what he cares about. His capacity to communicate what he cares about need only reach a standard which would enable others to vocalise what he cares about by **acting strictly as his agent**.

In section 5.3 I argued that the concept of autonomy underlying informed consent should permit as many patient's decisions as possible to be regarded as competent. However, some patient's competence should be assessed. This assessment should take place by considering whether the patient possesses certain capacities (see Thorpe's C test [1994]). The Department of Health (2001, section 2.5) holds any assessment of a patient's competence should not be based on the outcome of his decision. It follows that, if the patient was prior to his consent decision considered competent to lead his own life, this assessment must be based on the reasons the patient gives for his decision. I argued in section 5.3 that the reasons a patient gives must be recognisable as reasons to those assessing his competence (Wicclair, 1991, page 92). However, I have argued throughout this thesis that autonomous decisions need not be good decisions. It can be concluded that a competent patient must only have the capacity to give reasons for his decision that are recognisable as reasons, but that these reasons need not of necessity be good reasons for his decision.

6.4. Patient rationality

This section will examine instrumental rationality and a patient's beliefs and values.

6.4.1. Instrumental Rationality

When a patient makes an autonomous consent decision he is not making a decision about what to believe. He is making a decision about which course of action he believes would be best for him. Baron (1994, page 29) defines instrumental rationality as whatever kind of thinking best helps people to achieve their goals. He argues that for an agent to be rational simply means he uses effective means to achieve his goals. This could involve following the rules of logic, using a heuristic, or even choosing at random in certain circumstances. Let it be assumed that the type of rationality a patient uses when making an informed consent decision is instrumental rationality. In this section I will examine two objections which challenge this assumption. The first objection will argue that it is impossible to use instrumental rationality in the context of informed consent. The second objection will argue that it is impossible to assess a patient's capacity for instrumental rationality in the context of informed consent. I will conclude that both of these objections fail and that a competent patient should use instrumental rationality when making his consent decision.

Let it be accepted that instrumental rationality is the appropriate type of rationality for people to use when making most personal decisions. Consider someone about to purchase a car. It follows the potential purchaser's previous experience in this field means he is able to select the means he has found most effective in the past when deciding which option to purchase. Next consider someone who is being asked to consent to the donation of a kidney to a relative. This is a unique situation he cannot have faced before. It might be argued that because the potential kidney donor has no experience of kidney donation, he has no means of choosing an effective strategy with which to make his decision. It might be further argued that this means the potential kidney donor would find it impossible to use instrumental rationality

when making his consent decision. It is certainly true that a patient cannot have a handy heuristic for kidney donation. However, it does not follow that a patient in this situation cannot use instrumental rationality. The patient may have no experience of kidney donation, but he probably will have experience of making decisions in which his understanding was limited. For instance, he may have previously faced an investment decision when he had no background experience in financial markets (see section 4.2). It follows that he may be able to select an effective means to achieve his goals even when his understanding is limited. He might, for instance base, his decision on a logical assessment of all the information underlying his decision in the light of his goals and values. Alternatively, he might consider whether he should trust those advising him. If he decides his advisors are trustworthy then he might simply accept their recommendation. This argument can be generalised to all informed consent decisions. It follows that it is possible to use instrumental rationality in the specialised context of informed consent.

Let it be assumed that instrumental rationality is the type of rationality used to make informed consent decisions. Secondly, let it be accepted that the practice of informed consent requires a patient's competence can be assessed in some circumstances. If this were not so, the purpose of informed consent could not be to respect patient autonomy whilst ensuring non-autonomous patients can receive beneficent care (see section 4.5). It follows that it must be possible to assess a patient's capacity for reason. Thirdly, let it be assumed it is impossible to assess whether someone has the capacity for instrumental rationality. These three propositions are incompatible. This leads to the following conclusion. If it is accepted that the practice of informed consent requires that it is possible to assess a patient's capacity for rationality, and it is also accepted that someone's capacity for instrumental rationality cannot be assessed then it

can be concluded instrumental rationality should not be the type of rationality used when giving informed consent.

I will present two arguments to show that it is possible to assess whether a patient has the capacity for instrumental rationality. Instrumental rationality is solely concerned with an agent having effective means to obtain his goals. However, in practice, assessing how well instrumental rationality helps a patient achieve his goals might become confused with an assessment of his goals according to Evans and Over (1996):

Can a serial killer, for example be called completely rational if his preference is for murdering people and he chooses the optimal way of doing this?" (Evans and Over 1996, page 34)

It is important not to conflate two distinct questions. Firstly, does the serial killer have effective means to achieve his murders? Secondly, are the serial killer's goals rational in some sense? In this section I am only interested in answering the first of these questions. Does a patient have effective means to achieve his goals? The rationality of his beliefs and values will be discussed in section 6.4.2.

My first argument to show that it is possible to assess someone's capacity for instrumental rationality goes as follows. Dworkin (1988, page 20) regards someone's autonomy as a global property of that person involving reflection. It might then be argued, by analogy, that instrumental rationality is also a global property of a person. If this analogy is accepted, then a patient's capacity for instrumental rationality could be assessed by assessing how successful he is in achieving his goals in life. It might be assumed that if someone has effective means to achieve his goals, in general then he also has effective means to achieve his

goals when giving informed consent. This assumption would concur with the presumption of patient competence within the practice of informed consent (see the General Medical Council, 1999, page 5 and the Department of Health, 2001, Paragraph 2.1). However, this assumption is not true in all cases. Consider a patient who had effective means to achieve his goals in general before he became a patient. However, once he becomes a patient, factors such as fear, depression or medication might cause him to lose this capacity for instrumental rationality. It follows that my argument by analogy is unsound.

My second argument runs as follows. I argued in section 5.3 that the assessment of a patient's competence is only useful in circumstances when treatment is expected to return him to his former life and interests. This return may be a matter of degree. I further argued in section 5.3 that prima facie it could be assumed that a patient's goal is to return to his former life and interests. It follows that if a patient consents to treatment, his decision appears to be instrumentally rational. However, it might be argued that, in the above circumstances, if a patient understands the information relevant to his condition and refuses to give consent to treatment, then his decision is not an effective means to achieve this goal. Prima facie it might be concluded that, in these circumstances, a patient's refusal to give consent is evidence that he does not possess the capacity for instrumental rationality. For instance, consider a patient who understands he will die without an appendectomy and who refuses to give consent. It seems reasonable to assume that such a patient does not possess the capacity to use instrumental rationality. It can be concluded it is possible to make a prima facie assessment of whether a patient's refusal to give consent is instrumentally rational in circumstances in which treatment is expected to substantially return a patient to his former life and interests. However, this prima facie conclusion is open to rebuttal (see section 5.3). I argued there that a competent

patient must be able to give reasons for his consent decision. I further argued these reasons need not be good reasons but they must be recognisable as reasons (see also Wicclair, 1991, page 92). For instance, if a Jehovah's Witness refused to consent to some life-saving operation requiring a blood transfusion, his refusal would not be regarded as evidence that he lacks the capacity to use instrumental rationality. However it can be further concluded that, in the above circumstances, if a patient understands the information provided and is unable to give some reason for his refusal of consent, then he lacks the capacity to use instrumental rationality. It might be objected that the above conclusion depends on the outcome of a patient's decision and to use such a decision as evidence of incompetence runs counter to guidelines given on informed consent. The General Medical Council (1999, section 19) holds that if a patient's decision appears irrational or not to be in his best interests, then this is not evidence the patient is incompetent. See also the Department of Health (2001, section 2.3.) and the judgement in Sidaway [1985]. The accepted position, according to these guidelines, is that the outcome of a patient's decision may point to incompetence. The outcome of a patient's decision may also trigger an assessment of his competence (see section 4.1). However, according to these guidelines the outcome of a patient's decision should not be regarded as evidence of a patient being incompetent. My conclusion clearly runs counter to the above guidelines. I will now argue that my conclusion does not run counter to either the practice of informed consent or respect for autonomy.

Consider a patient who refuses to consent to an emergency appendectomy without which he will probably die. Let it be assumed that when refusing consent, this patient simply says no. Let it be further assumed that when asked for a reason for his refusal of consent, the patient simply says I don't want to. Let it be still further assumed that these answers are the only

communication from the patient to his medical team. In the practice of informed consent this patient would be regarded as incompetent. It might be argued that this patient lacks the capacity either to understand or weigh the information provided. However, we can question whether there is evidence for the patient lacking these capacities. Let it be accepted that if this patient had consented his decision would have been accepted. It follows that the only possible evidence for his incompetence in these circumstances is the outcome of his decision.

However, let it be assumed that another patient in the same situation is able to give reasons for his refusal of consent. These reasons must include his goals and values. Let it be also assumed that the patient understands the information provided and his decision is not an effective means to serve his stated goals and values. In practice this patient's decision would again be taken as evidence that he was unable to weigh the information provided and he would be regarded as incompetent. It can be concluded that if a patient's refusal of consent is taken as evidence that he lacks the capacity for instrumental rationality, then this does not conflict with the practice of informed consent.

The judgement in *Sidaway* [1985] states that a patient may refuse to give consent for reasons that are rational or irrational, or for no reason. It might be argued that refusing to accept a patient's refusal of consent as valid, even if he is unable to give reasons for his decision, means failing to respect his autonomy. This argument again illustrates the need to be precise about the system of autonomy underlying the practice of informed consent. It seems clear that Christman's concept of autonomy would regard such a patient's refusal of consent as autonomous provided he did not resist its development subject to certain conditions. I have argued that informed consent should be based on respect for Frankfurt's (1988, page 83, originally 1982) concept of autonomy which concept involves reflection which in turn

involves reasons. It follows that, provided Frankfurt's concept of autonomy underlies informed consent, failing to respect a patient's refusal of consent, in the above circumstances is not a failure to respect an agent's autonomous decision. It further follows that instrumental rationality could be the type of rationality used to make informed consent decisions.

Beauchamp and Childress (1989, page 69) believe that it would be wrong to chain informed consent to fully autonomous decision making because this robs informed consent of any meaningful place in the practical world. I have argued that the truth of this conclusion depends on the concept of autonomy employed (see section 5.3). However, if informed consent were tied to completely logical decision making this would rob informed consent of any meaningful place in the practical world because very few patients might be regarded as competent. For this reason I believe that instrumental rationality should be the type of rationality used by a competent patient when making informed consent decisions.

6.4.2

Beliefs, goals and values

I argued above that a competent patient only needs to have the capacity to use instrumental rationality. I also showed that it is possible for someone to be instrumentally rational when intuitively he appears to be irrational, using the example of an efficient serial killer. Both the Department of Health's guidelines (2001, Paragraph 2.3) and the legal judgment given in the case of Sidaway [1985] agree that a patient may make a decision based on his own goals and values and that the rationality of these goals and values cannot be challenged. This position might be called the Humean position because reason is simply the slave of the passions:

Reason is, and ought only to be the slave of the passions, and can never pretend to any other office than to serve and obey them. (Hume 1978, page 415, originally published 1739 - 1740)

In this section I will argue that a Humean position would form an inadequate basis for the practice of informed consent because informed consent should not be solely concerned with rationality and a patient understanding his position. In this section I will consider instrumental rationality to be whatever kind of thinking best helps people to achieve their goals as defined by Baron (1988, page 29) It might then be argued I am only concerned with a crude form of instrumental rationality. However there are two reasons to support my adopting the above definition of instrumental rationality. Firstly this definition seems appropriate to the practice of informed consent. Secondly, and more importantly this simple definition does not conflate the concepts of instrumental rationality and autonomy. In this section I will accept that personal autonomy does not impose any constraints on the content of an autonomous agent's goals and values. However, I will argue that personal autonomy requires more than the Humean position on rationality because an autonomous agent's goals and values must have some simple structure.

I will now examine the beliefs of a patient. The content of beliefs may vary. For example, some beliefs concern values such as whether it is right to eat meat. These are beliefs about what is of value. Other beliefs concern facts about the world such as whether it is raining. These are factual beliefs. The Department of Health's (2001, section 2.3) guidelines state that if a patient bases his decision on a misrepresentation of the facts about the world, as opposed to an unusual value system, he is incompetent. It would seem that if a patient misrepresents the facts about the world he might be unable to understand the information provided to him concerning his condition. For instance, an anorexic patient who believed she

was fat when in fact her physical condition was failing would be considered incompetent because of this false belief. This concurs with the guidelines of both the General Medical Council (1999, page 5) and the Department of Health's (2001, section 2.1). However, an anorexic patient who understood her failing condition and the fact that if she failed to eat properly she might die, but who still refused to eat adequately, might be considered competent according to Draper (2000, page 133). Let it be accepted that if a patient is unable to understand why he needs treatment that he will be unable to make an autonomous decision concerning any proposed treatment (see section 6.1). It follows that when a patient's beliefs clearly misrepresent his physical state or his prognosis he should be regarded as incompetent. Someone's beliefs, goals and values are not things existing independently but in a set (Wittgenstein, 1969, proposition 141). It might be argued that an anorexic patient who had no false factual beliefs, and possessed the requisite cognitive abilities, might be regarded as incompetent because of the structure of her general beliefs, goals and values. The structure of the set of an autonomous agent's beliefs, goals and values will now be examined.

I argued above that if an agent holds an erroneous factual belief concerning his condition this affects his ability to act autonomously. I will now consider an agent's beliefs about what is of value. These beliefs define what an agent cares about and in the rest of this section will be considered as an agent's goals and values. Frankfurt (1999, originally 1992) argues an autonomous agent's will must have some form of unity. This he defines as being wholehearted:

If ambivalence is a disease of the will, the health of the will is to be unified and in this sense wholehearted. A person is volitionally robust when he is wholehearted in his higher order

attitudes and inclinations, in his preferences and decisions, and in other movements of the will.
(Frankfurt, 1999, page 100, originally 1992)

If a person's will is not wholehearted then he is ambivalent then Frankfurt (1999, page, originally 100, 1992) argues an ambivalent agent cannot make up his mind because he does not know what he cares about most. Frankfurt regards wholeheartedness as concerned with the organisation of an agent's will:

Wholeheartedness is not a measure of the firmness of a person's volitional state, or of his enthusiasm. What is at issue is the organization of the will, not its temperature. (Frankfurt, 1999, page 100, originally 1992)

I argued that Frankfurt's concept of autonomy should form the basis of informed consent in sections 3.5.4 and 5.3. It follows that the set of a competent patient's goals and values must have some organisation or structure based on wholeheartedness. What constraints the idea of wholeheartedness imposes on a competent patient's goals and values will be examined next. Let it be accepted that someone's will is concerned with what he cares about and the things he cares about must include his goals and values. Frankfurt (1988, page 84, originally 1982) argues if someone cares about something he must continue to care about it unless circumstances change. It follows that an autonomous agent's will is concerned with things that have persistence. Frankfurt (1988, page 91, originally 1982) also argues if someone's will is not ambivalent he must be able to care about some things more than others. It further follows that if someone cares about some things more than others his will must be organised in such a way that it enables him to rank the things he cares about. The ability to rank as it is used here

only means that an agent can order his goals and values. It does not imply that he must be able to give relative weights to different goals and values. It also follows that if a patient makes an autonomous informed consent decision he must have the ability to rank his goals and values affecting this decision. However, I have argued that a patient's goals and values concerning some particular decision do not exist independently of his other goals and values (Wittgenstein, 1969, proposition 141). If this is accepted it leads to the following tentative conclusion. An autonomous consent decision can only be made by a patient who is able to structure all his goals and values by ranking them.

It might be objected that my tentative conclusion only imposes a very weak structural condition on autonomous decisions. It might be argued that if a person cares about certain things, and can rank all the things he cares about, this weak condition is insufficient to guarantee that his decisions are autonomous. This would certainly be the position of Christman (1991, page 11). He argues the set of autonomous desires should be minimally rational by not being manifestly inconsistent. Christman's idea can be illustrated in practice by again considering the case of Ms B [2002]. Recall that Ms B was kept alive by a ventilator and wished to have it switched off. Hypothetically, let it be assumed that Ms B desired both living and wanting the ventilator switched off. These two desires are inconsistent with one another. It follows that, according to Christman's concept of autonomy, Ms B's decision to have her ventilator switched off would have been non-autonomous because her set of desires was not minimally rational. However, had Frankfurt's concept of autonomy been used to assess Ms B's autonomy in this situation, then her decision might have been regarded as autonomous. When an agent cares about an inconsistent set of the things, what is important as far as Frankfurt's concept is concerned, is not that the agent must stop caring about some of these things in order to make this set manifestly consistent (Frankfurt 1999, pages 160, 161). What

is important is that the agent is able to decide which of those things he cares about most and commit himself to any decision he makes. It follows that had Ms B cared more about having her ventilator switched off than life, Frankfurt would have regarded her decision as autonomous. This discussion again illustrates the need to be precise about the concept of autonomy that informed consent respects.

I have tentatively concluded that an autonomous agent must be capable of ranking *all* his goals and values. This conclusion has the unfortunate consequence that if someone is unable to make one autonomous decision, because he is ambivalent, that he will be unable to make *any* autonomous decisions. In practice it would be difficult to accept such a consequence. Consider again the young woman who is diagnosed with leukaemia who cares greatly about having a child of her own. This patient has two options. The reasonably good chance of a cure provided she opts for immediate treatment, or the more dangerous option of delaying treatment so she may possibly have a child of her own. Let it be assumed that she is ambivalent with regard to these options because she cannot decide which option she cares about most. It follows that she cannot make an autonomous decision in this case. However, it seems ridiculous to hold that as a result of this, she is incapable of making any other autonomous decisions in her life. Examples cannot be used to show that a proposition is true, they may only point to the truth of something. However, examples can show some proposition is untrue. It follows that my tentative conclusion, that an autonomous consent decision can only be made by a patient who is able to structure *all* his goals and values by ranking them, is false. This tentative conclusion might be modified and replaced by the following conclusion. **An autonomous consent decision can only be made by a patient who is able to structure his goals and values, relevant to this particular decision, by ranking them.**

This thesis is concerned with applied philosophy, and if my conclusion is to be useful, then it must be possible to assess whether a patient can rank his goals and values relevant to a particular decision. Frankfurt argues that an autonomous agent is wholehearted about some decision if he is satisfied with this decision. Satisfaction in this situation does not mean that the agent reflects on his decision rather it means an absence of any restlessness to change the decision (Frankfurt, 1999, page 103, originally 1992). This condition mirrors the first of Christman's (1991, page 11) conditions for an autonomous desire. Clearly, if an agent cares about a decision, he cannot be indifferent towards it (Frankfurt, 1988, page 83, originally 1982). Let it be assumed that an agent is unable to rank what he cares about relevant to some particular decision. Let it be further assumed that the agent makes this decision. It seems clear that if an agent both cares about his decision and is unable to decide on the relative importance of what he cares about relevant to this decision, then he must have some degree of restlessness to change his decision. It follows that if an agent is satisfied with a decision he cares about he must be able to rank the things he cares about relevant to this decision. It further follows that it is possible to assess whether a patient can rank his goals and values relevant to a particular informed consent decision by asking whether he has an absence of restlessness to change his decision.

The practice of informed consent regards a consent decision as *competent* subject to the following conditions. The patient must be able to understand the information provided, communicate, and be able to weigh this information when making his consent decision. This position is set out by the C test [C, 1994]. I argued in section 1.2 that the C test implicitly requires that a patient must be able to use instrumental rationality and possess a set of goals and values. These goals and values need have no particular content or structure. I suggested

above that this might be called a Humean position. I have also concluded above that an autonomous decision can only be made by someone who is able to rank his goals and values. I will now examine some of the implications of accepting this conclusion for the practice of informed consent. Hume argued that someone could be acting rationally even if he chooses one goal at the expense of another goal he cares about more:

“This as little contrary to reason to prefer even my acknowledg’d lesser good and have a more ardent affection for the former than the latter.” (Hume 1978, Book II, Section III, page 416, originally published 1739 – 1740).

Intuitively such a decision seems incompetent. My conclusion reached above is philosophically interesting because it would explain why such a decision is incompetent. It might be argued that in practice, people do not use instrumental rationality to obtain something they care about a little in preference to something they care about a lot, unless a very crude definition of instrumental rationality is adopted. I would merely point out that in practice it seems entirely possible for a drug addict to make an instrumentally rational decision to choose taking drugs, which he doesn’t care about, in preference to his lover for whom he cares a great deal. It follows that someone may indeed use instrumental rationality to obtain something he cares about a little in preference to something he cares about a lot. Such a decision is incompetent, not because it is irrational, but because it is non-autonomous. It seems inconceivable that an autonomous agent might care about two options and choose the option he cares about the least. This is because it would imply that the agent could choose the option he cared about least without any restlessness to change his decision. It can be concluded that

an instrumentally rational decision need not of necessity be an autonomous decision. It can be further concluded that informed consent guidelines might regard some non-autonomous decisions as competent.

In this chapter I have argued that, in the context of informed consent, an *autonomous* decision is one subject to the following conditions. The patient must actually understand the information relevant to his decision, must be able communicate and must be able to use instrumental rationality. In addition, the patient must possess a set of goals and values, relevant to his decision, which he is able to rank. It follows that in the context of informed consent respecting the accepted guidelines would automatically respect all autonomous decisions. However, I concluded in section 4.5 that the purpose of informed consent is to respect patient autonomy and enable patients to make autonomous decisions whilst allowing non-autonomous patients to receive beneficent care. I concluded above that informed consent guidelines might regard some non-autonomous decisions as competent. It follows that in some situations, current informed consent guidelines might respect the decisions of some non-autonomous patients thereby possibly denying them beneficent care. It might be assumed that such situations do not occur in practice. However, such an assumption would be false. Draper (2000, page 133) argues that in certain cases, if an anorexic patient fully understands her situation, then her decision to refuse food might be regarded as competent see section 1.2. Using the accepted guidelines on competence, as set out in the C test, Draper may well be correct. However I do not believe all such patients should be regarded as competent. Let it be accepted that the purpose of informed consent is to respect autonomy whilst at the same time ensuring non-autonomous patients receive beneficent care. It follows only anorexic patients' who understand their position, are instrumentally rational and *autonomous* should be regarded as competent. I concluded above that an autonomous decision can only be made by someone

who is able to rank his goals and values relevant to that decision. It follows that only anorexic patients' who understand their position, are instrumentally rational and are able rank their goals and values should be regarded as competent. This suggests that Draper is partially correct, and some anorexic patients might be regarded as competent if the purpose of informed consent is to respect patient autonomy. **In the light of the above discussion I believe that, a competent patient must be able to rank his goals and values, in order to fully serve the purpose of informed consent.**

I argued in section 5.3.2 that the concept of autonomy underlying informed consent should allow as many patients as possible to be regarded as competent. It might be argued that by adding an additional condition to the current practice of informed consent, I am reducing the number of patients who would be regarded as competent. I accept this argument but believe this additional condition is a necessary condition if it is accepted that the purpose of informed consent is not simply to respect patient autonomy but also to ensure non-autonomous patients receive beneficent care. However, even if my additional condition is accepted as part of the practice of informed consent, it might still be possible for a small number of anorexic patients who fully understood their position, could communicate and whose decisions were instrumentally rational, to make competent decisions to refuse food. Whether the decision of such an anorexic patient was a competent decision would depend on whether she had an absence of restlessness to change her decision. The above conclusion might lead some to question whether informed consent should indeed be based on respecting autonomy whilst ensuring non-autonomous patients receive beneficent care. It might be suggested that informed consent would be better based on respect for persons (see section 2.2). Such a debate is outside the remit of this thesis. I have argued that autonomy is central to our lives. For this reason, I

would suggest that informed consent should be based on respecting autonomy whilst ensuring non-autonomous patients receive beneficent care.

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