Autonomy and the Principles of Medical Practice

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1 Introduction

There is virtually universal agreement amongst ethicists and physicians that respect for patient autonomy is an important, even indispensable principle in the ethical practice of medicine [1]. United States law recognizes the centrality of patient autonomy by prohibiting, in ordinary circumstances, the imposition of medical treatment on a mentally healthy adult patient without his or her free and informed consent [1]. Medical practice is not always straightforward. Conflicts can arise in specific cases, between the physician's obligation to respect patient autonomy and the physician's other ethical obligations—for example, the imperatives: to do no harm; to act in the patient's best interest and to respect justice. In the course of everyday medical practice, challenging cases result in ethical dilemmas owing to the many different and sometimes conflicting responsibilities that physicians have to patients, to society, and to themselves. The field of medical ethics is charged with the study of such conflicts with the promise that better and more just solutions may be achieved by defining the problems and applying the principles that result in successful and morally just patient care: patient autonomy, nonmaleficence, beneficence, and justice. The purpose of this chapter is to examine the medical ethical

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principle of respect for patient autonomy by exploring the philosophical origins and underscoring the importance of more formalized and structured ethical training in medical practitioner training. Much of this topic has been previously reported by us [2]. The prose of the original article is largely presented herein with minimal redactions.

The two most influential philosophical approaches to ethics (Utilitarian and Deontological theories) agree on the centrality of the principle of respect for patient autonomy. It is interesting to note, however, that they do so for different reasons, which will be examined briefly with the intent to deepen our understanding of the principle and highlight the difficulties that may arise as physicians seek to apply the principle in daily professional practice.

Utilitarian and Deontological approaches will be addressed from their respective theoretical perspectives and contrasted with ethical theories that focus on the virtues and vices that characterize people as good or bad. The latter ethical theories, so called "virtue ethics", have their origins in the writings of Plato [3, 4] and Aristotle [5], and offer insight both into the debate on patient autonomy and on how ethical thinking can be taught [6]. In the process of this textual interpretation, a theoretical and clinical basis for the importance of patient autonomy as an ethical tenet and for its incorporation into medical practitioner training will be considered.

2 The Centrality of the Principle of Respect for Patient Autonomy

Engaging patients with respect for their autonomy is based on a fundamental acknowledgement of the freedom to hold and to act upon judgments that are grounded in personal values and beliefs. How rationality, freedom, values, and beliefs are interpreted has been the subject of intense and exhaustive philosophical inquiry [7, 8]. Fortunately, the two main sources of contemporary normative ethical theory (Deontological, Utilitarian) do not differ significantly in these areas. They do, however, differ in their reasons for embracing the principle of respect for patient autonomy.

The first of the aforementioned ethical theories stems from the work of Immanuel Kant (1724–1804), who is associated with Deontological (duty-based) ethics [9]. According to Kant, an individual's capacity for reflective judgment and rational choice confers upon the individual the authority and right to determine his or her own moral destiny. Individuals make decisions for themselves, and others have the obligation to respect their judgments and choices. According to Kant, to violate a person's autonomy is to disregard his or her own goals and to treat the individual as a means to someone else's ends, rather than respect the individual as an end in himself or herself. Kant thereby advances a moral imperative of respectful and dignified treatment of persons as ends in themselves [9].

The principle of respect for patient autonomy follows directly likewise from the other main contemporary source of normative ethical theory: Utilitarianism.

According to John Stuart Mill (1806–1873; best-known theorist of the Utilitarian school) [10], an action is morally right if it maximizes net utility for all persons affected by the act [11]. In his classic work *On Liberty* [12], Mill argues that people's choices should be respected, and individuals allowed to do whatever they choose to do—so long as their actions do not interfere with others' freedom to do as they choose. Mill opposes paternalism by maintaining that each individual, on balance, is the best judge of what is in his or her best interests. Thus, an individual's judgments of what would maximize his or her utility should be respected. If it is believed that a mature and mentally healthy individual is choosing something self-destructive, the person can be reasoned with and persuaded to understand the danger, but ultimately the individual should be assumed to be the best judge of his or her own interests, and her choice should be respected.

Because respect for patient autonomy requires that the physician take into consideration the expressed wishes of the patient, this principle conforms to Mill's settled position [10]. Respect for patient autonomy can be seen as a special case of society's larger obligation to maximize utility by allowing people to develop morally in accordance with their own convictions.

3 From Principles to Virtues

Respect for patient autonomy is, consequently, a principle that both Utilitarians and Deontologists support. Confronted with tough cases (bizarre circumstances that produce strange consequences, or recalcitrant patients), these schools of thought can occasionally diverge in their conclusions. In deriving their initial theoretical commitments neither doctrine considered the complex world of twenty-first century medical decisions. However, to leave behind thousands of years of ethical thinking simply because they do not address specific, medical situations would be to ignore insights that have shaped human thinking to this day. Some practical and psychological difficulties that arise in the application of these theories in a medical setting have been noted in the last four or five decades in other contexts [6, 13–16].

For example, Utilitarianism suggests that moral agency involves or should involve a kind of cost-benefit analysis of the consequences of various alternative actions one is considering. Acting morally involves simply performing that action whose net benefit is greatest. Critics argue that this is an unrealistic account of the way real people make considered decisions in actual circumstances [14]. At the very least, this account distorts conditions by relying on an overly rationalistic and an overly simplified, psychological account of human agency. Critics note that the world is more complicated and the human psyche deeper and richer than this picture suggests [17]. Decision-making is deeply influenced by an individual's emotions, attachments, personal habits, and society's customs and norms. These are not minor psychological influences that might be eliminated by adopting a more "rational" decision-making procedure. These are fundamental facts

about human nature and hence constitutive of us as human beings and (by extension) moral agents. An acceptable and useful ethical theory must take account of these realities and must not substitute a simple, mechanical decision-making procedure for the rich (if sometimes muddled) psychological complexity of real human agency.

Critics of Utilitarianism and Deontology also note that these schools of thought have very little to say about the important issue of a person's moral character [14, 18]. Because these schools focus on the individual act as the locus of moral judgment, the most that can be said is that a person has good character if he or she more often than not performs the right actions. But virtue ethicists hold that moral character is not just a matter of counting favorable and unfavorable outcomes. Character is not primarily a matter of making the right decision in rare, difficult cases. When someone's moral character is examined, the person's long-term and customary way of responding to the ethical aspects of all situations that arise every day in his or her personal and professional life are scrutinized. A person of estimable character is a person who is finely attuned to the moral dimension of his or her interactions with others, intuitively capable of discerning the right thing to do, and naturally inclined to do it. Of course, the hope is that he or she is naturally inclined to do that which moral principles would dictate, but the emphasis here is not on getting the right answer. Rather, the emphasis is on being the kind of person who notices the moral aspect of things, and does what is right because it feels, quite naturally, like the right thing to do. A person's character encompasses his or her perceptual acuity, patterns of attention, capacity for affective resonance with others, moral judgment, and ingrained tendency to do what he or she sees/feels/knows to be the right thing.

One could make the argument that moral character has no direct relevance to the complex world of medical ethics. So long as the correct course of action was followed, and the proper course of consideration and debate adhered to, then the agents pursuing this resolution were correct in their moral thinking. This argument is attractive because it attempts to simplify medical ethics into a prescribed set of principles that, if followed, will yield the right course of thinking/action. It has just been acknowledged that such principle-based ethical theories will occasionally come into conflict with each other and can be limited by their lack of specific consideration of the complicated world of modern medical ethics, but does this really matter? Can human beings live with the approximations that principle-based ethical doctrines provide for complicated medical ethical problems, or should society instead consider other approaches that may be more difficult to define or teach but that allow for more specific and complicated subject matter by not being bound by simplistic and sometimes anachronistic first principles?

Virtue based ethics, by espousing virtues that pertain more to an individual's habits and relationships with others and with his or her society (i.e., character) can provide such a path to a potentially more relevant ethical discourse in the complicated modern world. As moral character involves cognitive, affective, dispositional and behavioral dimensions, it cannot be summed up in any single principle or dictum. As Aristotle noted, "ethics is not an abstract science and cannot be taught as if

it were geometry. On the contrary, moral education is complex, nuanced, and multi-dimensional—a matter of learning principles, yes, but also of developing perceptual acuity, shaping emotional sensibility, and cultivating self-discipline in one's behavior" [19]. If medical ethics is understood in terms of character and if the ultimate objective is to develop an ethically upright physician and healthcare professional, it seems necessary to think more broadly about moral education as part of medical training. In this area, too, insight can be drawn from the ancients and their understanding of character and moral virtue.

4 Respect for Patient Autonomy as a Medical/Professional Virtue: Classical Understanding of "Virtue" (*Arête*)

The thinker who has made the most significant contributions to society's understanding of moral character is Aristotle (384–322 BCE). According to Aristotle's analysis, character is best understood in terms of certain virtues: a person of excellent character is one who possesses the virtues characteristic of a good person. The Greeks focused on certain virtues as most important (wisdom, temperance, courage, justice, and piety), but of greater interest is Aristotle's analysis of just what a virtue is, why it is valuable, and how a person can be trained in virtue.

According to the classical concept, a virtue can be thought of as a characteristic of excellence. So, for example, the virtues of a race-horse (i.e., the characteristic excellences of a race-horse) would be those qualities or features that make it a *good* race-horse such as speed, strength, and endurance. Socrates even spoke of the "virtues" of a lowly kitchen knife [4]. In order to be a good kitchen knife, a knife must possess certain qualities that make for excellence such as sharpness, balance, and maneuverability.

Of course, Aristotle was not chiefly interested in race-horses or kitchen knives. These are just examples to help understand the concept of a characteristic excellence (i.e., a virtue). As an ethicist in the classical tradition, Aristotle was interested in what qualities or traits make a person a *good person*. These are the virtues, the characteristic excellences, with which he was concerned. As mentioned above, classical Greek philosophers thought that the list of human virtues include, above all, wisdom, courage, temperance, and justice. Aristotle noted all of these as well, but to understand his view, his analysis of courage is noted as an example.

According to Aristotle, having courage indicates striking the right balance with regard to the emotion of fear. A person who has too much fear or who fears things that are not truly dangerous, is not courageous but cowardly. A person who has no fear, or who fails to fear things that are genuinely threatening, is not courageous but rash and foolhardy. A courageous person has the right amount of fear toward things that are genuinely dangerous.

It should be noted that when possibly dangerous situations are confronted, individuals do not normally make conscious, rule-based decisions about whether to be afraid or not. On the contrary, the tendency to be easily frightened (or not) is more

of an abiding disposition or character trait.[1] One's tendency to be more (or less) easily frightened may be partly inborn but Aristotle thought it mostly a result of one's past experiences, training, social customs, and the influential role models that one has encountered along the way. As a child, the training consists mostly of behavioral conditioning, but as one grows older and confronts more complex and diffuse threats and dangers, one begins to think more reflectively about these matters and perhaps one's fear-response becomes, over time, more informed by a kind of practical wisdom (*phronesis*). If an individual is fortunate, he or she might meet someone more advanced in this kind of practical wisdom (a *phronemos*) and by listening to this person's words, observing his or her emotional responses and watching how and what he or she does, a person can learn what it is like to think and feel and act like a courageous person. Emulating this person's attitudes and actions can refine different habits of feeling and action, and thus an individual can acquire, in a more mature and developed form, the virtue of courage. And in acquiring one of the most important human virtues, we become better human beings.

Everything that has been said about courage can be said of the other moral virtues as well. They involve striking a balance ("finding the golden mean") [5] between two extremes; they involve being attuned to the relevant aspects of a situation, feeling the right emotions in response, and acting with practical wisdom. And as with courage, the other virtues are acquired via experience, practice, reflection, and emulation of a practically wise and virtuous person.

After this extended discussion and focused insight into Aristotle's ethical views, it is possible to explain and defend the contention that respect for patient autonomy should be considered not only as a principle but also as a virtue. It is important that a healthcare professional understand the principle and be able to reflect on why it is important and how it applies to the medical field. But the best healthcare professional would be one who instinctively regards every patient as an individual with beliefs and values that are worthy of respect, one who feels empathic resonance with the patient and is naturally inclined to be attentive to what the patient says and incorporate the patient's perspective into his or her medical decision making. In making treatment decisions the healthcare professional strikes the right balance between strictly clinical considerations and a respect for patient judgment of what is most important. And when it seems to the medical professional that the patient is not grasping the significance or the gravity of the clinical indicators, the physician engages the patient in conversation, addressing him or her as a person capable of being moved by information and rational persuasion. By doing all of this with the kind of ease that characterizes the graceful athlete or the well-practiced musician, this healthcare professional is worthy of admiration as one who can teach such behaviors effectively.

The analogy to the musician is Aristotle's own; the etymological connection between "virtue" and "virtuoso" is not accidental. A person must learn to be

[1] Aristotle's word is "hexis"—sometimes translated as "habit." The important point is that it is not a momentary state, but an enduring disposition to feel and to act in a certain way.

virtuous, Aristotle told us, just as a student learns to play the flute. At first it does not come easy; one has to work at it; one has to practice. At first the finger positions and breath control may seem unnatural and awkward. Indeed, the whole process may be unpleasant in the beginning. But as one learns and practices, the coordination of breath and finger-movement becomes easier, and the skilled motions that seemed so awkward before becoming second nature. Aristotle added that in the process of learning to play well, one is simultaneously learning to enjoy playing while becoming a flautist.

Clearly, to become a virtuoso one also needs a teacher to point out weaknesses in one's technique, to offer constructive criticism, to help one learn what to listen for, to discuss the fine points of theory and practice, and finally to provide a model of excellence in performance. An effective teacher must know music theory, of course. But more importantly, an effective teacher must have a kind of hands-on practical wisdom that he or she also acquired only with a lifetime of practice and dedication to the art. Relating to the everyday practice of medicine, the importance of making rounds with an experienced, virtuous, practically wise professor (*phronemos*) becomes foundational. In order for students to acquire virtue, there is much practice involved that includes but is not limited to instruction in technique, decision-making, and equanimity. The physician's empathy and compassion for his or her patient will resonate rationally and emotionally between them; together they engage in a treatment plan with mutual respect and courage [20].

There will of course be challenges in attaining moral virtue and applying the principle of respect for patient autonomy according to the golden mean in many cases. Problems exist when the physician decides what is best for the patient and the patient disagrees. The virtuous physician will try to persuade the patient using logic and appealing to rationality. Furthermore, the wise physician will consider the possibility that he or she could be wrong. Part of the virtue of respect for patient autonomy is a measure of epistemological modesty. Aristotle urged us not to expect precision or certainty when dealing with subject matters as imprecise as ethics or the workings of biological systems [21]. Finding the "golden mean" will never be a matter of applying an algorithm or a hierarchical protocol; yet an agent who has achieved moral virtue in this area should be able to resolve the problems that arise in difficult clinical conditions.

Furthermore, the constant evaluation of the "golden mean" allows for reevaluation of experiences and complications that may never have been covered in the extant philosophical or ethical traditions. Such a transition from ethical theory to ethical practice is more easily made through virtue-based ethics rather than through prescribed ethical principles, and, as has been argued, allows for a more effective pedagogical model than merely memorizing principles and conflicts in the history of ethical thought. Daily rounds led by an experienced moral agent (*phronemos*) should not only consider the physiological and clinical status of the patient but also explore the moral issues that are operative or could be operative under these varied circumstances. In this way, ethical reflection and practice become second nature.

The idea that ethics should be taught during residency is not new and has a growing number of proponents. Many authors [22–24] have extolled the benefits of

continued ethical education in medicine on every level and on every occasion. The few studies that have been performed on the efficacy of clinically based ethical training during medical school have been resoundingly positive. This should be part of the medical curriculum or at least part of daily practice. Respect for patient autonomy will improve and will help to establish the idea that the principle of respect for patient autonomy will best be served by clinicians who have achieved a measure of virtue in their pursuit of moral excellence.

While we do not claim to have the ideal pedagogical form of medical ethical training, it has been argued that the complicated world of modern medical ethics requires a curriculum that can be easily applicable to complicated problems and that can be taught effectively by those who practice it on a daily basis. Models that are based on virtues are likely better able to satisfy the needs of the profession. These models are more psychologically realistic and likely to be more effective as a basis for medical ethical training. We look forward to a future of medical ethical debates as the subject becomes less of a compartmentalized specialty and more of a universal aspect of medical training and an everyday concern among healthcare professionals. Such debates will more effectively evaluate and reevaluate the questions of patient autonomy and other cornerstones of medical ethics.

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