



The concise argument – choice, choices and the choice agenda

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Lucy Frith

Choice is probably one of the most often discussed areas in bioethics, alongside the related concepts of informed consent and autonomy. It is generally, *prima facie*, portrayed as a good thing. In healthcare, the 2000s saw the UK Prime Minister Tony Blair pursue the 'Choice Agenda' where, 'As capacity expands, so choice will grow. Choice will fundamentally change the balance of power in the NHS.'¹ In a consumerist society giving consumers more choice is seen as desirable. However, choice is not a good in itself, giving people more choice in certain situations can be problematic: i.e. consumerism drives economic growth and this has a detrimental effect on the environment; and increasing the range of choices a patient is offered is often not the best way to improve the quality of healthcare provision.² The assumptions behind the valuing of choice need careful unpacking and this Issue of the Journal of Medical Ethics includes papers that explore choice in a number of areas.

This Issue's Editor's choice is Tom Walker's 'The Value of Choice',³ which puts forward a suggestion for the importance of the symbolic value of choice. There are a number of ways of categorising the value of choice in healthcare. One account sees choice as valuable because it is by choosing that individuals make their life their own. Another account sees choice as valuable for instrumental reasons, people are generally, assuming they are sufficiently informed, the best judge of their own best interests. Walker argues for an additional third reason, the symbolic value of choice, originally proposed by Scanlon. This sees choice as valuable because being given the option to choose, whether or not one takes it up, not the act of choosing is what makes choice valuable. Being offered the option to choose has a 'communicative role' in that it communicates that the person has standing and, for certain types of choice, being denied the opportunity to choose, 'can be both demeaning and stigmatising.' Walker states that denying someone the opportunity to choose in certain circumstances does not communicate anything untoward, and he goes to explore how we might determine when

not allowing someone a choice would be demeaning. Here he stresses the importance of context in making this determination, it is not fixed by the features of a patient, but what being 'allowed' or 'denied' the opportunity to make a choice reveals about the healthcare professional's view of the patient. 'It communicates that they either see those patients as competent and equal members of society, or that they do not.' Denying a patient the opportunity to choose an ineffective treatment, for example, does not communicate a negative judgement. Walker says his account, 'is intended to supplement existing accounts, not replace them. Because choice is valuable for more than one reason no single account can capture everything that matters.'

The importance of pointing to the context of the choice is highlighted in Walker's paper and it is only through careful examination of the context of that offering that we can determine if, in fact, this is an area where choice should be offered and to whom. Such an examination is carried out in Cameron Beattie's paper,⁴ which considers the High Court review of service provision at the youth-focussed gender identity Tavistock Clinic. Beattie disagrees with the High Court's view that it is 'highly unlikely' that under-13s, and 'doubtful' that 14–15 years old, can be competent to consent to puberty blocker therapy for gender dysphoria. Beattie argues that having puberty blocker therapy is a choice that minors should be given the opportunity to make. In principle, children of that age could be competent to make the decision and that the decision is no more complex than other medical decisions that Gillick competence has conventionally been applied to. Children of this age fall into what Walker calls a 'transitional' group, 'Of particular importance here is the extent to which societal features mean members of some groups find it particularly hard to be recognised as competent and equal members of society. That includes members of groups subject to discrimination....It also includes those who are in what we might call transitional groups such as teenagers struggling to be recognised as competent.' In the case of

denying puberty blockers, the symbolic value of choice is clear.

The paper by Zeljka Buturovic⁵ examines the debate over young childless women requesting sterilisation. There has been a discussion in the literature that critiques doctors' hesitancy to accede to this type of request and Buturovic argues against these criticisms. The argument is that rather than a doctor's refusal to sterilise a young childless woman or putting up obstacles to this being examples of, variously, inconsistency, paternalism, pronatalist bias and discrimination, it is understandable that doctors should be reluctant to follow this unusual request, and such hesitancy is of potential benefit to the young woman. This hesitancy can act as a filter for women who are not seriously committed to sterilisation. This, in essence, is the opposite argument to Beattie's paper, that the barriers put up to prevent people exercising their choice in this case are warranted. Young childless women should have their choice scrutinised and if necessary delayed so that it can be ascertained if the choice is a genuine one, and 'to weed out (the) confused and uncommitted.' Ultimately, that choice should be available for young childless woman, but it is a choice, given its long-term consequences and likely lack of reversibility, that should be carefully considered.

These papers show that choice is a contextually based, complex and multifaceted concept and approaches such as Walker's, give us tools to think more carefully about the value of choice and what that means in particular situations. A consideration of choice is not complete without thinking about the effects of our choices on others, and this needs to be at the forefront of any ethical analysis. The 'choice-agenda' can often be a proxy for an individualistic conception of personal responsibility and a construction of the 'good' of the choice as being solely about that individual's right to exercise a choice, rather than a more nuanced consideration of the wider, or even limited, effects of that choice on others. Although we have well-worn ways of thinking about harm – harm to others and liberty limiting

principles⁶ – how the exercising of individual choice might harm others is often debatable and unclear, and political with a small and large P! For instance, in July 2021 Boris Johnson, the UK prime minister, announced that mask wearing would now be one of personal choice. The government would end the legal obligation to wear a face covering, ‘We will move away from legal restrictions and allow people to make their own informed decisions about how to manage the virus.’ Johnson went on to say: ‘Guidance will suggest where you might choose to do so - especially when cases are rising and where you come into contact with people you don't usually meet in enclosed spaces, such as obviously crowded public transport.’⁷ This mandate for ‘freedom-day’ was criticised in a number of letters in high ranking medical journals,^{8,9} arguing, ‘The narrative of “caution, vigilance, and personal responsibility” is an abdication of the government’s fundamental duty to protect public health. “Personal responsibility” does not work in the face of an airborne, highly contagious infectious disease. Infectious diseases are a matter of collective, rather than individual, responsibility.’⁸ In this case, someone’s personal choice to not wear a mask on public transport, where social distancing is impossible, conflicts with someone else’s choice

to travel to work as safely as they can. As the critics of this policy and work in public health ethics notes, one person’s choice can have a significant detrimental effect on others, and in situations like this, such as this mask wearing example, where not allowing choice, that is maintaining the legally mandated requirement to wear a face mask (unless there are reasons for an exemption), is an ethically acceptable restriction on ‘personal choice.’ In Walker’s terminology disallowing this choice it is not demeaning or stigmatising, as it applies to everyone, and does not fail to recognise any particular person or group as equal members of society.

Choice is often portrayed as a good thing like parenthood and apple pie and the use of choice by politicians to whip up support and bolster their political agendas, as shown by the examples of Blair and Johnson, shows the rhetorical power of the concept. But to really address in what circumstances choices should be offered, to whom and what type of choice, we need theoretical tools to help us understand and be attentive to the wider implications and the papers in this Issue help us to do that.

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ORCID iD

Lucy Frith <http://orcid.org/0000-0002-8506-0699>

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