to patient participation. The enthusiasm of some doctors for unilaterally prescribing treatments, without due regard for the wishes of patients, has had to be curtailed. Policies about informed consent, for example, and the widespread introduction of natural death legislation have enabled patients to have more say in choosing their treatment. Advance directives and DNR policies also encourage the involvement of patients in setting appropriate goals. A more educated and empowered patient population, an improved awareness of the palliative mode of care, a co-ordinated multidisciplinary approach, and improved medical communication skills will lead to treatment that better meets the needs and interests of patients, and at less cost.

2) *Futile treatments should be curtailed:* The medical options presented to patients for consideration should not include futile treatments. If a patient requests expensive yet futile treatments then the doctor is obliged to discuss the situation with a view to refusing the patient's request. The principle of patient autonomy cannot be regarded as absolute, and it must be tempered with medical reasoning and consideration of the opportunity-cost to other patients. If futile treatments are withheld and withdrawn, the cost-effectiveness of medical care will be improved.

3) *Voluntary euthanasia:* A small but significant group of terminally ill persons want medical aid to die, even despite the optimal provision of palliative care. Respect for their autonomy and compassion for their suffering are crucial features of voluntary euthanasia. Although euthanasia should never be performed for economic reasons, savings would clearly result from its practice.

4) *Minimise physician conflict of interest:* The referral of patients to clinics or laboratories in which physicians have a financial interest, the referral to hospitals which offer incentives, and the prescription of brand-name drugs produced by companies that ply physicians with gifts are examples of conflict of interest. Also, physician ownership of medical technologies and fee-for-service reimbursement structures create vested financial incentives and the potential for abuses. This can lead to over-treatment, erosion of the integrity of the medical profession, and the excessive use of resources (3). Medical establishments should prohibit certain kinds of activities,

monitor and supervise conduct, and penalise improper conduct.

5) *Control the influence of lawyers:* The practice of 'defensive' medicine has increased, particularly in America, where lawyers have a vested interest in medical litigation. Defensive medicine is not necessarily good medicine. It tends to distort the doctor-patient relationship and to escalate costs. Control of the influence of lawyers on the practice of medicine is indicated.

6) *Evaluation of new technologies:* The extensive and routine use of new technologies frequently occurs before their cost-effectiveness is properly researched. Costs can be contained if new developments are scrutinised for their effectiveness and indications before being widely introduced.

7) *Democratic allocation of resources:* The egalitarian principle demands universal and equal access to services. In determining the priorities for service provision, the experience in Oregon provides an interesting model and suggests that resources can be allocated based on 'community values' (4). Essentially, the areas of health care to be funded are ranked according to their importance as perceived by the community. Such a method of allocation at a macro level is likely to maximise the satisfaction of the needs and interests of members of the community.

These types of strategies, unlike the proposal for age-based rationing, are morally just, and they guard against the dehumanising effects of bureaucratic systems. The above strategies respect and enhance the autonomy of individuals while encouraging the cost-effective distribution of health care resources for the equal satisfaction of individual needs and interests.

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Autonomy and the akratic patient

SIR

I am flattered that my worries about autonomy were selected for criticism by Raanan Gillon in his December editorial (1). One of the criticisms misses the mark, I believe. Gillon writes: 'because there can be very few – if any – people in real life who always act for the best, all things considered by Mr McKnight's argument all the rest of us should be regarded as weak-willed and therefore irrational (in his sense) and therefore non-autonomous'. But it was no part of my argument that only someone who is never weak-willed (some Kantian superman?) could be counted as rational. I assumed, without thinking that it needed any argument, that most of us most of the time do act in accordance with what we think to be best, all things considered, and thus count as rational in my sense. 'Rational' can be used in the sense of 'capable of rational thought' or in the sense of 'thinking and deciding rationally on a particular occasion'. It is possible for someone who is rational in the first sense, to think and decide irrationally on some occasion. Someone (and perhaps only someone) who is rational in the first sense could be irrational in the second way. That is how I propose to describe an akratic person. There is a corresponding distinction between the question whether someone is autonomous in that he/she is capable of thinking and deciding autonomously in general and the question of whether he/she is thinking and deciding autonomously on particular occasion. It is the second question that interests me in the case of the akratic patient.

Gillon also attacks my argument (which he spells out far more carefully than I did myself) on the grounds that it depends on the implicit premise that akratic action is irrational action and that premise is false. 'Rational', he thinks means simply 'based on reason' rather than 'based on the best reason' and as long as the akratic agent has reasons of some sort he qualifies as

rational. No doubt this is a possible usage, but I think mine is quite standard. When we accuse someone of irrationality we do not (usually?) imply that he has no reasons, but that his reasons are not good enough. The interesting thing about the akratic person is that he says this of himself. It would be hard to deny that in Gillon's (excellent) example of eating *foie gras* he would have behaved *more* rationally, given his knowledge of the facts, if he had resisted the temptation rather than succumbed to it.

Davidson's akratic agent, let us remember, not only knowingly chooses the less good course of action but does so freely; he is capable of either. There is a constant temptation in the description of akratic behaviour either to supply extra reasons which we are not being told about or to suggest that either the agent lacks adequate knowledge or his choice is not really deliberate. But then he is no longer akratic. In the first case the extra reasons render him perfectly rational (in my non-metaphysical sense) because his decision *does* now correspond to what he judges best, all things considered. In the second case he is no longer akratic because he is not choosing knowingly or alternatively not choosing freely. I think Gillon succumbs to the temptation in his reactions to the puzzling case of Jones. His first inclination is to look for further reasons – perhaps he is a Jehovah's Witness or a Christian Scientist – which he is concealing from us. But then Jones becomes a standard Jehovah's Witness (with an additional problem about needles) who is being coy about his reasons. He is not akratic because he *is* choosing what he considers the best thing overall. ('Best treatment' may mislead us here. For the normal Witness best treatment is no treatment.) If this fails Gillon's second reaction is to look for signs of mental disorder. This will take the form of showing either that he is so deluded that he lacks an adequate 'knowledge base' for his decision and so decides unknowingly or that though his knowledge is adequate he lacks adequate willpower and

so is incapable of deciding otherwise. But then again he is not akratic anymore. The interesting case arises when we are unable to find any further reasons for Jones's decision, but equally there is no independent evidence of severe mental disorder (and Gillon agrees that the verdict of mental disorder requires further evidence and is not justified by the content of the decision alone). His knowledge of the facts seems adequate and there is no *independent* evidence of lack of willpower other than the discrepancy between his decision and his beliefs. What do we say now?

Autonomy is a concept with a rationalist pedigree. It combines the notion of having reasons for one's actions with that of being in control of those actions. For a rationalist where oneself is one's rational self these coincide. The interest of akasia is that it pulls the two apart. When Gillon succumbs to temptation and eats *foie gras* he is in (non-metaphysically) perfect control of himself. He does it calmly and deliberately, unlike a compulsive *foie gras* addict. But his choice is less than completely rational. While Gillon depicts me as a super-rationalist I am in fact less of one than he is himself. His rationalism emerges in his description of children as 'autonomous in the sense of being able to make decisions for themselves based on reason' (without considering that these might be two independent attributes rather than one) and his frequent use of the phrase 'mental disorder' which has rationalist connotations (an irrational self is a disordered self). Once control over one's actions is allowed to vary independently of the rationality of those actions autonomy becomes an unstable compound. Is Jones autonomous because he is (apparently) in control of his decision to refuse treatment or non-autonomous because his reasons are, by his own admission, bad ones? Does respecting his autonomy entail accepting his decision because it is his or taking seriously his own claim that his reasons are bad ones (in which case overriding his decision would not be

paternalism at all but sincere respect for his 'real' autonomy)? Gillon's notion of adequate autonomy is a useful contribution to the debate but it does not, I think, make the question go away.

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International medical ethics: is it possible?

SIR

The final day of the Fifth International Conference on Ethics in Medicine (London, September 1993) was entitled International Medical Ethics: Is It Possible? Speakers came from five countries, representing four per cent of the world's population. One member of the audience could, perhaps, claim Asian origin; none was from China, Japan, sub-Saharan Africa or (I think) Latin America.

The discussion was erudite – but it was based wholly on the liberal-Judeo-Christian ethic assumed, shared and enjoyed by every member of the audience. It was comfortable and convergent – but international it was not, for the great majority of the people of the world receive health care from systems that neither share our mind-set, nor see any point in moving towards it.

Until Western ethicists stop endlessly examining their own navels, international medical ethics, theoretically possible, certainly desirable, will remain wildly improbable.

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