

Autonomy and the akratic patient

Christopher J McKnight *The Queen's University of Belfast*

Author's abstract

I argue that the distinction which is current in much writing on medical ethics between autonomous and non-autonomous patients cannot cope comfortably with weak-willed (incontinent) patients. I describe a case involving a patient who refuses a blood transfusion even though he or she agrees that it would be in his or her best interests. The case is discussed in the light of the treatment of autonomy by B Brody and R Gillon. These writers appear to force us to treat an incontinent patient either as autonomous, just like a rational agent whose decisions are in accordance with his beliefs or as non-autonomous, like comatose patients or children. Though neither is entirely satisfactory I opt for describing such patients as autonomous but point out that in cases like this the principle of respect for autonomy does not give a determinate answer about how the patient ought to be treated.

From Socrates onward weak-willed (incontinent, akratic) action has been thought to pose problems for philosophy. Socrates, Plato and, on most accounts, Aristotle, thought the problems so acute that they declared such action to be impossible. They are followed in our own day by R M Hare (1), W Charlton (2) and others. Ranged against them are D Wiggins (3) and D Davidson (4) who writes: 'Does it never happen that I have an unclouded, unwavering judgement that my action is not for the best all things considered and yet where the action I do perform has no hint of compulsion or the compulsive? There is no proving such actions exist; but it seems to me absolutely certain that they do'. In this paper I want to agree with Davidson and add that I am more certain of the existence of such actions than I could be of any theory which tells me the opposite and to suggest that weak-willed actions do not fit well into a taxonomy such as is often adopted in writings on medical ethics which divides patients into the autonomous and the non-autonomous. As a result I want to argue that in such

cases the principle of respect for autonomy fails to yield a determinate answer as to how a patient should be treated.

Davidson characterises incontinent action as follows: 'In doing x an agent acts incontinently if and only if (a) the agent does x intentionally; (b) the agent believes there is an alternative action y open to him and (c) the agent judges that all things considered it would be better to do y than to do x'. I am unhappy with the word 'intentionally' here especially since Davidson thinks intentional actions require reasons. This makes it look as though an incontinent agent must have reasons for acting against his reasons and incoherence threatens. Following Socrates I want to substitute 'willingly' for 'intentionally' and I have deliberately made it a feature of the case to be discussed that the patient himself acknowledges the irrationality of his choice.

Recognition of the possibility of incontinent action forces us to distinguish between a rational agent who sometimes acts irrationally and a non-rational agent who is incapable either of rational or of irrational action. Declaring an akratic agent autonomous classifies him together with an ordinary non-akratic agent; declaring him non-autonomous involves putting him in with non-rational beings such as animals, comatose patients and those in advanced stages of Alzheimer's Disease. Neither classification is comfortable.

I want now to consider the case of John Jones. John Jones arrives in a casualty department after an accident and is told that, because of the blood he has lost, he needs an immediate transfusion in order to save his life. When asked for his consent he refuses and when asked for his reason says that he is afraid of needles. 'I know I am being irrational', he says, 'I know transfusion would be the best thing for me and I don't want to die. But I simply cannot face a needle in my vein'. It transpires after further questioning that as a small child he suffered a painful and traumatic experience with a doctor when being given injections.

What should we say about Jones's autonomy? Is he autonomous in spite of his confessed irrationality or is he not? If he is, what does the principle that autonomy should be respected tell us about the

Key words

Autonomy; akrasia

appropriate way to treat Jones? In order to answer this question, I shall describe briefly the views on autonomy expressed by two of the more sensitive writers in this area, Baruch Brody and Raanan Gillon. Brody (5) claims that autonomy (which he refers to as competency) is a process notion not an outcome notion. This means that however irrational a decision may seem by our lights it may still be an autonomous one, providing it has been arrived at by a process which is recognisably rational. No matter how crazy the starting point and no matter how crazy the final decision, autonomy may still be present if the route from one to the other is rational. The rationality involved relates to the patient's ideas about what is rational and not ours. Having made the point Brody proceeds to qualify it. If the decision is one which we regard as weird and if the issue is a serious life-and-death one we would be justified in scrutinising the rationality of the process more severely than we would otherwise. I quote: 'If a patient goes through a process of decision-making and comes to an unusual conclusion ... then the patient may still be fully competent Nevertheless health-care providers are at least entitled to use that unusual outcome as a basis for re-examining the competency of the patient in question'.

What then do we require in order to judge a process to be rational? 1) The ability to receive information from the surroundings; 2) the capacity to remember information received; 3) the ability to make a decision and give a reason for it; 4) the ability to use the relevant information in making the decision, and 5) the ability appropriately to assess the relevant information. Let us see how Jones fares on Brody's tests. There is little doubt that he passes test 1). He has absorbed the information that he will almost certainly need a transfusion without which he will die. He knows too that this will involve an injection which he dreads. There is no reason to think that he lacks information. Equally he has no problems with memory. There is no suggestion that in the time needed to reach his decision he has forgotten what he has been told by the doctors or his fear of needles. Doubts begin to arise when we reach 3) – the ability to make a decision and give a reason for it. Though he has made a decision the story makes it quite clear that the reason he gives is one which he himself admits is a bad one. Much depends here on how much weight we put on the phrase 'the ability to give a reason'. Surely someone can have the ability to do something without exercising that ability on all occasions. He may need to do it sometimes to convince us that he has the ability at all, but it is too much to require that he always should. It is quite possible then that Jones has the ability to make rational decisions but on this occasion is not exercising it. We may wonder how, given the emergency nature of the situation, we could find out that he did have the ability rather than being a non-rational agent who lacked it altogether. We might wonder too

why, given the seriousness of the decision, he should choose this moment to decide irrationally but if we insist that autonomy is the ability to give reasons rather than the exercise of that ability it is dogmatic to deny his autonomy under 3). In fact Brody (6) seems to have a quite different type of case in mind. 'There are some patients', he writes, 'whose incompetency consists precisely in that they continue to waver concerning what they wish. Decisions eventually have to be made and people who are unable to come to some decision or who are continually changing their minds are incapable of participating appropriately in decision-making processes'. Jones is not like this at all and Brody's worry is irrelevant to him. Brody's fourth condition requires the patient to be able to use the relevant information in arriving at his decision. It is difficult to know how to apply this to Jones partly because it is not clear which is the relevant information and partly because it is not said what it is to use information. Suppose the relevant information is that refusal of transfusion means imminent death. Has he used this in deciding to refuse a transfusion? We can surely argue that he has not since a rational patient with that information would have reached the opposite decision and accepted transfusion and Jones has admitted his irrationality. The only other relevant 'information' is that he fears needles and presumably his decision is rational relative to that information. Anyway, even if we decide that on this occasion none of the information has been used in arriving at the decision this is not enough to show that the patient lacks the *ability* to use relevant information, it shows simply that he has not exercised it. Brody's (6) comments on requirement 4) are as follows: 'Some patients can receive information relevant to their case and can remember it but do not take it into account in making their decisions. Sometimes this is because the information, while relevant from the perspective of the health-care provider, is not relevant from the values and perspective of the health-care recipient. This poses no challenge to the competency of the patient. In other cases however the patient does not take the information into account either because he or she does not understand the implications of the information or because he or she is denying the validity of that information'. It is not at all clear how this applies to Jones. It seems just wrong to say that he is denying the validity of the information – he accepts it all. In his case since his decision diverges from his values the information which is relevant to his values (his prospects of survival if he accepts a transfusion) is different from that which seems relevant to his actual decision (he is afraid of injections). The values of the providers seem irrelevant. Nor does condition 5 help us much – the ability to assess the relevant information. Brody is thinking here of depressed or euphoric patients whose condition leads them to overestimate or underestimate the seriousness of the outcome. There is nothing in our

story to indicate that Jones is in such a condition. Someone could try arguing that his fear of needles was so great that it was distorting his decision-making ability but it would be dogmatic to insist that this must be the case.

I conclude from this that Brody's theoretical account of the difference between competent and incompetent patients is unable to accommodate Jones. This is because, though Brody frequently and quite correctly insists that competence is not an all or nothing notion but something which varies with time and with different areas of activity (someone who is financially incompetent might still be competent to make decisions about treatment) and something also which admits of different degrees, he lacks a distinction between a patient such as a child or a senile geriatric patient who is judged incompetent because he is non-rational and Jones who, though he is on this occasion behaving irrationally, is far from being non-rational and should be counted as rational and hence competent because he has the ability to make rational decisions even though on this particular occasion he is not exercising it.

But those who know Brody's book will know that it is not primarily about ethical theory but is a description and analysis of a large number of cases. Maybe Brody's case histories can enlighten us on how Jones should be treated even if his theory does not? The only case which looks relevant is Case No 4, the case of Dr D (7). This man had a right testicle removed because of cancer and more recently the cancer has been discovered to have spread to the lungs. He has responded somewhat to chemotherapy but found the treatment distressing and requested that it should be discontinued. All that is now available for him are what are described as 'last hope experimental protocols'. To quote Brody, 'Mr D says that he doesn't want to be enrolled in these protocols, primarily because he fears the side-effects of the treatment'. (Does the patient actually give this as his reason or is it speculation by the doctors?) 'At the same time he says he is not ready to die and would take any treatment that offered him any hope for prolonging his life even for a short time.'

Brody decides that there is no serious reason to question the competency of Mr D and that his refusal of treatment must therefore carry considerable weight. The interesting part comes next. 'One question remains to be answered', writes Brody. 'Should the team push Mr D over the meaning of the apparent contradiction between his decision not to be treated and his claim that he would do anything to prolong his life ...? We have two reasons for not treating him. One is his expressed wish that he not be treated. If he were to retract this decision when it is pointed out to him that it contradicts his ... expressed statement that he wants to be treated so that his life can be prolonged we would have strong reasons for treating him Moreover in changing his mind he would be telling us that the side-effects

are less horrendous than dying prematurely. Given the principle of consumer sovereignty we would have to assess the consequences of treating him as favourable He should be asked very specifically whether his statement that he would do anything to continue living really means that he would accept the chemotherapy despite his expressed wishes otherwise or whether it only means that he would accept some treatment which did not have horrendous side-effects.' Brody concludes that if a discussion becomes impossible for any reason we should not treat Mr D, 'primarily because we are not justified in reading into his ambiguous remarks a retraction of his unambiguous refusal of treatment'.

There are many interesting things here. What I find encouraging is Brody's apparent readiness to allow that Mr D is competent despite the apparent contradiction in his attitudes. Even here, though, I am worried that this is only because he takes the refusal as relatively unambiguous. What depresses me is Brody's idea that if the patient changes his mind he automatically shows that the side-effects of therapy are less horrendous than dying prematurely. This is to make Mr D a rational patient and simply excludes the possibility of irrationality. If Mr D is irrational, in no way does it follow that a change of mind indicates that one option is more or less horrendous than the other. Things get worse when Brody raises the possibility of discussing the apparent contradiction with the patient. If the discussion takes place at all he seems to take it for granted that the patient will elucidate matters one way or the other either by saying that he really means to refuse chemotherapy and the wish to be kept alive does not include being kept alive by those means, or by saying he has changed his mind and will now accept the chemotherapy. But why assume that this must be so? Why can Mr D not respond by saying 'I mean both'? It may well be irrational to continue holding these conflicting desires but it is not impossible unless we have already decided that irrationality is impossible. Suppose the patient does respond in this way; what do we do? Brody does not tell us because he does not consider the possibility but I am afraid that his reaction might well be that we should reassess Mr D's competence and I need hardly say that in my view that is the wrong response.

Sadly, I can find no assistance here for Jones. We should remind ourselves too that Jones is in a different position from Mr D. The worry about Mr D is that he has conflicting wishes. Jones's wishes are quite clear; he rejects a transfusion. The conflict in his case is between this wish and his values which include survival and so require this treatment. It would beg the question to try to make the cases more similar by saying that Jones's decision to refuse treatment shows that really he fears needles more than he does the consequences of refusing transfusion. That way he is no longer irrational.

Let us now turn to Gillon (8). Unlike Brody, Gillon is concerned with theory and not cases. He

gives a careful account of autonomy which we need to consider in the light of our Jones case. 'Autonomy', he writes, '(literally self rule) is in summary the capacity to think, decide and act on the basis of such thought and decision, freely and independently and without as it says in the British passport *let or hindrance*'. He then distinguishes three aspects of autonomy. 'Autonomy of thought embraces the wide range of activities that are called "thinking for oneself", making decisions, believing things, having aesthetic preferences and making moral assessments. Autonomy of will is the freedom to decide to do things on the basis of one's deliberations. Autonomy of action – the patient whose voluntary muscles are paralysed by curariforms but who is conscious because his anaesthetist has forgotten the nitrous oxide and who tries in vain to devise a way of stopping the surgeon cutting him is perhaps a paradigm of a person whose autonomy of thought and will are active but whose autonomy of action is temporarily completely absent'.

What is welcome here is that Gillon is prepared to recognise different dimensions of autonomy which may vary independently of one another rather than supposing as Brody tends to suggest that we are dealing merely with different degrees of the same thing. How does Jones emerge on Gillon's criteria? It is fairly clear I think that his autonomy of thought is not impaired. His powers of reasoning are not in question. Gillon though appears to disagree with Brody about autonomy being a process notion. 'Impaired autonomy of thought', he writes, 'is not necessarily a matter of impaired reasoning: reasoning may be fairly unimpaired but based on an information substrate that is grossly distorted by for example delusions, false perceptions, hallucinations or a mixture.' Autonomy of thought for Gillon is not just a matter of reasoning but of the sanity or otherwise of the assumptions from which that reasoning starts. Gillon is primarily interested in people under the influence of drugs or alcohol but one might toy with the idea, though Gillon does not, of saying that Jones's fear of needles, on which his decision is based, is sufficiently exaggerated to allow us to rule that he is not autonomous, as we might do with someone with crazy beliefs like a patient who thinks he is a poached egg. But his fear really looks very unlike the 'delusions, false perceptions and hallucinations' mentioned by Gillon. Autonomy of *action* is uncontroversial in this case partly because there is no suggestion that Jones's autonomy is impaired in this respect and partly because Gillon believes that such impairment however gross, never justifies overriding a patient's decision. The interesting question is whether Gillon would say that our patient was volitionally autonomous or not. Impairment of volitional autonomy may be extrinsic or intrinsic. As examples of extrinsic impairment Gillon considers someone who is forced at gun point to take part in a piece of medical research where we would definitely

say that his autonomy was limited and contrasts him with someone who is offered payment to take part where we would be more reluctant to say this. None of this applies to Jones as far as the story goes. What then are we to say about possible intrinsic impairment? Here Gillon says: 'The mere presence of intrinsic pressures such as stress, neurosis and grief, though they may diminish a person's autonomy, does not justify overriding what is left. On the other hand, gross intrinsic impairment of volitional autonomy may also occur and is especially obvious in certain psychiatric conditions, including severe depression and certain phobias'. To show that Jones lacks volitional autonomy then we must show that he is in one of these pathological conditions. Though this may be so I see no hope of showing that it *must* be. The relevant emotion here would presumably be fear of needles. If it is, what reason is there for thinking that it has paralysed or depressed the patient to the extent that we must claim impaired autonomy for him? I can find nothing then in Gillon's discussion to suggest that Jones as described is not fully autonomous in all three aspects (with the possible exception of autonomy of thought). And yet there is no match between the deliverances of his autonomous thought on the one hand and his autonomous action and volition on the other.

How then should we treat Jones, whose choice diverges from his values? One response is to say that, contrary to what he says, Jones is not really all that worried about the prospect of imminent death. The reasons he acknowledges for accepting transfusion are not really his reasons at all or are not as strong as he makes them out to be. He is misleading us about his reasons either because he is lying to us or perhaps because he is himself deceived. Such a person is not akratic since his choice is entirely in accordance with what he takes to be the strongest reason, ie the terror of injections. A second reaction might be that he is sincere enough about his reasons but that his real choice is not, as he claims, a refusal of treatment but an acceptance of it. He is misleading us about his real decision but again there is no akrasia present since the decision and the reasoning are in line. There is however a third response which is to accept all that Jones says. He sincerely believes that transfusion would be the best thing and at the same time he sincerely decides to refuse it. On such an account we have a genuine case of akrasia where what Jones chooses and what his reasons tell him are in conflict. If Jones is in this condition is he autonomous?

To deny that he is to say that, on this occasion at least, Jones's position is the same as that of non-rational beings such as animals whom we can treat as we think best without any worries about what they might feel about it. This seems unsatisfactory. If on the other hand we treat him as autonomous we do not distinguish between him and a rational agent whose choices match his values. In that case how can we still assert that autonomy involves

rational choice rather than just choice? Insofar as the notion of autonomy is unclear so of course is that of respect for autonomy. If autonomy tracks choice then respect for autonomy becomes Brody's principle of consumer sovereignty but it is no longer clear why the consumer has to be an informed consumer or why his reasons have anything at all to do with the matter. If on the other hand autonomy tracks reasons, respect for Jones's autonomy requires us to accept his reasoned conclusion that transfusion is the best thing and ignore his refusal of it. If we take the second line Jones gets a transfusion; if we take the first he does not. It is unclear to me which of these is required by respect for his autonomy. I conclude that the notion of autonomy and the associated principle of respect for autonomy are not as helpful or illuminating as is often supposed.

Christopher J McKnight, MA, BPhil, is a Lecturer in Philosophy in the Department of Philosophy, The Queen's University of Belfast.

References

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- (4) Davidson D. *Essays on actions and events*. Oxford: OUP, 1980: 29.
- (5) Brody B. *Life and death decision making*. Oxford: OUP, 1988: 101–102.
- (6) See reference (5): 102.
- (7) See reference (5): 115–118.
- (8) Gillon R. *Philosophical medical ethics*. Chichester: Wiley, 1985: 61.

News and notes

Biomedical periodicals conference

An International Conference on Biomedical Periodicals will be held from June 16–18, 1994 in Beijing by the Chinese Medical Association.

Any requests for information should be

directed to Dr Jiang Yongmao, Chinese Medical Association, 42 Dongsi Xidajie, Beijing 100710, China. Tel: 5133311 ext 362. Fax: (861) 5123754.

News and notes

Fellowship in clinical bioethics

The Department of Bioethics at the Cleveland Clinic Foundation invites applications for a one-year bioethics fellowship residency, beginning July 1st 1994. The programme has an interdisciplinary focus and includes academic, clinical and research bioethics components.

Each fellowship is tailored to meet individual strengths, needs and interests. Concentrations in medical sub-specialties (for example, geriatrics,

infectious disease) are available.

Stipend and health care benefits are provided. Completed applications must be received by January 15th. For information contact: Martin L Smith, STD, Department of Bioethics, P-31 Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44195, USA. Telephone: (216) 444-8720.