

Respect for autonomy generates no right to information

© Viktor Weichbold (2013)

NOT accepted for publication in Bioethics, 2013

Preamble

Bioethics is a discipline of – let us say: – *not very high* standards of reasoning. Arguments of bioethicists frequently contain logical errors and flaws. One such error is revealed in this article: it is the failure to recognize that a consequence of some thing X cannot be at the same time a condition for X (in order that X becomes real).

In fact, **Beauchamp & Childress** (in their work **Principles of Biomedical Ethics**) commit this error. They claim that respect for autonomy requires a doctor to provide information to a patient, and that the patient's autonomy is fostered by information. Strangely: autonomy is here both a condition for and a consequence of receiving information.

Abstract

It is generally recognized that the patient has a right to information, and it is usually argued that this right derives from respecting patient autonomy. The latter, however, has recently been challenged. In this article further arguments are provided to reject the view that *respect for autonomy* generates a right to information on the part of patient, or an obligation to disclose information on the part of the doctor. As an alternative, it is proposed that all rights and duties which exist within the doctor-patient-relationship are founded in a silent contract concluded between the two.

Introduction

Respect for autonomy has come under pressure. Its role as a fundamental moral principle in medical ethics as suggested in the influential work “Principles of Biomedical Ethics”¹ has been questioned by several authors. L.R. Walker, for instance, points out that the principle includes a notion of autonomy which is inadequate in three respects: “it fails to properly identify nonautonomous actions and choices, it gives a false account of which features of actions and choices make them autonomous or nonautonomous, and it provides no grounds for the moral requirement to respect autonomy.”² Additional criticism has been raised by T. Walker who challenges the claim that respect for autonomy generates a requirement to obtain informed consent from a patient or research participant.³ By analyzing different accounts of autonomy Walker finds that, on each account, there exist situations where a person’s autonomy is not disrespected despite not providing him/her information about treatment or inclusion into research. He concludes that, while all of these accounts support the claim that consent is needed for treating a patient, “they do not support the claim that *informed* consent is needed for this purpose.”⁴

T. Walker’s analysis opens a new front against the principle of respect for autonomy by putting in question the relationship between autonomy and information. This relationship has been little reflected so far despite its pronounced role in founding the patient’s right to information and, correspondingly, the doctor’s duty to disclose information. It is commonly argued that both the patient’s right and the doctor’s duty are due to respecting autonomy. Thereby, it is presupposed that information is somehow linked to autonomy so that, if a person’s autonomy is to be respected, also the informational status of this person becomes an object of moral duties. But this presupposition is undermined by T. Walker’s analysis whose results indicate that the link between autonomy and information is dubious – too dubious to serve as the platform on which moral duties arise. In ultimate consequence, the results even deny that the doctor’s duty to disclose information to a patient is founded on respect for patient autonomy.

Interestingly, T. Walker does not draw this radical conclusion. Instead, he promotes a position which appears to be neither fish nor fowl. He thinks that, in order to respect autonomy, the patient’s consent must be obtained; and in order to obtain a valid consent, the patient must be told what the doctor is going to do. “I cannot, for example, consent to my doctor removing my appendix unless I have some idea that what she is going to do is to remove my appendix.”⁵ So there is the minimal requirement that the patient be informed about *what is to be done*. Without this minimal information the patient would not be able to give a valid consent, and the failure to obtain

¹ T.L. Beauchamp & J.F. Childress. 2008. Principles of Biomedical Ethic, Sixth edition. Oxford: Oxford University Press: 99-148

² R.L. Walker. 2009. Medical Ethics needs a new view of autonomy. J Med Phil; 33:594-608:594

³ T. Walker Respecting autonomy without disclosing information. *Bioethics* 2012. DOI: 10.1111/j.1467-8519.2012.01971.x

⁴ T. Walker, *op.cit* note 3, p.1 (Abstract; italics added)

⁵ T. Walker, *op. cit.* note 3, p. 4.

valid consent would be a failure to respect autonomy. So Walker comes to the conclusion that "... on none of these accounts [of autonomy] does an obligation to respect autonomy [...] generate a requirement that doctors and researchers disclose information *beyond telling their patients and research participants what is to be done*".⁶

But this position is, as said above, neither fish nor fowl. It denies on the one hand that there is a requirement to disclose information, but declares on the other hand that nevertheless a minimum of information must be disclosed. Is the latter true? Is Walker's argument correct: that I cannot consent to a treatment without knowing what the treatment is? I do not think so. I can easily imagine of a situation where I consent to a treatment without knowing what will be done. For instance, if I suffer from severe pain and say to the doctor: "Please help me, and I agree on anything you do in order to cure my pain!" – so this is certainly a valid consent to the treatment, without knowing what it will be. Or take another example: a researcher asks me to participate in a study where the study goal demands that participants be not informed about what is to be done. Instead, they are assured that study participation bears no risks and are paid a fair sum of money for their cooperation. If I agree to participate – that would surely be a valid consent and my autonomy would not be disrespected despite not knowing *what is to be done*.

T. Walker's resolution of the problem which his analysis has accurately addressed is not convincing. Indeed, the results of his analysis suggest a more radical resolution. They suggest that respect for autonomy and the duty to disclose information have nothing to do with each other, so that not the slightest piece of information needs to be provided as a part (or consequence) of respecting autonomy. In other words: the obligation to provide information – if it exists – is not founded on respect for autonomy. Medical ethicists are wrong with their claim that the principle of respect for autonomy is the basis of a moral duty to provide information to the person whose autonomy is to be respected.

The main goal of this article is to expand T. Walker's analysis and to provide further arguments against the view that respect for autonomy generates an obligation to provide information to the autonomous person. The arguments will be drawn from an examination of the relation between autonomy and information. It will be shown that information is not linked to autonomy in such a way that autonomy would be disrespected if information were not provided. From these arguments (and the ones provided by T. Walker) I will conclude that the principle of respect for autonomy does neither create a right to information on the part of the patient nor an obligation to provide information on the part of the doctor. Such a right and an obligation – if they exist – must be founded somewhere else. I will argue that both of them are founded in a (silent) contract between the doctor and the patient where the two protagonists covenant their mutual rights and duties while exercising a doctor-patient-relationship. This contract is, to my view, the true basis for the right of a patient to be fully informed about all matters pertaining to his/her case.

⁶ T. Walker, op. cit. note 3, p. 2.

Examining the relation between autonomy and information

There are several concepts of autonomy in the literature on Medical Ethics which can be reduced to three paradigms⁷: first, autonomy as *capability*; second, autonomy as expressed by *autonomous choices*; and third, autonomy as a private *authorization* (called “sovereignty”). The three paradigms differ in the way how they relate information to autonomy; so we have to examine them separately. Let us start with the third paradigm which establishes this relation in a more transparent way than the two others.

(1) Autonomy in the conception of “sovereignty” is a purely formal authorization: it is a person’s entitlement and right of self-disposal. Autonomy in this sense is very similar to the authorization of a political sovereign: like the sovereign over the state rules the autonomous individual over his/her domain which is (in the medical context) his/her body and mind. Sovereignty includes that the sovereign alone is authorized to dispose of the ruled domain and thereby is free from external control or coercion. This implies that no person is allowed to invade or exploit this domain without the sovereign’s explicit approval. In the medical context this means that no intervention into a person’s body or mind must be made unless the person has approved of it. For this purpose, the patient’s consent is needed before diagnostics or treatment can start.

It be noted that it is the person’s *consent* what is needed to respect sovereignty – not necessarily *informed* consent. Respecting sovereignty (autonomy) requires nothing more than obtaining the sovereign’s approval. Whether the approval is based on well-informed insight, or uninformed trust, or cash, does not matter: autonomy is respected whenever consent has been obtained. This applies also to situations where the sovereign is not told *what is to be done* (as in the examples given above). Of course, the sovereign may (and normally will) make his/her approval contingent upon provision of information. But that does not mean that he/she would not have full sovereignty without that information. If no information is provided, he/she may refuse to give approval – which expresses full sovereignty though no information has been disclosed! We see that, on this account of autonomy, information has no impact on autonomy: neither does disclosure of information implement or increase it nor does withholding of information diminish it. Providing information is important for pragmatic reasons (it helps the sovereign decide whether or not he/she should give approval), but it is nothing that affects autonomy. Hence it follows that respecting autonomy cannot include a moral requirement to provide information (because a moral principle cannot imply something which is out of its scope). Nor does, in return, autonomy imply a moral right to obtain information. This is not to deny that such a right may exist – but it is to deny that it is a part or corollary of respect for autonomy.

(2) Let us now turn to the two other paradigms of autonomy. The main difference between them is that the first one (“autonomy as a capability”)

⁷ T. Walker, op. cit. note 3, pp 2-6, where also references and literature samples are provided; J. Wilson. Is respect for autonomy defensible? J Med Ethics 2007; 33:353–356: 353.

conceptualizes autonomy as a property of persons, while the second one (“autonomous choices”) conceptualizes it as a property of choices or actions. The difference is overcome, however, if we look at the ways how they relate information to autonomy. In either paradigm, namely, autonomy is thought to critically depend on the person’s understanding of (or insight into) the subject on which he/she is about to make a decision. And the person’s understanding, on its part, is critically depending on the availability of information: “persons understand *if they have acquired pertinent information* and have relevant beliefs about the nature and consequences of their actions.”⁸ Thus, availability of pertinent information is seen as a necessary prerequisite either for a person or for choice to be *autonomous*.

This view, however, has several strange consequences. The first is that it conceptualizes autonomy as a *gradual* property which can have different degrees or levels of implementation. Which level is implemented depends on (inter alia) how much information a person has obtained about the case in question. A person with no information has no autonomy (he/she would have to decide blindly) while a person with the maximum possible insight into the case would have maximum autonomy. If we adopt this view to everyday clinical practice we are forced to recognize that many patients present with very low levels of autonomy. Still worse, some of them may lack autonomy as they lack the understanding of the nature of their disease and how it can be diagnosed and treated. Missing this understanding, they fail to meet a necessary criterion for autonomy. Thus, they cannot be regarded as autonomous persons or their decisions as autonomous choices, respectively. What is to do in this case? Can the doctors disregard their choices and wishes because they are not autonomous? No, somebody could interject: the doctors are obliged to inform them about the disease and the treatment in order to foster their autonomy. Thereafter, the person can autonomously decide. – But why are the doctors obliged to inform the person? – Because of respect for autonomy! – But there is no autonomy, so where does the obligation come from?

Where there is no autonomy, there can be no respect for autonomy. And where there is no respect for autonomy, there cannot be a moral duty founded on respect for autonomy. This applies particularly to the duty to provide information in order to foster a person’s autonomy. This duty is commonly seen as arising from the principle of respect for autonomy: “As a positive obligation this principle requires both respectful treatment in disclosing information and actions that foster autonomous decision making.”⁹

At this point it becomes obvious which error inheres in the relation between autonomy and information as conceptualized in the first and second paradigm. The error is that information is at the same time a prerequisite and a consequence of autonomy. Information is required for autonomy to become real, and autonomy is required for information to be provided. This is like a dog which chases its own tail.

⁸ T.L. Beauchamp & J.F. Childress. op. cit. note 1, p. 127 (italics added).

⁹ T.L. Beauchamp. 2007. The ‘Four Principles’ approach to health care ethics. In: *Principles of Health Care Ethics*, Second edition. E.R. Ashcraft, A Dawson, H. Draper and J.R. McMillan, eds. John Wiley & Sons: 3-9:3

Another strange consequence of the two paradigms is that not only autonomy, but also *respect for autonomy* is a *gradual* thing. Respect is owed to persons (or choices) in proportion to the degree of their autonomy. In other words: low-level autonomy requires only little respect and high-level autonomy requires high respect. This is an implication of the moral duty to foster autonomy: fostering autonomy would be useless if all levels of autonomy earned the same respect. Thus, the gradual view of autonomy implies that people be treated unequally when it comes to respecting their choices and decisions. This implication may come in conflict with the moral principle that all humans be treated equally.

At any rate, respect for autonomy cannot be the basis for a duty to provide information when this information is at the same time a prerequisite for implementing autonomy. In this case persons who lack information were lacking autonomy too and therefore were unable to induce a moral duty in others that information be disclosed to them. This is an untenable consequence so that we have to reject the view that information is a prerequisite for autonomy.

What is the true role of information within the field of making autonomous decisions? Not that of a necessary condition for autonomy, but of a promoter for the *quality* of our decisions. Information helps us better recognize and consider the various aspects of a problem so that we can include them into the process of decision-making. Through this, the chance increases to make a *good* decision (e.g. a correct, effective, foresightful, ... decision). But the goodness of a decision has nothing to do with autonomy. Neither does autonomy (in whatever sense) warrant that a decision will be good nor does the absence of autonomy rule that out. Likewise, we can never conclude from a wrong decision that the deciding person was non-autonomous, as little as we can conclude from a right decision that it was made by an autonomous person.

Summarizing the results of our examination we see that autonomy, however conceptualized, does not depend on the availability of information. There is also no other connection between them: neither does provision of information promote autonomy, nor does withholding of information diminish it. Even the complete lack of information does not impact on autonomy.

So the conclusion is: in the absence of any linkage between autonomy and information the duty to respect autonomy cannot found any duty with regard to providing information. In detail: respect for autonomy generates neither a right to information on the side of the patient nor an obligation to disclose information on the side of the doctor.

Where does the right to information come from?

If we deny that *respect for autonomy* is the basis of a right to information: what then is the basis of this right? Before giving the answer three points need to be clarified. First, we must emphasize that it is a *right* what is to be founded – not only a private claim or an accepted custom or something else less mandatory. Thus, there needs to be a theoretical foundation of a right.

Second, if we concede that the patient has a right to information, this does not imply that there is a corresponding obligation to provide information on the side of the doctor. Indeed, the patient's right to information obligates nobody in the world to provide the sought information. At the most, it obligates other people to not hinder him/her when trying to obtain information. But that is all. So if we want to found also an obligation to disclose information on the side of the doctor, we need to found it separately. It is not a derivative or counterpart or implication of the patient's right to information.

Third, the doctor's obligation to disclose information must exactly correspond to the patient's right to information. This means that a) the doctor is the person in charge of providing the information the patient requests and b) the doctor's obligation is confined to provide information only as far as it pertains to the patient's case (e.g. the illness why he/she has consulted the doctor). Hence, it is very specific information which is covered by the patient's right to information and the doctor's obligation to provide it.

Having clarified these three points the answer to the above question lies before our eyes. The basis of a right (on the part of a party A) and a corresponding obligation (on the part of a party B) can be nothing else but a mutual agreement (between A and B). Rights and obligations do not come into existence other than through acts of volition; so we must assume that such an act of volition – a mutual agreement – underlies the patient's right to information and the doctor's duty to provide it. To obtain mandatory status, this agreement must have the dignity of a contract. So we must assume that there exists a contract between the patient and the doctor in which either party declares its rights and its obligations.

Among the obligations declared there is the doctor's duty to fully inform the patient about the results of examinations and the measures to be done, including their consequences and risks, in order to allow the patient make adequate decisions, if needed. But also the patient is obligated to truly and fully inform the doctor about his/her illness and health status. Otherwise the doctor would barely be able to make correct decisions about the measures to be done. So it appears that the right to information exists not only on the part of the patient but also on the part of the doctor, and the same applies to the obligation to disclose information.

Obviously, the doctor-patient-contract is not worked out explicitly nor is it put in effect explicitly. Nevertheless, we have to assume that such a contract exists. Otherwise we were in difficulties when trying to explain why both the doctor and the patient have very specific rights and duties which exactly address to each other, and which are embedded in the doctor-patient-relationship. So there must be a silent contract between them, which is put into effect when this relationship is initiated. The contract remains in effect as long as the relationship lasts. In some aspects, however, it includes even lifelong lasting duties (e.g. discretion).