ACTA UNIVERSITATIS LODZIENSIS
FOLIA PHILOSOPHICA 21, 2008

https://doi.org/10.18778/0208-6107.21.07

*Paweł Łuków**

THE LIMITS OF CONSENT

The doctrine of informed consent is a moral foundation of contemporary medicine and a central topic in bioethics. The core of the doctrine is the thesis that patient's free and informed consent authorises the practitioner to perform medical procedures. This part of the doctrine is clear and uncontroversial. Serious doubts appear however at the moment the question of the need of authorisation is asked. The typical, if not orthodox, answer is that acting only in authorised ways the doctor respects patient's autonomy. Autonomy is therefore a central moral value in the practice of contemporary medicine. Whatever other values may be important, autonomy is key to the moral regulation of the patient-physician relationship.

I would like to question this view, first, by presenting two main concepts of autonomy that are parts of the orthodoxy. An analysis of these concepts shows that they lack conceptual resources necessary for the explanation of the value of autonomy, and for this reason cannot provide a plausible moral justification for seeking patient consent. The ideal of autonomy, on which the orthodoxy of informed consent is based, had been borrowed from areas which are significantly different from that of patient-physician relationship. In response to these difficulties I am going to offer a programmatic view which departs from the idea of consent and makes use of the concept of agreement. The practice of seeking agreement between the patient and the physician is justified not by the need to protect a privileged moral value – be it autonomy or any other value – but by the need to establish the patient's good in a particular case of his or her relationship with the physician. The determination of the patient's good cannot, however, mean mere willingness of the parties of the relationship. The process of establishment of patient's good must be governed by principles that set limits on what can be justifiably agreed to. The account of agreement that I shall sketch is inherently Kantian in that it requires the foundation of consent on

* Uniwersytet Warszawski.

autonomous principles, i.e. on self-justifying principles. As I have already said, I am going to offer a program rather than a detailed theory.[1]

One caveat before I proceed. I am not going to discuss legal aspects of the doctrine of informed consent. I focus on the *moral* underpinnings of the practice of seeking patient's consent.

In the bioethical literature one can distinguish two concepts of autonomy, both of which are versions of the right to self-determination. One, which I shall call action autonomy and which was proposed by Ruth R. Faden and Tom. L. Beauchamp in their book *A History and Theory of Informed Consent*, holds that although one can speak of autonomous individuals, the underlying and workable concept of autonomy refers to action. An action is autonomous if it is intentional, performed with understanding and in freedom from controlling influences [Faden, Beauchamp, pp. 245–246]. Accordingly, a consent is valid if, based on relevant knowledge provided by the physician and without being subject to influences that can redirect her decision, the patient accepts a plan that a certain procedure be performed by the physician.

A characteristic feature of this concept of autonomy is that it sees decision as in some sense isolated from the patient or his other intentions. To see this, one only needs to note that this concept of autonomy is focused on action, and so it does not take into account the links between a patient's particular intention concerning a particular action and his other intentions. Particular intentions are embedded in networks of intentions and an adequate concept of autonomous action must account for that fact. The concept of action autonomy, however, does not do that. To name just two ways in which intentions belong to networks of intentions, one needs to observe that some particular intentions are determined by person's more general intentions; e.g. I intend to eat a salad because I am hungry and have formed a more general intention to eat something. One intention can also be a condition for the realisation of some other intention; e.g. I intend to eat the salad only if I do not have fruit for desert, otherwise I intend to have just the main course [cf. Bratmann, esp. chapter 3].

To a significant degree, networks of intentions are shaped by what the agent holds to be the right way of forming intentions. For this reason to establish the relation of a particular intention to other intentions, one needs to know what principles of forming intentions a person followed in the decision making process. However, Faden and Beauchamp's view of intention does not contain any such principles. Although one might suppose that the set of principles of this sort would have to include the theorems of decision theory, it does not seem be a satisfactory solution of the problem. First,

[1] This paper contains ideas I develop in detail in my book [Łuków 1].

some patients may be decisionally competent and yet incapable of using the theory. Secondly, the theorems characteristically do not single out any choices. For example, a contradiction of intentions is a reason for modification of one of them but it does not say which of the conflicting intentions should be modified.

The isolation of decisions from agents is well illustrated by the example of the driver who extends his arm to signal for a turn during rain and gets his hand wet. The authors of *A History and Theory of Informed Consent* hold that he intends his hand getting wet even if he did not think of his hand getting wet when he decided to signal for a turn [Faden, Beauchamp, pp. 244]. They say that if the driver knows the general truth that extending one's arm through the window during rain leads to one's hand getting wet, then getting *his* hand wet must be seen as a part of his intention of signaling for a turn. This conclusion is clearly wrong because it ignores referential opacity of propositional attitudes [Quine]. It is impossible to say whether the driver intended to get his hand wet without knowing how getting his hand wet relates not only to his belief but also to his other intentions. For example, he could have believed, wrongly, that if his arm were outside the car for a very brief time his hand would remain dry. So having the intention to signal for a turn during rain he could have had no intention to get his hand wet. All this shows that in order to assign intentions one has to integrate them with agent's other intentions.

On its own, the separation of intention from the agent need not be a problem. It is, however, a serious weakness in the context of justification of the practice of seeking patient's informed consent. If it is patient's autonomy that is protected by the practice one would like to know what exactly the patient gets when his consent is sought. But if a central aspect of autonomy is isolated from the patient it is not clear what is achieved for him. Even if this concept of autonomy does help explain what consent protects it does cannot locate it in the patient.

These difficulties of the conception of autonomy of action seem to be overcome by the conception of personal autonomy, which was offered by G. Dworkin in *The Theory and Practice of Autonomy* [Dworkin] and whose philosophical underpinnings are found in H. Frankfurt's paper *Freedom of the Will and the Concept of a Person* [Frankfurt 1, pp. 5–20]. This article contains the basics of Frankfurt's theory of the person. According to this view an autonomous person is someone who voluntarily accepts her desires and moral beliefs and acts on them. Actions issue from first order desires which can be shaped by desires of higher orders. On this view of autonomy a consent is valid if patient's choices of medical procedures reflect her first order desires. Authorisation of the physician is therefore a process of achieving agreement between one's self and one's choices.

The key to an understanding of this concept of autonomy lies in its idea of the person, according to which first order desires move the person to action whereas desires of the second and higher orders do not necessarily do so and yet it is their possession that makes a being a person. It is necessary for my agreeing to a certain procedure that I desire it but it is not necessary that my desiring of my desiring of this procedure actually leads to my desiring it. If one accepts this claim it is difficult to understand what role second and higher order desires play in this concept of autonomy. Since second order desires do not have to produce first order desires, their existence or their being related to first order desires in a certain way cannot explain one's having first order desires, and so they play no significant role in the explanation of one's choices. The category of second and higher order desires is useless from the point of view of explanation of behaviour. It seems that the category is introduced for the moral reason of attaching a kind of importance to action which is accompanied by second and higher order desires. To say that someone is a person does not therefore mean that she falls under a certain descriptive category. It is to judge her as realizing a moral ideal.

This ideal is presented in *The Importance of What We Care About* [Frankfurt 2, pp. 257–272]. Here Frankfurt draws a picture of a person who consciously shapes his moral identity. Frankfurt explains that we spontaneously desire to create our own personalities because this is part of what we are. There are two fundamental objections to this ideal of authenticity. First, although it is widely accepted by members of the political culture of modern democracies, it is not obvious that striving for authenticity is part of human nature, as Frankfurt's account suggests. It seems factually doubtful that the thesis about universal human striving for authenticity is true. Secondly, individuals can identify with all sorts of desires, many of them being widely recognized as wrong. It would therefore be helpful to know how one should choose the first order desires that one may identify with. Neither Dworkin nor Frankfurt do that.

Dworkin and Frankfurt's concept of autonomy would be mistaken even if they did provide standards for choice of desires one may justifiably identify with. The reason is that the ideal of authenticity requires that individuals *actually* endorse certain first order desires. To do that, they would have to go through the process of explicit identification, and this may be a too demanding requirement for some individuals in some situation, which is sometimes painfully vivid in medical contexts. The conception of personal autonomy does not explain the value of autonomy but only presents a moral ideal.

It is not my intention to argue that the ideal of autonomy, however understood, is mistaken. It should, however, be noted that unless a compel-

ling conception of the value of autonomy is provided, one cannot assume that it will be valid for every individual. Until such a conception is provided, one cannot just assume that every patient values personal autonomy,[2] and so that an effective justification of seeking patient consent has been offered. Relying on an unjustified ideal can lead at best to useless practices and at worst to serious wrongdoings, in both cases turning into prejudice. For patients who share this ideal, seeking their consent is an empty ritual of the like-minded. For patients who do not value autonomy, seeking their consent in order to respect their autonomy must mean forcing them to live by standards they do not accept.

The difficulties discussed so far are in a large measure consequences of the fact that the two concepts of autonomy as self-determination had been derived uncritically from contexts which are significantly different from the context of the patient-physician relationship. The concept of action autonomy obviously originated in research contexts in which the subject's liberty and rights are endangered. As Faden and Beauchamp clearly show in the first, historical part of their book, the doctrine of informed consent was initially put forward in response to the atrocities of the medical experiments conducted during the Second World War. The victims of those experiments were harmed because they did not accept the sufferings they went trough, that is, because they did not see these sacrifices as part of their own good. The concept of personal autonomy clearly derives from the modern democratic political culture and consumerism which is clearly associated with it [cf. Jonsen 1, pp. 116–119; Jonsen 2; Rothmann]. One of the moral foundations of both is the ideal of citizen self-determination.

The therapeutic relationship between physician and patient is different from both research relationship and the relationship between citizens of modern states. In research it is the researcher who initiates the relationship and whose good – i.e. scientific success – is the primary reason for the initiation of the relationship. In therapeutic relationship however, it is the patient's good that is at stake. The patient seeks medical advice and so it is her who initiates the relationship. Since the patient initiates the relationship she is concerned about her own good, that is, she wants to return to health. Patients strive for their own good in a way which is significantly different from the way in which citizens pursue their good. Citizens are usually self-sufficient, capable of self-defense and equal as negotiators. Patients are typically much more dependent than physicians, much more vulnerable, and their bargaining power is significantly lower that that of physicians.

[2] Actually, research suggests that patients' attachment to autonomy is not as widespread as one might suppose based on the mainstream bioethical literature [e.g. Ende et al., pp. 23–30; Nease, Brooks, pp. 593–600; Strull et al., pp. 2990–1994.

If we remember the distinctiveness of the physician-patient relationship we will see that autonomy understood as self-determination cannot be the reason for seeking patient consent. A sick person becomes a patient when he requests physician's expertise and if the physician is willing to provide him services which he believes are within her professional expertise. Once we observe that it is patient's search for professional help together with the physician's willingness to provide it that constitute authorisation, it will become clear that the role of patient consent to medical procedures cannot equal authorisation.

A physician-patient relationship is initiated by their mutual concern for the good of the patient. To see why the point of informed consent should be seen in the patient's good rather than in self-determination, one needs to observe that their understandings of that good may be significantly different. The differences of perception of the patient's problem can be seen when we focus on serious, chronic and incurable diseases. In such cases the life situation of the physician is usually sufficiently different from that of the patient to make it clear that there is a pressing need to establish the nature of the patient's problem and what, if any, ways of medical treatment are available.

To make the differences in perspectives more visible we can use ideal models of the patient's and the physician's perspectives.[3] Since they are ideal models, they may never have exact empirical instantiations but their elements are usually present to some extent in every case of a serious disease. For the patient her illness is a disruption in life, which she perceives as an evil as judged from the perspective of her life plans. The plans are frustrated and need to be changed or abandoned altogether if her life is to continue. Since her understanding of the evil of illness is seen from the perspective of patient's life plans, her illness is a unique and personal phenomenon which needs to be explained in terms of her past and accommodated in the future.

In the perspective of physician a patient's illness is a standard event in his both professional and personal life. He sees the disease as an evil but in a less emotional and more conceptual way. For the physician the evil of the disease is not unique and personal. His knowledge requires him to see the disease as a repeatable event capable of generalised and standardised description and treatment. The disease appears to the physician as an instance of a class. He does not see the patient's disease as an element of the patient's life narrative but as a detached and single event.

As I already said, the descriptions of the two perspectives present ideal models and so they are schematic, clearly not universal and perhaps simp-

[3] In what follows I rely on [Toombs].

lified. They should be treated as repertoires of components of the two perspectives which can be present in particular relationships in various configurations. Whatever their weaknesses and limitations, the models show the point of seeking informed consent. It is the difference in perspectives that makes it necessary to seek patient's consent in order to find a shared conception of that good rather than to respect a right to self-determination. This good may be complex and heterogeneous, depending on who participates in the physician-patient relationship. It is easy to imagine that for patients who value self-determination the good may be identical with their autonomy. But in the case of patients for whom self-determination is not a priority their good can be of a different, perhaps much more complex nature. For still other and, I think, the majority of patients their good may be a combination of autonomy in their both versions with other moral values.

The view that the purpose of seeking informed consent is to establish a shared conception of the patient's good in a particular case of the physician-patient relationship requires a modification and an expansion of our understanding of informed consent. The modification is that informed consent is not consent anymore. It is not patient's consent because the patient is not seen as a passive participant of the relationship who is supposed to say yes or no to the physician's proposals. The patient is an active participant in the relationship who brings an important input that provides a basis for a structuring of the relationship. The patient reaches an agreement with the physician rather than consents to physician's proposals. The agreement is conditional on both the patient's expectations and the physician's ability to satisfy them. It is informed mutual agreement.

The expansion of our understanding of informed consent is that agreement must be governed by rational standards and not simply by one or more moral values. Since actual patients may have various moral beliefs, a justification of informed agreement cannot presuppose shared moral beliefs that shape the process of reaching agreement. If such a framework of moral values were presupposed seeking agreement would be oppressive to those who do not share it and empty for those who do. If the agreement is to avoid the two dangers an account of it must provide minimal standards of reaching agreement, and these standards must not be reducible to a set of presupposed moral beliefs as it was the case in the two concepts of autonomy discussed earlier.

As I already said, the problem with the two conceptions of autonomy was that they presupposed a moral perspective without being able to provide its justification. For this reason the two conceptions are acceptable only to those who happen to share a particular moral perspective. An account of agreement that avoids exclusion of those with different moral beliefs would

have to be based on principles that are acceptable to all concerned, independently of their particular moral perspectives. It would have to include conceptual devices that allow both the patient and the physician to bring in their moral beliefs and test them from the point of view of their acceptability to all concerned.

The proposal of an expanded account of informed consent is essentially Kantian. It is Kant's theory of practical deliberation that requires acceptability of principles to all, i.e. universalisability of principles of interaction, and that relies on the concept of a maxim which is the required conceptual device for including diverse beliefs in that deliberation.[4] Such principles would set limits on consent but not in the way in which it is done by the two concepts of autonomy, that is, by assuming a set of particular moral beliefs, but by governing the process of reaching agreement. The result of such an agreement would not be a *modus vivendi* resultant from mere willingness to participate in the relationship but a mutual agreement whose boundaries are rationally defensible.

The proposed account of informed consent would be based on principles which are autonomous in a way that is much richer than autonomy of action or person because their validity would not depend on convergence of desires and/or moral beliefs. Such principles would be autonomous in that they would not need actual endorsement by anyone. In Kantian autonomy *auto* refers to *nomos*. Autonomous principles are self-justified; they are not justified – as we could see in the concepts of action and personal autonomy – by anyone's self. Such principles are autonomous in the way analogons to the original Greek sense: independence from other city-states and the will of a tyrant. Kantian autonomy is independence of principles from others' beliefs and from the tyranny of one's own unreason.

Bibliography

[Bratmann] M. Bratmann, *Intention, Plans, and Practical Reason*, Cambridge, Mass. 1987.

[Dworkin] G. Dworkin, *The Theory and Practice of Autonomy*, Cambridge 1988.

[Ende et al.] J. Ende, L. Kazis, A. Ash, M. A. Moskowitz, *Measuring Patients' Desire for Autonomy: Decision Making and Information Seeking Preferences among Medical Patients*, in: "Journal of General Internal Medicine" 1989, Vol. 4 (1).

[Faden, Beauchamp] R. R. Faden, T. L. Beauchamp, *A History and Theory of Informed Consent*, New York–Oxford 1986.

[Frankfurt 1] H. Frankfurt, *Freudom of the Will and the Koncept of the Person*, in: "The Journal of Philosophy" 1971, Vol. 68.

[4] I rely here on the constructivist interpretation offered by [O'Neill]; I developed some aspects of this interpretation in [Łuków 1, pp. 204–221] and further in the book mentioned in footnote 1 above.

[Frankfurt 2] H. Frankfurt, *The Importance of What We Care About*, in: "Synthese" 1982, Vol. 53.
[Jonsen 1] A. R. Jonsen, *A Short History of Medical Ethics*, New York–Oxford 1999.
[Jonsen 2] A. R. Jonsen, *Introduction to the History of Bioethics*, in: N. S. Jecker (ed.), *Bioethics: An Introduction to the History, Methods, and Practice*, Sudbury 1997.
[Łuków 1] P. Łuków, *Granice zgody: autonomia zasad i dobro pacjenta*, Warszawa 2005.
[Łuków 2] P. Łuków, *The Fact of Reason. Kant's Passage to Ordinary Moral Knowledge*, in: "Kant-Studien" 1993, Vol. 84.
[Nease, Blair Brooks] R. Nease Jr., W. Blair Brooks, *Patient Desire for Information and Decision Making in Health Care Decisions: the Autonomy Preference Index and the Health Opinion Survey*, in: "Journal of General Internal Medicine" 1995, Vol. 10 (11).
[O' Neill] O. O'Neill, *Constructions of Reason*, Cambridge 1989.
[Rothman] D. J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, New York 1991.
[Strull et al.] W. M. Strull, B. Lo, G. Charles, *Do Patients Want to Participate in Medical Decision Making?*, in: "The Journal of the American Medical Association" 1984, Vol. 252 (21).
[Toombs] K. S. Toombs, *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient*, Dordrecht–Boston 1992.
[van Orman Quine] W. van Orman Quine, *Reference and Modality*, in: *From a Logical Point of View. Nine Logico-Philosophical Essays*, Cambridge 1961.

Paweł Łuków

Granice zgody

Doktryna świadomej zgody jest moralnym fundamentem współczesnej medycyny i jednym z kluczowych zagadnień bioetycznych. Podstawą tej doktryny jest teza głosząca, że świadoma zgoda pacjenta upoważnia lekarza do podjęcia postępowania medycznego. Teza ta nie podlega w zasadzie dyskusji. Poważne wątpliwości pojawiają się, gdy pytamy o potrzebę takiego upoważnienia. Najczęstsza odpowiedź brzmi, iż zabiegając o świadomą zgodę pacjenta, respektujemy jego prawo do decydowania o sobie, czyli jego autonomię. Autonomia uznana jest za centralną wartość moralną. Jakiekolwiek inne wartości mogą być istotne, ale to autonomia jest kluczem do określenia właściwej relacji pacjent – lekarz. Autor niniejszego artykułu poddaje w wątpliwość taki pogląd. Analizuje dwie główne koncepcje pojęcia autonomii: autonomii działania i autonomii osoby, oraz stawia tezę, że żadna z nich nie wyjaśnia, na czym polega wartość autonomii i w związku z tym nie wskazuje, dlaczego lekarze winni zabiegać o zgodę pacjenta. Ideał autonomii, na podstawie którego zbudowana jest doktryna świadomej zgody, został zapożyczony z obszarów w istotny sposób różnych od tego obszaru, w którym znajdujemy relację pacjent – lekarz. Aby uporać się z problemami wynikającymi z powyższego, autor dystansuje się od idei zgody, a skupia się na pojęciu porozumienia. Próba poszukiwania porozumienia między pacjentem a lekarzem nie jest uzasadniona potrzebą ochrony uprzywilejowanych wartości moralnych (czy to autonomii, czy innej wartości), lecz podyktowana jest potrzebą ustalenia, co jest dobre dla pacjenta, będącego w relacji z lekarzem. Dobro pacjenta ma być wyznaczone za pomocą zasad, które określają granice tego, na co można w sposób uprawniony przystać. Obraz porozumienia przedstawiony jest przez autora w duchu myśli kantowskiej.