Autonomy & the Refusal of Lifesaving Treatment

by BRUCE L. MILLER

Contemporary, normative ethics—both theoretical and applied—has reacted against utilitarianism because of its tendency to regard the individual as little more than a recipient of good and evil. To avoid the pernicious effect of this notion, many philosophers have insisted that the concept of a person as an autonomous agent must have a central and independent role in ethical theory.[1] From this position there is firm ground to resist coercion and its less forceful, but more pervasive, cousins: manipulation and undue influence. It also provides a warrant for treating a person's own choices, plans, and conception of self as generally dominant over what another believes to be in that person's best interest.

In biomedical ethics, the concept of a person as an autonomous agent places an obligation on physicians and other health professionals to respect the values of patients and not to let their own values influence decisions about treatment. The conflict of patient values and physician values becomes most troublesome when a patient refuses treatment needed to sustain life and a physician believes that the patient should be treated. The conflict can be resolved by taking a firm line on autonomy: any autonomous decision of a patient must be respected. On the other hand, the physician's obligation to preserve life can be placed above the patient's right to autonomy and refusals of treatment can then be overridden when they conflict with "medical judgment."[2] The notion of medical judgment used here is not clear, and it may only be a gloss for "what doctor thinks best." Neither extreme position is tenable; both are insensitive to the complexities of such cases, and the second removes the right to autonomy altogether. But, the conflict between autonomy and medical judgment is not as sharp as it seems.

Four Cases

Consider the following cases.

CASE 1. *A doctor, sixty-eight years of age, had been retired for five years after severe myocardial infarction. He was admitted to a hospital after a barium meal had shown a large and advanced carcinoma of the stomach. Ten days after palliative gastrectomy was performed, the patient collapsed with a massive pulmonary embolism and an emergency embolectomy was done on the ward. When the patient recovered, he asked that if he had a further cardiovascular collapse no steps should be taken to prolong his life, for the pain of his cancer was more than he would needlessly bear. He wrote a note to this effect in his case records and the hospital staff knew of his feelings.*[3]

CASE 2. *A forty-three-year-old man was admitted to the hospital with injuries and internal bleeding caused when a tree fell on him. He needed whole blood for a transfusion but refused to give the necessary consent. His wife also refused. Both were Jehovah's Witnesses, holding religious beliefs that forbid the infusion of whole blood. The hospital lawyer brought a petition to the home of a judge. The patient's wife, brother, and grandfather were present to express his strong religious convictions. The grandfather said that the patient "wants to live very much . . . He wants to live in the Bible's promised new world where life will never end. A few hours here would nowhere compare to everlasting life." The judge was concerned with the patient's capacity to make such a decision in light of his serious condition. She recognized the possibility that the use of drugs might have impaired his judgment. The hospital lawyer replied that the patient was receiving fluid intravenously but no drugs that could impair his judgment. He was conscious, knew what the doctor was saying, was aware of the consequences of his decision, and had with full understanding executed a statement refusing the recommended transfusion and releasing the hospital from liability. The judge went to the patient's bedside. She asked him whether he believed that he would be deprived of the opportunity for "everlasting life" if transfusion were ordered by the court. His response was, "Yes. In other words, it is between me and Jehovah; not the courts . . . . I'm willing to take my chances. My faith is that strong . . . . I wish to live, but not with blood transfusions. Now get that straight." The patient had two young children. There was a family business and money to provide for the children, and a large family willing to care for them.*[4]

CASE 3. *A thirty-eight-year-old man with mild upper respiratory infection suddenly developed severe headache, stiff neck, and high fever. He went to an emergency room for help. The diagnosis was pneumococcal meningitis, a bacterial meningitis almost always fatal if not treated. If treatment is delayed, permanent neurological damage is likely. A physician told the patient that urgent treatment was needed to save his life and forestall brain damage. The patient refused to consent to treatment saying that he wanted to be allowed to die.*[5]

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CASE 4. *A fifty-two-year-old married man was admitted to a medical intensive care unit (MICU) after a suicide attempt. He had retired two years earlier because of progressive physical disability related to multiple sclerosis (MS) during the fifteen years before admission. He had successfully adapted to his physical limitations, remaining actively involved in family matters with his wife and two teenage sons. However, during the three months before admission, he had become morose and withdrawn. On the evening of admission, while alone, he had ingested an unknown quantity of diazepam. When his family returned six hours later, they found the patient semiconscious. He had left a suicide note. On admission to the MICU, physician examination showed several neurologic deficits, but no more severe than in recent examinations. The patient was alert and fully conversant. He expressed to the house officers his strong belief in a patient's right to die with dignity. He stressed the "meaningless" aspects of his life related to his loss of function, insisting that he did not want vigorous medical intervention should serious complications develop. This position appeared logically coherent to the MICU staff. However, a consultation with members of the psychiatric liaison service was requested. During the intitial consultation the patient showed that the onset of his withdrawal and depression coincided with a diagnosis of inoperable cancer in his mother-in-law, who lived in another city. His wife had spent more and more time satisfying her mother's needs. In fact, on the night of his suicide attempt, the patient's wife and two sons had left him alone for the first time to visit his mother-in-law.*[6]

In the first two cases, the most compelling intuition is to respect the refusal of treatment. The patients are competent, exercising their right of autonomy to refuse treatments they believed not in their interest. The patient in Case 1 believed further resuscitation was needless, for it would only briefly prolong a life of great suffering. His concern was for life on earth. The patient in Case 2 believed the transfusions would deprive him of salvation. His concern for life hereafter made whatever life on earth he could get from the transfusions insignificant. In Case 2 the Superior Court and the Court of Appeals recognized the patient's right to refuse transfusion and none was given. Though the patient's chances were thought very slim, he recovered and was discharged from the hospital. In Case 1, two weeks after the embolectomy the patient suffered acute myocardial infarction; his heart was restarted five times in one night. He recovered to linger for three weeks in a coma. On the day his heart stopped, plans were being made to put him on a respirator. The Jehovah's Witness was fortunate, retaining his life on earth without risking the loss of life everlasting. The physician was not so lucky; his right to an autonomous decision concerning the manner of his own death fell victim to the technological imperative—"If you *can* do it, you *should* do it."

Cases 3 and 4, however, incline to the view that patient autonomy may be overriden by medical judgment. In Case 3 there is no apparent reason to justify the death of this otherwise healthy victim of meningitis. His medical condition is not hopeless, as was the condition of the doctor in Case 1, nor does he have a religious objection to treatment like the Jehovah's Witness in Case 2. Our intuition is to treat him against his will. In Case 4 the patient's disability may give us pause; it does prevent a full life, yet he had managed until his mother-in-law became ill and the family began attending to her needs. We might expect that family discussion of the problem could lead to a resolution that would restore the patient's desire to live.

At first glance the position that although there is a right to autonomy from which patients can refuse lifesaving treatment, the right is not absolute and sometimes medical judgment can override it is a tenable one; for there is nothing surprising about a right that is not absolute.[7] However, acknowledging the limits of rights does not mean that rights can be overriden when their exercise conflicts with others' judgments. If medical judgment can override the right to refusal of treatment, then all four patients should have been treated against their will, for in each case a physician believed that the patient should be treated. If this is implausible, given our intuitions on Cases 1 and 2, then we have to say that autonomy is supreme and the refusals of lifesaving treatment should have been respected in all four cases.

One way around this impasse is to develop a list of conditions that must be taken into account to determine whether a refusal of treatment should be respected,[8] for example, age of the patient, life expectancy with and without treatment, the level of incapacity with and without treatment, the degree of pain and suffering, the effect of the time and circumstances of death on family and friends, the views of the family on whether the patient should be treated, the views of the physician and other medical staff, and the costs of treatment. This is a plausible approach; with it the refusal of treatment for meningitis can be justifiably overriden and the refusal of treatment for the doctor suffering from cancer justifiably respected. The meningitis patient is young and will recover without residual defect to lead a full life; the cancer patient will die soon in any case, is suffering greatly, and even though resuscitated is not likely to survive with a capacity for conscious awareness.

The problem with this approach is twofold. First, the list of characteristics is so vague, and hence subject to alternative interpretations, that the right to autonomy, and with it the right to refuse lifesaving treatment, can again be overruled. In practice it might turn out that refusals of treatment would be respected only if there were few negative consequences and everyone agreed with the decision. Second, this view shifts the focus from the patient's refusal to the patient's condition. Appealing to a list of diagnostic and prognostic features and to the consequences for others of treatment versus nontreatment makes the decision one

about the patient rather than one *by* the patient. The patient's refusal becomes simply one of many factors to weigh in arriving at a decision. But the thrust of placing the patient's right to autonomy in the forefront of medical ethics is to counteract just that tendency to secure those decisions *for* patients that are appropriately theirs. An approach that preserves this priority must be developed.

Four Senses of Autonomy

If the concept of autonomy is clarified, we will have a more rigorous understanding of what the right to autonomy is and what it means to respect that right, thus illuminating the problems regarding refusals of lifesaving treatment. At the first level of analysis it is enough to say that autonomy is self-determination, that the right to autonomy is the right to make one's own choices, and that respect for autonomy is the obligation not to interfere with the choice of another and to treat another as a being capable of choosing. This is helpful, but the concept has more than one meaning. There are at least four senses of the concept as it is used in medical ethics: autonomy as free action, autonomy as authenticity, autonomy as effective deliberation, and autonomy as moral reflection.[9]

Autonomy as free action. Autonomy as free action means an action that is voluntary and intentional. An action is voluntary if it is not the result of coercion, duress, or undue influence. An action is intentional if it is the conscious object of the actor. To submit oneself, or refuse to submit oneself, to medical treatment is an action. If a patient wishes to be treated and submits to treatment, that action is intentional. If a patient wishes not to be treated and refuses treatment, that too is an intentional action. A treatment may be a free action by the physician and yet the patient's action is not free. If the meningitis victim is restrained and medication administered against his wishes, the patient has not voluntarily submitted to treatment. If the patient agrees to pain relief medication, but is given an antibiotic without his knowledge, the patient voluntarily submitted to treatment, but it was not a free action because he did not intend to receive an antibiotic. The doctrine of consent, as it was before the law gave us the doctrine of *informed* consent, required that permission be obtained from a patient and that the patient be told what treatment would be given; this maintains the right to autonomy as free action. Permission to treat makes the treatment voluntary and knowledge of what treatment will be given makes it intentional.

Autonomy as authenticity. Autonomy as authenticity means that an action is consistent with the person's attitudes, values, dispositions, and life plans. Roughly, the person is acting in character. Our inchoate notion of authenticity is revealed in comments like, "He's not himself today" or "She's not the Jane Smith I know." For an action to be labeled "inauthentic" it has to be unusual or unexpected, relatively important in itself or its consequences, and have no apparent or proffered explanation. An action is unusual for a given actor if it is different from what the actor almost always (or always) does in the circumstances, as in, "He always flies to Chicago, but this time he took the train." If an action is not of the sort that a person either usually does or does not do, for example, something more like getting married than drinking coffee, it can still be a surprise to those who know the person. "What! George got married?"

A person's dispositions, values, and plans can be known, and particular actions can then be seen as not in conformity with them. If the action is not of serious import, concern about its authenticity is inappropriate. To ask of a person who customarily drinks beer, "Are you *sure* you want to drink wine?" is to make much of very little. If an explanation for the unusual or unexpected behavior is apparent, or given by the actor, that usually cuts off concern. If no explanation appears on the face of things or if one is given that is unconvincing, then it is appropriate to wonder if the action is really one that the person wants to take. Often we will look for disturbances in the person's life that might account for the inauthenticity.

It will not always be possible to label an action authentic or inauthentic, even where much is known about a person's attitudes, values, and life plans. On the other hand, a given disposition may not be sufficiently specific to judge that it would motivate a particular action. A generous person need not contribute to every cause to merit that attribute. If a person's financial generosity is known to extend to a wide range of liberal political causes, not making a contribution to a given liberal candidate for political office may be inauthentic. On the other hand, most people have dispositions that conflict in some situations; an interest in and commitment to scientific research will conflict with fear of invasive procedures when such an individual considers being a subject in medical research. Many questions about this sense of autonomy cannot be explored here, for example, whether there can be authentic conversions in a person's values and life plans.

Autonomy as effective deliberation. Autonomy as effective deliberation means action taken where a person believed that he or she was in a situation calling for a decision, was aware of the alternatives and the consequences of the alternatives, evaluated both, and chose an action based on that evaluation. Effective deliberation is of course a matter of degree; one can be more or less aware and take more or less care in making decisions. Effective deliberation is distinct from authenticity and free action. A person's action can be voluntary and intentional and not result from effective deliberation, as when one acts impulsively. Further, a person who has a rigid pattern of life acts authentically when he or she does the things we have all come to expect, but without effective deliberation. In medicine, there is no effective deliberation if a patient believes that the physician makes all the decisions. The doctrine of *informed* consent, which requires that the patient be informed of the risks and

benefits of the proposed treatment and its alternatives, protects the right to autonomy when autonomy is conceived as effective deliberation.

Gerald Dworkin has shown that an effective deliberation must be more than an apparently coherent thought process.[10] A person who does not wear automobile seat belts may not know that wearing seat belts significantly reduces the chances of death and serious injury. Deliberation without this knowledge can be logically coherent and lead to a decision not to wear seat belts. Alternatively, a person may know the dangers of not wearing seat belts, but maintain that the inconvenience of wearing them outweighs the reduced risk of serious injury or death. Both deliberations are noneffective: the first because it proceeds on ignorance of a crucial piece of information; the second because it assigns a nonrational weighting to alternatives.

It is not always possible to separate the factual and evaluative errors in a noneffective deliberation. A patient may refuse treatment because of its pain and inconvenience, for example, kidney dialysis, and choose to run the risk of serious illness and death. To say that such a patient has the relevant knowledge, if all alternatives and their likely consequences have been explained, but made a nonrational assignment of priorities, is much too simple. A more accurate characterization may be that the patient fails to appreciate certain aspects of the alternatives. The patient may be cognitively aware of the pain and inconvenience of the treatment, but because he or she has not experienced them, may believe that they will be worse than they really are. If the patient has begun dialysis, assessment of the pain and inconvenience may not take into account the possibilities of adapting to them or reducing them by adjustments in the treatment.

In order to avoid conflating effective deliberation with reaching a decision acceptable to the physician, the following must be kept in mind: first, the knowledge a patient needs to decide whether to accept or refuse treatment is not equivalent to a physician's knowledge of alternative treatments and their consequences; second, what makes a weighting nonrational is not that it is different from the physician's weighting, but either that the weighting is inconsistent with other values that the patient holds or that there is good evidence that the patient will not persist in the weighting; third, lack of appreciation of aspects of the alternatives is most likely when the patient has not fully experienced them. In some situations there will be overlap between determinations of authenticity and effective deliberation. This does not undercut the distinctions between the senses of autonomy; rather it shows the complexity of the concept.

Autonomy as moral reflection. Autonomy as moral reflection means acceptance of the moral values one acts on.[11] The values can be those one was dealt in the socialization process, or they can differ in small or large measure. In any case, one has reflected on these values and now accepts them as one's own. This sense of autonomy is deepest and most demanding when it is conceived as reflection on one's complete set of values, attitudes, and life plans. It requires rigorous self-analysis, awareness of alternative sets of values, commitment to a method for assessing them, and an ability to put them in place. Occasional, or piecemeal moral reflection is less demanding and more common. It can be brought about by a particular moral problem and only requires reflection on the values and plans relevant to the problem. Autonomy as moral reflection is distinguished from effective deliberation, for one can do the latter without questioning the values on which one bases the choice in a deliberation. Reflection on one's values may be occasioned by deliberation on a particular problem, so in some cases it may be difficult to sort out reflection on one's values and plans from deliberation using one's values and plans. Moral reflection can be related to authenticity by regarding the former as determining what sort of person one will be and in comparison to which one's actions can be judged as authentic or inauthentic.

Resolving Apparent Conflicts

The distinction of four senses of autonomy can be used to resolve the apparent conflict between autonomy and medical judgment that the four cases generate. The action of the Jehovah's Witness in Case 2 is autonomous in at least three of the senses. It was a free action because it was voluntary and intentional. The patient was not being coerced and knew what he was doing. It was an authentic action because it was demanded by a strongly held religious belief. A Jehovah's Witness who accepted transfusion under the circumstances would be regarded as one who lacked the strength of commitment to resist earthly temptations; this would not be cause for blame, for it is understandable and, if you are not a Jehovah's Witness, commendable. The action was the result of effective deliberation because the patient knew he had a choice, was aware of the alternatives and their consequences, evaluated them on his values, and made a choice. The situation was so clear and his belief so strong that the deliberation probably did not take much time and thought; effective deliberation is long and painstaking only when the matter for decision is perceived to be difficult. Whether the patient engaged in moral reflection is difficult to determine. The case is not sufficiently detailed to know whether the patient ever carefully reflected on his religious beliefs. One can have strong beliefs without ever having thought carefully about them. Further, since no position has been taken on just what the standards for adequate moral reflection are, it is not possible to make a determination even if all the facts were there. Whether one can, or should, choose a life plan or a religious belief by reasoned inquiry (effective deliberation at the most general level) is a matter of controversy in philosophy and theology.

In Case 1, the physician with cancer, the refusal of treatment was a free action, authentic, and the result of effective

deliberation. The decision to treat the patient after he had refused resuscitation in the event of cardiovascular collapse was clearly a violation of his autonomy. He did not voluntarily submit to treatment; he was treated against his will even though no force or threat of force had to be used. He did not intend to submit to treatment, his conscious desire was not to be treated. The authenticity of the refusal of treatment is less a matter of identifying a particular strong belief and showing that the action is in accord with it, than it is a matter of the patient announcing that further resuscitation would incur needless suffering. Because this patient is a physician who has seen such suffering and is now undergoing it, it is more likely that the assertion is coming from the patient's values, and not as something that is not an authentic expression of himself. The refusal also appears to be the result of effective deliberation: the patient knew the alternatives and their consequences, his assessment and weighting of them cannot be regarded as nonrational or a lack of appreciation. Again we do not know whether and how this patient has reflected on the fundamental values that determine his judgment, but to require that he subject them to some sort of reflection before his wishes have to be respected would be to set the standards of autonomy too high.

In Case 4, the man with MS who attempted suicide, the action of the patient is a free action, that is, voluntary and intentional, and it is the result of effective deliberation, but it is not authentic. This was the outcome of the case:

The patient had too much pride to complain to his wife about his feelings of abandonment. He was able to recognize that his suicide attempt and his insistence on death with dignity were attempts to draw the family's attention to his needs. Discussion with all four family members led to improved communication and acknowledgment of the patient's special emotional needs. After these conversations, the patient explicitly retracted both his suicidal threats and his demand that no supportive medical efforts be undertaken.[12]

It is tempting to say that the actions of the patient, the suicide attempt and the refusal of treatment, were not free actions because they were neither voluntary nor intentional. Even though the patient was not coerced directly by another, he was pressured into the actions by his condition and the circumstances of his mother-in-law's terminal illness. Further, it was not an intentional action because he did not *really* want to die; he wanted attention and support. This position is not defensible. First, the claim that the actions were not voluntary rests on the fact that the pressure of circumstances as a motivating factor can be as strong as the direct threat of another person. Indeed, it is easy to imagine cases where it would be stronger. It is important to preserve a clear and distinct concept of voluntariness, and treat similar but distinguishable situations under a different rubric.

Second, the claim that his action was not intentional, that is, not his conscious object, is wrong for two reasons. It fails to distinguish the action of taking the overdose of diazepam from his saying that he wanted no treatment and that he wanted to die with dignity. It was his conscious desire to take the diazepam and to refuse treatment; whether it was his conscious desire to die with dignity is a separate matter. Its answer requires adducing considerations that belong to the notion of autonomy as authenticity. The belief that the patient did not want to die depends on knowing that he had gotten on very well for many years, that his change of view was coincident to the illness of his mother-in-law and the family's attention to her, that a desire to die is not consistent with the values revealed by the past several years of the patient's life, and that there is no apparent or proffered explanation of a change in values but instead an explanation of the alleged desire for death with dignity as a way of asserting his demands on his family. His suicide attempt, the taking of diazepam, and refusal of treatment were free actions, but they were not authentic.

The claim that the patient's taking of diazepam was the result of effective deliberation is more difficult to defend. The hospital staff regarded the explanation as logically coherent, but the appearance of logical coherence is not sufficient for effective deliberation. If the patient lacked relevant knowledge, made a nonrational assignment of weights to alternatives or failed to appreciate one of the alternatives or its consequences, then the decision to take an overdose and request that lifesaving measures not be started would not be the result of effective deliberation. The case description lacks the detail required to reach a definite conclusion on all of these. The most difficult is whether the patient overestimated the difficulty of continuing his life as a victim of MS; it is hard to imagine that he lacked knowledge, and even though we might regard his weighting of death versus continued life in his condition as mistaken, the severity of his condition and the difficulty of coping with it do not readily support a claim that it is not a rational weighting. Further, he is the person with MS and he is the one who has suffered it for fifteen years; for another person to believe that the patient fails to appreciate the severity of his condition seems on its face to discount the most relevant experience. On the other hand, his appreciation at the time of the attempted suicide might be said to have been altered by the perceived threat to his care and comfort. More information is required to decide this; even if his action is ultimately regarded as the result of effective deliberation, it is still not authentic. One might even say that the lack of authenticity influences the effectiveness of the deliberation. More strongly, if an action is not authentic, whether it is the result of effective deliberation becomes somewhat irrelevant; it is rather like asking whether a person effectively decided a matter based on values or plans that were not his own. As in the other cases, we have no clear evidence that the patient ever engaged in moral reflection, or if he did that the values and life plans he reflected about had direct bearing on the issues presented by his attempted suicide. It does seem that a person who has

had to manage his life with a seriously debilitating illness must have given some thought to what is important to him and what sort of life plan is suited to him.

In the case of the patient in the emergency room with meningitis, his refusal of treatment is autonomous in the sense of free action. But is it authentic and the result of effective deliberation? This is difficult to determine unless someone in the emergency room knew the patient well or is able to get to know the patient well. Presumably no one knows him and there is not enough time to get to know him; if treatment is delayed there is risk of brain damage and death. Assuming that the patient has the capacity for autonomy in all four senses, treating him would be contrary to his autonomy in the sense of free action; whether it would be a violation of his autonomy in the senses of authenticity, effective deliberation, and moral reflection cannot be determined. Treating him would make possible his further deliberation on whether he wished to live. On balance, it is more respectful of autonomy, given all four senses, to treat him against his will. On the other hand, it might be argued that meningitis has made the patient incompetent. Though the patient has voluntarily and intentionally refused treatment, his disease has removed his capacity to act authentically or to effectively deliberate. If this is so, then the patient's refusal is not an autonomous action, and the obligation to respect the autonomy of patients would not be abridged by treating the patient against his wishes.

A Bridge between Paternalism and Autonomy

This discussion shows that there is no single sense of autonomy and that whether to respect a refusal of treatment requires a determination of what sense of autonomy is satisfied by a patient's refusal. It also shows that there need not be a sharp conflict between autonomy and medical judgment. Jackson and Youngner argue that preoccupation with patient autonomy and the right to die with dignity pose a "threat to sound decision making and the total (medical, social and ethical) basis for the 'optional' decision."[13] Sound decision making need not run counter to patient autonomy; it can involve a judgment that the patient's refusal of treatment is not autonomous in the appropriate sense. What sense of autonomy is required to respect a particular refusal of treatment is a complex question.

If a refusal of lifesaving treatment is not a free action, that is, is coerced or not intentional, then there can be no obligation to respect an autonomous refusal. It is important to note that if the action is not a free action then it makes no sense to assert *or* deny that the action was autonomous in any of the other senses. A coerced action cannot be one that was chosen in accord with the person's character and life plan, nor one that was chosen after effective deliberation, nor one that was chosen in accord with moral standards that the person has reflected upon. The point is the same if the action is not intentional. When a refusal of treatment is not autonomous in the sense of free action, the physician is obliged to see that the coercion is removed or that the person understands what he or she is doing. Is it possible that coercion cannot be removed or that the action cannot be made intentional? This could be the case with an incompetent patient, not externally coerced, but subject to an internal compulsion, or who lacked the capacity to understand his or her situation. For incompetent patients the question of honoring refusals of treatment does not arise; it is replaced by the issue of who should make decisions for incompetent patients, an issue beyond the scope of this article.

If a refusal of treatment is a free action but there is reason to believe that it is not authentic or not the result of effective deliberation, then the physician is obliged to assist the patient to effectively deliberate and reach an authentic decision. This is what happened in Case 4. It is not required that everyone bring about, make possible, or encourage another to act authentically and/or as a result of effective deliberation. Whether such an obligation exists depends on at least two factors: the nature of the relationship between the two persons and how serious or significant the action is for the actor and others. Compare the relationships of strangers, mere acquaintances, and buyer and seller on the one hand, with those of close friends, spouses, parent and child, physician and patient, or lawyer and client. To borrow, and somewhat extend, a legal term, the latter are fiduciary relationships; a close friend, parent, spouse, physician, or lawyer cannot treat the other person in the relationship at arms' length, but has an obligation to protect and advance the interests of the other. For example, we have no obligation to advise a mere acquaintance against making an extravagant and unnecessary purchase, though it is an option we have so long as we do not go so far as to interfere in someone else's business. The situation is different for a good friend, a close relative, or an attorney who is retained to give financial advice.

The other factor, the seriousness of the action, is relevant to medical and nonmedical contexts. If, inspired by the lure of a "macho" image, my brother impulsively decides to buy yet another expensive automobile, how I respond will depend on how it will affect him and his dependents. If a patient refuses a treatment that is elective in the sense that it might benefit him if done but will not have adverse consequences if not done, a physician can accept such a refusal even though it is believed not to be the result of effective deliberation. On the other hand, if the refusal of treatment has serious consequences for the patient, the physician has the obligation to at least attempt to get the patient to make a decision that is authentic and the result of effective deliberation. For the patient with meningitis who refuses treatment (Case 3) the consequences of the refusal are indeed serious, but there is no opportunity to determine whether the decision is authentic and the result of effective deliberation and, if not, to encourage and make possible an authentic and effectively deliberated decision.

A crucial issue is whether a refusal of lifesaving treatment that is autonomous in all four senses can be justifiably overridden by medical judgment. It will help here to compare the Jehovah's Witness case with a somewhat fanciful expansion of the meningitis case. The former's refusal is autonomous in three of the four senses and could be judged autonomous in the sense of moral reflection if we knew more about the patient's acceptance of his faith and had a clear idea of the criteria for moral reflection. Though the belief of Jehovah's Witnesses are not widely shared, and many regard as absurd the belief that accepting a blood transfusion is prohibited by biblical injuncton, their faith has a fair degree of social acceptance. Witnesses are not regarded as lunatics. This is an important factor in the recognition of their right to refuse transfusion. Suppose that the meningitis victim had a personal set of beliefs that forbid the use of drugs, that after years of reflection he came to the view that it was wrong to corrupt the purity of the body with foreign substances. Suppose that he acts on this belief consistently in his diet and medical care, that he has carefully thought about the fact that refusal in this circumstance may well lead to death, but he is willing to run that risk because his belief is strong. This case is parallel to the Jehovah's Witness case; the principal difference is that there is no large, organized group of individuals who share the belief and have promulgated and maintained it over time. One reaction is to regard the patient as mentally incompetent, with the central evidence being the patient's solitary stance on a belief that requires an easily avoided death. An alternative approach is to not regard the patient as incompetent, but to see treatment as justified paternalism. Finally, the position could be that a refusal of lifesaving treatment that is fully autonomous, that is, in all four senses, must be respected even though the belief on which it is founded is eccentric and not socially accepted. Which approach to take would require an analysis of incompetence, a definition of paternalism, and an examination of when it is justified.[14] Defining paternalism as an interference with autonomy in one or more of the four senses might be an illuminating approach.

The conflict between the right of the patient to autonomy and the physician's medical judgment can be bridged if the concept of autonomy is given a more thorough analysis than it is usually accorded in discussions of the problem of refusal of lifesaving treatment. In some cases where medical judgment appears to override autonomy, the four senses of autonomy have not been taken into account.

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[7]*Ibid.*, p. 408.

[8]Mark Siegler, "Critical Illness: The Limits of Autonomy" *Hastings Center Report* 8(1977), 12-15.

[9]Beauchamp and Childress, pp. 56-62; Donagan, p. 35; Gerald Dworkin, "Autonomy and Behavior Control," *Hastings Center Report* 6(1976), 23; and "Moral Autonomy" in H. Tristram Engelhardt and Daniel Callahan, *Morals, Science and Society*, (Hastings Center, 1978), p. 156; Harry G. Frankfurt, "Freedom of the Will and the Concept of a Person," *The Journal of Philosophy* 68(1971), 5; Bernard Gert and Timothy J. Duggan, "Free Will as the Ability to Will" *Nous* 13 (1979), 197; Charles Taylor, "Responsibility for Self" in Amelie Rorty, ed. *The Identities of Persons* (Berkeley: University of California Press, 1976).

[10]Gerald Dworkin, "Paternalism," in Richard A. Wasserstrom, ed. *Morality and the Law* (Belmont: Wadsworth Publishing Co., 1971).

[11]This brief account draws on Dworkin, "Moral Autonomy," and Taylor.

[12]Jackson and Youngner.

[13]*Ibid.*, p. 405.

[14]Dworkin, "Paternalism"; Bernard Gert and Charles M. Culver, "Paternalistic Behavior," *Philosophy and Public Affairs* 6(1976), 45; and "The Justification of Paternalism," in Wade L. Robison and Michael S. Pritchard, eds. *Medical Responsibility: Paternalism, Informed Consent, and Euthanasia* (Clifton, N.J.: Humana Press, 1979), pp. 1-14.