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# Ethics

## EXPLORING THE LIMITS OF AUTONOMY

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□ **Abstract—Background: The ethical principle of autonomy is explored as it applies to situations in which patients' capacities to make decisions are questionable. Case Report: A 40-year-old man presented to the Emergency Department with an epidural hematoma, and refused to undergo emergent surgical treatment. Considering the acutely life-threatening nature of his problem and the inability to confirm the patient's capacity in the presence of a traumatic brain injury, the decision was made to proceed with emergent surgical treatment without consent. Discussion: The concept of conditional autonomy is introduced, defined, and employed to defend the process whereby a select group of patients may be treated without full knowledge of their wishes. © 2011 Elsevier Inc.**

□ **Keywords—autonomy; physician-patient relationship; epidural hematoma**

### INTRODUCTION

The principle of autonomy, in the context of the doctor-patient relationship, is the foundation of contemporary medical ethics. The legal precedent for medical autonomy was set in 1914, decreeing that "every human being of adult years and sound mind has the right to determine what shall be done to his body" (1). Over the ensuing century, the medical profession has striven to evolve from its history of paternalism, and grant patients the opportunity to make the decisions that intimately have an impact upon their health (2).

In most cases, the "reasonable" patient, when confronted with the relative risks and benefits of a medical intervention, will usually agree with its necessity, and engage in an alliance with the health care providers. However, it is important in daily practice to maintain the true standard whereby all patients have the rights and responsibilities of self-determination, and the physician acts as a trusted advisor rather than as the primary decision-maker. Doctors are trained to strive for beneficence in their actions, and at times, the "right" decision is not necessarily the one with the greatest likelihood of treating pathology, but the one most consistent with the patient's desires (3).

### CASE REPORT

A previously healthy 40-year-old man presented to the Emergency Department complaining of a persistent headache and local swelling 24 h after an assault during which he was struck in the head with a piece of wood. The patient was afebrile, normotensive, and hemodynamically stable, with a heart rate and rhythm that were unremarkable. Physical examination did not reveal any focal neurological findings. The patient was conversationally appropriate and oriented to time, place, and person, but did not submit to a formal mental status assessment. A computed tomography scan of the head revealed a large epidural hematoma with evidence of localized brain compression. Neurosurgery was con-

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sulted, and the neurosurgeon recommended emergent surgical treatment. After the nature of his condition and the need for prompt treatment were explained to him, the patient refused to consent to the surgery, insisting that "I have to go" without providing any further elaboration.

Despite numerous attempts to explore his refusal as well as his understanding of the precarious nature of his condition, the patient refused to provide any specific explanation or rationale for his refusal to submit to surgery. A prolonged discussion did not yield any evidence of psychiatric impairment or cognitive disability apart from this decision. However, he did not clearly demonstrate that he understood the nature and consequences of his actions. During an assessment of his personal values, the patient agreed that he would certainly want an aggressive surgical intervention if he had presented exsanguinating from a bullet wound. However, he still refused to accept the danger of refusing brain surgery or to provide any window into his decision-making process. He did not have any companions present, nor did he identify any surrogate decision-maker, family members, or friends who could be called to assist him.

## DISCUSSION

### *Decision-making Capacity*

Before allowing a patient to make an autonomous decision, the caregiver must ensure that the patient is cognitively capable of acting on his or her own behalf. It is important to distinguish between competence, a legal standard addressed in court and decided by a judge, and capacity, which refers to decision-making abilities assessed by physicians, relevant to specific patient interactions. When performing an assessment of capacity, the examiner must balance a healthy respect for autonomy with the duty to protect the patient's interests, and recognize when these are incongruous.

The specific techniques involved in formally assessing a patient's capacity have been described in detail and are largely beyond the scope of this report (4–6). Briefly, they involve ensuring that patients are able to communicate a choice, understand relevant information, appreciate their current situation and its consequences, and manipulate information rationally. It is important to recognize that capacity is not always absolute. Simple decisions with relatively minor consequences may be made without formally assessing capacity, or even by patients with a clearly diminished level of comprehension. In contrast, a higher standard of capacity may be required to make more serious decisions rife with potentially dire sequelae (7–9). This patient did not convince his caregivers of his ability to comprehend, to process, and to manipulate the relevant clinical information necessary to make a decision of major importance, and thus he was judged to lack decision-making capacity. Further, the extreme nature of his injury and the need for speedy surgical intervention did not allow time to go to Court and seek appointment of a guardian. Court involvement was complicated both by the need for speed and the lack of anyone (family, friends) who would be able to act as a guardian. The Court would, if there had even been time for a petition and hearing, have had to appoint a stranger to act as guardian and that stranger would have been heavily influenced by the physician's evaluation that intervention was essential to save the patient's life.

### *Conditional Autonomy*

"A right is not effectual by itself, but only in relation to the obligation to which it corresponds . . ." (10). To override a patient's objections without a court order, two essential criteria must be satisfied: the patient must be deemed unable to make an independent decision (i.e., lacking capacity), and an immediately life- or health-threatening pathology must exist that requires emergent treatment (11,12). If patients are treated against their will in the absence of these conditions, they may rightly seek civil or criminal redress for their grievances.

This case reinforces the concept of conditional autonomy. In other words, a patient must first demonstrate capacity before being empowered with decision-making responsibilities. In addition, even in cases where patients have capacity and refuse treatment, our duty as physicians is not finished. Patients still must be provided with the opportunity to exercise informed consent. Patients must recognize the risks, benefits, and alternatives, including the decision to do nothing; this is the basis of making an informed decision. In reality, obtaining informed consent often occurs simultaneously with the assessment of capacity, but both must be completed in order for doctors to satisfy their duty to the patient, regardless of whether the recommended treatment plan is followed.

In this case, explaining the seriousness of the situation was not sufficient to convince the patient to proceed. The caregivers did not coerce him to submit to surgery by threatening forced action. Giving a patient a choice between voluntarily assenting to a procedure and being forced into it against his or her will does not result in an informed or autonomous decision. Rather, the capacity of the patient to make the decision must be assessed, and if it is not present, then the patient should be told that he or she has been judged to be not qualified to make a choice.

The distinction between assent and dissent is almost irrelevant when assessing capacity. It is the gravity of the choice at hand, and not just the existence of conflict between patient and doctor, that should dictate these

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