

**The Dentist-Patient Relationship:  
Re-modelling Autonomy for Dentistry**

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## **Abstract**

Previous work in the field of the clinician-patient relationship has relied on a generalized understanding of the ethical structure of the clinical relationship. This thesis seeks to rebut that presumption, by claiming that differing clinical relationships raise diverse ethical issues that call for specific ethical solutions. By looking closely at the primary dental care relationship this thesis will propose three specific instances where the dentist-patient relationship faces unique challenges. The thesis will also go on to establish the claim that the current reliance on a rational notion of autonomy; one that is firmly attached to the consent process, is unable to theoretically address and adequately support the issues raised in relation to the dentist-patient relationship.

This work considers, through philosophical enquiry, a number of theoretical alternatives and examines in detail the extent to which an alternative way of understanding the dentist-patient relationship might be more effective in addressing the matters of ethical concern raised and, as a consequence, be more ethically robust.

The thesis concludes that a separation between our understanding of promoting and protecting autonomy enables us to re-visit and develop a more appropriate model of autonomy for the dentist-patient relationship that relies on a moderated, negative libertarian view. This transforms and simplifies obligations to the patient by providing an account that operates as a constraint in the clinical setting with

our wish to promote autonomy being understood as the action of restoring health  
itself.

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## **Overview**

The purpose of this thesis is to unravel and re-construct our understanding of the ethical underpinnings and consequent duties in the dentist-patient relationship. Although this thesis will consider several theoretical frameworks it is the intention of this work to take an applied approach that is able to inform professional practice in dentistry. The thesis starts from the premise that previous work in the field of the clinician-patient relationship has often relied upon a generalized understanding of the ethical structure of the clinical relationship. This has resulted in a somewhat homogenous view of the challenges faced by clinicians as well as naturally resulting in broad-brush solutions to the ethical dilemmas and the associated theoretical frameworks relied upon to address these concerns.

So why is this question important and of concern? This thesis relies on three basic premises: that dentistry is a profession; that professional relationships are subject to special duties required of the professional; and that one of the central duties in clinical relationships is the requirement to respect patients by respecting autonomy.

This thesis starts from the premise that dentistry is a profession. Although professionalism has its own debates and difficulties with clear definition, one of its key characteristics is that certain additional rights and duties flow from relationships formed as a consequence of that professional relationship. That is to say, that someone engaging the services of a member of a profession might

reasonably expect a differing standard of behaviour than someone engaging a tradesman. Some evidence of this can be seen in the Law's recognition of the duty of care relationship that exists between patients and their clinicians. It is a patient's right to expect that a clinician must exercise reasonable care and skill in any interaction that occurs between them (*Bolam v Friern Hospital Management Committee* (1957)).

How we interpret those rights and duties has a key bearing on how we might wish to justify the existence of any profession and the extent to which we ought to be concerned about the relationship. In the clinical professions there has been much discussion about the way in which clinicians ought to interact with patients and what duties are owed to patients as part of that relationship. The current general consensus being that a clinician is required to observe a respect for persons approach. This approach is based on the concept of respect for autonomy coupled with a duty to protect those unable to be self-determining (U.S Department of Health and Human Sciences, 1979). Further, respect for autonomy is largely understood to mean respect for a person who is able to self-legislate or able to make a judgment based on their own set of values or beliefs.

### **Overview of chapters**

This thesis seeks to query and examine this 'blanket' approach to the clinical relationship and to argue that dentistry has its own unique ethical challenges and as such, requires its own, perhaps unique, solutions. In Chapter One, this will be achieved by looking closely at the dentist-patient relationship and considering

three specific instances where dentistry faces particular difficulties. It is hoped by doing so that an argument for a separate model of ethical interaction may be made as well as identifying what matters any future model must be able to address.

Chapter One begins with an assertion that in the clinical professions the clinician-patient relationship and the resulting duties that this relationship creates are understood in terms of a general and ill-defined account of personal autonomy. Further, that a clinician's duties, that is to say, what is required of them, are heavily dependent and stem from a requirement to respect a patient's autonomy during the course of that relationship. The starting point for this chapter is to claim that greater clarity is needed in order to adequately define the pursuant duties that flow from the clinical relationship, and that the current general reliance on an ill-defined concept of patient autonomy is insufficient. This chapter claims that lack of clarity may lead to such duties being inadequately applied, too broad to be deliverable or in the worst cases circumvented.

Chapter One sets out to develop this claim by considering three hypothetical case studies that are central to the delivery of primary dental care; those being the challenges faced by delivering NHS and private treatment in the same setting; the challenges of cosmetic dentistry; and the challenges posed by the use of skill mix (differing dental professionals delivering treatment in the same context). Each case study considers the challenges in detail and proposes issues that may be of moral concern. The chapter claims that these almost unique challenges raise

important issues that must be addressed in order to claim that the ethical duties of a dentist are adequately discharged in relation to patients.

The chapter concludes by identifying a set of concerns that are of particular interest and significance to the dentist-patient relationship. These concerns are the use of deception in the dentist-patient relationship, the ability to draw clear limits to any duties required of dentists, the ability to correctly prioritise a patient's reasonable wishes and adequate emphasis on the process of healthcare (as well as the outcome of treatment). Finally the chapter concludes by questioning to what extent our current understanding of respecting patients and our use of autonomy can adequately address these issues.

Chapter Two considers a case study, *The Redfern Report* (DoH, 2001) in order to provide legitimate professional context and to expose the normative claims prioritized by those considering the issues at hand. The aim of this chapter is to gain insight into how we currently construct the clinician-patient relationship and its duties. This will be achieved by examining how ethical issues are explained in the report as well as what solutions are provided. This chapter will go on to claim that we generally understand and discharge ethical duties by relying on a hierarchical model of autonomy. Hierarchical models of autonomy view autonomy as a capacity rather than feature of persons. This requires an authentic reflective process to endorse those desires. A consequence of this is that our understanding relies heavily on the transactional aspect of the clinical relationship. This might be expressed as the authorization of treatment through the consent process. The

thesis will also consider the limitations of this approach and to what extent such an approach meets the needs identified in Chapter One.

Chapter Two, in meeting its aims, exposes two key components of the way in which we understand respecting patients. First; the link between consent taking and autonomy and second; our reliance on the transactional aspects of consent to claim that we have effectively discharged our duty to respect patients and their autonomy.

First the chapter considers the important link between consent taking and respecting autonomy. The chapter quickly deals with current understanding that the requirement to take consent is underpinned by a duty to both protect and promote patient autonomy. It is the position in this chapter that this is a non-contentious claim noting that even for those who are sceptical as to the value of respecting patients through the reliance on autonomy, recognize that consent is the method by which this is largely delivered.

Chapter Two then goes on to examine in detail *The Redfern Report* (DoH, 2001). *The Redfern Report* (DoH, 2001) is important because it demonstrates how a breakdown in the clinician-patient relationship led to huge public controversy over the way patients were treated in the NHS. The purpose of this examination is to expose the manner in which a breakdown in the clinician-patient relationship is understood. By critically examining the report we will be able to explore the normative beliefs that underpin the considerations of what led to the breakdown

in the relationship. The chapter seeks to claim that *The Redfern Report* (DoH, 2001) understands offences against patients (or in this case their close relatives) through deprivation of choice. The offences caused are seen as the result of a high-handed paternalistic approach that deprives the patient from taking part adequately in the consent transaction. Further the chapter goes on to reveal that the solution to this deprivation of choice is viewed in the report as being an *improvement* in the consent process with increased information as part of the transactional consent process.

Chapter Two concludes that this reveals that our current understanding of autonomy in the clinical setting relates closely to autonomous choosing and that we understand promoting and protecting autonomy through successful engagement in the consent process. Chapter Two concludes that we may be relying on a hierarchical model of autonomy to underpin our understanding of the duty to respect patients. Further, Chapter Two queries to what extent this might be an adequate model by which to address the concerns raised in Chapter One.

In Chapter Three we move on to consider how hierarchical models of autonomy operate and to what degree they can adequately address the concerns raised in the preceding chapter. We look at the pitfalls of understanding respect for persons and autonomy in this way and consider if it is an adequate approach at all.

The aim of Chapter Three is to consider to what extent hierarchical models of autonomy can provide an adequate account of the ethical challenges raised in the

dentist-patient relationship. This is achieved by careful exposition of the theoretical models as proposed by Frankfurt and Dworkin and later modified by others.

The chapter commences by drawing the initial link between a hierarchical approach to autonomy and the use of consent in the clinical relationship. It does so by considering both consent and the hierarchical model of autonomy rely heavily on the act of choosing in order to describe, protect or promote autonomy. By doing so, the chapter claims, it is likely that our understanding of autonomy in the clinical setting is most closely related to this construction of autonomy and therefore justifies looking at this form of modelling autonomy in more detail.

Chapter Three begins by considering some of the benefits of understanding autonomy in this way and outlines in detail the manner in which this model operates. The chapter notes that this approach may well be viewed as useful in that it is operational in construction and as such enables us to view autonomy as an ability of person. Taking such an approach may help us in an applied context such as the dental clinic, to identify those who might lack such an ability or feature of person, and therefore draw limits around a clinician's duty towards patients to respect autonomy. This may appropriately prompt us to consider alternative models of respecting patients where a patient is defective in their action of making a choice. The chapter notes how this practical approach to some extent makes it attractive in an applied context.

However the chapter also notes that the model suffers from some theoretical difficulties. The chapter, as part of the exposition, considers in detail the model's difficulties with manipulation, infinite regress and authority. The chapter explores the extent to which these difficulties might frustrate the claim that this understanding of autonomy is the most suitable way of respecting patients in the clinical setting and in particular in dentistry.

The chapter concludes that understanding respect for patients in this way suffers from fatal flaws in that it is unable to adequately account for the matters raised in Chapter One. The chapter claims that the model cannot sufficiently account for the dangers of deception raised in the hypothetical case studies. Further, as it relies heavily on defining autonomy in relation to the act of choosing this leads us to focus on respecting patients by relying on how they engage in the transactional aspects (consent process) of the clinician-patient relationship. Chapter Three considers that perhaps autonomy is not the appropriate way in which to meet the concerns of Chapter One and therefore adequately respect patients. It does this because its construction causes us to be too narrow in our application of respect for persons focusing on the treatment transaction rather than looking more broadly at the process. Further, it is argued that the hierarchical approach cannot adequately account for concerns with deception and manipulation; one of the key concerns raised in the hypothetical case studies in Chapter One. This, the chapter proposes, may cause us to look at other approaches to respecting patients that may address these concerns in a more adequate manner.



In Chapter Four, the thesis then considers if there are any alternative models that might provide a more appropriate approach to autonomy that are better able to address the concerns raised in Chapter One. First the thesis will look at 'best interests' and examine how a 'best interests' approach might operate. This will enable us to conclude to what extent a 'best interests' approach might provide solutions and what, if any, aspects of the model might be of concern.

The aim of Chapter Four is to test the extent to which 'best interests', otherwise understood as paternalism which often acts as an alternative to autonomy might potentially address the concerns raised in Chapter One. This involves looking closely at the manner in which a 'best interests' approach might work and examining the key principles that underpin that approach, those being non-maleficence and beneficence.

The chapter commences by looking at the theoretical rationale for 'best interests' and paternalism by examining the principle of beneficence that generates a paternalistic approach and provides its moral rationale. The chapter notes the attraction to beneficence is that it may well broaden our area of focus addressing the concern raised previously that the current construction is overly focused on the consent transaction and fails to encourage us to look more widely at what is 'best' overall.

The chapter however also raises some concern over the manner in which 'best' is defined and the historical difficulties with taking a paternalistic approach. The

chapter attempts to consider to what extent these concerns can be addressed and whether a strong or weak account of paternalism and 'best interests' may go some way to allay fears that the manner in which 'best' is determined may provide an adequate account of ethical interaction for the clinical setting. The fact that this approach may even be compatible with some conception of autonomy is also considered.

In Chapter Five we move on to consider a new account for the clinician-patient relationship proposed by O'Neill. The chapter considers O'Neill's proposal that the clinical relationship would be better served by relying on a principled account of autonomy. The chapter considers O'Neill's criticisms of the highly individualised accounts to which we currently appeal. By considering O'Neill's initial position the chapter attempts to expose the change of focus that O'Neill is proposing and her rationale for developing a new model of clinician-patient interaction. The chapter proceeds to consider O'Neill's proposition of principled autonomy in substitute for a highly individualized account. O'Neill presents five main benefits to taking her new approach and the chapter considers each of these with particular focus and concern for the move away from rights to obligations as well as O'Neill's claims about the role of 'authenticity' and patient responsibility. Concerns are raised about the role of 'obligations' in the clinical relationship and how this might repeat the concerns raised in earlier chapters about the highly medicalized and narrow nature of the dentist-patient relationship.

One of the central obligations of the new model O'Neill proposes is a commitment to be trustworthy and the chapter considers the implications of this. This is particularly relevant as an obligation to be trustworthy, O'Neill claims, means a duty to reject deception. As deception has been one of the key concerns of preceding chapters, Chapter Five considers the degree to which O'Neill's proposition is adequate for the problems raised in Chapter One.

The Chapter concludes that O'Neill's defence against deception is too narrow for our purposes and cannot legitimately be widened to meet the needs of dentistry. Further that a reliance on obligations rather than rights naturally gives rise to a highly narrow and medicalized relationship which may fail to take into account the broader concerns of the patient.

Finally the thesis will conclude that autonomy does indeed provide our best framework by which we can meet the concerns raised in Chapter One but that a much wider and less transactional model is necessary in order to meet the specific needs of the dentist-patient relationship. This chapter will consider a moderated negative libertarian account as a possible alternative construction of autonomy and examines the extent to which this account may go some way to meeting our needs.

The aim of Chapter Six is to propose an alternative approach to respecting patients that more adequately meets the needs of the dentist-patient relationship. The chapter works on a review of some of the key points and themes raised during the

proceeding chapters in order to set the scene for proposing an alternative approach.

The chapter claims that a focus on the transactional nature of the relationship; the consent process; and work on perfecting that process (through augmented information) fails to encapsulate some of the matters that ought to concern us in the dentist-patient relationship. Chapter Six reviews some of the difficulties of understanding clinical interaction in this way and how this fails to prioritise the important aspects of healthcare as an ethical endeavour.

Working on the premises raised earlier in the chapter, Chapter Six then moves on to propose a different account of autonomy as a potentially suitable model for the dentist-patient relationship. The chapter then proceeds to go through the proposed benefits of taking such a different approach and concludes by claiming that the proposed account of autonomy enables us to re-focus our understanding respect for persons away from a treatment model, toward a broader approach. The chapter also seeks to consider to what extent such an approach can deal adequately with our concerns with deception and manipulation.

Chapter Seven reviews the thesis and proposes recommendations for the future. The chapter begins with summarising the thesis's contribution to dentistry. It does so by recalling the progression of the preceding chapters and briefly outlining the findings of each. Chapter Seven then goes on to consider some of the limitations of the research. The chapter considers that the thesis does not seek to

cover the practical and general professional arguments of dentistry and takes a normative approach. This may give rise to questions about whether or not the findings of the thesis can be applied. However it is concluded that a normative approach gives important distance and an opportunity to critique the profession without being subject to professional bias or institutional constraints, an important feature of a rational approach. It is argued here that this is an important if not vital 'first-step' on the road to examining the complexities of the dentist-patient relationship and the development of a rational response. Finally the chapter considers recommendations for future work. Future work, it is concluded, lies with generating empirical evidence and facilitating stakeholder consultation in order for application to be possible. It is only by marrying the normative to the empirical that the findings of the thesis may then be translated into clinical practice.

## **Chapter One – Introduction**

In this chapter I will claim that autonomy is the primary principle that the clinical professions appeal to when they claim to respect patients. I will state that autonomy can be a difficult concept and that the clinical professions have yet to settle on a clear definition. Lack of clarity naturally leads to difficulties in accurate and meaningful application in the clinical setting and it is for that reason, I will propose, that we may need specific theoretical models to account for differing clinical encounters. I will attempt to establish this claim by looking at some of the specific challenges encountered in primary dental care using a hypothetical case study approach. It is hoped by doing so that I will be able to identify some of the issues raised by these case studies and conclude what any adequate theoretical model must be able to deliver in order to address the specific ethical needs of primary dental care.

Autonomy has established itself over the last few decades as one of the primary principles that ethically underpins the clinician-patient relationship. It is the principle that some regard as the first amongst equals (Gillon, 2003). The paternalism of the past has been rejected in favour of an approach that recognises rights and gives authoritative weight to the voice of the patient. In principle it affords patients the right to choose and manage their own healthcare experience. There is much to recommend it. Autonomy helps us to understand and express our dissatisfaction with paternalistic models of the past relied on in medicine and dentistry and provides an alternative. It is no longer acceptable for a clinician to make decisions for patients based on what they perceive to be in the patient's 'best

interests'. Patients are now afforded the right to make such decisions for themselves, irrespective of whether these decisions appear to be of some benefit to them. This is in recognition of the fact that as individuals it is more important to recognise our individuality than it is to derive some measurable benefit. Particularly when our definition is based on an expert's perspective of what that benefit is.

In recent times however, autonomy has also been subject to criticism. It is often viewed as a slippery principle that can be interpreted in many ways. It is not a term used commonly and indeed from a practical perspective many clinicians are unsure of what it means. There is no real agreement in moral philosophy either. As we shall see autonomy can be viewed as an acquired skill where a certain level of reflective capacity is necessary; a 'capacity of persons' or it can be viewed as an inalienable right to individuality; that is to say a type of personal sovereignty. This presents a problem for the clinical relationship. Medicine although supportive of autonomy in principle, has yet to settle on a firm definition of what it is and this inevitably leads to difficulties in translating the principle into the clinician-patient relationship. Without a clear definition we are unable to draw any limits. Depending on what view is taken of the principle, whether it be one of capacity, or a matter of individual sovereignty, this can dramatically affect the manner in which the clinical relationship is defined. Questions arise concerning when a patient may be viewed as not autonomous and therefore to what degree decisions might be made on their behalf. A clear view of autonomy is necessary in order to discern the rights of children or the mentally incapacitated and to adequately respect those

groups. This lack of clear professional and philosophical agreement on autonomy has caused some to look for alternatives rather than address the tangled mass of differing models. This is understandable in the circumstances as any principle used as the ethical basis of a functioning relationship needs to be capable of practical application as well as being philosophically robust in order to be worthy of use. O'Neill (2002) has pursued a route for example, that involves exchanging the use of autonomy as the founding principle of the clinical relationship for one of trust<sup>1</sup>. O'Neill (2002) asserts that this is because the concept of trust is far more appealing on a practical level in that most people have a clear understanding of what the concept of trust is whilst it still addresses the ethical challenges of the clinical relationship. As we will see later though, the concept of trust also has its limitations. Trust may not be able to adequately account for situations where the issue of moral concern involves, for example deception, which occurs outside the confines of the clinical relationship. Nor can trust sufficiently account for situations where we would like to give the patient's voice authority in the context of encounters where the clinician and patient disagree or indeed where the patient got what they wanted or needed but were dissatisfied with the method by which it was delivered. O'Neill's (2002) attraction to trust as a concept is based on her belief that clinicians intuitively understand trust as a concept making trust an attractive prospect in an applied professional setting. Attractive though it is to focus on the practical, any ethical model of patient-clinician interaction needs to be able to account adequately for the challenges that occur within that environment.

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<sup>1</sup> Note that this is a consequence of her proposing a change to principled autonomy.



In this thesis it is argued that for any model of the clinician-patient relationship to be either ethical defensible or practically applicable it must relate to the challenges faced in daily practice and provide robust answers. Many forms of autonomy and alternative ethical models for the clinical relationships have been proposed, but few, if any, consider the specific challenges faced by differing clinical relationships. The presumption has usually been that most clinical relationships experience similar ethical challenges and that the basic tenets of consent taking and confidentiality are adequately met by adhering to a 'blanket standard' of autonomy (or an alternative) that applies to all clinical disciplines. Such 'universality' of approach may fail to acknowledge the differing position that both clinician and patient may find themselves in. Indeed, it may fail to prioritise or worse take account of differing ethical challenges that each clinical role presents. In this thesis it will be argued that greater precision is needed in order to be certain that a model is adequate. There can of course be some degree of commonality so, for instance a general agreement that autonomy is the underpinning value in the clinical relationship. However, in addition to this it will be argued that a specific model of autonomy may be necessary to meet specific challenges that certain disciplines regularly face. Further by taking this more focused approach it also challenges proponents of autonomy to develop a more effective model or apply a more suitable model where autonomy appears not to provide answers to specific challenges but has historically been a point of ethical reference. Therefore, if we are to consider clarifying the use of autonomy in the clinical context we should aim to enable professionals to confidently draw limits around the concept and when it

applies as well as making any model more responsive and reflective of patient need.

### **Why primary care dentistry?**

Primary care dentistry may provide one such example of where a discipline may need to consider its own challenges. Dentistry, in particular provides a unique environment for the clinician-patient relationship. This unique environment is perhaps most apparent in the primary care setting where the vast majority of dental care is provided. The boundaries of dental care are much less well-defined than those found in primary care in general medicine. The reason for this is the relationship faces greater fluctuation than primary care medicine with the potential for a change in role for both practitioner and patient. This change can be seen perhaps most distinctly in three particular cases that are largely unique to dentistry in a primary care setting in the UK. Those are, the use of cosmetic treatment alongside therapeutic treatment, the delivery of both private and NHS care concurrently and finally the use of skill mix. Skill mix is perhaps not unique to dentistry within primary care but certainly here it is much less well defined as compared to medicine. This as we will see later, presents certain challenges. We will now consider each of these cases in detail, considering their specific challenges and what this tells us about the ethical requisites of the dental relationship.

Dentistry stands apart from many of the other clinical healthcare disciplines in that it routinely offers and provides both therapeutic and cosmetic treatments in a

primary care setting. Treatments such as tooth whitening, veneers, cosmetic crowns and orthodontic work may be prescribed and delivered as part of a general dental practitioner's daily work in his high street surgery. The fact that we draw a distinction between two types of treatment causes us to contemplate what the differences are between them and subsequently to consider if these differences have any ethical implications.

At first instance the distinction seems to reveal three main areas of ethical concern. These areas of concern are that; there are practical difficulties for the patient moving from a healthcare rubric to one of commercial transaction; cosmetic treatment relies more heavily on a subjective assessment of 'clinical need' and finally a dentist may quite understandably want to do something 'nice' for their patient.

Considering our first concern, it could be argued that when a patient moves from therapeutic treatment to cosmetic treatment that there is a shift in the ethical duties of the dentist toward the patient. That is to say a patient has moved from a healthcare rubric to one of commercial interaction. This is because the ethical underpinnings of each treatment differ from one another. Therapeutic dentistry might be described as procedures that address conditions that arise from dental disease, trauma or inherent physiology that affect a patient's ability to function and may be also causing them discomfort. We may also want to include prophylactic treatments in the therapeutic group where treatment is used to prevent conditions

resulting from disease, trauma or inherent physiology, as it is argued that these two forms of treatment share the same root characteristics.

Cosmetic treatment on the other hand is not related to arresting disease, repairing trauma (for the purposes of regaining function) or treating an inherent physiological problem that is affecting a patient's ability to function or is causing pain. It is a treatment where the focus lies on changing the appearance of a patient's teeth. As such then therapeutic treatment easily falls within the remit of a healthcare endeavour (to promote good through the restoration of health) and all the ethical duties that entails whereas cosmetic treatment does not. Perhaps in the most simplistic terms this is because therapeutic treatment seeks to promote good through the restoration of health where health is the prerequisite of accessing other goods. As a result, good health attracts more ethical importance than cosmetic treatment which seeks to merely to augment social inclusion.<sup>2</sup>

This might lead us to argue that maybe a dentist does not owe the same duty of care in a cosmetic case? Attractive though this is it seems hard to argue this adequately. From a practical perspective a patient is unlikely to be able to distinguish when a change in underlying duty of care is happening. Therapeutic and cosmetic care are often delivered within the same setting by the same practitioner in the same surgery as part of the same treatment plan. Dentists also

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<sup>2</sup> A distinction here could be drawn between want and need. That is to say that individuals *need* health to operate in society but may *want* cosmetic treatment. That is to say that good health is a prerequisite for accessing certain other goods such as education whereas good looks may give one an advantage but are not essential to accessing other basic goods. I do not wish to expand this argument too much here but rather to acknowledge the basic distinction in ethical terms between the two treatment endeavours.

benefit from their status as medical practitioners when offering cosmetic treatment in that patients assume that they are being treated under the same duty of care as if the treatment was therapeutic. Even if a dentist made the change in role explicit, it is likely that their professional status and the surgery context would still exert 'undue' influence. Increased trust on the part of the patient in relation to the dentist's advice would be a breeding ground for, at best, unintended coercion on the dentist's part<sup>3</sup>. Owing to this professional status then, it seems reasonable that a dentist would not be allowed to offer a cosmetic treatment to a patient that might be dangerous or the cause of later ill-health. When a patient is so vulnerable, regardless of the treatment they are undergoing, it seems counter-intuitive to surrender them to the maxim *caveat-emptor* (let the buyer beware) simply because the treatment is purely cosmetic. Further, a dentist's suggestion that a treatment be done carries a great deal of weight *because of* the duty of care patients believe lies between them, so to remove that duty of care it at certain times seems indefensible. What does this then mean for the patient? By attempting to argue against a change in the relationship and the duty of care of the dentist toward the patient in cosmetic treatment my point of concern is one of deception. I am concerned that patients may find themselves under a misapprehension concerning the nature of the relationship between dentist and patient. This deception may result in a dentist being able to exert undue influence

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<sup>3</sup> Interestingly although the legal basis for the dentist-patient relationship changes depending on whether the treatment is private or NHS that is to say that it is either governed by the law of contract or law of tort the standard of the duty of care remains the same. Contractual dentistry does not mean that the contract is the only measure of what is expected of the dentist. A dentist cannot legally limit the care he owes a patient no matter what waiver he puts in the contract nor may a patient sign away his right to claim for negligence.

on the patient either intentionally or unintentionally. This seems to run entirely counter to the patient's belief the dentist will always act in their best interests and, of course, this further increases the deception.

The challenges for dentist-patient relationships are further exacerbated by the fact that there is not always a clear distinction between what constitutes clinical need and what may be considered cosmetic desire. Clinical need in dentistry relies heavily on a subjective assessment by both dentist and patient. This can be seen particularly in the clinical assessment of orthodontic need, which for the most part relates to adjusting the appearance of a patient's teeth and no more. Ideas around needs assessment are complex issues and it is not the intention of this thesis to explore those in great depth but merely to contend that one patient's assessment or indeed one dentist's assessment of the 'need' to straighten someone's teeth may be different from another's (despite the introduction of IOTN scoring). The main ethical problem occurs no matter if the parties are in agreement with each other or not. As the assessment of need is subjective does that mean that a reduced duty could be imposed from outside the relationship even if both parties were in agreement that this was indeed a healthcare rather commercial relationship? If the parties disagree on this matter whose voice is authoritative? Can a patient prove need and therefore impose differing duties merely because of his preconceptions before treatment? Again it seems some of the preceding problems occur here: that a shifting relationship (between healthcare and cosmetic treatment) carrying differing duties is difficult to manage and ethically challenging. The consequence of this is again one of deception. A patient is prevented from

managing the relationship if he or she is uncertain of its structure and this then apportions greater weight to a dentist's advice than might be due.

Finally, in relation to this scenario it must be considered that the dentist can also face the temptation to do 'something nice' for patients. Dentists are, after all, skilled professionals whose skill, capabilities and sometimes resources extend beyond clinical need. It is not unreasonable to suppose dentists in their desire to do their best for their patients may persuasively suggest treatments that are beyond healthcare. Again similar concerns arise about the medical context in which a patient may find themselves. Their ability to discern either a change in relationship or the reduced ethical underpinnings and therefore the weight they should give to any 'clinical' advice may be impaired. After all these changes in the relationship are subtle and less than obvious and it is the uncertainty of the relationship status then that gives rise to a concern about deception. We will consider in due course our concerns with deception.

The difficulty appears to be then that there is some justification for regarding cosmetic treatment as outside the traditional healthcare relationship. It does not seek to restore health. For this reason cosmetic dentistry could be, some might argue, delivered as part of a commercial rather than a healthcare relationship. As we have seen this could be problematic. Owing to the clinical setting in which this kind of treatment is delivered and as part of a relationship with a healthcare professional we have considered that a patient may be vulnerable to the dentist exerting undue influence on them. This could result in the patient giving greater

weight to the dentist's advice than is reasonable. The outcome then must be that the patient is deceived; they are making decisions not based on reality and are deprived of being able to make a decision based on a true perception of the situation before them. It is precisely because of the special healthcare relationship that we recognise a patient is not on his guard, there is an inequality of power and as such this creates an ethical dilemma. We will consider in Chapter Two to what extent our current model of autonomy helps us to account for our concerns here. Before we do this however we will consider some more problematic cases.

The provision of cosmetic dentistry in the same primary care context is not the only challenge that the primary dental care practitioner faces in the clinician-patient relationship: modern primary dental care is now also offered not simply by dentists. Primary dental care such as scale and polish, simple restorations, simple extractions and other straightforward procedures may also be performed, albeit under the dentist's instruction, by hygienists (in the case of scale and polish) and therapists (scale and polish, restorations and simple extractions). This is a relatively new development for general dental services although the use of therapists has been a long-standing arrangement within the community dental service. A consequence of this is, from a patient perspective, that a patient attending a general dental surgery for treatment may be treated by different professionals with differing levels of qualification or training and differing roles and status. This has more recently been referred to as the use of skill mix (Buchan and Dal Poz, 2002). Initially, a patient attending a surgery will be examined by a dentist who will then decide on a diagnosis and prescribe a course of treatment as



appropriate. It may be then that a hygienist or therapist, depending on the prescription, carries out that treatment according to the dentist's assessment and instruction. Prima facie this seems to present no real ethical difficulty on two fronts. First, skill mix is also commonly used in general medical services and does not appear to present any real problem. Second, the patient is getting the care they need, in fact even to the degree that it is what their own dentist recommends. Is this really the case? I will consider these two points and attempt to conclude if indeed there are any ethical difficulties here.

First, in relation to the use of skill mix in medicine; today practice nurses, physiotherapists and other medical care professionals also work routinely alongside doctors in the primary care setting. These roles are familiar to patients and such professionals often have their own consulting rooms within a practice. A doctor will often go through a process of assessing a patient and then referring them to the relevant profession for further treatment. That is to say that although other professionals still work under the recommendation of the doctor, they are often bringing their own skill and training to bear on a medical problem rather than merely applying a 'dilute' form of medicine to the patient. Clear divisions between professionals in the medical setting are visible to the patient and it is contended that on the whole the patient is aware of the status and role of the person treating him. Perhaps this could be best described as viewing the role of the GP as a 'gatekeeper' who refers patients to other primary care specialists. This model of delivery in primary medical care by the use of established primary care specialisation is one that patients recognise and are familiar with (Buchan, 1990).

Recent research has shown that this is not the case in dentistry. Not only have dental patients been shown not to know the qualifications or general role of the person who is treating them, but they also are generally unaware that there are differing roles in dentistry and that other dental professionals exist, who are able to treat them (Dyer & Robinson 2008a;b). Of those patients who responded to a national questionnaire who *did* claim to know and be able to identify the differing roles in dentistry the majority made inaccurate or wholly incorrect distinctions (Dyer & Robinson 2008b). Perhaps of further concern is the fact that when the roles of therapists and hygienists were explained to interviewees most expressed concern and said they would be unhappy to be treated by such individuals.

This clearly presents an ethical problem. Patients are being treated in a context where they are under a mistaken belief that they are aware of the role of the person treating them. Further, this is not merely a rebuttable supposition that patients may be unhappy to be treated using skill mix or indeed that we are under the mistaken belief that they do not understand it. Rather, we have clear evidence that patients are unfamiliar with the use of skill mix in primary dental care, when aware of its use they are unaware of what that means with regard to their treatment. Worse still when they are made aware of these facts they are opposed, in the main, to the use of skill mix. Clearly there is a problem here in that patients are not clear on who is treating them and that they feel that this is unacceptable. This problem is likely to be symptomatic of the fact that dentistry, in a primary care setting, has a less established model of specialisation. In addition, the fact that

therapists work much more closely under the dentist's prescription and therefore supervision than other professionals in the medical context may make them appear to be less qualified dentists rather than primary care specialists. This may be linked to the fact that therapists and hygienists often carry out procedures that are routinely also done by dentists. This, it is suggested, casts the dentist in the role of supervisor, unlike his medical peers, who act as gatekeepers. This highlights two problems one ethical and one practical. First, patients are unable to distinguish dental roles, which in turn diminishes their (the patients') ability to make decisions for themselves. Second, patients are currently unhappy with the use of therapists in a primary care setting. Is this really a problem though? Does it matter that patients are unaware of who is treating them?

This leads us on to a related point; we could argue that patients are after all getting the care they need. As this is the reason that patients are attending the dentist, surely the outcome of their attendance should be the issue of ethical importance here? From research into the patients' perspective we can see from the research this is clearly not their view and that something more complex than simple treatment is occurring (Dyer and Robinson, 2008a;b).

Perhaps it is the fact that the patient feels they are being deceived into accepting something that is rather less than that which they were expecting even if the outcome is the same. It is suggested that this feeling of deception in some way is contrary to a patient's expectations of the dentist-patient relationship in that it damages their belief that the dentist is in some way providing care as well as

treatment; we will address the distinction between a healthcare model and a treatment focused model in detail in Chapter Six, however for the moment I simply wish to claim as part of the case study that clearly the process of treatment has an ethical significance on the part of the patient.

Following this line of thought, the dentist-patient relationship also differs in a unique way from medicine in that regardless of whether the care is provided on the NHS or privately it is paid for at source. This means that every time the patient attends the surgery they are directly billed for the treatment. Following Dyer and Robinson's (2008a;b) research we can see that there is some belief by patients that if they are paying for their care but the care is delivered by someone less qualified than a dentist then it may be reasonable to suppose that they should pay less for their treatment. Many patients expressed dissatisfaction with the fact that they were being charged the same whoever treated them. Again it is the same issue that patients feel they are in some way being deceived.

We can see from considering this example that clearly patients are unhappy with the situation that they find themselves in. This feeling of deception means that in real terms patients believe they are being manipulated during their treatment into complying with care that is contrary to that which they would have agreed to had they been aware of skill mix. Perhaps we can go further and say that it is the deception that is more of a problem than the skill mix itself. It is suggested that patients might still feel aggrieved if they were treated under a misconception that they were being treated by a dentist when in actual fact they were being treated by

a therapist even if they would have happily agreed to the therapist performing the treatment. It is clear then that the conduct of the relationship has some significance. That is to say that the treatment process has an ethical significance that cannot be assuaged via effective treatment.

The final challenge we are going to consider that is specific to dentistry is the provision of primary care from the NHS and the private sector. Although many clinical treatments are offered both under the auspices of the NHS or in private practice in relation to medicine, dentistry is unusual in that both NHS care and private practice may be offered often in the same surgery by the same dentist as part of the same appointment. This can make the distinction between the two types of provision difficult for the patient. Distinction between the two is made even more difficult by the fact that the division does not necessarily fall between therapeutic treatments and cosmetic ones. Many routine therapeutic treatments (posterior and some anterior composite restorations) are offered exclusively as part of private practice. Further some types of treatment, such as anterior composite restorations may be provided on the NHS in certain circumstances. This further complicates matters from a patient perspective since it falls to the dentist to decide whether the condition presenting is one that would qualify under the rules of NHS provision. This inevitably means that depending on which dentist you see you may get the same treatment but one would only treat you privately (despite being an NHS dentist) whereas the other might offer you the same treatment on the NHS. This can be challenging for dentists particularly when they find themselves under commercial as well as professional pressures. A patient's

interests are easily obscured when such a situation presents itself. Further difficulties arise for patients who may find they are paying for both NHS treatment and private treatment at the surgery. Therefore, unlike primary medical care where treatment is free at source (so anything paid for *must* be private), patients in dentistry pay for their NHS and private care at point of delivery. For many patients it is beyond their experience and unreasonable to expect them to be able to know how much certain procedures cost (or bands of treatment) and therefore whether or not the bill they receive is reflective of private or NHS care or a combination of both. In fact this is why the system was simplified into simple 'bands of treatment' or units of dental activity (Steele, 2009, pp.63-72).

Situations where the patient was deceived or persuaded (perhaps with the best of intentions) into consenting to a particular treatment unaware that they would be facing a big bill at the end is easily identifiable as problematic. Although the proposed treatment is agreed, the patient remains ignorant of the eventual cost, an aspect of that treatment that would very likely form an integral part of their decision. It would not be difficult to claim then that the patient had in some way been deprived of sufficient information and therefore had consequently been deprived of the ability to make a decision for themselves whilst fully cogniscent of the facts. Here the dentist is deciding on behalf of the patient that their (the patient's) clinical treatment is paramount and that the cost of it is of lesser importance: the patient is precluded from making that decision for themselves. As it is the patient who will be bearing the burden of that cost it seems counter intuitive to attempt to argue that the cost will be of no consequence to them.

However, would our assessment of the situation differ if indeed the patient would have agreed to the cost had they known about it? After all in this case the outcome for the patient would be exactly the same? Again it seems unlikely that most patients who found themselves in such a situation would be satisfied with the argument that they got what they would have agreed to in any case. This seems to place no value or weight on a patient's right to make that decision for themselves and further prioritises the patient's needs in a way that does not involve the patient's influence or endorsement.

### **Deception as a problem in clinical dentistry**

It seems then that all these case studies highlight an objection to deception as part of the clinical relationship. The cosmetic versus therapeutic example highlights difficulties with the changing patient role. The clinical context makes a transformation from patient to consumer ethically problematic. The complexity of the treatment context makes it difficult for patients to adjust to a situation where the exchange and advice given by a healthcare professional transforms from what may be deemed desirable for health (however health is defined) to one that is merely what is cosmetically possible. Deception here may not be deliberate; dentists may well be explicit about that change but still, owing to their training and profession, are able to exert undue influence. This influence may be intentional or otherwise, but it potentially leads to the patient feeling deceived. Even if the change in the duty of care is legitimate from a practical perspective it seems unworkable.

Returning to our example considering the use of skill mix in dentistry we know from a patient perspective that outcome is not the only indicator of satisfaction with the service received nor is it cost *per se*. Rather, the manner in which healthcare is delivered and the role that the patient expects to take in that delivery is somewhat greater than being the mere recipient of competent treatment. Deception in these cases seems to relate, not to what the patient was expecting to get, but by whom and by what method. Further, the use of deception either deliberate or accidental falls outside a patient's expectations of the dentist-patient relationship.

Considering our final example; examining the challenges of delivering both private and NHS care in the same context by the same practitioner, again the problem of deception arises. It seems insufficient to argue that the deception or confusion on the part of the patient as to context (private or NHS) can be justified on the grounds of clinical indication or the fact that a patient would have agreed to the treatment anyway had they known the distinction. Concerns about deception tell us that again the patient does not expect deception to form part of the dentist-patient relationship.

Are dental patients really any different from other patients though? Do they need a special model of interaction? Dental patients are, after all, the same patients who go to the doctor or therapist. The unique aspect of dentistry does not stem necessarily from the patients that are seen in dental clinics but rather the manner in which the delivery of care is constructed. Unusually for primary care several



quite separate types of care are offered in the same context often on the same patient at the same time, cosmetic and therapeutic, private and NHS and being a dentist or a dental care professional. This fluctuating environment with its potential for deception is of key concern. It is for this reason that a model of patient interaction needs to be developed to reflect these challenges.

What, then does deception tell us about the manner in which an ethical dentist-patient relationship should be conducted? What concepts does the use of deception offend? The problem with deception is that it prevents the patient taking part in the decision-making process of healthcare; it diminishes if not eradicates the authoritative weight that a patient's voice might carry. Deception deprives the patient from being able to follow their own moral policy and be self-governing. It is clearly important to patients that they not only receive the treatment they need but also that they receive it in the manner that they deem appropriate. Clearly from a patient's perspective healthcare is as much about the relationship and a patient's position in it as it is about the treatment they receive. There are clear indications that patients believe that deception should not form a justified part of the dentist-patient relationship. Therefore it is not simply the outcome that is important to patients from an ethical perspective but the manner in which care is delivered. This is a similar finding to our cosmetic example above, except that this time the deception is a product or consequence of the dentist-patient relationship rather than potentially a characteristic of the patient embarking on the relationship. In order to address both types of deception we

need to develop a model specific to dentistry that can account for deception occurring from both outside and inside the relationship.

A common theme shared by all the case studies seems to be one of deception. When considering the cosmetic versus therapeutic treatment scenario a difficulty in the dentist-patient relationship occurs when there is a shift from a therapeutic relationship to a commercial one. Let us be clear it is not because commercial relationships are prima facie problematic in relation to deception, in fact one might argue that this is a core feature of commercial interaction (hence the maxim, *caveat emptor*, let the buyer beware). It is rather that in the clinical context the relationship between dentist and patient is so unequal as to cause concern. It is contended that the medical environment and the professional status of the dentist can cause patients to give undue weight to a dentist's recommendation in relation to cosmetic treatments. A patient may believe that the dentist continues to have their best clinical interests at heart (in the same way as they ought to during a therapeutic treatment) but being deceived as to the fact that the dentist may now be legitimately considering the commercial benefits to himself, to some degree in preference to the well-being of the patient. After all, commercial transactions are perhaps defined by the parties considering the benefit to themselves; and duty of care transactions (therapeutic treatments for example) are defined by the more powerful party considering the benefit to the weaker. It is argued then that as the patient may be viewed as the weaker party at least in so far as they are not the clinical experts the consequence is that this type of transaction is not truly commercial. To view cosmetic treatment as a commercial relationship would need

us to believe that the patient is now on their guard and treats any advice that a dentist gives them in this context as a 'sales pitch' that they should treat with scepticism. It is the professional status of the dentist that enables him to exert this influence even if he explicitly states his or her commercial intentions and for that reason we become concerned as to his or her ability to exploit that status to the detriment of the patient.

The delivery of NHS and private dental care also raises some of the problems highlighted by cosmetic and therapeutic treatment. Here again there is a changing rubric of healthcare delivery from one that is funded by the NHS to one that is paid for wholly by the patient. It is doubly frustrated by the fact that NHS dental care for the most part is not free to patients and requires a form of part payment making it even less clear which scheme they are being treated under. As we have seen, patients often do not know which scheme their treatment falls under and can be faced with a large bill at the end. Dentists are not always explicit and this quite rightly leaves the patient feeling deceived; in that they agreed to the treatment but did not realize that the one they chose had a large price tag attached. Yet even where it can be shown however that had a patient known of the cost they would have agreed to it there still appears to be a problem of deception. This gives us an important clue as to what qualities a good model of interaction should have. The outcome of the treatment is not the sole focus from the patient perspective but also *how they were treated*. Interaction where deception is used but where the outcome is what the patient wanted can still fall short of what we would expect in a dentist-patient relationship from the patient's perspective.

This point is raised again when looking at the use of skill mix. Patients seem to object to the use of skill mix on several grounds all of which highlight different objections to the use of deception. The primary objection to skill mix usually involves the patient being unaware of the professional's status. This would lead us to conclude that patients have a certain expectation of their involvement in treatment and that they expect to be rather more than recipients of care. It seems that patients expect to take part in their treatment beyond merely understanding the treatment proposed. This will be an important point later. Objections to the use of skill mix together with the use of private and NHS care show us that from a patient perspective choosing their treatment from within a range of options is not sufficient. Patients expect to have further knowledge that tells them about the context in which they are treated and not merely what form the treatment will take<sup>4</sup>. Anything less leaves them feeling deceived.

### **Deception defined**

Clearly then, patients are raising objections to the use or existence of deception in their relationship with a dentist. What do patients mean then when they refer to deception? Novak et al. (1989, p.2982), from research into physicians' attitudes towards deception, defined it as "to make another believe what is not true, to mislead". The Oxford English Dictionary also defines deception as "to cause someone to believe something that is not true, typically in order to gain some

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<sup>4</sup> This point will be covered in detail in Chapter Six.

personal advantage” (ODE, 2001). But as we shall see, deception is not quite as simple as this.

According to these definitions deception’s key characteristic is that one party sets out to deceive the other by giving them misleading or incorrect information. There is an implication of wrongdoing on the part of the deceiver following these definitions. The deceiver gives some kind of misinformation to gain an unfair advantage over the deceived. We might then wish to assert that the ‘wrong’ might be found in that someone has potentially gained something to which they were not entitled by dint of deceiving someone else. Following this line of thinking our objection to deception could (along with other methods) be satisfactorily explained with reference to some element of intent on the part of the deceiver<sup>5</sup>. The cases presented thus far appear to be more complex than this in that no clear advantage may always be discerned on the part of the deceiver, nor may the outcome of the exchange in material terms be explained always by a material disadvantage to the deceived. Further, it is not always the case that there is deliberate deception on the part of the deceiver or indeed even a desire to deceive at all. This perhaps may be explained by considering, first, that deception may have a much broader definition and may occur by not giving sufficient information particularly that which is viewed as relevant by the patient. Second, that the act of deception for this purpose cannot be adequately explained by considering the outcome for the patient.

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<sup>5</sup> Notably this definition may be entirely appropriate for commercial transactions.

If the dentist is not setting out to tell the patient something that is not true then can the patient be deceived? Perhaps it is important in this case to treat this as a question of fact on behalf of the patient. It is not necessarily important that a dentist's motives are ones of deception in order for deception to occur. Different levels of familiarity with the medical context and inequality in the relationship in relation to medical expertise all create an environment where patients are vulnerable to deception. The increased power that a dentist holds as a result of their professional standing and clinical context means that a patient may be deceived when a dentist has withheld information that he *ought* to have known was relevant to the patient. A patient is deceived when they are prevented from knowing something they deem to be important. This deprivation can occur either by deliberate misrepresentation or by lack of information.

The situation is more complex, however. Proposing to widen the definition of deception shows that deception is linked to the second point; that from a patient perspective focusing on outcome is insufficient when attempting to identify whether or not deception has occurred. Clearly where a patient believes that they do not have full knowledge of the facts that they deem important to them they are unable to make a decision that has full authority. This is because, it is proposed, the context in which the decision is made has a bearing on the decision's authority. A decision made in full knowledge has greater authoritative weight than one made under a misapprehension even though both decisions are ostensibly the same.

A second point contends that deception can still exist in situations where the outcome would be the same if there had been no deception. Korsgaard states that:

“It doesn’t matter whether that would be all right with her if she knew about it. What matters is that she never gets the chance to choose the end, not knowing that it is to be the consequence of her action.” (Korsgaard, 1986, p.333)

This is because the existence of deception and consequently the misinterpretation of the facts by the patient means that they are prevented from giving any real assent to the action.

Further, Korsgaard states:

“The sense in which a good end is an object for everyone is that a good end is in effect one that everyone, in principle, and especially everyone who contributes to it, gets to cast a vote on.” (Korsgaard, 1986, p.334)

Therefore, deception for our purposes occurs when a patient is either misled or is given insufficient information to be able to give their full consent. Either case occurs when the patient believes that they were unable to play an appropriate role in care as they were prevented from making an accurate assessment of the situation. Deception, for the purposes of our definition can occur independently of outcome. A good or desired treatment outcome for the patient does not mean that they have not been deceived. It is clear from a patient’s perspective that their need to take part in their own care extends beyond the projected treatment outcome or, as we have seen in our skill mix example, even choice and knowledge of treatment. Clearly, context and the identity of those treating also are important in avoiding deception and providing an adequate patient experience.

Although deception appears to be problematic to the dentist-patient relationship, perhaps it is not the entire problem? After all there may be occasions where a clinician is clearly explicit about the nature and changes in a relationship and their identity and status. It would be hard then to assert that the problem rests with deception, especially when the patient is fully informed. As I have previously claimed though, even when a patient has been fully informed we might want to raise concerns about the reliance on a commercial relationship; a commercial relationship being defined by each party being largely responsible for their own satisfaction and outcomes. This is because despite the dentist being explicit about the changing nature of the relationship they may still be able to exert undue influence over the patient owing to their clinical status and the surgery context in which a patient finds themselves; what we might like to describe as offering treatment that is, at least in part, commercially motivated and 'under the cloak of medicine'. Perhaps then the nature of the relationship between dentist and patient is different from other types of relationship? Owing to the changing context and status of the dentist this might require us to consider if a completely commercial relationship in our examples is either justified or achievable.

What principle then can we appeal to in order to comprehend a patient's objection to the problems we have raised? One obvious principle that would help us explain these specific but not necessarily new concerns of deception might be autonomy. Autonomy is in basic terms a principle which confers the right or ability to be self-determining or self-governing and deception clearly interfere with that process. However as we have alluded to earlier, the way in which autonomy operates can



be seen in many contexts such as self-governance, liberty rights, privacy, individual choice, freedom of will, causing one's own behaviour and being one's own person and this can lead to confusion and differing emphasis on key components of autonomy. Despite diverse interpretations virtually all definitions agree that there are two conditions essential for autonomy, those being liberty (that is to say freedom from controlling influences) and agency (capacity for intentional action); disagreements usually occur in the interpretation of those conditions.

We can see clearly difficulties with the way in which the dentist-patient relationship is constructed and observations by patients where they deem deception to occur. However, we must consider why this is a problem. What exactly are patients objecting to when they object to deception? It would seem, that the occurrence of deception in some way interferes with a patient's ability to take part in the dentist-patient relationship. The use of deception prevents a patient from making an assessment of the key facts (as they interpret them) before them. Patients who do not have full knowledge or are misled in any way are unable to make authoritative decisions and may feel that this in some way reduces them. A key aspect of deception in this relationship also means that it is not reduced, as we have discussed, by the patient achieving their desired outcome nor is deception assuaged by the patient taking part and being knowledgeable about the proposed procedure.

## **Identifying the needs of a contemporary model of autonomy for healthcare encounters**

Can autonomy or indeed any other model adequately account in specific terms for the concerns we raise here? In order to make a clear and robust assessment of any model either current or proposed we need to both clearly identify our needs, as we have outlined in the preceding case studies and address the need to produce an ethically robust, but also practical model. I would like to propose that there are several key components that any adequate model will need to encompass. Those are; the model must respect the individual; be able to draw limits around the duty of care relationship; be able to adequately defend against deception; be able to correctly prioritise a patient's reasonable wishes; it must adequately emphasise the process of healthcare as well as adequate outcome. We will now consider each of those needs in turn in order to be clear on our aim.

It would not be contentious to claim that any modern model of healthcare interaction must start from the basic tenet of respecting the individual. Few if any today would attempt to argue that healthcare can claim to discharge its ethical duty by relying on a principle that enables sacrifice of the few for the benefit of the many in the provision of healthcare treatment. As Manson and O'Neill (2007, p.2) claim this may well be a result of the positive rejection of Second World War atrocities, none the less we have seen in the post war years that our understanding of healthcare ethics whether that be through the paternalism of the past, current reliance on autonomy today or indeed proposals for the future involving trust; all models share the same core characteristic, that of respect for the individual.

Primary care dentistry is particularly suitable for this approach in that the relationship between clinician and patient is extremely close. What is of concern to us here is not to successfully argue for an individualized approach, I would wish to take that as read, but to ask the question, how do we manage that relationship and respect the individual (here the patient) in the right way? If we wish to address the issues that concern a very close and individualised relationship, the exchange at the chair-side between two parties, we need to consider a model that addresses that exchange in an individualized manner.

In order for any model to have a practical application we will need to be able to draw limits around the duty that is owed by the clinician to the patient. A model that is very general and perhaps more indicative of an overall approach can create difficulties in application: it may be hard to see when the duties arising from that model cease to apply or are wholly inappropriate. A clear and precise definition of any model and clear parameters should prevent this from being the case. This supports my wish to claim that a specialized model for the challenges that differing medical relationships face is necessary and that a blanket standard may be insufficient to adequately account for the challenges of differing relationships as well as frustrating the need to confidently draw limits. A more precise model that relates and addresses issues that relate specifically to a particular relationship and which is better able to draw a line around or identify the matters that the model necessarily claims to address. Greater precision may help clinicians to identify with confidence those areas that fall outside the confines of that special and ethically defined relationship; it might be drawn for example where patients'

desires go beyond that which we might reasonably expect to form part of the patient-clinician relationship. We therefore might enable clinicians to limit their obligation without running the risk of failing to discharge their ethical duty.

The third key aspect we wish to address is to develop a model that helps to correctly prioritise patient's *reasonable* wishes or desires. As we have seen clearly patients attending an appointment would wish to have their medical needs addressed efficiently. After all we might argue that, this is the reason that they are attending. However, care must be taken not to view those needs in isolation and presume that as the business before us is medical in nature that only medical issues will be of relevance and therefore only medical information is of any significance. We have seen from our preceding examples that issues such as cost and the status or role of the practitioner also have a bearing on how a patient might wish to consent to his or her treatment. If we wish to claim that our model must respect the individual then it seems counterintuitive to conclude that we do not pay attention to matters that are of relevance to the exchange but do not directly relate to treatment. We will need to avoid models that, by their construction, tend to lend themselves more comfortably or inevitably to an overly medicalized construction of the dentist-patient interaction.

Finally, any theoretical model must be able to adequately account for a patient's concerns with regard to the process of healthcare and its ethical significance as well as the outcome of treatment. That is to say we may wish to avoid theories where the end justifies the means and that effective treatment rather than effective

care is the way in which we assess the quality of dentistry<sup>6</sup>. This point is closely related to the preceding point that any model must adequately emphasise a patient's reasonable wishes but it also reflective of the concerns that we have raised earlier in relation to deception. What deception and the patient's objection to it tell us about the clinical relationship is that equity or quality of process is as important to respecting a patient in the right way as a good clinical outcome. In short we cannot claim to have respected a patient in the right way simply by the patient getting what they came for. The manner in which patients are treated (for instance knowing the status of the person treating them or the origin of the treatment, private or NHS) forms an integral part of our wish to respect patients and as such any model of interaction must effectively reflect that.

We have considered earlier that current medical practice claims to rely on the principle of autonomy in order to respect patients. We will now turn to consider how autonomy and hence respect for patients appears to operate in the clinical setting. By doing so we should then be able to conclude to what degree the current model is able to account for some of the concerns I have raised here or if we will need to look elsewhere for a suitable model that is both ethically and practically suitable for primary care dentistry.

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<sup>6</sup> It is important to note that the terms health *care* and quality *treatment* are not mutually exclusive. However, I am using the term *treatment* to express situations where the treatment outcome is the measure of a successful interaction between dentist and patient. Whereas, I use the term *healthcare* as an expression of a successful process *plus* an adequate treatment outcome.

## **Chapter Two – Autonomy in Context**

As we have considered in Chapter One, there is strong agreement that patient autonomy underpins the clinical relationship as its moral compass and guiding principle. In this chapter, I wish to expose where this slippery concept operates and by doing so, what it reveals about the manner in which we construct the principle in the clinical setting. I will consider that the clinical relationship relies heavily on a consent-based approach to form the primary way that the autonomy of patients and therefore their interests are protected and promoted. I will then go on to consider and analyse the *The Royal Liverpool Children's Inquiry Report* (DoH, 2001) (hereafter referred to as the *Redfern Report*), the official investigation relating to the Alder Hey Scandal. In this report key aspects of the manner in which we respect patients and the way in which we understand our failures to do so are considered. My purpose in conducting this analysis is to enable the identification of the theoretical model of autonomy the clinical professions use as their point of reference. This will further enable me to consider to what extent the current professional construction of autonomy and therefore respecting patients adequately meets the problems and goals put forward in Chapter One.

First I wish to establish the link between informed consent and autonomy. I will then go on to claim that one of the areas where the reliance on autonomy is most prominent in the clinical relationship is consent to treatment. I wish to contend that consent accounts for a large proportion of how autonomy is understood

within current clinical practice. I would also like to consider the effect of this on how we understand patient autonomy.

### **The link between consent and autonomy**

From a practical and professional perspective consent serves to legitimate actions that would otherwise be unacceptable and in doing so recognizes, in the most simplistic terms, at the very least, the right of the individual to bodily integrity and the idea that no one should trespass upon any individual's person (body) without their prior agreement. As such, consent is one of the cornerstones of modern ethics in medical and dental practice. The concept of consent can be dated back to the great debates of the European Enlightenment and beyond. It is at the core of the social contract tradition, that is to say the moderating of personal liberties in order to gain some benefit. This can be compared with giving up total personal freedom for the protection of the state by, for example, observing the speed limit. A freely given consent can legitimate actions that would otherwise be unacceptable (for example medical treatment). This debate has been re-invigorated over the last thirty years in biomedical ethics to such an extent that informed consent is the most discussed theme in this context (Sugarman et al., 1999). In fact the concept of consent is so entrenched in our understanding of biomedical ethics that its presence today is rarely questioned.

For many, the basis of consent is the concept of autonomy. In fact this has largely become a presumption within the field of biomedical ethics. In Beauchamp and Childress's (2001) work on biomedical ethics, *Principles of Biomedical Ethics*, the

debate about the justifications that underline informed consent are only briefly discussed. They described the justification of informed consent as being:

“...to protect autonomous choice, a loosely defined goal that is often buried in broad discussion of protecting patients and research subjects. Historically we can claim little beyond the fact that a general, inchoate societal demand has emerged for the protection of patients’ and subjects’ rights, particularly their autonomy rights.” (Beauchamp and Childress, 2001, p.77)

Beyond this there is no further discussion in their chapter on *Respect for Autonomy* (Beauchamp and Childress, 2001, pp.57-112) as to whether or not autonomy should be viewed as the justification of consent (despite there being a further thirty-five pages discussing informed consent itself), such is the presumption. It is clearly accepted that whilst there may be discussion in some quarters as to whether this should be the case (Gunderson, 1990) it is largely accepted that informed consent is justified by appealing to the concept of autonomy.

Other thinkers such as Dworkin (1988) largely agree, also claiming that autonomy is generally viewed as the justification of informed consent. Despite Dworkin’s interest in the principle of informed consent being a moral one, many of Dworkin’s examples of this presumption come from a legal context because for Dworkin consent is a creature of law rather than ethics.

“In our view, the patient’s right to self-decision shapes the boundaries of the duty to reveal...and to safeguard the patient’s interest in achieving his own determination on treatment, the law must itself set the standard of adequate disclosure.” (Canterbury v. Spence (1972) as cited in Dworkin, 1988, p.101)

And:



“The constitutional right of privacy includes the right of a mature competent adult to refuse or accept medical recommendations that may prolong one’s life and which, to a third person at least, appear to be in his best interests... Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and may, if he be of sound mind, expressly prohibit the performance of life-saving surgery.” (Dworkin, 1988, p.101)

This view is shared by Meisel (1979):

“The purpose of requiring the patient’s consent to treatment is to protect his physical and psychic integrity against unwanted invasions, and to permit the patient to act as an autonomous, self-determining being.” (Meisel, 1979, p.420)

For Dworkin informed consent is a legal construct that the Law has devised in order to facilitate a moral principle; a patient’s right to be self-determining or governing without interference; that is to say individually autonomous. In fact even those scholars who have chosen to challenge autonomy as the justification of consent accept that this is the most widely held view.

Gunderson (1990) wished to argue for a more consequentialist approach as the underlying justification for informed consent. However when examining how we deal with exceptions to informed consent, he acknowledged that we identify how these disputes might be settled by referring to how the principle of consent is justified. Stating:

“Most judges and scholars have found its [informed consent] justification in the right of individual autonomy.” (Gunderson, 1990, p.251)

More recently Manson and O’Neil (2007) tried to provide an alternative justification for consent. They argued that many important elements of consent are sidelined because of our preoccupation with autonomy as the justification but

recognise that it is largely accepted within the biomedical ethical community that autonomy is seen as the justification for this principle.

“Contemporary discussions insist that informed consent should play a wider role in biomedicine than was envisaged at the time of the Nuremberg code...the justifications being given for requiring informed consent have supposedly been strengthened by appeals to various conceptions of autonomy.” (Manson and O’Neil, 2007, p.4)

It would seem therefore even for those who raise concerns in relation to autonomy that the consensus is largely that autonomy is the underlying principle of informed consent. However, consent is more complex today than a simple agreement or permission given by the patient. Consent today can only be regarded as valid if it is fully informed (World Medical Association, 2008 and Council for International Organizations of Medical Sciences, 2002). This, I wish to contend, alters the way in which a patient and clinician interact. The patient is not merely agreeing or disagreeing with a simple yes or no when the clinician proposes a treatment but is required to consider options and digest information delivered by the clinician. A patient must weigh in the balance what the clinician is proposing before consent is given. The patient’s role has developed then from being a consenting *recipient* of treatment who merely acquiesces or resists what is proposed to a consenting *participant* who must take part in the medical decision making. This in turn may reveal the way in which we both construct autonomy (as the underlying principle relating to consent) and identify what the clinical professions are trying to do with autonomy (protect or promote the principle).

## **Consent and autonomy in the *Redfern Report***

This acknowledged link between autonomy and consent may well be helpful in examining our current understanding of patient autonomy and the extent to which such an understanding is adequate for the concerns raised in Chapter One. One of the clearest ways we can gain insight into how we construct autonomy in medicine and dentistry is by looking at cases where this particular relationship between consent and the subtext of autonomy are considered. One such case is the report that resulted from the Alder Hey Scandal. The extent and degree to which information forms a key role in promoting autonomy was considered in great depth in the light of the Alder Hey Scandal. These considerations may shed some important light onto the manner in which information giving forms a key role in the consent exchange as well as how autonomy is understood in medicine. I will now turn to consider what was revealed in the *Redfern Report* (DoH, 2001) and how this might expose how the clinical sciences understand consent and autonomy in the patient-clinician relationship.

### **Redfern Report: findings**

The procedures relating to the removal and retention of organs primarily at the Alder Hey Hospital was subject to an official inquiry, *The Royal Liverpool Children's Inquiry* (DoH, 2001) more commonly referred to as the *Redfern Report* (DoH, 2001). In order to give us greater insight into the issues involved in the 'scandal' and to attempt to gain some understanding of the issues of moral concern we now turn to examine the findings of the *Redfern Report* (DoH, 2001) in some detail. This report is of particular interest to us as it focuses heavily on consent-taking. As

I have previously discussed, there is a clear link between our understanding of consent and our understanding of autonomy. It is hoped by examining the report and the manner in which the matters are discussed that we might gain some insight into medicine's construction of patient autonomy.

The inquiry focused on the harvesting of organs and tissue, for the purposes of research, from children who died at the Alder Hey Hospital between 1948 and 1988 and subsequently (and most controversially), what was known as the van Velzen years, between 1988 and 1995. The inquiry examined the procedures used in the removal, retention and disposal of human tissue and organs following coroners' and hospital post mortem examinations. The legality of these actions was assessed by examining the extent to which the Human Tissues Act 1961 had been complied with. This involved the examination of professional practice and management action and systems, including what information, if any, was given to parents of deceased children relating to organ or tissue removal, retention and disposal.

The requirement of Section 1(2) of the Human Tissue Act (1961) was to ascertain if, having made such reasonable enquiry as may be practicable; he or she [the clinician] has no reason to believe that any surviving relatives of the deceased child object to the body being used for therapeutic purposes; medical education; or research. The starting point must be that the clinicians do have reason to believe that parents might object. The scope of the inquiry, according to the *Redfern Report* (DoH, 2001), must be:

“...that at the end of it the clinician can truly say he has no reason to believe there might be an objection.” (DoH, 2001, p.3)

The *Redfern Report* (DoH, 2001) found that in the case of Alder Hey there was:

“...abundant evidence of failure on the part of clinicians to make requisite enquires of parents to see if they objected. There is no evidence that the medical profession ever attempted to construe the HTA...However clinicians did acknowledge in evidence the difficulties in reconciling their ‘paternalistic attitude’ to the wording of the HTA. They conceded that parents should have been asked, for instance, about the retention of hearts. Consequently the paternalistic attitude cannot be sustained as an explanation of what occurred. The bald fact is that on the evidence the medical profession did not properly consider the HTA in the first place.”(DoH, 2001, p.3)

The *Redfern Report* (DoH, 2001) found that the failure to comply with the Human Tissue Act (1961) and the enormity of what happened in the eyes of the parents could be summed up with the following question:

“Would any parent not have objected if told that every organ of their child would be taken and in most cases left untouched for years without even an attempt at clinical histology examination?”(DoH, 2001, p9 )

The *Redfern Report* (DoH, 2001) then goes on to outline the extent and management of the collections of organs and tissue at various hospital sites and discusses the management breakdown and incompetence of Professor van Velzen. After this summary of the procedures at the Alder Hey Hospital the report turns to examine the harm caused to the parents.

The report states that throughout the inquiry the interests of the parents have remained of paramount concern. The essence of the parents’ complaints, the report alleged, is that they [the parents] believe they were:

“Deliberately mislead into thinking that they were burying their deceased children intact, when in fact each child had been systematically stripped of his or her organs, a large majority of which remained stored and unused from 1988-1999.”(DoH, 2001, p12)

The Report states that the inadequate handling strategy adopted by Alder Hey only served to aggravate the situation.

The *Redfern Report* (DoH, 2001) then goes on to make its recommendations for the future. One section of these recommendations, which differs from the mainly procedural changes proposed, is a new approach to consent taking. The report states that a fully informed consent is always required in circumstances such as this and “nothing less”(DoH, 2001, p.21 ). Fully informed consent must be “freely given without imposition of pressure. It is the application of basic principles of respect for person, their welfare and wishes.”(DoH, 2001, p.21)

The report interprets fully informed consent to mean that parents must be informed of the identity of each organ to be retained and the purpose for which it is used. “Blanket consent is inadequate for organs but is worthy of further consideration with regard to the retention of small tissue samples for diagnostic purposes, medical education and research.”(DoH, 2001, p.22)

For the *Redfern Report* (DoH, 2001), fully informed consent means that a person must have all the information required to form a final decision. It is not enough for a clinician to request to examine a body after death indicating that they may or may not take some tissue. The next of kin need to understand what is involved in a

post mortem no matter how distasteful giving this information may be for the clinician.

The Report goes on to develop a test for the level of detail a clinician must give in order that a fully informed consent can be deemed to have been taken. The test being “...whether any significant detail not mentioned could have led to a different decision by the next of kin. If so, then the test for fully informed consent will not have been met.”(DoH, 2001, p.22)

The *Redfern Report* (DoH, 2001) is as explicit both in its rejection of the model of paternalism as it is inconsistent with the principle of respect for persons and in its emphasis on the requirement of a fully informed consent. The report does acknowledge that consent forms were used in the process of organ retrieval and retention at Alder Hey. This would lead us to believe that some attempt at consent taking was made. However, the report concluded that the consent forms used at Alder Hey were inadequate, not clearly defining the terms ‘organ’ and ‘tissue’. The report also examined a model consent form published in The Royal College of Pathologists in March 2000 entitled *Guidelines for the Retention of Tissues and Organs at Post Mortem Examination*. They found that this model was too formal and complex. The report concluded that none of the forms provided the “basis for clinicians to obtain a fully informed consent and properly to set out and record the decision.”(DoH, 2001, p23)

The *Redfern Report* (DoH, 2001) suggested a new approach to consent taking. This would rely heavily on a new form of consent form laid out in a question and answer format. It should be completed jointly with the clinician, a bereavement adviser and the next of kin. The emphasis from the report is for the form to be longer and more detailed. The focus of which being that only explicit detail is sufficient enough to result in a fully informed consent as previously defined by the report. The report does make clear again, however, that “a more liberal attitude [to consent] should be considered with regard to the retention of tissue, particularly in the form of wax blocks and slides.”(DoH, 2001, p.24)

The *Redfern Report* (DoH, 2001) appears to have two main findings. First, that the clinicians involved in the Alder Hey Scandal did not take adequate consents for the purposes of the Human Tissue Act (1961). Second, that as this practice was widespread across the NHS; many consents taken were too paternalistic and therefore ethically redundant. Any consent, according to the *Redfern Report* (DoH, 2001), in order to be valid has to be fully informed. The reason for this, the report concludes, is that we must adhere to the principle of respect for persons which is interpreted as meaning that individuals are enabled to make their own decisions and be self-governing. Therefore, although consents were taken *per se*, they were insufficient to be of merit and did not adhere to the spirit of the principle of respect for persons.



### **The *Redfern Report*: interpretation**

The findings of the *Redfern Report* (DoH, 2001) give us an opportunity to expose the normative values that inform the concept of respect for persons (commonly accepted as patient autonomy) in the clinical setting. The key components in the report that I wish to consider are the emphasis on information giving and how that informs our understanding of patient autonomy. Followed by an analysis of the distinction made in the *Redfern Report* (DoH, 2001) between what was described in the report as the 'van Velzen years' and general medical practice at that time (all be they both viewed as inadequate by the report) to see if that distinction yields any further insights.

The media, at the time of the Alder Hey Scandal, reported the events in terms of the doctors involved having repeatedly harvested organs and tissue of deceased children *without* the consent of the children's parents. "The organs were stripped without permission from babies who died at the hospital between 1988 [and]1996." (BBC, 2001)

"The scandal first broke in 1999 when it emerged that the hearts and other organs of 170 children who died at Bristol Royal Infirmary had been kept without their consent. The scandal at Alder Hey emerged soon after. It became clear that organ harvesting at the hospital went back decades." (Batty and Perrone, 2001)

This reporting differs slightly from the findings of the *Redfern Report* (DoH, 2001). In the vast majority of cases consent had been sought from either the parents or another appropriate relative. The finding of the *Redfern Report* (DoH, 2001) was that although consent was sought, it was inadequate for the purposes of the

Human Tissue Act (1961). Clinicians had made insufficient enquiries of the parents and were therefore unable to be certain that the parents had no real objection to what was proposed.

Further, the *Redfern Report* (DoH, 1961) interprets the Human Tissue Act (DoH, 1961) to have a much higher standard of information giving necessary to consent than that which was required at common law at that time. For the purposes of common law, clinicians acting under the direction of Prof. van Velzen, had for the most part gained 'valid' legal consent. They had asked patients, in accordance with common practice at that time, for permission to remove tissue or organs for the purpose of research or medical education (*Bolam v Friern Hospital Management Committee*, (1957)). Indeed the *Redfern Report* discusses the inadequacy of the consent forms (because they lacked information) used acknowledging that some attempt at consent taking was made (DoH, 2001, p.23). Common law states that as long as a practitioner acted (in this case gave sufficient information) in accordance with common practice (i.e. what any other reasonable practitioner would do in the same circumstances at the time) he has discharged his common law duty (*Bolam v Friern Hospital Management Committee*, (1957)). In fact, of the four doctors involved in the scandal who were called to the General Medical Council (GMC) under charges of professional misconduct all but one were exonerated (Hawkes, 2001). This leads us to consider why the *Redfern Report* (DoH, 2001) interpreted the Human Tissue Act (1961) in this way? After all, the principle of informed consent in the Human Tissue Act (1961) is an incorporation of common law into statute. One could reasonably suppose that the Human Tissue Act (1961) should

be interpreted in line with other law in that area. However this perhaps goes some way to exposing our understanding of patient autonomy in the clinical setting. In attempting to give a voice to patients concerns about the manner in which they have been treated the report contends that information and a fully informed consent form a vital part of respecting patients. This is where we begin to see an expansion of the consent process. Information in relation to consent must be sufficient enough for the patient to go through some form of reflective decision making rather than adequate enough to merely identify the options (rather than understand them) and opt for one. Patient autonomy is clearly understood in the terms of patient choice and importantly the *action* of choosing. We will return to this point in a moment but first I wish to consider the van Velzen years.

Perhaps significantly, the report focuses on the van Velzen years despite their remit being the years 1948-1995 (DoH, 2001, pp.129-320). I now wish to consider if this distinction between common medical practice of the time and the van Velzen years reveals anything else about medicine's interpretation of patient autonomy. The retention and retrieval of organs at Alder Hey was, according to the report, in contravention with the Human Tissue Act (1961) (only thirteen years after the start of the period of investigation). However as we have briefly considered this was a wide spread practice at the time across most NHS hospitals. In this regard Alder Hey does not distinguish itself. Consents, all be they 'blanket', were no different from the rest of the medical profession and therefore were largely regarded as adequate (in a legal sense the test being the reasonable man and therefore what is commonly done in the profession, (Bolam v Friern Hospital

Management Committee, (1957). Although the *Redfern Report* (DoH, 2001) expresses concerns about this practice and attempts to allege this is in contravention of the Human Tissue Act (1961) notably no one solely involved in that process was successfully disciplined or prosecuted (Hawkes, 2001). It is only when van Velzen is appointed that the procedures at Alder Hey diverge from common medical practice. Interestingly though this is not in relation to the manner in which consent was taken but rather the outcome; what subsequently happened to the organs or tissue after retrieval. The van Velzen years show a wholesale gathering of organs for no specific purpose that were inadequately stored and allowed to deteriorate and therefore put to no useful purpose. The *Redfern Report* (DoH, 2001) distinguishes the van Velzen years in that it claims that the offence in relation to the waste of material occurred because consents were given on the presumed *understanding* of the parents that the material would at least be put to some useful purpose and it is that waste and breach of trust that has caused the offence.

Despite this the report interprets the offence here as lack of information and therefore a resulting inadequate consent which deprived the parents of choice with regard to the retention of their children's organs. The report interprets the offence to the parents' autonomy in terms of them 'not knowing' what would happen to their children's organs rather than in terms of the blatant disregard to the sanctity of the items retained. This seems counter-intuitive, clearly, no parent would consent to retrieval and retention of organs of a deceased child treated in the same manner as at Alder Hey but it does tell us something about the manner in

which we understand autonomy in the clinical setting. Autonomy appears to be measured in terms of how patients (or parents as consent givers) engage in the clinical process and to what extent that engagement is effective. This is the first sight of an emergence of a narrow interpretation of consent in that necessary information as understood by the *Redfern Report* (DoH, 2001) really relates only to the medical choice before them and as such has very narrow parameters. The permissions given and the way we understand the offence here relates solely to the medical business at hand, (here the retention of organs), and the technicalities of that process rather than a wider consideration of what issues might be broadly of concern to the patient. The *Redfern Report* (DoH, 2001) interprets the offence as a lack of procedural accuracy and a dysfunctional choice on the part of the parents. That is to say that had the parents been given a more accurate or informed choice they would never have agreed to the retention of their children's organs in this manner.

This brings into question the information-based approach of health care and consent as proposed by the *Redfern Report* (DoH, 2001). We may wish to consider to what extent the difference in the level of information is an appropriate explanation that help us distinguish the van Velzen years from the remainder of the medical practice at the Royal Alder Hey Hospital (and beyond) and whether we believe it adequately reflects the importance attached to the donation by the parents. Indeed we will explore this point more thoroughly in Chapter Six. For the moment my main aim is to expose our current construction of patient autonomy in the clinical setting and to claim that action of choice; that reflective process is how

we understand, respect and promote a patient's autonomy: more information leads to better choosing and better choosing leads to better autonomy. The actual choice itself is merely the by-product of that autonomous process and by no means can account for our requirement to respect autonomy by itself.

The *Redfern Report* (DoH, 2001) clearly focuses its attention on the concept of consent and finds the inadequacy of consent taking at Alder Hey to be the issue of concern. For the *Redfern Report* (DoH, 2001) the purpose of consent is to protect the principle of respect for persons interpreted as being the right to have your "...welfare and wishes considered" (DoH, 2001, p.21). The report concludes that the offence caused was that parents would not have given their consent to the retention and retrieval of organs had they know that the material would be treated so poorly. One could interpret this as the parents being deprived of their autonomy in relation to the consent taken. They were unaware of a fact that would have significantly changed their decision to consent had they been aware of it. However one must ask the question would the same offence have been caused if the organs had been used carefully? Would parents then have felt that their autonomy was reduced because they were not sufficiently informed as to what purpose the organs would be put to if the organs had been treated with respect? After all, the organs could have been integral in finding a cure for childhood cancer, but the parents might have been wholly unaware that this was the purpose they were being used for.

What offence did the parents, according to the *Redfern Report* (DoH, 2001), seem to feel had occurred? According to the report the offence the parents felt had taken place was that they had been.

“Deliberately mislead into thinking they were burying deceased children intact, when in fact each child had been systematically stripped of their organs, a majority of which had been stored unused from 1988-1995.”(DoH, 2001, p.12)

We have briefly considered the possibility that had the organs had been put towards medical research or teaching and used in an appropriate manner the same offence may or may not have been caused. Both situations would have however involved a lack of information giving to parents who, at least by the *Redfern Report's* (DoH, 2001) standards, would have been regarded as insufficiently informed to give an informed consent. This would mean under the *Redfern Report's* (DoH, 2001) interpretation that their right to have their wishes respected (for our purposes their autonomy) would have been reduced if not entirely frustrated. Perhaps the proposed symbiotic relationship between autonomy and consent is self-defeating in that the developments in consent taking as proposed by the report attempt to try to give voice to broad concerns by improving patient autonomy; by respecting patients better by improving the ‘quality’ of a patient’s choice. If autonomy and its protection are understood in the terms of information giving it may be difficult to explain the offences caused by the mistreatment of the material adequately.

Despite these inconsistencies the *Redfern Report* (DoH, 2001) felt that the offences caused to the parents were best addressed through a new model of informed

consent. It is this new model that reveals how we understand consent and autonomy in medicine. Both the new Human Tissue Act (2004) and the *Redfern Report* (DoH, 2001) make it explicitly clear that the purpose of consent is to enable individuals to be self-determining rather than simply to give permission for acts that would otherwise be viewed as illegitimate. It may be deduced that the findings of the report and subsequent legislation felt it necessary to make clear to the medical profession the purpose of consent; that being that the legal basis of consent is to *promote* the autonomy of the patient. Further that by the act of giving medical information and thus promoting patient autonomy it shows that we understand the autonomy of patients largely through the action of choosing rather than the choices they make during the consent process. More information means better choices and increased autonomy. If nothing else it would be arguable that in the view of the *Redfern Report* (DoH, 2001) and later legislators the moral concern at issue as a result of Alder Hey was inadequate consent that resulted in an unjustifiable reduction of individual autonomy.

### **The *Redfern Report* – normative considerations**

We have previously argued that autonomy is largely regarded as the cornerstone and ethical basis of the clinical relationship. Further, we have seen through the analysis of the *Redfern Report* (DoH, 2001) that autonomy and consent are linked through the process of giving full information to patients about the clinical decision before them.



Clearly at first instance there has been a moving away, as we have seen from the *Redfern Report* (DoH, 2001), from the paternalistic attitudes of the past and a move towards autonomy. In this sense we might contend that this ascribes greater value to the patient voice. It would seem reasonable to conclude then that to some extent at least the aim of medicine and dentistry to construct the concept of 'respect for persons' by relying on the concept of autonomy through the use of the consent process does to some degree give additional value and weight to the patient as an individual. However, the manner in which this is achieved is by relying on information giving as the way to gain valid consent. It is suggested that this reliance on information giving as the method by which that voice is given weight or value may present some difficulties. These difficulties might be best divided into two areas, one is about the focus on information and how that prioritises the clinical agenda and second is that it relies on the presumption that information promotes autonomy and to some degree is a necessary condition of autonomy.

The first difficulty that arises is the focus on the clinician to deliver information to the patient about the procedure. It is the clinician who is the arbiter of which facts are pertinent and the focus of information is on adequately informing the patient about what is proposed in medical terms. As the information duty falls to the clinician, who is the expert, it is inevitable that the treatment or procedure proposed is the focus of consent. Further, as we are not attempting to promote the autonomy of the clinician in the exchange, the information is (for the purposes of satisfying consent) only required to flow in one direction from clinician to patient.

This inevitably means that the process can fail to prioritise those matters of concern to the patient, ironically the very one whose autonomy we are seeking to protect or promote. We have seen from our case studies in the preceding chapter that this can present some problems for patients. One clear example of this would be skill mix where patients quite validly consent to treatment by having all the options explained to them as required and are enabled to make an 'informed choice'. From the perspective of the clinician the patient is given all the information that they need in relation to their treatment decision but still patients report dissatisfaction when they learn that the treatment was delivered by someone who, despite being duly qualified, was not a dentist. From a professional perspective the patient's autonomy has been respected (by asking their permission) and promoted (by giving them information) but still patients report concern. This is perhaps because from a patient perspective the priority is incorrectly focused on the treatment and fails to take account of other factors that the patient may feel are an integral part of their autonomy. Similar criticisms can also be raised in relation to cosmetic versus therapeutic treatment and NHS versus private treatment. Can autonomy then as it is construed here, (in that it is promoted by information giving) help us to distinguish between those actions that might be of central importance to the patient? For example, considering the reliance on information in the negative for a moment, the reliance on information giving (or lack thereof) may make it difficult to normatively distinguish between the retention of the organs of a child and what then subsequently happens to those organs and the retention of a cancerous mole for research purposes. Reliance on

information giving and consent might lead to conclude that for normative purposes autonomy of the patient (or parent) is similarly reduced in both cases.

It is not suggested that this is a fatal blow for autonomy *per se* but does highlight the practical difficulties in its application. If you are the holder of the information, but are not the subject of moral concern to whom the information relates, it can be difficult to affect the information exchange in an effective manner to support the recipient's autonomy.

The second point is more problematic and relates to the construction of autonomy itself and our requirement or desire to promote good. The difficulties in promoting good are again subdivided into two aspects. The first aspect is straightforward the question does information always promote good? Consider again our example of the retention of organs against the retention of a mole. If we work on the premise that increased information promotes autonomy and that we work from the perspective that autonomy is a good, this may then require us to increase autonomy whenever possible (perhaps with some limitations on duties required of us as appropriate to the relationship). If we follow this logic, then we may be able to contend that further detailed description and extended permissions for each procedure performed on a retained organ increase and better respect the autonomy of the person who gave the initial permission for retention. This seems counter-intuitive, there must be some point at which the requirement to obtain repeated permissions could cause distress to the donor and that this harm could not be re-interpreted as a good on the basis that it increases autonomy. In fact,

this point is considered in the *Redfern Report* (DoH, 2001) but not explored except to say that less information may be permissible in cases involving “...small tissue samples for diagnostic purposes, medical education and research.” (DoH, 2001, p.22)

As we will consider next in Chapter Three, hierarchical models of autonomy rely heavily on the process of decision-making and the way in which a patient would order their preferences. These models do not require however vast knowledge but merely the ability. Does this mean then that someone with less medical knowledge is less able to prioritise than someone who is more knowledgeable? Perhaps consent to treatment not only fails to prioritise what is important to patients but also relies on the misapprehension that information is important to autonomy. As we will see a patient may be able to make an autonomous decision that legitimately orders their priorities knowing very little about the procedure. Does autonomy require that a patient becomes a medical expert in the field and can express their expertise and if so to what extent? Consider an example where a patient is experiencing some severe symptoms and visits his dentist for a diagnosis. The dentist suspects oral cancer and wishes to take a biopsy. The patient agrees and understands all the implications that such a biopsy may have as well the manner in which it will be taken. The patient does however have one proviso that should cancer be diagnosed that the clinician does not disclose this to the patient. The patient’s reason for this is that he has a mortal fear of cancer and believes that should he receive such a diagnosis he will not attend for the life saving treatment that he needs; instead he exercises his autonomy that will enable

him to access the treatment he needs and declines a diagnosis. When the dentist returns it is as feared but the patient declines information of any kind and but consents to the treatment. According to the *Redfern Report* (DoH, 2001) if information is the key to promoting autonomy, one must conclude that this patient is less autonomous than his neighbour who consented with full information despite both being self-determining.

Full information may also suffer from practical difficulties as well as our normative concerns. How do we decide on a practical level what amounts to 'full-information' particularly if that aim to give full information is not anchored by any other aim or principle that would help us to establish robust parameters? When is full or even sufficient information full or sufficient? Again the legal answer is 'reasonableness' but this may fail to acknowledge the individual nature and value we seek to recognise. If we could agree on a 'full-information' approach (which has certainly been attempted from a legal perspective), does this satisfy the matters raised in the case studies in relation to deception? Does a patient want or need to know everything to feel that their autonomy has been respected and in what ways does telling a patient everything address the apparent inequality in the relationship? If one of the tenets of autonomy is to give individuals a personal value how does full information recognise that value? Is not the delivery of full information merely an attempt to mould the patient into a micro-dentist that is to say the aim is to bring the patient up to the level of the dentist so that they are not deceived? It does nothing to recognise them as individuals with their own set of personal priorities or expertise. It implies that in order to be an equal in the

dentist-patient relationship the impetus is on the patient to transform into a clinician only then will we be able to claim that their autonomy is being respected or perhaps more worryingly that they are even autonomous at all.

Further difficulties arise however from the relationship between autonomy and information. As we have previously considered the relationship between the patient and clinician is in some respect unequal. Although there is much debate as to whether this is a meeting of experts or bares the features of an unequal or more properly fiduciary relationship to some degree the exchange of information may have an important role to play in promoting good. It would be a dis-service to patients to conclude from our previous criticisms that information is not important to patients or that they are not interested in receiving it. The question is can we claim that the good promoted relates to the patient's autonomy or are there other principles that would better explain the importance of that exchange perhaps in line with a weaker construction of autonomy?

It seems that there are several points here we will need to consider if we are able to robustly draw any conclusions about the suitability of autonomy as an underpinning of the ethical relationship. We have considered some of the challenges on how best to prioritise the wishes of patient and how we distinguish between matters of importance and matters that are unimportant. We also raised concerns as to whether or not information is the key to understanding this? Our overall aim has to be far more global than this however if we are in the business of health care and we accept that health care by its very nature is an ethical

endeavour how then do we best care for patients? Is treatment our only focus and is it the focus on treatment that necessitates the reliance however ineffective on autonomy? If we changed our approach to respecting patients to encompass a greater emphasis on care overall and reduced our reliance on a treatment model could we then consider other ethical approaches such as paternalism or trust as legitimate ways in which to respect the individual?

Before we turn to alternative models however, I wish to consider in detail a model of autonomy that is closely linked to that which the *Redfern Report* (DoH, 2001) seeks to promote; the hierarchical models of autonomy. By careful exposition of this approach to autonomy we can consider if our current understanding and manner in which we deliver autonomy can account for the concerns raised in Chapter One that are specific to dentistry or indeed if the dentist-patient relationship needs an alternative model to adequately protect and promote respect for patients.

## **Conclusions**

The *Redfern Report* (DoH, 2001) perhaps exposes two key elements that are of importance here. First that where an offence, such as this, occurs we turn to the consent process to explain our concerns. As we acknowledge that consent is underpinned by the principle of autonomy (consent itself being the conduit through which we respect autonomy) this shows us that we largely understand autonomy to be an issue of self-determination through choice making. The 'lack of respect' parents were shown in this case is understood in terms of deprivation of

choice rather than, for example, breach of trust, breach of best interests or indeed deprivation of liberty. The response to the Alder Hey cases shows us that not only do we see autonomy as the rationale for consent taking but also we interpret offences to patients in terms of lack of adequate consent. This cyclical relationship between consent and autonomy shows us the importance of choice. Choice is the way in which we respect patients and lack of choice is how we understand lack of respect for patients.

The *Redfern Report* also reveals that information giving has become central to our understanding of an adequate consent. It is not sufficient, according the *Redfern Report* (DoH, 2001) to give patients a choice; a patient is entitled to have enough information to weigh in the balance their options and be able to consider the merits of the options in front of them. It is only then that their autonomy has been adequately respected. To not offer full information is to deprive the patient of their right to fully consider the options. For consent to be valid it must be fully informed; a patient is not autonomous merely by being self-determining in relation to their choices a patients is autonomous through the *action* of knowing what they are choosing. To summarise autonomy for the *Redfern Report* is weighing in the balance (the action) plus choice rather than blind choice alone.

This leads us to consider what model of autonomy, where the action of choosing is central, might we be emulating in the clinical setting? One model that places reflective practice at its centre is the hierarchical model of autonomy. As we will see in the following chapter hierarchical models of autonomy understand



autonomy through the process of the ordering of our preferences where we identify those of primary importance that ought to direct us to act (or not act) in particular ways. As we certainly appear to place significant importance on the action of choosing when we respect patients careful analysis of the hierarchical models may well help us indentify a suitable model for the concerns we raised in Chapter One in relation to our hypothetical case studies.

### **Chapter Three – Hierarchical Models of Autonomy**

In Chapter One we have considered three clinical contexts in which specific issues have arisen, those being the use of the cosmetic alongside the therapeutic in a primary care setting, the use of both NHS and private care in a primary care context and the use of skill mix. A common theme that has arisen from all three case studies has been a problem of deception. We have also considered briefly that any objection to the use of deception in the dentist-patient relationship might be explained in terms of appealing to autonomy. In Chapter Two we have considered the importance placed in current medicine on respecting autonomy through the process of consent. In order to assess the adequacy of our current approach we have considered the report (*Redfern Report*, DoH, 2001) relating to the Alder Hey Hospital Scandal. By close examination of the *Redfern Report* (DoH, 2001) we have exposed the reliance on the use of consent as the manner in which we respect patient autonomy. We have also exposed reliance on a claim that the lack of consent explains matters where we believe a patient has not been duly respected including where we believe they have been deceived. The findings of the *Redfern Report* (DoH, 2001) emphasise the importance of information in the process of consent-taking and this has led us to conclude that for medicine the process or action of consent is the way in which we understand patient autonomy and that the lack of information accounts for our concerns. As I have mentioned earlier, models where the *action* of considering options is integral to defining and identifying autonomy are commonly referred to as hierarchical models of autonomy.

The aim of this chapter is to consider the extent to which understanding patient autonomy in this way gives us an adequate account for the purposes of the dentist-patient relationship. We will do this by first reminding ourselves of some of concerns with regard to deception in the dental context raised in Chapter One. By doing so, it is hoped, we can be clear what types of deception we are concerned with. I will then go on to consider in detail the hierarchical accounts of autonomy. Particular attention will be paid to the manner in which these models operate and most importantly the extent to which hierarchical models can account for our concerns with deception. Finally we will return to the case studies proposed in Chapter One and consider whether or not indeed the hierarchical approach is the most appropriate way to account for our concerns.

### **Defining deception for the dental context**

We have considered in the Chapter One that patients regard any form of deception in the dentist-patient relationship as problematic. Deception is not merely confined to a deliberate act on the part of the dentist. Deception can occur, from a patient perspective, when they do not know of something that they feel they ought to have known, even if it would not have materially affected their decision. Deception can occur, for example, when a patient is treated privately rather than on the NHS even if they would have agreed to the fee anyway. Further, it may also occur where the treatment is delivered by a professional with a different status than the patient thought despite the treatment being identical. The expectations of patients seem not to focus exclusively on outcome of treatment but also on mode of delivery, and even more obtusely not even on the method of delivery but on

their role as a fully informed adult in that delivery at every stage. Therefore it seems important to patients that they are fully cognisant of all the facts as *they* see fit during treatment in a manner that we might wish to describe as a partnership approach (that is to say they are as equal partners as possible in the relationship) rather than recipients with the power to make key decisions. It appears that it does not matter that some of that information may not be material to the patient in terms of their health.

It seems if we are to address patient concerns we need to consider re-defining deception in a very broad sense and removing the element that necessarily requires some form of moral culpability. That is to say, for our purposes we do not need to define deception as someone actively choosing to gain an unfair advantage. For us deception can also occur as an effect of incompetence on the part of the deceiver. That is to say that, looking at our case studies, a patient may feel deceived even when the dentist in no way set out to deceive them nor derives any real benefit from the deception. Deceit may occur with a deliberate agenda on behalf of the deceiver, but rather here it is not a necessary component. If we accept that the definition is much broader we will need to explain and understand deceit in terms of what principle it offends in relation to the patient rather than in terms of the moral culpability of the dentist.

We will also need to consider the effect of manipulation as a form of deception. As we have seen in the Chapter One manipulation type deception relates to the influence. The effect of different influences need not relate to concealment of

information in the way ordinary deception does, but rather non-persuasively influences an individual into making choices they would not have otherwise made. In clinical relationships when medical authority is being exerted over patients, manipulation can easily operate. Patients may find themselves adopting the priorities of their dentist or giving undue weight to their advice contrary to their own (the patient's) values and priorities. We have seen from the case studies that the recommendation or offer of cosmetic treatment may be one such example; a dentist may generate a desire in a patient to have their teeth 'fixed' where previously they had not perceived a problem.

As we have already alluded to, the principle of autonomy would seem an obvious port of call in attempting to resolve this much broader definition of deception in the clinical relationship. It is a principle that certainly has been in recent years regarded as a founding principle of the clinical relationship. As we have previously seen, autonomy in its most basic terms is regarded as the right or ability to be self-governing, ascribing a personal value to the individual and not treating people as a means to an end. Any act therefore that might interfere with a person's right or ability to be self-governing might be prima facie viewed as an offence against autonomy. This might go some way then to explaining our concerns with deception. Might autonomy be the way in which we can explain our concerns and defend against them?

If we are to successfully make this claim we must go beyond the basic consensus and look more closely at the manner in which autonomy operates or is respected

to see if it is suitable for our purposes. There is much disagreement concerning an actual definition beyond a broad consensus that two conditions are necessary for autonomy to operate successfully, liberty (that is to say freedom from controlling influences) and agency (capacity for intentional action). Beyond this lie many models of autonomy. We will look at one perspective in particular, the hierarchical models. Our focus on this particular model is a consequence of our current construction of consent as a consequence of the *Redfern Report* (DoH, 2001) and therefore autonomy in clinical practice. As we have seen in Chapter Two, consent is not only underpinned by autonomy but is also the method through which we largely understand respect for patients (and in the negative appeal to consent when we believe patients have not been duly respected). Both consent and hierarchical models of autonomy rely on the *action* of choosing as the key to understanding autonomy and therefore how it might best be protected and promoted. It seems likely then that as we rely heavily on this construction of *action* of choosing in the clinical setting that we are appealing to hierarchical accounts of autonomy when we respect patients. As a result, it is hoped by having a relatively in-depth assessment of hierarchical accounts of autonomy we can see what merits they have in relation to our case studies and the concerns they highlight and whether this might be an adequate model for the purpose of the dentist-patient relationship.

The notion of autonomy as a capacity in modern times is largely the result of work done in the early 1970's by Harry Frankfurt, Gerald Dworkin and Wright Neely<sup>7</sup> who developed a 'hierarchical' account of autonomy. These hierarchical accounts share the same core feature; that a person is autonomous when their act is motivated by a first-order desire that is endorsed by a second-order desire.

There is much to recommend the simplicity of this approach when considering the notion of autonomy. First, it clearly captures the distinguishing feature of persons and their capacity for self-reflection and endorsement of desires over and above animal response. Second, the focus on the reflective process is a move away from conflict of personal autonomy with metaphysical determinism. Third<sup>8</sup>, it is content neutral, which allows the notion to be easily applied to the more empirical aspects of ethical debate, particularly where respect for autonomy is of primary concern and some means must be found to adjudicate between competing value claims.<sup>9</sup>

That is not to say that the hierarchical notion of autonomy does not suffer from a number of theoretical difficulties. It is hoped by critically analysing these difficulties that we may gain a clearer understanding of what an adequate version of the hierarchical model might look like and see if it is suitable for our purposes. With this in mind it is contended that there are three main difficulties with the hierarchical approach to autonomy as proposed by the Frankfurt, Dworkin and

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<sup>7</sup> I am going to concentrate on Frankfurt and Dworkin in this paper, as they have been the most influential.

<sup>8</sup> Perhaps most importantly for the purposes of medical ethics.

<sup>9</sup> Of particular relevance here would be the competing claims of patient, medic and perhaps even the NHS.

Neely group. These are first, problems with manipulation; second, problems with regress and third, problems with authority.

Let us first look at the hierarchical notion of autonomy, what values it seeks to accommodate and in what manner it addresses them. Then we will proceed to look at each of these objections in turn and how they may be addressed.

### **The Hierarchical Models of Autonomy**

According to Dworkin the notion of autonomy is a term of art. It is a term that has been used to make sense of a tangle of intuitions, conceptual and empirical issues and normative claims (Dworkin, 1988). The model of autonomy that has resulted from Dworkin and Frankfurt's work is a clear attempt to give some solidity to those intuitions. The question must be asked, however, what are the intuitions of which Dworkin speaks?

On reflecting on the hierarchical model of autonomy developed by Frankfurt (1971) and Dworkin (1988) there is a clear purpose and shared essence in the issues that the model attempts to address. The founding core value must be viewed as the concept of self-government. Indeed the main concept of the model is the notions of first and second-order preferences as a form of self-government. The theory of persons worked out by Frankfurt (1971) and the explicit theory of autonomy put forth by Dworkin (1988) build on this core essence; for them this is the capacity that distinguishes us from animals. However, to claim that this is the distinguishing feature of their hierarchical model would be to over simplify. After



all, other models of autonomy could lay such a claim. Models that view autonomy as a form of personal sovereignty also require self-government to be at their core.

The hierarchical model approaches the concept of self-government in a different manner. Whereas sovereign autonomy is contextual or conditional the hierarchical model tells us about what autonomy is as a capacity of persons. The hierarchical model goes further, it views autonomy as a capacity of persons and explains what the exercise of that capacity would involve. For Dworkin and Frankfurt it is not sufficient to say that 'if I do what I want I am self-governing'. Dworkin and Frankfurt propose a richer understanding of autonomy; for them self-government means being in charge of your desires rather than your desires being in charge of you. It is this approach in Frankfurt's theory of persons that enables him to distinguish us from animals. We are not mere slaves to our desires but able to create a policy of behaviour that may at times contradict instinctive desires but makes us masters not servants of our wants and needs. In this way the hierarchical models allows us to be more selective in our ascribing the 'label' of autonomy to others. Unlike the sovereign model where all individuals are considered autonomous (other than when they cannot do what they want) the hierarchical model enables us to consider persons as not being autonomous either in certain situations or as a continual state of being. This emphasises the contrast between the hierarchical model and the sovereign models; autonomy is viewed as

an internal process as compared to the sovereign model where autonomy is viewed externally<sup>10</sup>.

Paradoxically, presuming a link is agreed between those who are autonomous and the bearing of moral responsibility, the hierarchical model supports the principle of 'respect for persons' in a more empirically satisfying manner. We do not *prima facie* presume autonomy exists in a person and therefore do not unfairly burden those who are not autonomous with responsibility. Further, the hierarchical model enables other individuals who are not autonomous to be supported whilst still maintaining autonomy as a supreme principle. That is to say, if we can agree that autonomy is a capacity and therefore not possessed by everyone at all times (in contrast to sovereign autonomy) we are then able to reconcile this view with other concepts such as beneficence and paternalism but still allow autonomy to form the underpinning of our ethical approach to respecting persons. Therefore for Dworkin and Frankfurt autonomy is a capacity to self-govern not a *prima-facie* right in of itself. We must now consider how Frankfurt and Dworkin constructed their model of hierarchical autonomy with this view of autonomy as a capacity at its core.

### **Understanding hierarchical models of autonomy**

One of the central themes shared by both Frankfurt's and Dworkin's notion of autonomy is that of the hierarchy of desires. It is this ordering and evaluation of desires that is the core feature of what constitutes their interpretation of personal

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<sup>10</sup> That is to say that the sovereign model relates to how 'we' treat people and can become confused with the idea of respect for person at the exclusion of other desirable values. Whereas, the hierarchical model relates to what we are able to do.

autonomy. Frankfurt (1971), who first developed the concept of hierarchy of desires, did so to enable him to draw a clear distinction between animals and humans, believing that the distinction lay in the human will. Frankfurt noted that it is not a uniquely human characteristic to have wants<sup>11</sup>, desires or indeed to make choices. What is unique to humans, so Frankfurt contended, is the ability to form what he describes as second-order desires: that men besides wanting or choosing or being moved to do this or that, can also want to have (or not to have) certain desires and motives. Many animals are capable of having what he referred to as first-order desires that are simply a desire to do or not to do something. No other animal other than man, has the capacity for:

“...reflective self-evaluation that is manifested in the formation of second-order desires.” (Frankfurt, 1988, p.129)

This could therefore lead us to conclude that if A wants to X and on reflection A wants (or does not want) to have the desire to X that as A has both a first and second-order desire this must be sufficient to be viewed as a person (or for our purpose, be autonomous). Frankfurt did not feel however that this was sufficient, as it tells us little about A’s likely course of action and there are too many possible conflicts. Frankfurt proposed that the necessary and sufficient conditions for personhood would be that A wants to X, A wants (or does not want) X to be his first-order desires (i.e. A has a second-order desire) and A wants that X be his will that motivates him to act. Therefore someone can have a desire of the second-order either when he wants simply to have a certain desire or when he wants a

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<sup>11</sup> Please note the term desire and want are used interchangeably here (as Frankfurt did) for ease of language although the use of the term want would more properly describe Frankfurt’s view.

certain desire to be his will<sup>12</sup>. For Frankfurt, it is situations of the latter kind, which he referred to as second-order volitions that he regarded as essential to being a person. It is possible, therefore, that there are beings that have second-order desires but no second-order volitions. Those beings in Frankfurt's view could not be regarded as persons because despite having second-order desires they do not care about their will. Frankfurt refers to these beings as wantons. Wantons' desires may move them to do certain things without it being true of them either that they want to be moved by those desires or that they prefer to be moved by other desires.

It is this view of *volitional endorsement* where the link can be seen with Dworkin's explicit theory of autonomy. For Frankfurt a person is autonomous where their motivation to act is *volitionally endorsed*<sup>13</sup> by a second-order desire (Frankfurt, 1988). Volitional endorsement<sup>14</sup> can be understood to mean that not only does a person have a second-order desire but that also they want that desire to be their will (that motivates them to act). For example, a person is autonomous during the act of smoking a cigarette when the desire to smoke that cigarette has been endorsed by a further desire to be a smoker and that the person approves of that desire and wants it to become his will which motivates him to act. Similarly for Dworkin an autonomous person is one who:

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<sup>12</sup> Therefore an act can be said to be '*volitionally endorsed*' when it is approved of by a second order desire that that desire should be one's will that motivates one to act.

<sup>13</sup> Ibid footnote 12.

<sup>14</sup> Endorsement here refers to the approval of the first order desire by the second-order volition.

“...does his own thing” where “the attitude that [the] person takes towards the influences motivating him...determines whether or not they are to be considered ‘his.’”(Dworkin, 1976, p.26)

That is to say that following Dworkin’s notion, a person is autonomous if they endorse the desire that motivates them to act in a particular manner.

Therefore on Dworkin and Frankfurt’s analysis of autonomy a person prejudices their autonomy where the desire that motivates them to act is not volitionally endorsed: that there is no second-order volition that endorses their first-order desire to act. This would seem on the face of it completely credible. Returning to our smoker; a person would not be acting autonomously when in the act of smoking a cigarette, where although there was a first-order desire to smoke a cigarette there was in fact a second-order desire to give up cigarettes and that they would want that desire to become their will that motivates them to act (or in this case not to act). Here the second-order desire does not endorse the smoking of a cigarette. In this case some other motivation must be coming into play that results in the act of smoking rather than the exercise of personal autonomy (most obviously perhaps the addiction to nicotine). It could be said then that the desire to smoke is the result of an addiction and is not truly ‘his’ in Dworkin’s sense. Further, where a smoker has a first-order desire for a cigarette and a second-order desire not to be a smoker and the person wants that second-order desire to become their will that motivates them to inaction and that person does not smoke a cigarette but only because they have run out and no cigarettes are available it is not their will that motivates them to inaction but rather happy circumstance and therefore they would still not qualify (for the purposes of this inaction) as

autonomous. This is because they have not made their choice 'freely' but rather have been the victim of circumstance. This might help us to interpret our objection to deception in the case where a patient would have elected to private treatment anyway had they been given the choice. Even though the outcome forms part of their second-order desire it fails to transform into a second-order volition in that it is circumstance rather than the operation of will that informs the outcome. Therefore, the patient cannot be said to be being treated privately as the operation of their autonomy, irrespective of the fact that private treatment is their second-order preference.

It is this view of the will that motivates one to act that allows Frankfurt's and therefore Dworkin's theory to move away from the difficulties that theories of autonomy have with metaphysical determinism. This is because Frankfurt's conception of will and therefore what it means to be a person, relates only to the process of reflection that a person goes through which eventually motivates them to act. The will then is the motivation that culminates in an action (or inaction) and has no relationship to the metaphysical at all. Free will for Frankfurt is a matter of an internal process largely irrespective of how desires come about, whether they are determined. This enables the concept of 'freedom of will' to still form an integral part of the definition of a person (and therefore autonomy) but to not be affected by the metaphysical debate.

Frankfurt contends that some concepts of freedom of will are fundamentally a matter of doing what one wants but these only capture the concept of acting freely

and miss entirely the notion of an agent whose *will* is free (Frankfurt, 1971). To deprive someone of being able to act freely does not necessarily deprive him or her of free will. For example, where someone has their freedom restricted but is unaware of it (say a choice is removed without their knowledge) although their freedom to act is restricted their will remains as free as ever. Therefore, freedom of action is the freedom to do whatever one wants but freedom of will is the freedom to want what one wants (within the context of the hierarchical approach). Further, it is in the securing of conformity of his will to his second-order volitions then that a person exercises freedom of will. And it is in the discrepancy between his will and his second-order volitions, or in his awareness that their coincidence is not his own doing but only happy chance that a person who does not have this freedom feels the lack of it. The question of free will then for Frankfurt is a-historical; it is not subject to questions about whether or not one's will is one's own or part of a determinist world. It is sufficient to say that free will is the product of an ordering of preferences and the freedom to want what one wants as an outcome of a second-order volition.

Using Frankfurt's work on the theory of persons and his concept of freedom of will Dworkin moves on to develop his theory of autonomy. Dworkin recognises that whilst Frankfurt's theory captures the intuitive essence of what it means to be a person it is insufficient for a theory of autonomy. This is because Frankfurt's model does not seek to address the issue of values acquired through illegitimate means. This is of particular importance to us in relation to considering the matter of deception in our case studies. Frankfurt's theory of persons takes an a-historical

approach in its recognition of personhood. Whilst this is a legitimate approach when trying to capture an internal process it allows desires adopted by, for example indoctrination, to still be viewed as second order volitions and to view the person who acts on them as fully free. For Dworkin this is insufficient for a theory of autonomy, it is counter-intuitive that a person could be viewed as autonomous simply because they have ordered preferences acquired by 'brain-washing'. Dworkin's formula for autonomy then is the theory of authenticity<sup>15</sup> (as proposed by Frankfurt) plus procedural independence.

"A person is autonomous if he identifies with his desires, goals, and values and such identification is not influenced in ways which make the process of identification in some way alien to the individual. Spelling out the conditions of procedural independence involves distinguishing those ways of influencing people's reflective and critical faculties which subvert them from those which promote and improve them."(Dworkin, 1988, p.18)

It is in this way that Dworkin hopes to capture the hierarchical sense of self-government whilst recognising that some level of independence is necessary for a theory of autonomy.

### **Independence and autonomy**

Dworkin's approach to the issue of independence is also a defining feature of the hierarchical model. Independence is divided into two categories, procedural and substantive independence. Procedural independence requires that a person is free from situational or personal interference that impacts on their ability to make a free choice. Therefore *X* could be said to have procedural independence if and only

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<sup>15</sup> I.E. Second-order volitions as previously described.



if their desire to be moved to act has not been produced by manipulation, deception or the withholding of relevant information. That is to say that procedural independence is affected by *external* factors. Substantive independence may be deemed to exist where a person does not defer independent judgment (Dworkin, 1988, p.22). Therefore substantive independence cannot be said to exist, for example, where a person has deferred judgment to the legal system, a moral authority or God, as they are required to retain control over their decisions and actions. *X* could be said to have substantive independence with regard to his motivations if and only if he does not renounce his independence of thought prior to developing them<sup>16</sup>. Substantive independence is forfeited by internal factors<sup>17</sup> (i.e. personal choice).

For many theories of autonomy the existence of both of these types of independence are both sufficient and necessary conditions for the existence of autonomy. This is where the hierarchical model differs. For Frankfurt neither procedural nor substantive independence are necessary conditions of his notion. Frankfurt focuses purely on the internal process, considering the ordering of preferences in relation to any given issues as the only criteria to take into account. This a-historical approach has its attractions. It reinforces the intuitive belief that autonomy is a feature and capacity of persons not a situational one. By rejecting or refusing to consider either type of independence the focus of analysis remains on the internal process of the person rather than any context that a person might find

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<sup>16</sup> I.E. Prior to developing his motivations.

<sup>17</sup>'Internal factors' is not perhaps the best form of words here but is used to contrast with the idea of 'external factors' for procedural independence.

themselves in. This also helps to retain focus on what we mean when we refer to autonomy rather than what context in which it can be said to exist, allowing us to get closer to a definition. There are of course difficulties with this approach. Although it allows us to get some kind of definition within our reach it makes it difficult to apply. The a-historical approach is open to problems with deception. For Frankfurt, a person is still viewed as autonomous in relation to their second-order desires even when they were acquired through some form of deception, for example, hypnosis. The problems with deception will be discussed in greater detail later.

Dworkin, whilst still maintaining the same focus of 'internal process' as Frankfurt, acknowledges the theoretical difficulties with foregoing the requirement for procedural independence and re-introduces this into his model. However Dworkin's account merely requires that procedural independence exists; a person must come to have her desires by procedurally independent means. Dworkin avoids the deception problem resulting from the a-historical approach simply by ruling *ex cathedra* that a person is not autonomous with respect to those desires that she has been deceived into possessing. Dworkin has been criticised for this approach (Taylor, 2005). It is not theoretically satisfactory to simply list situations where it is intuitively plausible that a person would suffer from lack of autonomy but rather that an account must be provided of why a person's autonomy would be thus undermined so that differing influences can be differentiated. It certainly is inadequate in helping us address our concerns with deception. This problem with deception will be covered in more detail later.

It is perhaps Dworkin's approach to substantive independence that is of most interest here in our attempt to gain a greater understanding of the hierarchical model. As part of Dworkin's development of what he describes as a theory<sup>18</sup> of autonomy he proposes some criteria for his theory. One of those criteria is that any theory of autonomy should be consistent with other values.

"I suggest that the theory not imply any logical incompatibility with other significant values, that is, that the autonomous person not be ruled out on conceptual grounds from manifesting other virtues or acting justly." (Dworkin 1988)

For this reason, Dworkin argues that there is no place for substantive independence within his theory of autonomy. For Dworkin, a theory of autonomy should be consistent with other values such as 'loyalty, objectivity, commitment, benevolence, and love' (Dworkin, 1988, p.21). These values require a person to defer independent judgment subject to the commitment they made according to the value proposed thus limiting their freedom. It is this 'deferring of independent judgement' that makes these values incompatible with substantive independence. Dworkin argues for other theorists values such as promise, worship, obedience to command or conformity to law are all inconsistent with autonomy (Downie & Telfer 1971; Rachels, 1971; Scanlon, 1972; and Wolff 1970). The reason being, that surely a person is not thinking or deciding for himself in accordance with preferences, tastes and belief when he adheres to these other values. He either does not form independent judgements about what he should do, or if he does, he does not act on them. To predict his actions (in that a person responds

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<sup>18</sup>I am using the term 'theory' here as opposed to 'notion' to reflect Dworkin's own words: his intention to develop a theory rather than a definition of autonomy.

automatically without reflection) we must know what the agency deferred to thinks he should do. It would seem then, for these theorists that autonomy is largely a question of substantive independence.

“What is essential to the person’s remaining autonomous demands that a person is in any given case his mere recognition that a certain action is required by law does not settle the question of whether he will do it.” (Scanlon, 1972, p.215)

Dworkin counters, saying that knowing what an agency requires is not sufficient to predict a person’s actions. We must make reference to his desire to do what the agency requires of him. It is his decision, arrived at freely (without deception, manipulation or coercion, in a procedurally independent manner), backed by reasons, that makes the agency’s wishes effective in determining actions. He is doing what he wants and leading the kind of life he thinks is worth leading; how then can he not be autonomous? In this sense Dworkin contends that autonomy is still in existence as the restriction of the person is freely chosen according to certain values. For Dworkin the problem with substantive independence is that it cannot allow the transfer of authority and therefore precludes good as well as bad reasons for giving up independence. This approach is very individualistic and runs into problems when it is applied to relationships because it places such a high value on making decisions for oneself. Dworkin’s account agrees that it is indeed good to make decisions for oneself but there is no need to descend into absolute individualism and for this reason he rejects substantive independence as a requirement for his model of autonomy.

Dworkin accepts that there are other ideals that also come into conflict with desirable values, in particular liberty. Liberty clearly conflicts with other values

that involve commitment such as love, loyalty or promises yet we do not deny that liberty is valuable or argue for a weaker conception. Dworkin contends that this is because there are perhaps differing kinds of liberty: liberty that is associated with contextual freedom (for example the freedom to go out on a Saturday night) and political liberty (the freedom to not have another's wishes imposed upon our own). It is objections to the second kind of liberty that we raise and it is this kind of liberty to which we raise presumptions. Even if political liberty is inconsistent with other values (Dworkin uses the example of being free to use one's talents to make as much money as one can) such as equality it is a contingent fact that the exercise of liberty may diminish liberty it is not liberty itself that is in conflict. The conflict of autonomy, considered as a substantive notion, with other values is not contingent but necessary. There is no possible situation where one could make a commitment to a friend and remain substantively independent.

Dworkin asserts that despite arguing for a weaker conception of autonomy in this sense he is still able to argue for normative claims about authority. As he puts it, "in short, we don't need it and it's not a very good thing anyway" (Dworkin, 1988, p.25). Dworkin contends that conceptions of autonomy that involve substantive independence lead to theoretical mistakes about political and moral authority. Consider Wolff's use of the strong conception of autonomy to deny the legitimacy of any state (Wolff, 1970, p.14). Dworkin's criticism of Wolff's argument is the overly strict interpretation of authority. Authority cannot be said to be obeying commands simply because they are commands, no one has ever argued for that concept of authority and therefore it cannot be rejected on that basis. However,

even on a more reasonable view of authority explicit agreements to obey or the making of promise do forfeit substantive independence but why should these views also forfeit autonomy? Dworkin holds that it is the value of autonomy that the promises or commitments a person makes are his own, are part of the person he wants to be and define him as a person (Dworkin, 1988, p.26). Dworkin asserts that if the autonomy that Wolff speaks of is inconsistent with commitment or promising then it has no claim to be the supreme value.

One of the problems with relinquishing the need for substantive independence is the fear that the link with responsibility may be broken. A man cannot be responsible for acts that he committed whilst not substantively independent. Mill disagrees with this view; a man cannot escape responsibility for committing an act merely because it was required of him from a higher authority. He is then responsible for precisely that, forfeiting his autonomy without due consideration (Mill, 1859, p.186). If we accept this as the case the link with responsibility can still be maintained in Dworkin's theory and cannot be used as an argument to require the inclusion of substantive independence.

Dworkin therefore argues that some level of independence is a necessary component of autonomy. This is in order to avoid desires that may be acquired by illegitimate means such as deception. Although Frankfurt does give us an account of freedom of will in his theory of persons, thus acknowledging the importance of freedom at some level his a-historical approach cannot account for desires that were illegitimately acquired before the critical moment in time. Dworkin in an

attempt to counter this difficulty does require some independence but this is the weaker form of procedural independence. Dworkin explicitly rejects the need for substantive independence as part of his theory of autonomy as he feels that a theory of autonomy should be compatible with other desirable values which require some forfeit of substantive independence and that if independence is forfeited as part of an adherence to some personal policy then this does not pose a problem to the hierarchical model.

Dworkin as part of his criteria for a satisfactory theory of autonomy insist that there should be ideological neutrality. The concept should be one that has value for different ideological outlooks. It should not be the case that only individualistic ideologies can value autonomy. However differing ideologies may differ in the weight that they ascribe to autonomy, the compromises that a different ideology might feel are reasonable, whether the value be intrinsic or instrumental and so forth.

Whilst, as we have seen, there is much to commend the simplicity of this approach the hierarchical model of autonomy does suffer from some theoretical difficulties. The three main difficulties with Frankfurt and Dworkin's hierarchical model of autonomy are the difficulty with deception, the threat of regress and the problem with authority. Each poses a significant threat to the success of the hierarchical model of autonomy. I will now turn to look at those problems in detail and the revisions that Frankfurt and Dworkin made to their original analyses in order to address these theoretical difficulties. It will be seen that Frankfurt mounts a

detailed and somewhat although not entirely, successful response and defence. In contrast Dworkin takes a more lateral approach and shifts the supposed purpose of his model to avoid the criticism but without really providing any answers. I will then turn to look at how other theorists have dealt with the difficulties of the model and again to what extent they are successful.

### **Hierarchical models of autonomy: critique and response to the problems of deception, regress and authority**

I wish to contend that whilst the three difficulties pose equal threats to the success of the model they differ from each other in one key way. The problems of both authority and regress are internal dilemmas which whilst they could be the cause of a theoretically unsatisfactory break-down in the function of the hierarchical model do not pose a threat in themselves to the view that autonomy is a personal characteristic identified through an internal process because they are in of themselves internal problems. The problem of deception poses a different threat however. This is the difficulty that arises when an autonomous (or otherwise) person engages with others and is a difficulty not with the internal process but with the way in which people interact with each other. This is a relational challenge which, I contend, may be difficult to address when focusing on autonomy as an internal process or personal characteristic. This is because if the whole question of autonomy rests on the success of an internal process or otherwise, it is the manner in which information is processed that indicates whether or not a person is autonomous. However, how that information was acquired in the first place must be of equal importance, if the information is false, deceptive or



manipulative in any way then surely this must affect the individual's autonomy? As we will see, most of the hierarchical theorists recognise this as a difficulty but attempt to solve it by refining the internal process rather than addressing the problem of deception externally. We will first look at each of these problems in turn and how Frankfurt and Dworkin sought to address them. I will then turn to look at more recent attempts to address these issues and assess the extent to which they have been successfully addressed.

### **Problems with deception**

We will first consider the difficulty with deception. It is counter-intuitive that a person could be viewed as being autonomous with respect to their desires where those desires have been acquired by some nefarious means, such as manipulation, indoctrination, deception or even hypnosis. This difficulty with deception arises for Frankfurt because he takes an a-historical approach to autonomy. It is sufficient for Frankfurt's account that the first order desire is endorsed by the second irrespective of the origin of the first order desire. The a-historical approach does not require any assessment of how a particular desire was acquired, it merely focuses on the process required for autonomy at any given particular time. For Frankfurt the means by which a first or second-order desire is acquired is irrelevant, it is merely the endorsement of first-order desires by second-order desires that is important; a 'snapshot' in time so to speak. The difficulty with this approach is that a nefarious third party could in some way influence an individual into having a first-order desire and also a second-order desire that endorses it. For example, a schoolboy is introduced to smoking by a

friend, the friend is very popular and the schoolboy is keen to emulate him. The schoolboy takes up smoking and smokes a cigarette he wants the cigarette and he endorses that desire because he believes smoking is cool as his friend does it. Following Frankfurt's account of autonomy the school boy is acting autonomously in smoking the cigarette as he endorses that desire despite the fact the his second-order endorsement is perhaps originally acquired through the illegitimate<sup>19</sup> influence of his friend. An objection to this must be raised. It is theoretically unsatisfactory to ignore the manner in which endorsements are acquired when constructing a notion of autonomy particularly where deception may threaten.

Dworkin appears to have a response to this objection in that he requires the individual to have procedural independence. Therefore following our school boy smoker Dworkin's account of autonomy would clearly block the school boy from claiming autonomy if his second-order desire to be a smoker was the result of undue influence from his friend and the policy had been adopted to merely emulate another rather than it being a freely adopted policy. It would appear *prima facie* then that Dworkin has solved the problems with Frankfurt's a-historical approach.

It must be said however that Dworkin simply asserts without sufficient argument or explanation that any second order desire that cannot be said to be procedurally

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<sup>19</sup> Illegitimate may perhaps be distinguished from legitimate in that legitimate influence is a case of helping someone to see something that they can then pass their own judgement on; illegitimate on the other hand is perhaps getting someone to do or think something whilst precluding them from passing their own judgment.

independent cannot be said to be sufficient to support his notion of autonomy. Dworkin appears to have recognised the difficulty with the a-historical approach but offers no real solution. It is contended, that it is not theoretically sufficient to list situations in which a person may not be autonomous but rather there needs to be an account of why that situation destabilizes autonomy. This would then enable us to distinguish situations where the influence might not undermine autonomy (for example education) from situations that do undermine it (for example indoctrination).

### **The problem of infinite regress**

Frankfurt's (1971) and Dworkin's (1988) analyses of autonomy also faced the problem of infinite regress. For the hierarchical model of autonomy a person is autonomous with respect to their desires if their effective first-order desire is endorsed by a second-order desire. This poses the question then, is a person autonomous with respect to that second-order desire and if so, why? If the answer is, because the second-order desire is in turn endorsed by a third-order desire an infinite regress threatens; one must then ask if in fact that third-order desire is so endorsed and so on *ad infinitum*. If this is not the case and a second-order desire carries weight for reasons other than it is also endorsed by a higher-order desire that would render the Frankfurt and Dworkin's account of hierarchical models of autonomy incomplete.

This argument could perhaps be countered by claiming that indeed a person is not autonomous with respect to their second-order endorsing desires but *is*

autonomous with respect to the first-order desire that has been so endorsed, because autonomy is simply constituted from that endorsement. However, neither Frankfurt nor Dworkin use this defence, perhaps because this would lead them to the third objection, a problem with authority.

### **The problem with authority**

The problem with authority poses the question, how can one be viewed as autonomous with respect to desires that form part of a process during which one is not autonomous. That is to say why do second-order desires hold any authority over first order desires? As Gary Watson points out:

“Since second-order volitions are themselves simply desires, to add them to the context of conflict is just to increase the number of contenders; it is not to give a special place to any of those in contention.”(Watson, 1975, p.218)

### **The response**

Faced with these three difficulties both Frankfurt and Dworkin modified their original analyses. Frankfurt recognised that his theory was beset by a problem with deception (as well as difficulties with regress and authority) because it relied on the claim that a person is autonomous with regard to his or her desires by endorsing them through a deliberate psychic event. The problem being that one could always question a person’s autonomy with respect to that event. As a result Frankfurt modified his account to include a satisfaction based analysis of identification (Frankfurt 1998, pp.98-107). On this analysis a person does not need to engage in any ‘deliberate psychic event’ for them to identify with their

desires. One could be viewed as being autonomous with regard to a particular desire if one accepts that desire as his own: it is a sufficient condition that the desire "indicates something about himself"(Frankfurt, 2002, p.160). It is Frankfurt's contention that a person, in accepting a desire, will reflect on it to see if it expresses something about themselves. It is this acceptance that constitutes their endorsement of it, in the sense that one might endorse the claim of a person that they have a certain quality without evaluating the merits of the person making that particular claim. Frankfurt, does not require that a person then endorses their endorsement as this would lead to regress; it is sufficient that she identifies with the first-order desire by being satisfied with her second-order attitude to it (i.e. endorsement).

Despite Frankfurt's modification however, this does not resolve the problem with deception. This is because a person could be unwittingly hypnotized or indoctrinated into possessing a first-order desire in such a way that he believes it originates from within him. In this sense an individual would both endorse a first-order desire and be satisfied with it for Frankfurt's purposes. However, one could not possibly view them as being autonomous but rather heteronomous.

Frankfurt also attempted to eliminate the problem with the threat of regress by claiming that a person's decisive identification with one of his desire's would eradicate it (Frankfurt, 1988a, p.21). In Frankfurt's later account he argued that a person is autonomous with respect to their first-order desire if he decisively endorses it with a second-order volition (Frankfurt, 1988b). Frankfurt made a

direct response to the threat of regress problem, claiming that if a person endorses his effective first-order desire “without reservation...in belief that no further accurate inquiry would require him to change his mind,” (Frankfurt, 1998, pp.168-169) there is no need for a person to then further consider whether or not they are indeed autonomous with respect to that desire. In addition, this approach also tackles the difficulty with the problem of authority in that through a person’s decisive identification with his endorsing second-order volition the person in question will endow his volition with the authority that it previously lacked.

Dworkin takes a rather different approach to modification of his hierarchical model of autonomy. Dworkin in his original work had already acknowledged the problem with deception when developing a full theory of autonomy. Dworkin had tackled this difficulty by ruling *ex cathedra* that a person is not autonomous with respect to desires that are the result of deception. As previously discussed however, this gives us little guidance on how to distinguish those who may be regarded as having been deceived from those who have not, for example distinguishing the difference between desires acquired through indoctrination (and therefore illegitimate means) and education (legitimate). Therefore this approach could be regarded as insufficient to be theoretically satisfactory. This is particularly problematic in relation to our case studies. At what point does clinical advice or education or even indeed information become manipulation and undue influence? In response to this criticism Dworkin states that he attempts only to propose a global theory of autonomy in that “a second order capacity of persons is to reflect critically upon their first order preferences, desires, wishes and so

forth”(Dworkin 1988, p.20). Dworkin asserts that he is not concerned with the more local aspects of what conditions must be met for a person to be viewed as autonomous. Once this is understood, Dworkin contends, the problems with regress, authority and deception disappear. This is difficult to comprehend. Dworkin clearly feels the need to at least rule *ex cathedra* that deception is a confounding factor of autonomy but give no guidance on its identification. If indeed Dworkin wishes merely to promote the concept of autonomy as an ordering of preferences or hierarchy of desires why would he find it necessary to allude to this ‘local’ concept? Further, by asserting that his theory is only to be seen in a more global concept Dworkin reduces its usefulness. This is because in many discussions about autonomy it is not the psychological capacities that a person must possess in order to have the capacity to be autonomous that is at issue; many agree that some level of second-order reflection is necessary (Bratman, 2003b; Christman, 1987). Rather it is the exercise of that capacity for reflection and how it results in a person being autonomous that is at issue. By taking a more global approach Dworkin is no longer offering a theory of autonomy that can play a major role in discussions where localized questions are posed as to a person’s autonomy in relation to a particular desire or a particular action.

### **Initial conclusions**

Despite the advantages of the hierarchical approach to autonomy it would seem that it still suffers from a number of theoretical difficulties. It would seem the a-historical approach presents serious difficulties for the notion. Whilst focus on the process has its merits, the history of how second-order desires were acquired must

be viewed as significant. Although all three problems need to be tackled effectively to enable the hierarchical model to maintain credibility, it is contended in this chapter that the problem with deception poses the greatest threat. A theory of autonomy that is subject to problems with deception is self-defeating since it fails to protect the one value that it intends to promote; some concept of independence of thought, mind or deed.

### **Some solutions**

A number of writers have gone on to develop a second-generation of non-hierarchical theories of autonomy. Using the Frankfurt-Dworkin model as the origin of their views they have attempted to address some of the theoretical difficulties whilst retaining the spirit of their predecessor's theory. Two of the most prominent theorists of this new generation are John Christman (1987; 1993) and Michael Bratman (1999; 2000). Other writers have used the Frankfurt-Dworkin model as a springboard into an even more diverse approach, one example being the co-herentist approach of Laura Waddell Ekstrom (1993). These writers have all attempted to solve one or more of the difficulties discussed above to some degree. We will now turn to consider how successful they have been.

It would seem from the preceding discussion that the hierarchical model of autonomy is doomed to failure because of the threat of deception. For this reason, John Christman (1987; 1993) has developed an historical approach to autonomy in an attempt to address this very objection when using a hierarchical approach.



Christman contends that an agent P is autonomous in his desire at time t if and only if:

- i. "P did not resist the development of the desire (prior to t) when attending to this process of development, or P would have not resisted that development had P attended to the process;
- ii. The lack of resistance to the development of the desire (prior to t) did not take place (or would not have) under the influence of factors that inhibit self-reflection;
- iii. The self-reflection involved in condition I is (minimally) rational and involves no self-deception
- iv. The agent is minimally rational with respect to the desire at t (where minimal rationality demands that an agent experience no manifest conflicts or beliefs that significantly affect the agent's behaviour and that are not subsumed under some otherwise rational plan of action)." (Christman, 1993, p.288)

The problem is that Christman's historical analysis still fails to fully solve the danger of deception and enable a person to be fully autonomous in relation to their desires. Returning to our schoolboy smoker, imagine a situation where a schoolboy is forced to smoke by the school bully. Over time the boy comes to enjoy cigarettes and also his notoriety at school for being a smoker. The schoolboy discovers that in fact the school bully has done him a favour in forcing him to smoke; he is now a lot more popular at school and has a wider circle of friends (perhaps to the degree that his school work has improved due to his new found friends). He now agrees that smoking was 'for the best' even though he rejects the manner in which he was initially forced to smoke. Therefore at time t1 he discovers that smoking is a good thing and despite his rejection of the process from time t1 onwards he is fully autonomous with respect to his desire to smoke. Imagine this in relation to our concerns about cosmetic dentistry. For example a dentist offers a patient an orthodontic appliance. The patient at the time does not feel that there is anything wrong with the appearance of their teeth but agrees to

the appliance as he views the dentist as the expert with his [the patient's] best interests at heart. At first the patient finds the appliance very uncomfortable and expensive but over time comes to accept that as now all his friends have one and he is 'one of the crowd' that it was 'for the best'. Was that patient really autonomous in relation to agreeing to the orthodontic treatment? Again at time t1 for Christman the patient now has acquired an autonomous desire in relation to an appliance. However, we might want to raise concerns about the manner in which that desire was originally acquired through the influence of dentist. It seems counter-intuitive that we would be satisfied with a model of autonomy, or indeed a principle, that allows what we might initially observe as a wrong-doing, (that is to say the dentist using his clinical authority to persuade a patient against the patient's current better judgment) to then legitimize it later when the patient has been overcome. This is particularly problematic as it requires that we explain this satisfaction by relying on the same principle, autonomy, that we would have used to object to the deception in the first place.

Christman also accepts that a person can be autonomous with respect to their desires even if that at the time of the adoption of such desires there was no possibility of self-reflection so long as the context preventing self-reflection was freely chosen. An example of this could be perhaps seen in a recruit freely joining an elite part of the army which requires that soldiers, by subjugating their will, unquestioningly follow the orders of the commander. The soldier has autonomously chosen to subjugate himself to the wishes of his commander but is precluded from the opportunity for self-reflection. The soldier still however meets

Christman's criteria for autonomy because at time  $t_1$  he has autonomously chosen to subjugate his will. This is because he would not have resisted the development of desires at  $t_1$  had he attended to the process, he is minimally rational and is not self-deceiving. However he only has the desires that the commander instructs him to have and therefore this cannot be sufficient for him to qualify as autonomous but rather heteronomous. Therefore, Christman's account sadly, does not effectively deal with the problems with deception.

Bratman (1999; 2000) developed a reason-based approach to the analysis of autonomy after what he believed to be fatal objections to Frankfurt's satisfaction based approach<sup>20</sup>. Bratman argues that Frankfurt's (1998) account of deception is unsatisfactory because it does not require that a person endorse those of his desires that he is said to identify with (Frankfurt 1998). Owing to this, Bratman contends, a person might meet Frankfurt's criterion for him to be satisfied with a desire (in so far as he identifies with it) simply because he has not yet rejected it and yet the mere failure to reject an idea does not mean one identifies with it (Bratman 1999).

On Bratman's account, a person is autonomous with respect to a desire if they decide to treat it as reason giving (that is to say end-setting) in the relevant circumstances. However Bratman acknowledges that a person's decision to treat a desire as reason-giving is not sufficient as to regard them as autonomous with

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<sup>20</sup> This is because a person could identify with a reason and for Frankfurt's theory is therefore 'satisfied with it' merely because one has not yet rejected it.

respect to it. This is because, using our smoker, an unwilling addict may decide to give into a craving because it is too painful to resist it (Bratman 2000)<sup>21</sup>. Here the smoker decides to treat the desire for a cigarette as reason giving in Bratman's sense of end-setting but is not autonomous with respect to it. The reason, Bratman contends, that the smoker is not autonomous with respect to the desire for a cigarette is that the desire is incompatible with the agent's *other* standing decisions or policies concerning what to treat as reason giving (Bratman 1999). In order to be viewed as autonomous with respect to a desire one must not only treat it as reason giving but must also be satisfied with the desire. For Bratman, this satisfaction means one not having:

“reached and retained a conflicting decision, intention or policy concerning the treatment of one's desires as reason-giving.”  
(Bratman, 1999, p.44)

This enables Bratman to avoid the threat of regress and the problem with authority. This is because he bases his account of what constitutes a person's standing decisions, intentions, and policies by reference to his broadly Lockean account of personal identity, on which an agent helps:

“...ensure appropriate psychological continuities and connections [to retain her identity over time] by sticking with and executing [her] prior plans and policies, and by monitoring and regulating [her] motivational structures in favour, say, of [her] continued commitment to philosophy.” (Bratman, 2000, p.45)

This means that as a person's standing decisions, intentions and policies are constitutive of themselves they then possess the authority (enabling Bratman's

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<sup>21</sup> Bratman uses the example of a drug addict but continuity the example of smoker has been substituted for that of drug addict.

account) to assess which first-order desire they are then autonomous with respect to and which they are not. Indeed, this account also precludes the need to question a person's autonomy with regard to their standing decisions, intentions and policies. This is because these values form what Noggle (2005, pp.87-88) describes as the authentic-self and therefore the question as to whether or not one is autonomous in relation to them does not arise, as they are, so to speak, us; our inner-self.

Although this approach is invaluable in addressing two of the three difficulties that Frankfurt and Dworkin's approaches pose, those of regress and authority, it still fails to solve the problem of deception. This can be seen when considering our example of hypnosis again. Consider that a person has been hypnotised into both having desires and accepting those desires as her own. Just as that person satisfies Frankfurt's criteria so too does he also meet Bratman's. This is owing to the fact that, as a result of hypnosis, this person treats their desire as being reason-giving in the sense of end-setting and they do not conflict with any of his other policies because he has not formed any views about the status of desires acquired via hypnosis. As has previously been stated however, desires acquired this way cannot be viewed as being legitimate for the purposes of establishing autonomy. It is suggested, however, that Bratman might respond to this criticism by contending that these desires do not flow from the person in the correct manner. In fact Bratman has stated explicitly that he has not yet tried to address the problem with deception (Bratman 2003a, pp.175-176). Bratman has suggested that he could perhaps strengthen his criterion that a person's decision to treat a desire as reason

giving not conflict with other policies and also add a historical component to block any revised versions of the problem with manipulation but he has yet to explore this in detail (Bratman 2003b, p.106).

It seems therefore that the problem with deception is very difficult to avoid. However, Ekstrom's (1993) coherentist approach seems that it might be immune to this objection. Ekstrom uses the same starting point as Frankfurt and Dworkin: that a person is autonomous with respect to those 'desires' that move one to act. Ekstrom departs from previous work, however, by focusing on what it means to be autonomous with respect to one's preferences rather than one's desires. For Ekstrom a preference is a very particular sort of desire. It is one:

- (i) "for a certain first-order desire to be effective in action, when or if one's acts, and;
- (ii) that is formed in the search for what is good." (Ekstrom 1993, p.603)

This approach replicates that of Frankfurt and his second-order volition except that for Ekstrom a person forms a first-order preference because they find that first-order preference to be good whereas for Frankfurt it may be for any reason at all.

One of the core features of Ekstrom's analysis of autonomy is the distinction she draws between 'self' and 'true or most central self'. For Ekstrom a person's self consists of her character together with the power for 'fashioning and re-fashioning' that character, where a person *S*'s character at time *t* is constituted by "the set of

propositions that S accepts at t and the preferences of S at t" (Ekstrom 1993, p.606). A person's 'true or most central self' consists of a subset of acceptances and preferences that cohere. Ekstrom gives three reasons why these cohering preferences and acceptances should form the central self. First because they are long-lasting guides for action as they are well supported by reason. Second, attitudes that constitute the central self are defensible against external challenges; they are the attitudes that are entrenched in our minds over time. Third, those preferences are elements of one's central self that we are at ease with owning and are ones we can act on wholeheartedly. Therefore, for Ekstrom, a person is autonomous with respect to their preferences "when they cohere with their other preferences and acceptances" (Ekstrom, 1993, pp. 611-612) and thus can be recognized as members of their central self. The benefit of this contends Ekstrom is that when a person acts autonomously they will not only be able to give reasons for their actions but they will be acting in a way that is characteristic of them.

It is by taking this approach that Ekstrom appears to successfully deal with the problem of deception. This is because Ekstrom requires that in order for a person to be viewed as being autonomous with regard to their preference it must be justifiable with regard to their core preferences. Core preferences on Ekstrom view are constitutive of the agent so therefore any deception in relation to core preferences would result in a new agent but not in a loss of autonomy. Ekstrom avoids the problem of deception by requiring that a preference originates with that person's self in a particular and objective way. However where situations arise where the core preferences by happy coincidence coincide with an attempt to

deceive is a person's autonomy although perhaps unaffected perhaps fatally not respected? For example, a clinician proposes a treatment option to a patient that is both in the patient's best interest and also in the best interests of the clinician, perhaps because it gives him some kind of financial reward or increased status. The clinician proposes the treatment predominantly because it is in his best interests rather than the patient's. The patient consents to the treatment believing that it is in his best interests which conforms to his core preferences (and indeed it is in his best interests). Following Ekstom's account the patient is surely autonomous they have after all made their decision based on the correct set of facts in line with their own freely adopted policy but still there seems something amiss. Perhaps it is because the hierarchical approach and the view that autonomy is exclusively a personal characteristic misses something important about autonomy. That autonomy is an internal process but that it does not operate in a vacuum. We must intuitively recognise that where autonomy is operating on the correct facts but is clearly not being respected it is in some way diminished by the deception that is going on. For this reason it may be that Ekstom has successfully dealt with the problem of deception but not to the satisfaction of those who would use the model to help people assert their position in the context of a relationship.

It is the same coherentist approach that also assists Ekstom in dealing with the problems of regress and authority in that if a person is to be regarded as autonomous with respect to a particular preference that preference must originate from that person's self in a particular, objective way. This is similar to Bratman's approach in his reason-based account of autonomy although he does not take a



coherentist approach. That this problem may be solved by other approaches does not reduce the appeal of Ekstrom's approach. However, it may be undermined by the fact that it provides insufficient conditions whereby a person may be viewed as being autonomous with respect to their preferences. Consider our diligent soldier example once more. It could still be contended that there may be situations where a person who subjugates his will to a third party allows the will of that third party to cohere to the person's 'true or most central self'. This would then mean that any preferences they acted on would still for Ekstrom's account be autonomous. However, the solidity of Ekstrom's claim here would rely on our construction of autonomy and whether it be broad or narrow. For the purposes of a narrow construction the property of autonomy could be said to apply to a person with respect to their desires and actions if they meet some criterion plus the negative criterion that they are not alienated from them. In this case although we could perhaps accept the claim that our soldier acts *authentically* he does not, as Ekstrom claims, act autonomously. However, on a broader construction where the property of autonomy could be said to be that a person is autonomous with respect to their desires if she is not alienated from them then, following Ekstrom, we could agree that the soldier is indeed acting autonomously. The debate here must be then on what construction of autonomy we adopt rather than the success or otherwise of Ekstrom's solution to the hierarchical problem with deception.

It would seem that the difficulties with regress and authority are more easily solved within the confines of viewing autonomy as a personal characteristic by refining what we understand to be the requirements of the internal process. In

contrast the problem with deception is more difficult to address. For the hierarchical model the difficulty with deception is that in order to retain the integrity of the concept of autonomy as a quality of person one must try and address the problem by refining the necessary and sufficient conditions of the internal process. The problem with deception could be easily solved by accepting that doing something, (that it to say having a desire), that is the result of deception is a bad reason for doing so, but this approach would require the admission that autonomy is not totally about the internal process but does also have some relational aspects to it. It also opens the door to metaphysical debates about the various merits of good or bad reasoning, something which Frankfurt and others have studiously tried to avoid.

### **Case studies**

At first instance the hierarchical model may be well be useful in that it gives us a clear reference point where we can examine the extent to which a patient's is adequately respected, the moment when they choose to act and the extent to which that *action* is volitionally endorsed (Frankfurt, 1971) and is procedurally independent (Dworkin, 1988). The point at which we are likely to wish to examine this volitional endorsement and procedural independence is at the point of consent to treatment, after all, this is the point where a patient's will directs them to act (or not) and is the moment where a transaction between the dentist and the patient occurs. This is useful in the sense that we can be clear about what aspect of the relationship we need to concentrate on when we are concerned with respecting patients and indeed is reflective of the approach taken in the *Redfern*

*Report* (DoH, 2001). Further, the fact that we can focus in this way and the richness and functionality of Frankfurt's account enables clinicians to identify situations where patients lack autonomy and prevents overburdening patients incapable of such reflection. In addition, as we are concerned with patients and the conditions and internal processes that relate to their *action* of choosing the consequence of this is we are better able to draw limits around the duties owed by a clinician. This is because for the hierarchical models, a patient's autonomy only relates to the *action* of choosing and therefore a clinician's duty to promote autonomy (if we agree that is their duty) only needs to consider the medical choice at hand and how best to support the self-determination of the patient through information giving to satisfy this account.

By returning to our case studies there are two concerns that we may want to raise when relying on a hierarchical account of autonomy in dentistry. The first is to consider our concerns with deception and how the model struggles to theoretically account for this. The second concern that we will consider is more practical. We will consider how the reliance on information giving leads us to be overly focused on the medical transaction and may distract us from prioritising patients' concerns.

Our first case concerned the use of cosmetic treatment alongside therapeutic. There were three main areas of concern to consider, first the difficulty in the transition between cosmetic and NHS treatment; second, the subjective assessment of clinical need, and; third, that a dentist might reasonably want to do something nice for a patient. These three areas of concern serve to highlight the

risk that a patient may well be deceived as to the nature of the dentist-patient relationship when the treatment being discussed is cosmetic. The result may be that a patient fails to apportion the correct weight to any advice that a dentist may give believing that the driver of the dentist's advice is the duty of care relationship. In reality the dentist might quite reasonably, be considering their own commercial interests as well as, or even to the exclusion of the patient's. The consequence of this is that the patient is deceived. To what extent can our hierarchical accounts explain our concerns?

Following Frankfurt's initial account it would be sufficient to say that our patient in the cosmetic dentistry setting is autonomous so long as the treatment decision they make is the result of an internal reflective process; they want their decision to be their desire and they want that desire to motivate them to act. However as we have seen, Frankfurt's account is a-historical so we are not able to account for how the patient may have acquired that desire in the first place (here through the influence of the dentist and the dental setting). Clearly this account is insufficient for us to adequately address our concerns.

Perhaps we might be able to express our concerns in terms of lack of procedural independence; that the patient has the required reflective capacity and has exercised it but there is something wrong with the way they initially acquired that desire (here undue influence from the dentist)? Dworkin explains this in terms of volitional endorsement (as describe by Frankfurt) *plus* procedural independence. Therefore, our patient cannot be viewed as making autonomous decisions where,

despite an adequate reflective process, the initial desire was acquired illegitimately. After all, procedural independence cannot be said to exist if the patient's desire to have cosmetic treatment is the result of some form of manipulation or deception. This appears to be, *prima facie*, an attractive prospect, we have an explicit theory of autonomy that enables us to draw limits and detect where it is present plus we are attempting to account for (unlike Frankfurt's account) circumstances where that autonomy is reduced or frustrated. However, in order for this construction to be useful it must be sufficiently theoretically sound for us to identify those situations where the issue of lack of procedural independence is clearly identifiable. According to Dworkin's (1988) account this is merely a statement of fact. Dworkin simply rules *ex cathedra* that autonomy cannot exist where procedural independence is absent. This is insufficient for us to rely on in practical model. It is inadequate for us to say that a patient's autonomy is adversely affected simply because we intuitively believe that to be the case. We need to be able to identify more clearly those instances where deception occurs from those instances that might better be described as, for example, education. Although we are close to a suitable model, Dworkin's account is too vague in relation to the issue of deception for our purposes.

As we have seen there have been various attempts to address the issue of deception in a hierarchical context. Christman (1993) attempt to address this issue by using an historical approach. A patient can still be viewed as autonomous in relation to their desire should they come round to the dentist's way on thinking in the end, despite having made the initial choice against their better judgement by

relying on the perceived expertise of the dentist. This again seems problematic, it is hard to ethically justify, especially through the use of autonomy, a situation where so long as the patient eventually sees things from the dentist's perspective he is autonomous with respect to a clinical consent he gave that, at the time, was against his better judgement. Bratman's (2000) approach similarly does not adequately defend against our concerns with deception in relation to our case. For Bratman, our patient would be autonomous in relation to their consent if they viewed it as 'reason giving'. Bratman's account again is problematic if the patient is not only persuaded into having a desire for straighter teeth but also accepts that desire as their own. This is because the patient treats their desire as reason giving (in the sense of end-setting) and this desire does not conflict with their other desires as they (the patient) have yet to form an opinion on desires acquired as part of the clinical process. Just as this account would satisfy Frankfurt's construction so too does it satisfy Bratman and fails to adequately defend against deception.

At first instance Ekstrom's (1993) proposal appears to be the solution. A patient could be viewed as not autonomous in relation to their consents where their preferences do not form part of and cohere with their true inner self; the self that marks out one's character. Preferences acquired through the persuasion of the dentist which do not form part of the inner self will not cohere with one's overall character and for that reason cannot legitimately motivate one to act in a manner that is characteristic (and therefore legitimate). However, for our purposes there is a fatal flaw that may concern us in a professional context. What Ekstrom's

theory cannot account for is where a patient's internal and characteristic preferences serendipitously coincide with the dentist's persuasion. This ought to concern us. It seems counter-intuitive to regard a patient as acting autonomously and therefore conclude the dentist is respecting them when the clinician has persuaded the patient to consent to a treatment on the basis of their (the dentist's) self interest rather than the patient's best interests. We must feel that a clinician ought not to be able to make the claim that they adequately respected a patient where, by sheer chance, their interests coincide but the dentist is motivated by something other than the interests of the patient. For this reason it would seem that the hierarchical accounts of autonomy fail to adequately address our concerns with deception.

This leads us on to consider our second concern in the practical application of the hierarchical model. The use and claims made around information. This is perhaps best exemplified by our concern about the use of NHS and private practice in the same appointment as well as our concerns about the use of skill mix and a patient's objections to it. Our concerns with those cases related to information that was not directly linked to the treatment in hand and potentially had no bearing on the success of the treatment but was of personal significance to the patient (here the eventual cost of the treatment in the NHS and private example and the status of the clinician in the skill mix example). The hierarchical models rely heavily on the *action* of choosing to give us an adequate account of autonomy. This, as we have seen, has been interpreted and applied in the clinical context through the reliance on patient consent. The *Redfern Report* (DoH, 2001) goes further and augments

consent taking to mean a fully informed consent in response to concerns about the manner in which we respect patients. 'Fully informed' however relates to the choice in front of the patient, that is to say, whether or not to opt for the clinical treatment on offer. A patient may well make a fully reflective decision about the treatment proposed and therefore for our purposes is autonomous and self-determining. However this may fail to capture something of importance to the patient. Consider our NHS and private treatment examples and the use of skill mix. Neither of the concerns we raise in relation to these case studies relates to the direct medical choices the patient is faced with. In the NHS and private treatment the patient may well have consented to the treatment anyway but feels aggrieved the costs were not made clear from the start. In the skill mix case study the patient may well have got the treatment they wanted and needed and have readily consented to the treatment fully cognisant of the facts, none the less the patient feels deceived. This leads us to a practical concern about the hierarchical accounts. As the hierarchical account relies on the action of choosing it leads us to focus on what we perceive to be the choice in question; consenting to or declining consent for treatment. The consequence of this is a very medicalized perspective on what might be necessary in order for a patient to make a reflective and therefore autonomous decision. As it is dependent on the clinician to provide the information in order that a patient's preferences may be ordered and expressed, it naturally leads to the clinician prioritising what information is material to the decision before the patient (i.e. the treatment on offer). This in turn leads to a very medicalized conception of what being 'fully informed' means. The danger being that in a clinical context we consider we have respected the patient by enabling



them to determine their own treatment choices but have failed to prioritise matters of importance to the patient such as, in our case study examples, the eventual cost of the treatment and the status clinician treating them. In fact, this information in relation to cost or clinical role may not be material to the patient's decision making either but despite this the patient feels less respected by being kept in the dark. It seems difficult to satisfactorily claim that a patient has had their autonomy respected by giving them a choice over their treatment options but failing to recognise other matters of importance to them. This might lead us to consider that although the hierarchical accounts give a clear attempt at what it might mean to be autonomous they fall short of helping us respect autonomy.

## **Conclusions**

The hierarchical model has much to commend it. It makes a significant contribution to our understanding of the concept and gives a structure to our intuitions and beliefs about independence of thought and self-determination and the distinction that we draw between ourselves and the animal kingdom. However, its application beyond the sense of individual analysis is problematic. Whilst ever the hierarchical model helps us analyse what may constitute an autonomous desire for the individual it has difficulty defending that process in the context of a relationship with others. This is a serious flaw. For a model of autonomy to be practically applicable it must be able to deal with situations where a person's autonomy is under threat from outside influence and enable us to distinguish between situations where a person may have acquired views through an educative process from those where deception has occurred. The model must

be capable of identifying difficulties with deception even when distant from the situation the individual currently finds themselves in.

It seems that there is a divergence in what we need from our model of autonomy in order that it can adequately address the matters that concern us. We certainly need to be able to account for and identify situations where deception occurs. The hierarchical model is effective at helping us do that because we are able to trace the authority of action from first and second-order preferences to culminate in volitional endorsement of that act. This enables us to comprehend the problem with deceit not simply on the basis that the outcome was what the patient wanted but rather on the more subtle basis that it is not sufficient to desire the same outcome, a patient must be free to come and to move towards that end on their own account in order that their autonomy be preserved.

Deception seems more difficult to address on the basis that one of the features of deception is that (here the patient) we acquire the desire at some level to act in accordance with the manipulators agenda. That is to say that deception where we find ourselves acting on a falsely based premise and that way our choices and therefore autonomy are impeded externally. Deception is problematic because we adopt the desires to act in a certain manner and therefore the deception occurs internally. It is hard therefore for a model of autonomy to account for our acting in a way that after all forms part of our set of desires even if we might be concerned as to the way in which we acquired them. We have seen various attempts to account for the problem with deception but none have been able to account

successfully for our difficulties. It seems as we have discussed earlier that this relates to the hierarchical model's individualistic approach. Indeed the two main criticisms of autonomy as a principle from both feminist and communitarians is that it is too narrowly atomistic and second that a narrow concern with patient's rights neglects social dimensions of healthcare. Communitarian's for example argue that the idea of 'self' that has developed since Kant is one that views the self as cut off from others (Kuczewski 2000), lacking in its appreciation of social dimensions of identity.

"The Communitarian view of the person sees the self as constituted by social roles, communal practices, and shared deliberative exchanges." (Kuczewski, 2000, p.182)

Similarly, feminist writers such as Carol Gilligan and Virginia Held have argued that the dominant understanding of 'self' is based in autonomy and furthermore is a masculine conception, while feminine paradigms emphasize relationships (Gudorf, 1994). Susan Wolf describes this feminist critique of contemporary bioethics as related to liberal individualism: Feminism, states Wolf, often views liberal individualism as impoverished, encouraging disregard of relational bonds. Thus, states Wolf,

"[T]here is some overlap between non-feminist communitarian critiques of autonomy in bioethics and feminist cautions against mistaking autonomy's sufficiency." (Wolf, 1996, p.17)

John Hardwig, responding to these criticisms, argues that the paradigm of medical decision making should be shifted away from one that places sole locus of medical decision making on an individual's values and rights toward a paradigm that incorporates the values of the family and others whose interests are affected. Hardwig states:

“I am a husband, a father, and still a son, and no one would argue that I should or even responsibly could take a sabbatical, another job or even a weekend trip solely on the basis of what I want for myself.” (Hardwig, 1990, p.8)

These are very plausible criticisms of autonomy and we have already seen that there are problems with the individualistic nature of the notion, in that autonomy finds it difficult to account for challenges that fall outside that individualised sphere. However we must question as to whether a more relational approach that lent less emphasis to autonomy and the right or desire of oneself to be self governing would go any way to addressing the matters raised by our case studies and in particular our concerns with manipulation and deception. Could it be that these two concerns could be better addressed by a model that depended less on the authority of the individualised voice, that they are legitimate parts of a clinical relationship as long as they are tempered by other principles such as best interests? Or indeed that autonomy still has a role to play but may not be the only principle to which we appeal? For that reason I will now turn to consider the concept of best interests.

## Chapter Four – Best Interests and Paternalism

We have considered in Chapter Three both the benefits and some of our concerns with the hierarchical account of autonomy. As we have seen the hierarchical accounts go some way to helping us give due ethical weight to the individual as it has a strong individualistic component. The hierarchical account also helps us to draw limits round our duty to respect patients through the lens of autonomy by defining occasions where autonomy is absent. However, we have also raised concerns. Our two most prominent concerns relate to the theoretical difficulties with defending against deception and, from a more practical perspective, the overly medicalized approach that is a consequence of relying on a construction of autonomy that is based on the *action* of choosing causing us to lose sight of other matters of concern to the patient.

In this chapter we will consider if an alternative way of considering the patient's interests might in fact be more appropriate from both an ethical and practical perspective. By considering what is in the patient's best interests perhaps we can widen the area that is of concern and not attempt to discharge our ethical duty to the patient largely through the consent process. I will consider to what extent the concept of best interest might address the concerns in the dentist-patient relationship we have raised earlier. This concept will be considered both on its own merits as well as the extent to which it might be compatible with a weaker account of autonomy. By using and relying on two principles it may be possible to address some of the concerns raised in chapter three in relation to hierarchical accounts whilst maintain the attraction to individualized way of respecting

patients and their right or ability to be self-determining. In order to assess this effectively we will first consider the roots of paternalism and the concept of best interests by looking at the principle of beneficence. We will then go on to consider the link between beneficence and paternalism in order to assess the merits of how paternalism operates. We will consider various interpretations of paternalism and the extent to which differing accounts may go some way to helping us with the concerns raised in preceding chapter. Finally we will review the possibility of paternalism being used in a complementary manner to moderate our account of autonomy and to what extent that is successful.

Paternalism has a long established history as a moral point for reference for the doctor-patient relationship, starting with the religio-scientific cult of Pythagoreanism and the Hippocratic Oath to the present day where clinicians still commit to a version of that Oath. In more recent times however, paternalism has been subject to criticism. Changes in patient expectations, a culture of patient rights and a move to greater patient autonomy have brought challenges to the medical profession and prompted a re-evaluation of the paternalistic position of clinicians. We will first consider whether or not paternalism can continue to offer a complete moral rationale for the dentist-patient relationship. In order to go some way towards answering this question, this discussion will trace the roots of paternalism through an examination of the principle of beneficence that provides paternalism's moral underpinning to an analysis of various models of paternalism and their deficiencies and benefits ending with a conclusion as to the value of paternalism in the clinician-patient relationship.

Since paternalism is at its simplest, defined as benefiting others against their wishes choices and actions it is necessary to first consider the principle of beneficence that generates paternalism and provides its moral rationale. It is hoped by doing this that we can not only establish the link between paternalism and beneficence but also by increasing our understanding of beneficence and its deficiencies it will give us greater insight into the various models of paternalism later on in this discussion.

### **Beneficence**

In the vernacular the term beneficence is associated with acts of mercy, kindness and charity. The Oxford English Dictionary defines beneficence as “the act of doing kindness; a charitable act or gift” (OED, 2005). This is a rather narrow definition of beneficence and relates only to one aspect of the principle, the act of doing good. There are, however, for our purposes both broad and narrow definitions of beneficence. How do we then define beneficence? Our starting point could be a quote from Alison Luthrie’s character in *The War between the Tates*:

“I was less morally ambitious than you; I didn’t aspire to do good. I only wanted to do no harm.”(Luthrie, 1975, p.271)

Commonly, we intuitively distinguish between doing good and not doing harm. Philosophers use beneficence to refer to doing good and non-maleficence to refer to not doing harm. However, a broad definition of beneficence actually incorporates the principle of non-maleficence. There is some warrant to do this because anyone who is said to be acting beneficently in the narrow sense; acting to

promote good, cannot be said to have discharged their beneficent duty if they have violated the duty of non-maleficence (Frankena, 1973). The case could however be made for a narrower definition where a necessary distinction is made between beneficence, and non-maleficence. Beneficent euthanasia is an example of this, in that if death is always a harm (there could be some debate as to whether this is the case) does the benefits of elimination of pain and suffering outweigh this harm? Clearly a narrow definition might be useful where the two principles conflict particularly in relation to the same person. For the purposes of our understanding of paternalism however, a broader definition may be a more attractive proposition. This is because we are not trying to attribute or mediate between the merits of various possible acts but rather have a broader understanding of what duties a doctor might owe to a patient by relying on that principle via a model of paternalism. If we therefore accept that in order for a doctor to have discharged his duty of beneficence toward a patient he must also act non-maleficently a broader definition incorporating both the requirement to do no harm (non-maleficence) *and* the requirement to positively promote good (beneficence) seems the most morally robust. This is particularly the case as a narrow definition of beneficence relies only on the requirement to positively promote good and not a requirement to do no harm.

Whether we adopt a broad or narrow definition of beneficence it is necessary to examine the strength of the duties or obligations arising from such a principle. If our model of paternalism relies on the principle of beneficence, what does it



require of a physician in order that he or she may claim to have discharged their duty? That is to say what are the limits to the obligation to act beneficently?

Following a broad definition, Frankena distinguishes four elements:

- “(1) One ought not to inflict evil or harm (what is bad);
- (2) One ought to prevent evil or harm;
- (3) One ought to remove evil, and;
- (4) One ought to do or promote good.” (Frankena, 1973, p.47)

Frankena arranged these elements in order of priority stating that the last may be an ideal rather than an obligation. Although not explicit Frankena has distinguished between a moral duty to do no harm (point 1) and a requirement to positively act. Frankena admits to considering point (1) as an absolute duty and the further points as those actions that might be required of us in certain circumstances (points 2-4). Following Frankena’s definition then for an individual to describe themselves as acting beneficently it would be sufficient for them to do no harm with acts positively promoting good being only an ideal not a requirement. The requirement on an individual to actively promote good then is quite weak.

Childress (1982) taking Frankena’s definition categorises these elements of beneficence further dividing them more explicitly into two categories:

- “Non-maleficence: 1. One ought not to inflict evil or harm (what is bad)
  - Beneficence: 2. One ought to prevent evil or harm
  - 3. One ought to remove evil
  - 4. One ought to do or promote good.”
- (Childress, 1982, p.29)

Beneficence then for both Childress and Frankena is a combination of both a strong duty to do no harm and a weaker requirement to positively promote good. For our purposes in that we are principally interested in medical paternalism it seems that the weaker requirement might need further clarification. Are there any occasions where a requirement to actively promote good might be stronger? What limits might there be to this requirement? That is to say toward whom and under what conditions does an agent owe a *duty* of beneficence rather than an ideal? This is particularly important in that if paternalism relies on the principle of beneficence as its rationale and one wishes to invoke paternalism as a justifiable model of behaviour one must be aware of the limits of beneficence. Perhaps the answer lies in the relational aspect of the clinician-patient relationship?

It is reasonable to assert that our duty of beneficence presupposes roles and relationships. Mill (1859, pp.304-306) noted that the duty of beneficence is an imperfect duty because we are free to practice it toward various individuals; we have discretion in its application because no other party has a correlative right to it. Nevertheless, some philosophers have argued that there is an obligation of beneficence to specific individuals in certain circumstances. D'Arcy for example describes it as:

“A has a duty of beneficence to do X for P when:

1. When P is at risk of significant loss or damage (such as severe injury or death);
2. When A's action is necessary to prevent this loss or damage;
3. When A's actions would probably prevent it;
4. When the likely harms to A are minimal;
5. When the benefit that P will probably gain outweighs the likely harm to A.” (D'Arcy, 1963, pp.56-57)

It is these conditions, according to D'Arcy (1963) that remove A's discretion about acting beneficently toward P. This then gives a further interpretation to the definition to the principle of beneficence. Following a broad definition of beneficence the requirement to positively promote good is somewhat weaker than the duty to do no harm therefore in a basic or general sense even if one is relying on the principle of beneficence to justify the morality of their act they may be able to do so at different levels. Generally, to realise a level of beneficence that incorporates the act of positively promoting good may be praiseworthy but to fail to do so would not give rise to blame. However, there may be certain occasions or relationships where the ideal of actively promoting good transforms and carries greater obligation. Following D'Arcy's analysis, a medical relationship would seem to qualify under these criteria resulting in an increase in the level of duty owed to the patient in order that one could be said to have satisfied the obligations arising from the principle of beneficence. If we are satisfied that this is the case, then any model of paternalism within this context which is relying on the principle of beneficence would require the physician not only to do no harm, but also to positively promote good. There are further discussions to be had as to what extent one would be required to promote good and how we limit this obligation. It is suggested that D'Arcy's first criteria, "[When P is at risk of significant loss or damage (such as severe injury or death)]" might be useful in assessing those limits and at what point when those limits are reached that the duties required in order that one could rely on beneficence then reduce back to one of simple non-maleficence. However, it is not the aim of this discussion to explore and set those limits. What is of interest for our purposes is that if we are contending that there is

a requirement to positively promote good, how do we define what good (that is to say, benefit) is?

### **Defining benefit – the link with paternalism**

Therefore the final question about beneficence is what is a benefit and who determines what counts as a benefit? What we have discussed so far is very focused on the actor, what is required of them and little attention has been paid to the recipient of the beneficence. It is at this point that the link between paternalism and beneficence becomes most clear. An understanding of how we define benefit and therefore who determines that definition is the key to understanding paternalism. When considering the definition of benefit and determining who is the arbiter, Feinberg uses this example:

“Suppose a stranger approaches me on a street corner and politely asks me for a match. Ought I to give him one? I think most people would agree that I should, and that any reasonable man of good will would offer the stranger a match. Perhaps a truly virtuous man would do more than that. He would be friendly, reply with a cheerful smile, and might even volunteer to light the stranger’s cigarette.”  
(Feinberg, 1984, p.392)

For the purposes of this analysis whether Feinberg’s *ought* is interpreted as a duty or obligation or as an ideal or virtue is of no account. The question here is whether or not it is the stranger’s wishes that I refer to when considering whether or not I have fulfilled my duty or ideal of beneficence. For example, perhaps I could convince myself that what the stranger needs, in contrast to what he wishes, is a refusal and a lecture on the dangers of smoking, would that not indeed mean I am promoting good? When there is a conflict between the recipient and the actor as to

the benefit derived whose voice is authoritative? This is a concept we will return to as part of our discussion about paternalism and the concept of best interest as it is at the centre of the controversy about paternalism but it is a question raised by the application of the principle of beneficence. Kant held that the recipient should define beneficence as:

“I cannot do good to anyone according to my concept of happiness (except to young children and the insane), but only according to that of the one I intend to benefit; and I am not really being kind if I force a gift on him.” (Kant, 1999, p.122)

However, not all interpretations of beneficence are non-paternalistic. Many focus on needs rather than desires and preferences. How do we then determine for our purposes how the benefit is defined within dentistry? In order to do this we need to return to the Hippocratic Oath.

In the context of medicine (in the broadest sense) the principle of beneficence has provided the basis for what we might describe as an ethically acceptable healthcare system that focuses on “...the prevention and damage to persons, and to support their survival, health and capacities for action.” (O’Neill, 2002a, p.151)

Following the Hippocratic tradition benefit has traditionally been interpreted on a need rather than a desire or preference basis. This is perhaps borne out of a belief that in any healthcare relationship the clinician is the expert; the holder of the key information that forms the basis of the reason for this encounter and as such is therefore best placed to make decisions that will most effectively solve the

presenting problem and provide the best outcome for the patient. The result of this is, as O'Neill points out that:

“Any healthcare system with these aims will, inevitably concentrate a great deal of power and knowledge in the hands of its practitioners who could therefore coerce, deceive or exercise undue influence on patients and their relatives.” (O'Neill, 2002a, p.151)

For many years clinicians have relied almost exclusively on their own views, experience and judgement in order to determine what is in a patient's best interests in relation to their treatment, information and consultation. This can be seen clearly in the Hippocratic Oath which is still taken today on entry to the profession.

The Hippocratic tradition is clearly benefit orientated. Considering the example below we can better assess the language of the Hippocratic Oath. It is the 'benefit of the sick' that serves as a justifying reason for the Hippocratic physician's conduct and shows the link and reliance on the principle of beneficence:

“I will apply dietetic measures for the *benefit of the sick according to my ability and judgement*; I will keep them from harm or injustice. I will neither give deadly drug to anybody if asked for it, nor will I make suggestions as to this effect. Similarly I will not give to a woman abortive remedy...Whatever houses I may visit, I will come for the *benefit of the sick*, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.” (Hippocrates, 400BCE as cited in Edlestein, 1967, p.165)

Additionally another summary of the Hippocratic tradition is:

“...as to disease, make a habit of two things – to help, or at least to do no harm.” (Hippocrates, 400BCE cited in Edlestein, 1967, p.165)

It is this Hippocratic tradition that provides the clear link between beneficence and paternalism within medicine and dentistry. Paternalism is clearly implied by this benefit-orientated ethic. A Hippocratic doctor or dentist promises to act for the benefit of the sick according to their own ability and judgement. When considering the text and context, Edelstein concludes that the physician:

“...promises to guard his patients against the evil which they may suffer through themselves. That men by nature are liable to inflict upon themselves injustice and mischief and that this tendency becomes apparent in all matters concerned with their regiment, this is indeed an axiom of Pythagorean dietetics...The physician must protect the patient from the mischief and injustice which he may inflict upon himself if his diet is not properly chosen.” (Edlestein, 1967, pp.23-25)

If we follow Edelstien’s interpretation of the oath the physician has a duty to protect the patient even from him or herself. Paternalism can also be seen to emerge elsewhere from the oath. As Konald notes:

“The paternalism implicit in the Oath’s instruction that the physician refuses the patient’s requests in some cases and judge what confidences to keep is an important element of its legacy... This tradition honors the individuality of the doctor-patient relationship, professional secrecy, and the physician’s duty to promote the patient’s welfare. In these and other matters, ethical formulations by the physicians have been paternalistic, making the physician the dominant part in determining what action will best advance both the doctor’s and the patient’s interests.” (Konald, 1962, pp.164-170)

Following the Hippocratic tradition enables us to draw a clear link between the principle of beneficence and the paternalistic concept of best interests. The benefit

derived for the patient is one that is determined on a needs rather than a desire basis. Need is assessed medically in accordance with the expertise and abilities of the doctor (or dentist). As we shall see that is not to say that the preferences and desires of a patient carry no weight at all but following this approach it is important to note that it is the doctor's voice that carries authority and not that of the patient.

### **Paternalism**

Paternalism has been a recognised model since at least the time of Kant, who denounced paternalistic government for benevolently restricting the lives of its subjects. Kant's concern was that government "cancels freedom". However, Kant never considered the kind of paternalism that we would associate with the parental relationship in relation to the state where the state cares for its subjects like a parent does for their child. Similarly Mill (1859) did not consider types of paternalism that might apply to those who have limited or no personal autonomy. However, despite the lack of anticipation on their part clearly we are all familiar today with relationships that warrant intervention by one party in a life that is substantially non-autonomous and this remains a widely accepted model of justified paternalism. This form of paternalism starts with incompetent children in need of parental supervision and extends to other incompetents in need of care analogous to beneficent parental guidance.

As we have seen however, in recent times paternalism has become a more controversial model of moral interaction. It has faced challenges from other values



in particular autonomy and especially in the field of medical paternalism. In order to consider these challenges we will first need to look at how paternalism is defined and what differing interpretations might offer in answer to any of our criticisms.

The Oxford English Dictionary dates the term paternalism from the 1880s long after Kant and Mill, it gives its root meaning as “the principle and practice of paternal administration; government as by a father; the claim or attempt to supply the needs or to regulate life of a nation or community in the same way a father does his children.” (OED, 2009) The allusion to father seems to presuppose two features of the paternal role: first that a father acts beneficently and second that he makes all or at least some of the decisions relating to his children's welfare rather than letting them make those decisions. As we have seen in our analysis of the Hippocratic Oath in healthcare this analogy is taken further: as a professional has superior training and knowledge this places the physician in a more authoritative position in order that he or she may decide what a patient needs. This is of course based on an interpretation of beneficence (the moral rationale for paternalism) being defined on a need rather than preference basis.

Paternalism always involves some form of interference with or refusal to conform to another person's preferences regarding their own good. Paternalistic acts can involve force, coercion or even deception, lying manipulation of information, or nondisclosure of information. This seems a somewhat inauspicious start for a model of moral behaviour based on a principle of promoting good. One can see

already that if these behaviours are justified within the model of paternalism the focus of this model must be the *outcome* of beneficence and not the *means*. Certainly this seems to have the ring of utility about it and we shall consider this point later on. Although a great deal of literature considers that all actions of paternalism involve restricting autonomous choice a wider definition might be more helpful here. A wider definition would involve including all non-acquiescence or intervention in another person's preferences, desires, or actions with the intention of either avoiding harm or providing a benefit. In this way we are to consider that some forms of paternalism may be desirable where they provide a model of beneficence for those who act on behalf of non-autonomous beings. In this way, if we were to consider autonomy as a principle of primary importance (despite our concerns with the current model) we would still be able to provide an alternative moral model for those who might for some reason be unable to satisfy an autonomy threshold. For our purposes then we may be said to follow a broad definition of paternalism similar to that proposed by Beauchamp and Childress. "Paternalism...is the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden." (Beauchamp and Childress, 2001, p.178)

This definition is useful in that it is normatively neutral. Although it presumes an act of beneficence it does not consider whether or not the beneficence or the way in which it is defined carries any moral weight. In this way we can see clearly what is required to identify a situation as paternalistic without at this stage making a

normative judgment. This is not to say that this definition cannot enable us to identify situations that appear to be paternalistic but in fact are not.

One example of this appeared in biomedical research on prisoners. The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research reported that the close nature of prison environments creates the potential for abuse of authority and as a result coercion and exploitation of prisoners (Levine et al., 2004). Although prisoners disagreed the Commission found that the coercive environment of prisons was sufficient to prevent prisoners taking part in research.

At first glance this would appear to a clear case of paternalism but further consideration shows that it is not. The commission maintained that if prisons were shown not to be coercive environments then prisoners could indeed take part. Therefore the Commission's justifying ground was in fact that we cannot predict whether or not prisoners will be exploited when they are in an environment which makes them vulnerable and that we should prohibit research to which prisoners might validly consent because we cannot successfully monitor as to whether or not that is the case. A simple non-normative definition then allows us to identify situations of paternalism without being drawn into a debate about the various merits of paternalism itself. However we must now consider some of the finer points of paternalism and how it operates.

### **Paternalism – refining the definition**

As we have seen in our analysis of the principle of beneficence, it is this principle that has provided the basis of paternalistic actions towards patients. For example, traditionally physicians have taken the view that if disclosing certain information to patients could cause them harm [the patient] then they are justified and obligated to withhold that information.

Beauchamp and Childress exemplify this point by considering a case where a man brings his father, who is in his late sixties; to his physician because he suspects his father's daily problems of recall and reasoning may be Alzheimer's disease (Beauchamp and Childress, 2001, p.180). The man also makes an impassioned plea to the physician not to tell his father if the tests indicate Alzheimer's. Tests subsequently indicate that the father probably does have the disease. The physician now faces a dilemma because of his conflict between demands of respect for autonomy and demands of beneficence. The physician considers his patient's right to know but is concerned about the supposition that the diagnosis is accurate [which this is not] and that apparent lack of competence of the patient. The physician feels that because of this he is compelled to rely on the principle of beneficence and therefore withholds the diagnosis.

In this case it would seem that there is little to find fault with. The physician has after all first considered and respected his patient's autonomy and being unable to view the patient as autonomous has then proceeded to invoke the principle of beneficence has acted paternalistically. Would we, however, view this case in the

same way if, again the information might cause harm but the diagnosis was more reliable, say of terminal cancer and the patient was indeed competent? Mill (1859) despite being opposed to paternalism considered temporary beneficent interventions in a person's actions to be justified on some occasions. He argued that a person who is ignorant of a significant risk – for example crossing a dangerous bridge – may justifiably be restrained in order to ensure that they are acting intentionally and with adequate knowledge of the likely consequences. Once warned, the person should be free to choose whatever course he or she desires. Mill (1859) did not consider this temporary intervention as a real infringement of liberty and therefore he did not consider this paternalistic. It is not contentious to suggest then that paternalistic intervention might be justified in cases where the subject of moral concern is non-autonomous and perhaps even temporarily in cases where the subject is autonomous in the name of beneficence on rare and temporary occasions as Mill describes. The real problem comes for paternalism in attempting to justify overriding autonomous choice in an environment where patient autonomy is the way in which we understand respecting patient.

Feinburg (1984) attempted to address these issues by further defining paternalism into both strong and weak categories which he later modifies into hard and soft paternalism. In his account, cases where an agent is required to intervene on the ground of beneficence *only* to prevent “substantially non-voluntary conduct” to protect the persons against their own substantially non-autonomous actions is defined as weak paternalism (1984, pp.113 and 116). Examples of this might include cases where a consent or refusal is inadequately informed, severe

depression or pain that prevents rational deliberation or addiction all of which bear the element of lack of free choice. Weak paternalism would then require that a person's competency to be compromised.

Strong paternalism occurs where a person's risky or unwise choice is externally overridden despite them being substantially autonomous. It is only then that by overriding that autonomous choice in the person's best interest that one could be described as relying on strong paternalism. According to Feinburg (1989) in order for the action to be described as strong paternalism the subject whose autonomy is being overridden need not be fully informed or indeed completely voluntary but must nonetheless be acting in a substantially autonomous manner.

Feinburg (1989, p.14) concedes that in fact it "may be rather misleading to think of weak paternalism as any form of paternalism at all". This is because it is not this weak form of paternalism that causes any real problems. It is not contentious to argue that an individual may need protection from harm in situations that are completely beyond their control. The difficulties with paternalism arise in connection with what conditions we should consider and protect others from self-harm.

Any defence of paternalism and assessment of its justification is normally divided into three main positions. These are anti-paternalism, justified paternalism that relies on the principle of respect for persons and justified paternalism that relies on the principle of beneficence. All three positions agree that some form of weak

paternalism as outlined by Fienberg (1989) is justified. This is the case even for anti-paternalists mainly because in the case of weak paternalism substantially autonomous actions are not at stake.

Anti-paternalists reject strong paternalistic actions because they believe such actions violate individual rights and conflict with free choice. One of the criticisms of paternalism from the anti-paternalist stance is that to give paternalism to a state or class of persons such as physicians is undesirable. More persuasively they also object to paternalism on the grounds that the authority for any action should rest with the individual concerned. This may be interpreted as strong paternalistic actions are indicative of a lack of respect for autonomous agents and does not treat these individuals as moral equals. The result of which is that they are considered by the paternalist as “less than independent determiners of their own good” (Beauchamp and Childress, 2001, p.182). As both Dworkin and Childress contend, when others impose their conception of good on us they preclude us from receiving the respect to which we are entitled. This is problematic even if we do receive a benefit and their assessment as to what was good for us exceeds our own evaluation (Dworkin 1978; Childress 1998).

Anti-paternalists also criticise paternalism standards as being too wide-reaching. This then, they contend, enables paternalism to become entrenched in institutions if it provides the basis of policy and allows for far too much intervention. Harris considers that in principle this would allow “...the imposition of a Spartan-like regimen requiring rigorous physical exercise and abstention from smoking,

drinking, and hazardous pastimes subject to the threat of criminal sanctions.”  
(Harris, 1967, p.585).

Clearly though this argument at best only provides a rebuttable presumption against paternalism. However, anti-paternalists argue that paternalism as an institutional concept allows for potential abuse. Further it is contended that because of paternalism's focus and reliance on the concept of beneficence, it can preclude other virtues and values that we may consider desirable. Suppose a father is considering making a live organ donation to save his son. Donating a kidney will clearly be of no medical benefit to him yet do we not admire his sacrifice and think this is a virtuous thing to do? A strong paternalist however might be required to stop him considering or indeed following this course of action to prevent the father doing harm to himself. Paternalism might in this situation be able to support the father's course of action by allowing for no intervening in this situation on the basis that the benefit derived is one of social or emotional merit that outweighs the medical harm? However, this cannot be said to be the case in all situations. Would a paternalist be able to mount the same defence were he or she to be required to consider a situation where the donation was to be made anonymously? Again a paternalist might try to allow for the action based on a less definable concept of benefit. Perhaps the donor gains some general social benefit or a large degree of self-satisfaction that can be shown to outweigh again any harm? The assessment then of the moral value of such a situation for an autonomist would be that the donor is being allowed to exercise his autonomy without interference whereas for a paternalist it might be assessed in terms of the



benefit derived be that medical, emotional, social or a combination of all three. One challenge for that paternalist might arise in the form of self-sacrifice where it is hard to claim that any benefit for the subject of moral concern is derived at all: for example where a donor makes a donation that results in his or her own death. This may be a situation where we greatly admire the courage and heroism of an individual but cannot seem to find any benefit at all. Would not a paternalist be required to intervene in these circumstances? Does strong paternalism then preclude more extreme examples of heroism?

One of the examples that most anti-paternalist literature relies upon is involuntary hospitalization. One example of this was the case of Catherine Lake. Lake suffered from arteriosclerosis which on occasion could leave her with memory loss and periods of mild confusion. At other times Lake was alert and completely lucid. Lake never presented a threat to anyone else and whilst at her trial was apparently completely rational. However Lake was committed to a mental institution on the basis that she was considered confused and defenceless. The court considered however that she was “mentally ill”, a “danger to herself” and “not competent to care for herself” (Katz, Goldstein and Dershowitz, 1967, pp.552-554). Anti-paternalists argued that since Lake was not a danger to others and perfectly understood the risks involved she should not have been detained. Beneficence therefore for the anti-paternalistic does not have authority over autonomy.

## **Paternalism moderated to work with autonomy**

Other supporters of paternalism consider that paternalism is justified not only by benefit but also by consent. For them paternalism can be justified if:

1. “the harms prevented from occurring or the benefits provided to the person outweigh the loss of independence and the sense of invasion the intervention causes;
2. the person's condition seriously limits his or her ability to make an autonomous choice;
3. the intervention is universally justified under relevantly similar circumstances, and;
4. the beneficiary of the paternalistic actions has considered, will consent, or would, if rational, consent to those actions on his or her behalf.” (Beauchamp and Childress, 2001, p.183)

Browning-Hoffman claims that in some cases we ought to consider that individuals are deserving of our help, even if their routine life seems a rational one. Browning-Hoffman exemplifies this by considering where a man owing to his religious beliefs frequently engages in self-mutilation on the basis that, in his role as a true prophet of God, it is better for him to sacrifice a body part rather than the present course of the World that would result in greater loss of life. (Browning-Hoffman as cited in Beauchamp and Childress, 2001, p.184). His capacities are too diminished and the danger he presents to himself too severe to allow him complete independence.

In order for a strong model of paternalism to be justified it needs some limitations, particularly to avoid the criticisms of the anti-paternalists. Several theories have attempted to limit paternalism by appealing to the concept of consent. Gerald Dworkin appealed to this principle, he considered that “the basic notion of consent is important and seems to me the only acceptable way to try to delimit an area of justified paternalism” (Dworkin, 1972, p.67). This was also the approach taken by

Carter who argues that consent plays a central role in justifying paternalism and contends that no other concepts are relevant (Carter, 1977, p.32). VanDe Veer agrees contending that “acting in a seriously encumbered manner [where] it is highly probable that they would give consent to the intervention if the opportunity were available.” (VanDe Veer, 1986, p.424)

The basic supposition of the consent-based theory is that any rational person would give their consent to a paternalistic intervention based on the theory of beneficence in order to protect themselves from harm (Dworkin, 1972). The further premise being that any *right-minded* person is prone to be tempted to make choices that may have consequences beyond their imagining that are consequently irreversible. In addition, it is suggested, most *right-minded* people may also acknowledge that at times social pressure or plain temptation may cause them to engage in activities that are clearly not in their best interests when other factors such as pride interfere with their decision making. Further, in other cases individuals may mistakenly believe that they are fully cognisant of the necessary facts where as in actual fact an important part of their knowledge in relation to a decision is missing say for example that smoking causes heart disease as well as lung cancer or that the bungee rope they are about to rely on has in fact not been checked in the manner in which they thought. It is by using consent in this way that its proponents believe the bounds of paternalism would be limited. Those wishing to engage in paternalism could only do so if they could contend that they would have consent from the individual of moral concern had they [the subject of moral concern] been similarly in the position of the paternalist. This could

perhaps help us with the difficulties with the organ donor in that a consent basis of paternalism perhaps could take account of situations where we still wish to promote values such as heroisms. If it could be shown that no implicit consent could exist in certain circumstances this might enable other values to take precedence over paternalism when appropriate.

Rawls (1999) and Dworkin (1972) both believed that a form of justified paternalism could be supported based on the belief that rational agents would consent to paternalism and even to sanctions to help them avoid actions that might have unpleasant consequences. An example of this would be the requirement to wear a motorcycle helmet and a fine for not doing so. However according to their theory it is those with defective autonomy who would otherwise give their consent if that defect were removed who are intended to be covered by this justified paternalism not those who are completely autonomous in relation to the question at hand. At first it would appear that there is a presumption that the paternalist has to envisage a situation where the subject of a moral concern has some specific autonomy deficiency and therefore is required to step in. However, Rawls and Dworkin contend that this predicative model is not the basis of their theory. Rather that they are relying on a Kantian concept of what the autonomous agent would have consented to in the hypothetical circumstances of consent (Dworkin 1972; Rawls 1999).

This appears to be an attractive proposition as not only would it possibly not preclude other values such as self-sacrifice and heroism but also would be

compatible with autonomy itself. Further it would bring together both the principles of beneficence and autonomy so that paternalism would respect rather than override autonomy. The difficulty that arises relates to our concern about the apparent, though disputed, predictive aspect of the theory. That is to say that this model does not require the individual's actual consent. It would be argued here that despite Rawls (1999) and Dworkin's (1972) contention that this form would limit the bounds of paternalism it could still potentially incorporate more circumstances of justified paternalism than its proponents first envisaged.

Although rationalising and bringing together paternalism and consent is an attractive ideal it is contended here that in reality they are the antithesis of each other. The foundation of paternalism is beneficence alone and it is easier to see it in those terms and consider its merits without attempting to justify it on the grounds that the subject of moral concern in some way metaphysically consented to the act of paternalism all along. Consent or lack thereof relates to the ability to control one's life and paternalistic actions limit that control. The value of paternalism or otherwise relates to whether or not limitations of that control are useful and justified. To imply that somehow the subject of moral concern has control or would have agreed to relinquish control had they been in a different position is an anathema. For this discussion is it merely a matter of apportioning the correct weight to beneficence and autonomy in order to help us decide which should have the authoritative voice in situations of conflict.

## **Passive paternalism**

As we have seen when considering Feinburg's distinction of strong and weak paternalism there are cases where paternalism may be easily justified as there is no substantial overriding of autonomy. Further, following Mill's (1859) example of the man on the dangerous bridge it may also be relatively straight forward to justify strong paternalism in cases where the intervention is for a relatively short period of time without a substantial reduction in the subject's ability to exercise their free will. Such minor all be they strong paternalistic measures are common in hospitals. For example protecting someone from a fall out of bed even though they don't want the side up on the bed or not giving bad news immediately as the diagnosis is yet to be confirmed by further tests. Beauchamp and Childress (2001) contend that these forms of strong paternalism are justified only if:

1. "A patient is at risk of a significant, preventable harm;
2. The paternalistic action will probably prevent the harm;
3. The projected benefits to the patient of the paternalistic action outweigh its risk to the patient;
4. The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted." (Beauchamp and Childress, 2001, p.186)

How do we then address situations where patients request procedures that clinicians do not believe to be beneficial perhaps on grounds of futility or potential harm caused? How do we then mediate in these circumstances? This leads us to consider one of the less discussed areas of paternalism, passive paternalism.

The usual aspects of paternalism discussed with vigour typically focus on active paternalistic interventions. Passive paternalism however, particularly in medicine

is an area of specific concern. Passive paternalism occurs when a physician simply refuses to carry out a patient's preference on the basis of patient focused beneficence (Childress, 1982; Quill and Brody, 1996). Common examples often involve the sterilization of otherwise healthy women. Sterilization is often refused for women of child-bearing age on the grounds that it is not in their best interest despite their apparent competency and strongly held desire not to have children (Basson, 1981, pp.135-136).

Passive paternalism is also central to debates on medical futility. Hospitals often apply to turn off ventilators on the grounds that it is non-beneficial to patients in a persistent vegetative state in that it will not heal their lungs or other failing organs. It is argued that if indeed support for such patients is futile then denying patients and their representatives' requests for treatment could be justified under passive paternalism. Even restrictions for withholding treatment for severely premature babies on the grounds it is virtually futile are supported. It is justified not on the basis that it is harmful to the patient but that treatment will not bring about the benefit sought either to the patient. Therefore, a proven claim of medical futility here effectively cancels the physician's duty to provide a medical procedure. Perhaps because the medical element of the relationship has been removed for reasons of futility it means that a physician's duty to act beneficently is reduced to non-maleficence, to do no harm rather than to actively promote good. This in turn returns their relationship to one of common humanity rather than a special relationship of doctor and patient. Criticisms of some of this discussion however

centre on the fact that futility could be considered a question of wasted resources and general utility rather than one of truly passive paternalism.

As Lantos et al. (1989) point out medical futility is often regarded as:

1. "the procedure cannot be performed because of a patient's biological condition;
2. the procedure cannot produce the intended psychological effect;
3. the procedure cannot reasonably be expected to produce the benefit that is sought;
4. The procedure's burdens, harms and costs outweigh its anticipated benefits." (Lantos, et al.,1989, p.82).

Really only the first three criteria can truly be regarded as medical futility. Criterion four merely reflects the restrictions and application of healthcare rationing. To take account of criterion four would mean adopting a normative stance on a person's right to treatment and would cloud our argument by introducing a subjective element.

## **Conclusions**

Returning then to the issues raised in Chapter One that we wish to address; respecting the individual, being able to draw limits, prioritising patient's reasonable wishes and assuring the process by avoiding deception and manipulation, how far does paternalism go toward addressing these needs?

At first instance paternalism seems to be a suitable for our needs in that it bears a strong individualistic component; that of the interests of the patient. Not only that, but paternalism also requires of the actor (here the dentist) that he or she actively



promotes the best interests of the patient. Respect for persons here then would be adequately served in two senses. One that the individual is prima facie recognized as being of value and two that there is a requirement on the part of the paternalistic dentist to promote the interests of the patient. For this aspect our needs are met.

We may now turn to our second requirement, that the clinician is able to draw limits around his or her obligations to the patient. As we have considered one important aspect of any account of paternalism requires that the actor believes that our understanding of our beneficent duty also enables us to draw reasonable limits around what might be expected of a clinician with regard to a patient. As we have seen earlier although I wish to claim that a model of medical paternalism strengthens the duty of beneficence from a weak requirement overall to a stronger duty as a result of the special relationship between clinician and patient I would argue as a consequence of this that the duty owed is also quite clearly limited to the boundaries of that clinical relationship. That is to say that a patient subject to a paternalistic model might reasonably expect a clinician to offer them the best of dental care (subject to the practical constraints of resources and skill) but should not expect the dentist to offer them a lift home afterwards as clearly this falls outside the special relationship and the duty then to act beneficently is reduced to the weaker conception of more incidental or ordinary relationships. In summary the duty for the clinician is limited. It operates only within the confines of the special relationship and only those 'best interests' of the patient that fall within

that special relationship give rise to a duty that the dentist needs to discharge. It would seem that for this aspect paternalism meets our aim.

Our third requirement, that we prioritise the patient's reasonable wishes may become more problematic. We have considered earlier that traditionally 'best interests', in the clinical setting, has been interpreted to mean clinical need. As the business in hand is medical in nature and the beneficent duty on the part of the practitioner is established owing to the medical business at hand from a practical perspective at least it would seem difficult to expand this definition to include matters beyond the clinical. After all a broader definition of need to include desire or wishes may inadvertently reduce the duty on the clinician to promote those interests at least of the patient. Further, as paternalistic models rely heavily on the position of actor (here the dentist) rather than that of the patient this necessarily reduces or calls into question the authoritative voice of the patient. If a patient cannot make his voice authoritative nor can he require the dentist to consider a duty of beneficence on matters that falls outside the medicalized relationship it would seem difficult for us to claim that we can prioritise a patient's reasonable wishes adequately. I would wish to acknowledge that is a practical rather than theoretical concern in that one could attempt to claim that as we also wish to argue for a more healthcare focused rather than treatment focused approach this might broaden the remit of a dentist and cause him to consider other aspects that are likely to be of concern to a patient. However problems may arise where presumptions are made (from a paternalistic stance) as to precisely what those concerns are. After all some patients may be very concerned about cost for

instance whereas others may find cost of no moment whatsoever. The problem arise because the dentist is able to work from his assessment of what is of concern (after all he believes he is best placed to decide) rather than actually asking the patient and for that reason I would claim that we have been unsuccessful in meeting our third requirement.

Finally we may wish to consider our last requirement that we wish to assure the process by avoiding manipulation and deception and the desire to claim our duty discharged by analysing only the success of outcome. Again it would seem that paternalism is unable to meet our requirements here adequately. As we have considered earlier coercion or even deception, lying manipulation of information, or nondisclosure of information are all permissible if they aid the actor to discharge his best interests duty. The focus of the action relies on what the actor (dentist) deems to be in the best interests of the patient that is to say the best outcome. Therefore (perhaps with some constraint) the best interest aim, for instance successful care, may well justify the means.

### **Summary**

It would seem then that although paternalism has some aspects to recommend it as a theoretical model it is unable to adequately meet the aims we considered in Chapter One. Our concerns with the process of healthcare and the desire in the primary dental care setting to assure the quality of a patient's experience as well as their treatment outcome struggle to be delivered or assured by relying on a paternalistic model of patient dentist interaction. For that reason it seems that

paternalism struggles to operate effectively as a principle on its own in the clinical context where a patient is viewed to continue to have their own autonomy. There is strong resistance to a position where an individual is able to make a decision for themselves but is precluded from doing so in the belief that another is better placed and as such has an authoritative voice. This is partly because paternalism draws its moral benefit by focusing on the 'outcome' of the interaction. However as we have seen in Chapter One in our example of skill mix where patients express concern that they do not know the professional identity of the person treating them 'outcome' is not the only measure of how we adequately respect patients. It is the utilitarian aspect of paternalism here that causes us difficulties as we cannot use an outcome focussed model to prompt us to divulge information that is not linked to the 'outcome' of the interaction (the treatment).

Further difficulties with paternalism are, as we have seen, the reliance on the principle of beneficence in that a patient is prevented from making a free choice if it is not the 'best' choice. Even if we did not wish to express the desire for free choice in terms of autonomy we need to be able to express this desire for free choice by appealing to an adequate account of some kind. If we consider the example of the use of private alongside NHS treatment we raised concerns about a patient's right to make that choice even in circumstance where the benefit derived might not be as great (for example the NHS treatment is not as good as the private one on offer). Choosing the 'best' treatment option on behalf of the patient has two consequences, first in order for us the claim that it is indeed the 'best' it must be treatment focussed, a clinician might struggle to maintain a legitimate paternalistic

stance if they claim expertise or knowledge of the patient outside those confines. Second (a direct consequence of the first point), if we are to take a patient-centred approach rather than treatment focused then the private option may not indeed be the 'best' because invariably it will be more expensive and as such may not be 'best' for the patient. There is nothing in the theory that requires us to consider that broader definition of 'best interests' and therefore we are unable to address the concerns raised in relation to NHS and private treatment.

It seems that paternalism either on its own account or attempts to rationalise it with the concept of autonomy cannot satisfactorily address the concerns we raised in relation to our case studies in Chapter One. Paternalism causes us to continue to be too treatment focused in that this is where the benefit and authority for action are seen to arise. Benefit is also outcome focussed and as such fails to force us to consider the merits and dignity of process that we wish to develop as part of our case studies. Further as I wish to assert that paternalism does really rely on beneficence and that it is counter-intuitive to believe that consent could act as its underpinning. As consequence of this is that we cannot adequately claim that it is compatible with autonomy. This makes it theoretically difficult to 'fix' some of the problems with both theories by reliance on each other and may cause us to look elsewhere for a suitable model of interaction for the dentist-patient relationship.

However a reliance on medical expertise as one of the ways in which the clinical relationship operates may not be altogether redundant. O'Neill (2002a) has gone on to consider a relationship that is underpinned or supported by appealing to the

concept of principled autonomy and it is now that I turn to consider whether this approach may be of use in developing an adequate framework for the dental relationship.

## Chapter Five – Principled Autonomy and Trust

We have seen in Chapter Three some of the concerns we have raised in relation to our current reliance on hierarchical accounts of autonomy. We have considered how our current construction of autonomy leaves us with a model of medical interaction that is both extremely complex, difficult to apply effectively, and overly medicalized. This has led us to contemplate alternatives and we have considered in Chapter Four both the benefits and some of our concerns with the concept of best interests and medical paternalism. As we have seen the best interest account does go some way to helping us give due ethical weight to the individual. The best interest account also helps us to draw limits round our duty to respect patients by confining that duty to the matters over which a clinician can legitimately claim expertise; the medical business at hand. However, we have also raised concerns. What the best interest account cannot legitimately provide, that is of concern to the dentist-patient relationship, is a broader account of *health care* as defined in Chapter One that takes into account a patient's wider reasonable wishes. Further, as we have seen the best interest account cannot deal effectively with our concerns with deception. Lying, deception and manipulation are all perfectly permissible features of this model so long as the principle of best interests is met. Therefore this makes the model unable to adequately address the concerns raised in Chapter One.

The aim of this chapter is to consider if, by taking a different approach and looking at the dentist-patient *relationship* rather than the patient in isolation we might be better able to respect patients and create a more ethically robust and equitable

clinical relationship. This chapter will explore these ideas by first considering O'Neill's concerns and her starting point for proposing a different model of clinician-patient interaction. We will then move on to look at O'Neill's alternative *principled* approach to autonomy and how this differs from the current individualized stance. As O'Neill is taking an applied approach we will also consider the effect of the principled approach on the clinical relationship. It is worth noting that as a consequence O'Neill's proposals are much less detailed than preceding accounts. O'Neill states that she wishes her account to be more practically digestible whilst remaining theoretically robust. Central to O'Neill's proposed principled autonomy is the consequent duty, on clinicians, to be trustworthy. This chapter will consider more specifically to what extent this obligation to be trustworthy addresses our concerns with deception and an overly medicalized approach. Finally we will re-visit the hypothetical case-studies from Chapter One to judge the degree to which O'Neill's propositions address some or all of our concerns in the dentist-patient relationship.

### **O'Neill's concerns with the individualistic account of autonomy**

As we have seen earlier we live in a "time of triumph of autonomy in bioethics in which the law and ethics of medicine are dominated by one paradigm – the autonomy of the patient" (Schneider, 1998, p.xi). In a post world war society, Manson and O'Neill argue this is a not at all surprising and is a rejection of and reaction to Second World War atrocities and totalitarianism (Manson and O'Neill, 2007, p.1). Others have argued that this 'autonomy dominance' is a consequence of the strong need for an individualistic account of respecting patients as a means



of overturning the historical difficulties with medical paternalism (Stirrat and Gill, 2004, p.127). Fox (1990) describes this as “the conceptional framework [that] has accorded paramount status to the value-complex of individualism, underscoring the principles of individual rights, autonomy, self-determination and their legal expression in the jurisprudential notion of privacy” (Fox, 1990, p.206).

Nonetheless there has been growing concern with this highly individualized approach for respecting patients. This concern particularly relates to what O’Neill asserts is a corrosive effect on the clinician-patient relationship. O’Neill begins her criticism by pointing out that our current individualised interpretation of the meaning of autonomy is very distant from the principles original proponents on which we claim to rely. O’Neill recalls that John Stuart Mill rarely used the term autonomy and when he did use it, it was with reference to states rather than individuals. Mill, O’Neill claims, “sees individuals not merely as choosing to implement whatever desire they happen to have at any given moment, but as taking charge of those desires, as reflecting on and selecting among them in distinctive ways” (O’Neill, 2002a, p.83-84). O’Neill further asserts that Kant also did not adhere to a highly individualised account of autonomy. For Kant, O’Neill asserts, “autonomy is not [equated] with any distinctive form of personal independence or self-expression. Kantian autonomy is manifested in a life in which duties are met, in which there is respect for others and their rights” (O’Neill, 2002a, pp.83-85). So for O’Neill Kantian autonomy is not a form of personal expression but rather “a matter of acting on certain sorts of principles, and specifically on principles of obligation” (O’Neill, 2002a, pp.83-84). For Kant

freedom of expression cannot operate legitimately if it does not have reference to the needs and rights of other individuals. Autonomy, then, is to some degree *earned* rather than presumed. Indeed “there can be no possibility for freedom for any one individual if that person acts without reference to all other moral agents” (Campbell, 1995, p.14). O’Neill refers to this *earned* autonomy as principled autonomy. Jennings is also supportive of this view claiming that Kant and others established that “morality requires a person to assume responsibility for his or her choice, actions and decisions and to act on the basis of informed reason and autonomously held principled commitments. Others in turn must respect the moral agency and reasonable commitments of the person in this sense” (Jennings, 2002, p.69). In summary unlike an individualistic account of autonomy then a principled account claims that there cannot be any autonomy without a correlative value of morality. I would wish to claim as part of that principled account there is also an implied necessary condition of freedom (as there is with other accounts of autonomy). That is to say that a principled autonomous agent must be in a position of free choice or free self-determination to be viewed as acting within the principled account. After all without this liberty (freedom) it would be unethical to make someone responsible for actions over which they have reduced control.

Perhaps it might be useful to note that individualistic accounts of autonomy also have a long tradition with roots in the Enlightenment and the struggle from which modern Western democracies sprang. This, Stirrat and Gill (2005, p.128) claim has led to a modern interpretation that each individual carries his or her own “quantum” of ethics. That is to say each of us is an island of our own values and

beliefs that no other may legitimately invade. The concern is that this represents an adoption of a number of powerful rights of independence without any related obligations. This lack of reciprocity means that “rights are multiplied assumed or attributed where they do not exist, replacing the language of duties which oblige even where there are no rights” (Dunstan, 1994, p.3). We have seen in Chapter Two evidence of this account. As Schneider points out “the overwhelming weight of bioethical opinion endorses not just the autonomy principle but a potent version of it”. This is perhaps erroneously based on “the assumption that autonomy is what people primarily and pervasively want and need”. Thus, as we have seen, the overwhelming view of individualistic autonomy in current biomedical ethics is one that confers “a right to act on one’s own judgment about matters affecting one’s life, without the interference of others” (Dunstan, 1994, p.3). O’Neill’s belief is that this approach is fundamentally flawed and that autonomy ought more rightly to be set in context with due reference to relationships and community. O’Neill proposes that “conceptions of individual autonomy cannot provide a sufficient and convincing starting point for bioethics, even for medical ethics...The supposed triumph of individual autonomy over other principles – is an unsustainable illusion” (O’Neill, 2002a, p.73).

One of the key concerns of O’Neill and others is the corrosive effect that the individualistic account has on the clinical relationship. Schneider (1998) claims that we can currently observe there are two types of autonomy operating in the clinical relationship those being optional and mandatory. Brock (1993) views the former as “entitling but not requiring the patient to take an active role in decision

making regarding treatment” (Brock, 1993, p.33). In the latter model “it is practically unwise and morally objectionable for a patient to forswear making a medical decision personally” (Brock 1993, p.33). Both of these approaches seem morally problematic and it is not surprising that O’Neill and others raise objections to them. Prima facie it would appear not at all equitable that a patient may assume rights to be involved in the decision-making element of their care but assumes no responsibility to do so. This leaves the clinician in a position where they do not have full authority for decision-making yet may well be burdened with doing so as a default. The latter mandatory example fares no better. It also seems unsatisfactory to force decisions onto patients and presume a form of moral value in self-determination to a perhaps tyrannical extent reminiscent of the very paternalism we wish to avoid. It is hard to disagree with such concerns. However, I would wish to add that there appears to be a background here of presuming a certain equality of position in the relationship between clinician and patient. This presumed equality is at the root of concerns raised as well as the proposed substitution of an individualistic account of autonomy with a principled one. As we have seen in earlier chapters it is commonly recognized that there exist a duty of care relationship between clinician and patient. This duty of care relationship is a consequence of the recognition that the relationship is unequal. No matter how informed a patient or how well qualified it is hard to imagine how one might successfully argue that the patient has the overriding authoritative voice. The patient may well have the right to consent but does not choose to be ill or in need of treatment or decide on the diagnosis or appropriate courses of treatment. This, some may claim, is an objective process and the options are not part of the

clinician exercising power but rather what is clinically indicated. Although this may be the case in some instances often the options presented are part of the *judgment* of the clinician and I would wish to argue, this imbues the clinician with rather more authority in the decision-making process than might appear at first glance. For this reason I would wish to raise an initial doubt concerning the claim that there is a lack of reciprocity in the clinical relationship as a consequence of an individualized approach. We will however consider this in more detail later on in the chapter in relation to our hypothetical case studies.

### **Principled Autonomy**

O'Neill's solution, to her objections to an individualized account of autonomy, results in her principled account. For O'Neill autonomy is not a feature of person in that it is neither an inalienable right nor an ability to make personal decisions in a particular reflective way. Rather principled autonomy is a commitment to a certain set of assumed obligations that we can will as universal laws. It is O'Neill's aim to ground human rights in human obligation rather than the individualized accounts of human good (O'Neill, 2002a, p.78). O'Neill argues that this approach has five main advantages:

“First...that obligations are structurally connected to rights; second that their connection to action can be well articulated; the third and consequential advantage is that obligations are more readily distinguished and individuated than are rights; the fourth is that the approach is less individualistic than rights-based approaches. Finally...we can find better routes to the justification of obligations, and hence rights, than we can find to the justification of rights, and hence of obligations.” (O'Neill, 2002a, p.78)

For O'Neill the first important benefit of principled autonomy is that it focuses on obligations rather than rights. O'Neill points out that this is a more satisfactory solution in that if we focus on delivering obligations there is a correlative connection to rights. A right then would position itself as a consequence (in the sense of action) of an obligation rather than the reverse. The attraction to this approach, O'Neill asserts, is that we often claim rights in a proleptic sense. This can be somewhat self-defeating as rights require due recognition in order to exist. Where we anticipate rights where there is no correlative duty the right itself is undeliverable. O'Neill uses of the example of 'right to health'. O'Neill claims that in her view it is not possible to provide health for all, so there can be no correlative obligation to do so. This' O'Neill asserts is self-defeating because to claim a right where there is no corresponding duty is to claim not right at all. Obligations on the other hand, at least require action from the individual or organisation therefore an obligation to provide health for all is much more effective than to claim a right to it.

Second, the duty to meet certain obligations is what O'Neill describes as the "business end" of ethics. The reason for this is because (unlike rights) obligations are more closely linked to action. As with O'Neill's first point if no one carries out their obligations then no one's rights will be met. This view of the position of obligations is one also expressed by Weil:

"The notion of obligations comes before that of rights, which is subordinate and relative to the former: A rights is not effectual by itself, but only in relation to obligation to which it corresponds, the effective exercise of a right springing not from the individual who possesses it, but from other men who consider themselves as being under certain obligations towards him." (Weil, 1949, p.3)

Although O'Neill does not go so far to claim that obligations are a priority to rights she does assert that an observance of obligations does predate the more recent reliance on rights. O'Neill wishes to return to at least a position where obligations and rights cannot be separated; that both principles are mutually determining.

The third advantage that O'Neill claims with principled autonomy is obligations are described using the "language of action" (O'Neill, 2002a, p.81). This means that we can more readily distinguish obligations than we can rights. This is certainly an attractive proposition in the sense that for an applied approach (in the clinical context) it is much easier for the dentist to discern what is required of him or her if those requirements are an obligation to "*to do or to desist, to act or to refrain*" (O'Neill, 2002a, p.81). Whereas when considering rights such as a 'right to life' or 'a right to choose' what is actually required of the dentist is much less obvious. It may be considered though as to what is lost with these more practical calls to action? After all a *right to life*, is a much more complex and difficult concept that requires far more consideration than a narrow duty to maintain confidentiality. That is not to say that there is no room for academic debate around any duty (after all one may need to consider when it is appropriate, if ever, to breach confidentiality) but rather that the duty in the clinical setting as a *call to action* is surely met if the action is followed through. There is perhaps less *practical* impetus to consider the finer points of a duty because you can *prove* at least in your own mind that it is met whereas one is forced to consider and reflect on ones actions and motivations when claiming to have respected a right.

The fourth advantage is one that in describing autonomy as a set of obligations rather than as a set of rights we rightly (in her view) move away from the highly individualized accounts to one that looks at the bearers of obligations and the holders of rights. O'Neill's view is that when we talk about rights we naturally focus solely on the bearer of those rights rather than the individual or institution that might be called upon to deliver them. The consequence of this, O'Neill claims is that at times the bearer of rights bears them in a vacuum where it is not clear where or against whom those rights should be claimed. In contrast when we talk of obligations we have to focus on the relationship and therefore have a natural structure around which obligations and correlative rights are set. This means, particularly for the patient their rights are, O'Neill claims, more likely to be met because there is a specified agent (the dentist) to who the corresponding duty settles on. However, it is clear from O'Neill's account that we are not starting with rights and then attaching a corresponding duty, in fact quite the opposite. The duty is on the clinician to perform his or her obligation which is linked to a right held by the patient. We will look later on at one particular duty the clinician must adopt according to O'Neill's account, trust. For now however I would like to point out that the consequence of obligation setting by the dentist may cause us to be somewhat concerned about the patient's ability to set any kind of agenda in the clinical encounter despite the encounter generally being thought as for their [the patient's] benefit.

Finally, O'Neill claims that there is a better route of justification where obligations come, so to speak, before rights. This again relates to the need for an obligation



based approach to focus on the relationship (because it relies on action) rather than the individual. After all, O'Neill points out, we cannot fulfil our obligations if we do not know to whom we owe our duties. In some cases agents may have obligations to all others for example not to enslave but in other cases that may be confined to individuals such as the duty to maintain a confidence.

O'Neill's proposal therefore is based on entrenching obligations in the clinical relationship rather than trying to negotiate the individual autonomy of the patient. However, in order for the entrenching of obligations over and above rights would only be persuasive (despite some of our reservations) if there is a good argument for central human obligations. This concept relates most closely to the Kantian approach of universal law. Kant's premise rests on the notion for a principle (law) to be ethically justifiable that law must be universal. That is to say that the law can be applied to all people at all times.

### **O'Neill and the clinical relationship**

So far O'Neill has argued for a replacement of an individualised account of autonomy for a principled one on the basis that a principled account has greater moral authority. The basis for this claim rests on O'Neill's belief with all rights there ought to be correlative duties. This is coupled with a rejection of the individualized account on the basis that it has less moral authority and it is corrosive to the medical relationship. As part of making this principled account operationally possible, which is one of O'Neill's key concerns, she appeals to the concept of trust. Trust is, O'Neill asserts, a key component of any relationship. It is

important to note though that O'Neill's account of trust is one of, (as is her account of autonomy) a consequence of good behaviour rather than a blind faith decision. We will now look at how those two propositions translate into clinical practice.

The clinical relationship has, historically, been one that is covenantal in nature rather than contractual. A covenantal relationship is defined by an implied agreement between the parties to a number of duties and obligations (May, 1983). As the relationship is also subject to the auspices of 'duty of care' to reflect the inequality between patient and clinician, this has meant the majority of formal duties are adopted by the clinician rather than by the patient. As O'Neill points out (2002, p.119), mutual trust has been eroded in recent years in what she calls the "after glow" (2002, p.118) of medical paternalism and some very high profile cases of poor and unethical medical practice (Consider Chapter Two and the *Redfern Report*, (DoH, 2001) as an example). This, she suggests, has led to an implicit breakdown of the clinician-patient relationship. Further we have seen the rise of managerial ethics in health care, although individual clinicians tends to be patient focused, the dominantly consequentialist model of managerial ethics ultimately determines the health care that patients receive (consider the use of NICE as an example of this approach), (Jennings, 2002). To some extent this new managerial style may well be understood. The big decisions that affect a population are too important to be left in the hands of individual clinicians particularly in the context of an institution such as the NHS and its associated public funding. The temptation, it is considered, would be too great to promote the needs of the individual patient without due consideration to the greater good.

However, Illingworth asserts, this managerial approach is “antithetical” to the patient experience as it is at this patient-clinician level that trust is gained and bestowed. This managed approach has damaged the patient-clinician relationship (Illingworth, 2002, pp.31-46). This is because although the government in the UK has great influence in determining the type, scope and quality of caring environment they are not ultimately responsible for the ill individual.

In this traditional covenantal relationship the “central obligations of the clinician are competence, compassion, care and good communication” (Stirrat and Gill, 2004, p.129). Respect for autonomy currently means that the patient must be “treated with respect, be properly informed, be listened to, give their consent voluntarily, without coercion, and have their confidentiality fully respected” (Stirrat and Gill, 2004, p.129). This could perhaps be summarized as seeing the patient as a person rather than simply a presenting patient, an obligation to empathize with the individual. Atkins (2000) goes further than this and argues for an attempt to imagine what the clinical experience is actually like for *that* patient rather than a broader attempt at empathizing with a hypothetical patient in any given situation. This is of concern though for ethicists such as Draper and Sorrell (2002). Their view is that this is rather one sided as the patient does not adopt any correlative duties and that such an approach “dwells on the obligations of the doctors to the exclusion of the patients” (2002, p.335). Draper and Sorrell continue:

“Traditionally medical ethics has asserted that, as autonomous agents, competent patients must be allowed to decide for themselves the course of their medical treatment...it is for the doctor to communicate effectively all the relevant information, assess the patient’s competence, persuade

without coercing, and abide by whatever decision the patient makes. Little or nothing is said about what kinds of decisions the patient ought to make” (Draper and Sorrell, 2002, p.349).

The way in which we might wish to judge the ‘quality’ of a patient decision is only assessed by the degree to which the decision originates from the patient. Draper and Sorrell feel that this account is inadequate and that a patient taking responsibility for their decision is an intrinsic part of exercising their autonomy. Draper and Sorrell suggest that in practice their view has two effects. First, they claim, from a practical perspective a decision for which one has to take responsibility is more likely to be complied with although this is phrased as ‘more effective’ rather than compliance. The example used is to claim that one is more likely to successfully give up smoking in a situation where one has come to that decision oneself rather than being found in a predicament where cigarettes are banned. This claim seems to be somewhat tenuous in that a decision made in a highly individualized account bears the same qualities of being one’s own decision as this more principled account proposed by Draper and Sorrell. From this perspective it is hard to see in what way an individualized decision does not bear the same consequence. It is agreed that the responsibility is not directly linked in the same way that Draper and Sorrell wish to see to the situation one finds oneself in as a patient would be the same surely if one had made the decision under either account of autonomy? They go on the claim that if one freely chooses an option that carries a specific risk and the worst happens one is responsible for that decision. It is difficult to see in what way this claim differs from the current situation. After all if a patient currently makes an informed decision and a known risk of the procedure unfortunately occurs, the patient is not entitled to any legal

redress (*Bolam v Friern Hospital Management Committee*, (1957)). If a person chooses a curry that is described on the menu 'spicy' and they make that choice in an individualized way this does not afford them a route of complaint if the curry turns out to not be to their liking. The only difference in the accounts is that the initial choice is not underpinned by responsibility in an individualized account; responsibility here is merely a consequence of choosing. This implies that we are then trying to examine the quality of the choice by adding in a responsibility element that for the most part seems to be there already; the patient cannot separate themselves from their decision nor blame anyone else when their choice does not 'roll out' as they would have envisaged. One way or another they have to live with that decision. Further there is also a presumption implied here of rationality, that a decision ought to have a rational component to be of value. After all if we talk of quality of decision there must be decisions that lack quality. Where does this leave the competent patient when or if they make an *unwise* choice? Does that choice, because it lacks quality, fail to be autonomous in Draper and Sorrell's account? Would this mean that the clinician then became responsible by default in the same way where a patient lacks capacity?

The second claim of Draper and Sorrell relates to the situation a patient finds him or herself in. That is to say to what extent should a patient, as an autonomous agent, take on responsibility for their own ill health. It is not the intention here to start an account of the social determinants of health but this seems to be an unsupportable extension of the term responsibility. We might want to at least

consider from an ethical perspective that one cannot be held responsible for situations over which one has no control.

### **O'Neill and Trust**

O'Neill clearly is raising concerns about the individualized form of autonomy we currently observe and proposing that we appeal to a principled form of autonomy that attached duties to it as well as rights. O'Neill's intention here however is one of practical application she is concerned with making the clinical relationship function effectively and ethically. For that reason her concerns and re-thinking in relation to a principled account of autonomy prompts her to consider the concept of trust as one of her universal obligations. O'Neill asserts that in any relationship trust is an essential component. O'Neill in her Reith Lectures (2002b) remind us that Confucius considered that three things are essential for sound government those being weapons, food and trust. Of those three essential components trust must never be surrendered because without trust we cannot stand (O'Neill, 2002b). O'Neill contends that this applies universally whether we are viewed as individuals or operating in a community or profession. This is because "we have to be able to rely on others acting on what they say that they will, and because we need others to accept that we act as we say we will" (O'Neill, 2002a). Trust, O'Neill argues, is also fundamental to a moral community (O'Neill, 2002a) and "the fundamental virtue at the heart of being a good doctor". Illingworth has described this as "the scarcest of medical resources" which for O'Neill needs to be re-established as the cornerstone of the clinical relationship (Illingworth, 2002).

O'Neill's construction of trust is not a complex philosophical one in this regard and this is deliberate. Her attraction to trust is one of using the vernacular to make something meaningful and a deliverable action in the clinical setting. It is also a call to action and (perhaps importantly) does not require patients to trust clinicians but rather is a call to action to clinicians to behave in ways that encourage and support trust from patients. Clinicians must be trustworthy agents.

For O'Neill we need trust however, not as insurance against what we suppose will be the future actions of others but rather because of the uncertainty as to the future actions of others. There is certainly an element of risk in putting trust in someone or something over which you have no real control and it consequently introduces an element of vulnerability into the relationship. Although trust may be considered as a 'leap of faith' in that you are committing to something unknown that does not necessarily mean that trust should be blind. O'Neill proposes that trust ought only to be placed in those individuals or institutions that have shown themselves with clear evidence to be trustworthy. In this sense then trust for the clinical relationship, for O'Neill, is not a matter of presumption as a consequence of the authority of the clinician; trust is *acquired* as a consequence of the clinician's actions or deeds. This is how O'Neill distinguishes her form of trust from that of faith. As Yancey contends, "a person who lives in faith must proceed on incomplete evidence, trusting in advance what they can only make sense of in reverse" (Yancey, 2000, p.95)

For O'Neill then there are two necessary components to trust. The first is that one must first show oneself to be trustworthy through one's behaviour (by our deeds let us be known). That is to say that there is demonstrable competence to carry out the tasks that are subject to trust. The second is that the competence claimed is achieved through legitimate and reliable means. This could be interpreted for medicine and dentistry as the evidence that the means by which dentists or doctors are trained and regulated are adequate and, of course, that the individual clinician concerned has appropriately submitted to that process.

This is an attractive proposition but where does it leave us in relation to our concerns about deception? The type of trust that O'Neill concerns herself might be best described as breaches of the clinical relationship. Perhaps we can understand this where the clinician falls short of the reasonable standard expected of him or her. There are two concerns with this. First, to some extent O'Neill's account causes us to consider breach of trust as some kind of bad behaviour on the part of the clinician. After all O'Neill requires that trust ought not to be blindly placed and that the trust we place in clinicians is a consequence or ought only to extend to the extent to which clinicians behave in a trust worthy way. This is problematic at a micro level. A patient, who may not have had any personal dealings with a particular clinician can only make a judgment on the trustworthy nature of the clinician treating them based on a very basic assessment of clinicians in general. This, to some extent, puts them in a position of blind trust (or no treatment). It is fair to say that this might be assuaged to some degree with Manson and O'Neill's claims about the role of information in the consent process (that it might reassure



a patient someone is trustworthy by dint of the fact they are explicit about the treatment proposed).

### **Principled autonomy, deception and trust**

One of the features of trust as an obligation as proposed by O'Neill is its relationship with deception. As part of O'Neill's proposition to rely on principled autonomy as the manner in which we understand the clinician-patient relationship O'Neill categorically rejects both coercion and deception. O'Neill initially understands this rejection in terms of referring to consent. As O'Neill states, "action that either coerces or deceives others stands in the way of free and informed consent; conversely where free and informed consent is given, agents will have a measure of protection against coercion and deception" (O'Neill, 2002a, p.97). That is to say that no consent process ought to have coercion or deception as a feature if it is to be viewed as ethical. O'Neill takes this concern further and links it closely to her desire to establish trust as part of the clinical relationship. The rejection of deception as a feature of the clinical relationship provides a context in which the very rejection of deception and coercion gives rise to trust as a consequence. O'Neill claims that whilst individual autonomy is constantly in tension with trust principled autonomy provides the basis for relations of trust.

O'Neill states that relations of trust naturally require us to reject deception. This rejection is particularly important in the sense that deception can often be a tempting and useful strategy. O'Neill's deception is a "covert way of obtaining advantage or avoiding detriment; it is not always difficult; it is not always detected

even when it is detected it is often another day and the advantage has been gained” (O’Neill, 2002a, p.97). It is fundamental to O’Neill’s proposition for a new clinical relationship that we reject deception because it is this “obligation that provides the basis for trustworthy action; and trustworthy action can provide important evidence for anyone seeking to place trust” (O’Neill, 2002a, p.97).

How then does this relate to O’Neill’s claim that we ought to rely on a model of principled autonomy as the basis of the clinical relationship? O’Neill’s basic argument for an “obligation to reject deception” (O’Neill, 2002a, p.98) is based on the claim that no one who is committed to principled autonomy can make the deception of others the foundation of his or her life because we cannot make the principle of deception universal for all. O’Neill claims that the reason we cannot make deception a universal principle is because once deception became an endemic feature of relationships there would be catastrophic damage to trust. Furthermore, deception cannot be made universal because to do so would be practically ineffective. Deception requires trust from one of the parties in a relationship in order for them to be deceived. If one party already distrusts the other the attempt to use deception is likely to be futile as the party will not rely on the advice or actions of the attempting deceiver. If trust is severely damaged it is difficult for deception to operate. Deception therefore “cannot be a principled action for all” (O’Neill, 2002a, p.98).

Rejection of deception, O’Neill proposes, has wide-ranging consequences for the clinical relationship. Rejection of deception would then require a commitment to

avoid lying, false promising, promise-breaking, misrepresentation, manipulation, theft, fraud, corruption, passing off and many other ways of misleading (O'Neill, 2002a, p.98). However, O'Neill wishes to express this more positively and usefully points out that through truthful and careful communication, through simplicity and explicitness, through honesty and avoidance of exaggeration; in summary through trustworthiness the commitment to the rejection of deception may be clearly expressed.

In a departure for O'Neill's Kantian approach she does on go to make clear that she is not wishing the case to make this an absolute obligation. Just, she argues, as it may be necessary for the police force or tax system to sometimes employ coercion where in general there is a prima facie commitment to reject such behaviour so must we accept that some deception may be justifiable in or accepted by those whose fundamental belief is to reject it.

Does account of trust, in that it rejects the use of deception make it suitable for our purposes? Our first concern relates to O'Neill's reliance on consent to explain some of her concerns surrounding deception. O'Neill claims that one of the reasons she rejects the use of deception is that it interferes in the consent process by standing in the way of free choice. Free choice however relates here to choice over medical treatment. So for O'Neill a patient is deceived when the 'facts' they are considering for treatment choice are manipulated in some way. I wish to claim that there are two important consequences to this approach. First that it places a narrow definition of deception on the consent transaction in that, for O'Neill, a patient is

deceived by a deliberate act on the part of the clinician. This is perhaps shown by her understanding of deception as an attempt to gain “advantage or avoid detriment” (O’Neill, 2002a, p.97) implying that there is intent on the part of the deceiver (dentist). This is a much narrower definition of deception than the definition we considered in Chapter Two. For our purposes a patient is not only deceived as a consequence of a deliberate act but also and crucially where they did not know of something important to them [the patient] that they feel they ought to have *regardless* of the intentions of the clinician. Further, as O’Neill here is relying on avoiding deception via an *obligation* (and therefore action) on the part of the dentist the consequence is that we cannot broaden the definition to suit our purposes. This is because of the practical difficulty of *obliging* someone to either not do something they never intended or not do an act committed by another party. Second, that the importance placed on deception understood from the consent process naturally leads us to a very medicalized interpretation of the exchange. That is to say if we understand deception in terms of medical information the patient did not know but ought to have (on the clinician’s assessment of ‘ought to have’ rather than the patient’s) it is hard to see how we can successfully incorporate a wider view of respecting patients’ reasonable wishes to know information that falls outside the currently understood consent process (that is to say highly detailed information on the proposed procedure and little else).

More worryingly perhaps, when thinking about deception, one of our key concerns, trust provides little defence. It again may be reasonable to claim in general terms that deception is a breach of trust and therefore ought not to form

part of the clinical relationship. However this seems a rather convoluted and obtuse way of understanding any problem with deception. After all one could ask why should deception (where no personal benefit for the clinician is found and is done with the best of intentions) be viewed as a breach of trust? To claim that this is just not a feature that patients would deem to form part of a discerning trustworthy relationships seems to skim over the arguments. It is suggested that it is far more insightful to understand this in terms of deception interfering with the ability for a patient to make an unencumbered exercise of their own personal autonomy. A decision cannot be one's own if it is made on a misapprehension.

This is not the only area of concern. Let us suppose that the clinician is perfectly trustworthy but the deception comes from outside the relationship. For example that a patient is erroneously under the misapprehension that having his or her teeth whitened will encourage their partner to be more faithful. Nothing that the clinician has done or not done can give rise to our concerns that the patient is not making an independent choice. The clinician is not responsible for the misapprehension and the deception cannot be identified via a route of lack of trustworthy behaviour in the clinical setting. With an individualized account of some kind however; we are looking to the patient and the way in which their decision is made as the key towards authenticating their decision.

This leads on to another important consideration. We have concerned ourselves earlier with the overly medicalized way in which we currently respect patients. As we can recall from Chapter Two one of the key criticisms of the *Redfern Report* was

its failure to respond to the matters of real concern to the parents of the Alder Hey patients. In the same way that an augmented consent process leads one to overly focus on the proposed treatment so does the proposition of trust forming a pivotal part of the clinical relationship. Whatever our view on autonomy, whether that be principled or individualized the main aim must be to respect patients in an authentic way. The difference between the two approaches relates not to a disagreement that the patient has individual value but rather what duties one ought to adopt as part of that process. If this is the case then the position of the individual patient must carry some importance and form a part of setting the agenda in the clinical setting. The obligation as proposed by O'Neill on clinicians to be trustworthy, I wish to contend, has a potential unintended consequence in that it reiterates some of the concerns we expressed earlier regarding the use of medical information as a way of augmenting patient autonomy. If we are focusing on the actions of clinicians and merely assessing the relationship based on the effectiveness of the clinician to behave in a trustworthy manner (with the patient as reactive rather than proactive) this, I wish to argue, naturally sets a very clinical agenda. After all, it is perfectly reasonable for clinicians only be expected to extend their trustworthiness to areas of their own expertise, that being communication of clinical information (at best) and treatment. Even if we tried to claim that a trustworthy clinician must also consider the patient's wider welfare in his or her behaviour this still leaves the clinician in control of the situation and the patient, at best, the lucky recipient but not the driver.

Despite O'Neill's wish that patients take on more duties alongside their rights this seems difficult in relation to the use of trust. The mere fact that a patient is required to trust a clinician no matter how discerning their choice sets a medicalized agenda that, although quite rightly relates to the business at hand, does not require the wider needs of the patient to be considered. Although admittedly we could incorporate wider values to the call for 'trustworthiness' this seems rather unnecessary, despite the short-comings of autonomy a general belief that the patient's voice is best placed to make their needs heard seems more effective and reliable than an attempt to press clinicians to 'guess' what extra behaviour they need to show to be deemed worthy of trust.

### **Case studies**

Although I have raised some concerns about O'Neill's proposals, the fact remains that O'Neill has proposed a practical applicable model, which proposes an applied approach for the clinical setting which is worthy of consideration in relation to our hypothetical case studies.

In our first hypothetical case we raised concerns about patients' awareness of the difference between private and NHS treatment particularly when it is sometimes offered as part of the same appointment. Perhaps as we have outlined trust and adequate information could address this concern? At first instance and according to O'Neill's account we could attempt to argue that deceiving a patient by not explicitly spelling out the moment when treatment becomes private, or indeed any fluctuations between both clinical settings could be viewed as untrustworthy.

This would seem reasonable; a clinician ought to identify situations where he or she is personally benefitting from a change in treatment setting and those who do not would easily be seen to be breaching trust by not giving adequate information. That is to say that deception of this kind might be viewed as untrustworthy behaviour.

However, I would still wish to raise a concern here about the about the focus on the clinical encounter. Even if a clinician is explicit about the change of setting in the appointment the appeal to the principle of trust provides insufficient drivers to consider wider concerns (such as cost to the patient). More worryingly as O'Neill requires the dentist to behave in a trustworthy way rather than the patient to trust the clinician how will a dentist identify what the features of behaving in a trustworthy way are? Some instances may be intuitive but when the dentist with the absolute best of intentions wants to do what is best for the patient how can they reconcile that with the need to behave in a trustworthy way? Put in an alternative manner in what way when a clinician believes that the private option is in the patient's best interests does this alert them to being in danger of being untrustworthy? This is a particularly acute concern when information is not necessarily based on promoting a patient's autonomy but rather a way in which a patient can trust the clinician. What would drive the clinician to give specific pieces of information that add nothing to the clinicians view of best interests (and therefore their practical assessment of trustworthiness) and where there is no real requirement to provide information as a basis of promoting autonomy via consent.



Further concerns must be raised in relation to our cosmetic dentistry case study. This rests on the distinction we might wish to draw between treatment and enhancement. As we discussed in Chapter One drawing such a distinction may cause us to consider a shift in the relationship from one that is based on duty of care to one that is contractual and commercial in nature. Our main concern rested with a patient's ability to realistically discern the difference between advice given by a dentist under the auspices of duty of care from advice given under the auspice of commerce. Our main worry being that dentist could, quite innocently, unduly influence a patient into agreeing to a cosmetic procedure on the basis that the patient gives more weight to the dentists advice than they ought to. The patient believing that the dentist still retains some element of duty of care to his or her advice. The question that ought to be posed here relates to the scope of trust that O'Neill envisages. Is trust only a feature of a duty of care relationship? If trust extends beyond the duty of care relationship how can trust address this more contractual or business based relationship? It would seem that trust has its limits. It is in direct opposition to how we might understand a commercial relationship where an important feature is the 'hard sell'. We might wish to consider if trust is underpinned by O'Neill's principled autonomy where might that preclude this kind of commercial deception? It is difficult to see how that might be the case. As information giving is no longer a key component of the clinical exchange (in order to promote autonomy) information is only necessary as evidence of trustworthiness and as such a clinician is no longer obliged to think of patient autonomy in relation to information but merely behaviour that creates an atmosphere of trust. If trust however were not part of a commercial relationship

what would drive a clinician to disclosure and preclude him or her from deceit? Worse still, as O'Neill's proposal suggest that a patient takes on responsibility for their decision as well as rights, would a bad decision in relation to cosmetic treatment become their fault despite the clinicians well intentioned deception? It seems that there are some fatal flaws in O'Neill's proposal for the complexities of the dental setting.

Finally in our skill mix case we must consider if a patient is not aware of the clinician's qualification status is the clinician doing anything 'untrustworthy' here? If a clinician were doing the best treatment to an agreed and consented prescription what element of trust would make this information important? After all, as we have seen, the patient knows what is happening to them and they are getting what they need what would cause us to believe that this is still a situation devoid of trust? Although we could attempt to argue that full and frank disclosure would address this concern why would full and frank disclosure be a necessary condition of trust? We really need to be sure to what end disclosure is to be put in order for us to be sure what the limits of full disclosure might be. This sounds a little like tautology but I am working from a definition of disclosure that perhaps might better be described as adequate for trust from the patient perspective. How will the clinician calculate what is adequate to claim trust has been established. After all there is no real reason to drive the clinician to ask the patient what they want to know although that admittedly might be the best solution.

## **Conclusions**

When we set out to re-define the ethical basis of the dentist-patient relationship some of our key concerns related to a deliverable model with clear limits and one that respected the patient adequately whilst protecting against the dangers of deception. O'Neill has proposed an alternative account where patient autonomy imposes obligations as well as conferring rights. O'Neill is also highly critical of the current individualized account of autonomy claiming it corrodes trust in the clinical relationship. As part of her re-modelling the clinical relationship O'Neill requires trust to become a central element. Trust however is delivered through trustworthy behaviour on the part of the clinician and not blind faith of the patient. The consequences of viewing trust in such a way, as we have seen, is that this may lead to an overly medicalized focus with the clinician continuing to set the agenda of the medical exchange doing little to rest power from the clinician into the hands of the patient. We have also raised concerns about the responsibility patients are expected to take on both in relation to their own situation and the quality of their decision. Further still although at first instance trust would seem to intuitively defend against general deception (where someone sets out to deceive the other), it struggles to cope adequately with the particular type of deception that concerns us. As the clinician is tasked with behaving in a trustworthy manner in O'Neill's proposition and they are considering the patient's best interests a clash can occur where deception unintentionally occurs. After all if deception is unintentional but linked to the clinician's obligations how do we help the clinician identify it? That is to say that there is nothing in the trust account that would cause a clinician to consider that they acting in a deceitful way, after all if you are acting on a duty of

care basis in a patient's best interests you must surely be acting in a trustworthy manner even if the patient is deceived.

It would seem then that O'Neill's proposition just cannot address adequately the concerns we raise. Dentistry has its own challenges as we have seen and we need a differing model than can address the complexities of the dental primary care setting.

## Chapter Six – Analysis and Conclusions

In earlier chapters I have already argued for a more clinically specific theoretical model in the belief that this is the only way to adequately address the challenges of dentistry. I have considered alternatives to individual autonomy and to what extent they might provide solutions to the issues raised in Chapter One by respecting patients in a way that is ethically robust. In this final chapter I will now return to re-consider autonomy as a concept. I wish to make my contribution to the debate about respect for patients by first claiming that we do not need to seek to promote good (generally increased autonomy) by augmenting the consent process or transactional aspects of the dentist-patient relationship. I wish to claim that the act of restoring health is the appropriate forum within which to consider the promotion of good as part of a healthcare endeavour. In addition, the transaction between patient and clinician [consent] is a functional reflection of that endeavour which only need seek to safeguard the position of the patient, as the weaker party. I will then go on to claim that the attraction in attempting to promote autonomy at the transactional level through consent is beset with problems and to a greater extent can be self-defeating. This puts clinicians at risk of not discharging their ethical duties and indeed failing to respect patients in the right way. This will lead me to consider other models of patient interaction that seek largely to *protect* the patient's right to self determination rather than promote it, as autonomy is promoted elsewhere and merely needs to be *protected* as part of the clinical interaction process. I will propose a change in the way we respect patients by relying on a model that is reflective of that approach and show the degree to which it better addresses the concerns I raised. Finally, by appealing to

this model, I will address our concerns relating to the specific challenges of dentistry and in particular the problem with deception. First I wish to claim that healthcare overall is an ethical endeavour to promote good through the restoration or preservation of health. In doing so this should enable us to claim that we actively promote good through the restoration of health whilst avoiding the difficulties of trying to promote good through the clinical relationship.

### **The ethical endeavour of healthcare**

First I wish to claim that the action of restoring health is one of promoting 'good'. Kottow asserts that the practice of medicine has two main areas of moral concern; that of the 'quest of medicine' to be of help, to exercise some form of ethical benevolence and the more technical aspect of the therapeutic and the ethical limitations to which that must be subject (Kottow, 1999). Seedhouse would disagree, however, he argues that these two activities are inextricably linked (Seedhouse, 1988). Nonetheless, both agree that healthcare consists of more than the delivery of a medical service: healthcare has an ethical significance that extends beyond mere treatment. It has been asserted that healthcare forms, in a practical sense by restoring health, an integral part of addressing social inequality and carries the weight of the ethical imperative to address inequality (MacGibbon, Etowa and McPhearson, 2008). Further, however we wish to define it, there is an inextricable and widely acknowledged link between body and self which makes activity that involves the body specially linked to the concepts of self or the person as an individual (Gadow, 1980). As we have seen through the wide assertion of the link between body and self, this naturally leads us to consider if we accept that

healthcare as an endeavour has special ethical significance. One of the ways in which we might wish to see this reflected is through the effect on the individual and in turn how we reflect this professionally. We may conclude then that healthcare as an endeavour carries ethical weight and is widely seen as an ethical 'good'. Therefore it is relatively straight-forward to attach a claim of 'promoting good' to the action of restoring health. However, as we have seen previously it is not ethically satisfactory to claim that, simply by promoting a good one is behaving in an ethically robust manner and we will consider that point in a moment. Firstly we will consider the significance of the difference between the *aim* and the *action* of restoring health in order to focus our attention in the right place when claiming to promote good.

It seems that there is a distinction between the *aim* of healthcare as an ethical endeavour and the simple *action* of delivery of treatment. Healthcare as the overarching term is about a great deal more than efficient treatment as it seeks to deliver ethical goods through the *action* of treatment. If we assert that healthcare has an ethical aspect that relates to its very existence this might lead us to conclude that treatment is merely the *function* of the endeavour rather than the *aim*. If then we define treatment as the *action* rather than the *aim* this should prompt us to put treatment in its proper place in the manner in which our ethical values are formed. We might wish to ensure that our models of professional behaviour are led by the overall ethical endeavour (*aim*) that healthcare seeks to deliver, rather than measuring ourselves against the effectiveness of our treatment or indeed the competence of our transactions (*actions*). This does not mean

however that the process [*action* of treatment] has no ethical significance but rather that we may not wish to make too many claims about how much 'good' the process promotes or indeed seeks to promote through that function. In other words, to view treatment as an institutional and professional constraint and the instrument of our overall *aim* to be of help, or simply to claim to 'promote good'.

That is not to say that the way in which treatment is delivered is not significant or bears no examination. If we are to claim that the individual has an ethical significance and value ascribed to them, then the manner in which they engage with the profession must be considered carefully. As we have seen in Chapter One patients express concerns about the manner in which they are treated even if the end is the same. From a patient's view the end does not always justify the means (Dyer and Robinson, (2008a; 2008b). It may be possible to argue that this is not the case in terms of acute need (see the case of Dax Cowart, Knapp van Bogaert, D., and Ogunbanjo, G.A., 2010 <sup>22</sup>) but for most, their experience of health care does not fall into the category of what we may wish to term 'emergency medicine'. Nor do the social endeavours of health as claimed by MacGibbon, Etowa and McPhearson, (2008). For the vast majority (in the UK) the restoration of health in a primary care setting relates to aiding people to function better and thus reduce inequality in health status. It is not the intention here to consider health and social justice *per se* as this is beyond the scope of the discussion. Simply I wish to claim that the fact we wish to address inequality at all leads us to surmise that the individual has

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<sup>22</sup> Dax Cowart, who now lectures on the right to die, was a victim of severe burns who claims that despite his recovery and the fact that he is no longer in pain the treatment he endured at the time of his injury was not worth the recovery he now enjoys.



some importance or value and that we do not wish to abandon individuals to the mantra of 'survival of the fittest'. With recognition of an individual's importance and value we are able to conclude that a good clinical outcome may not override or justify problematic or unsatisfactory experiences of the patient journey. If this is the case then, that the individual is valued, how do we recognise this? As we have considered before, autonomy has established itself as the model through which we recognise an individual's value. We have considered a number of difficulties with this approach through the course of the preceding chapters but one thing we have learned is that the duty to respect persons in health care is not discharged simply by making patients better. The manner in which they are treated during that journey has, perhaps in some cases an equal, if not very significant part to play, in the ethical endeavour of healthcare. That is to say that it would seem to be difficult for one to claim successfully that one had met the endeavour of healthcare simply by restoring health regardless of the manner in which it was done. This of course challenges a very treatment focused model and the traditional tenets of the biomedical model of health<sup>23</sup>.

One example of this claim we have already consider is the principles of the *Redfern Report* (DoH, 2001) where there was a strong imperative to recognise the value

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<sup>23</sup> The human body is likened to a machine to be restored to health through treatments of one sort or another that arrest, or reverse, the disease process  
The health of society is seen largely as dependant on a state of medical knowledge and the availability of medical resources. (Taylor and Field, 1997).

and rights of an individual, defined as the concept of respect for persons. The manner in which patients and their deceased children were treated was of central importance. The end result of the medical treatment (and sadly its lack of success) was of little or no ethical significance in this case; simply, the interaction and lack of consultation and eventually lack of respect in relation to something of extreme significance to the parents (the organs of their children) was the issue under consideration. As we have seen, steps have been taken to address this issue and prevent recurrence. The manner in which this has been done has largely been through *improving* the consent process by increasing information given to patients with a view to augmenting their autonomy through increased knowledge. This approach contends that better choosing is more informed choosing and therefore better autonomy. This then gives us three main components to consider when respecting patients; consent, choice and individualised autonomy. These three concepts each carry differing statuses and operate in different manners. Reliance on this construction has led to some difficulties in the way in which patient interests are prioritised and causes concern in the way that patient interests are interpreted in a limited and medicalized sphere. The manner in which respect for persons is observed through individualised autonomy fails to address some of the key components we considered in earlier chapters. In order to address this I will outline what the difficulties are with a focus on consent in order to help me propose key components for an alternative.

## **Reviewing our current construction of autonomy in practice**

Individualised autonomy, as we have seen, is widely viewed and claimed to be the underpinning of the manner in which we interpret respect for persons. Individualised autonomy promotes autonomy through the function of choice and the action of choosing. That is to say that mere sheer choice and the effect that has on ones self-determination (i.e. that it enables one to decide for oneself one's own moral policy, action and direction). Individual choice therefore relies on our second component, choice itself, to operate as a mode of respect for persons. As we have seen there have been many criticisms of the 'mere sheer choice' argument. It focuses too heavily on the action and ability of the individual making moral considerations secondary to the action itself. In some respects rational autonomy could be said to be an attempt to address that criticism. The rational autonomy that we have considered as proposed by Frankfurt (1971) and Dworkin (1988) and the later modification of others could be said to be an attempt to anchor more firmly the moral authority of individualised autonomy by looking to introduce a further element into the act of choosing for oneself; that of reflection. In Chapter Three we saw that not all choices that are made could claim to have the authority of an autonomous decision. Only choices and importantly actions that are part of a hierarchical thought process, an ordering of preferences and an action of willing, can claim to have the authority ascribed as an autonomous decision. As we have seen this proposition is problematic in that the rational model has difficulties in effectively accounting for reflective decisions made or born out of manipulation and or deception. Furthermore it is also not clear why a reflective decision would have greater moral weight than say a gut reaction to a particular situation, for

example, the decision to jump into a lake and rescue a child. Would we want to give greater moral authority to standing on that shore line weighing up whether we want to ruin our shoes jumping into the lake rather than the decision to jump in immediately and not consider the consequence to our shoes at all?

### **The reliance on choice**

We have seen in earlier chapters that choice and the ability or manner in which it is made is also central to how we interpret the ethical foundation of the clinical relationship. Choice through the use of consent to treatment and enabling patients to make it [a choice] is largely seen as central and a defining action of how we respect patients. That is to say we respect patients by relying on a construction of individualised autonomy be that either rational or otherwise. In fact there are other well recognised areas of the clinical relationship which I will not cover in detail other than to mention here that they similarly rely on a choice centred approach, for example, the principle of patient confidentiality.

I propose that the attraction to choice is closely linked to our understanding of autonomy as a right or ability to be self determining; that we promote our sense of individual value by making individualised decisions about what happens to us or what action we take. In a modern and increasingly commercialised society this is perhaps a familiar and reassuring concept. It is easy to see how choice and consent are the embodiment of those ideals. However, by valuing ourselves through self-determination and choice alone we make the error of supposing that we have real control over every situation or indeed may try to claim that whatever

situation we find ourselves in, no matter how restrictive, as long as we are able to make a choice and determine our fate, we are autonomous. This is problematic particularly for medicine and dentistry. After all it is unlikely that any patient has chosen to be ill or in need of treatment. It is doubtful that we can claim that we are respected as individuals by exercising choice in a clinical setting from a restricted range of options (especially where all options possible might not be available for financial or institutional reasons) as a result of a physical 'problem' that is not of our choosing. I would wish to claim then that the reliance on choice is problematic. It is not clear in the hierarchical accounts why one choice has any real moral authority over another. Such accounts rely on the authenticity of the action of choosing rather than the moral authority of the choices made. Further, reliance on choice presupposes that the choice we make is an important form of self-expression. However this position is difficult to maintain when we choose from a very limited sphere of options (treatment) in a situation not of our choosing (ill-health). At most it is a very limited form self-expression.

### **The reliance on information**

The current reliance on the three components of consent, choice and individualised autonomy also have another perhaps unexpected consequence in the clinical setting. If we rely on authorisation via consent and the use of choice to promote individual autonomy we necessarily reduce the clinical interaction to a matter of meeting treatment need. Treatment need might best be described for our purposes as the need identified by the clinician on examination of the patient. A clinician therefore might be able to legitimately claim that they had promoted

their patient's autonomy by offering them a choice of treatment thus enabling them to make a choice and then delivering the treatment. That choice also raises another matter. If choice and consent are the manner in which we promote autonomy and we wish people to make an informed (rational) choice as an autonomous individual then we must be required to promote autonomy through the delivery of knowledge and understanding of the options proposed. This poses another practical but ethically significant problem, that of information.

There has been much concern in clinical literature about the increasing burden on clinicians in relation to information giving. As we have seen in the *Redfern Report* (DoH, 2001) the response to concerns about effective promotion of individual autonomy and therefore adequate respect of persons has been to respond by making sure that greater and greater quantities of information are given. This clearly is an indication or implies that respect for persons in the clinical setting has developed from an individual construction of mere, sheer choice to one of rational autonomy that requires reflection from the patient, a weighing in the balance of the facts (Mental Capacity Act, 2005) before an autonomous decision is made. In fact those patients that cannot 'weigh in the balance' so to speak are deemed to be incompetent (wanton, Frankfurt, 1988b) and deprived of the right to be completely self-determining. A model for respect for persons that has an individualised (rational) autonomy underpinning is inextricably linked to choice making. This in turn has been interpreted in medicine and dentistry into consent. Consent has evolved from a authorisation model or a simple 'yes' or 'no' to one that requires rational reflection (although paradoxically the decision need not be

'rational' to satisfy the Law). This model necessarily requires information in order to enable the reflective process or at least to improve it. A focus on information reinforces the treatment model simply because the manner in which a patient's autonomy is promoted is via their right to make a decision about what is *proposed* by the doctor or dentist. I cannot help but think that this is somewhat futile. As we are attempting to promote autonomy, this seems a very restrictive way to do so. It is similar to claiming that you are promoting someone's liberty by allowing them to choose whether they prefer cell *a* or *b* in a prison. As Berlin states, "the mere existence of alternatives is not, therefore, enough to make my action free although it may be voluntary". (Berlin, 1997, p127)

We cannot claim that autonomy of any kind is promoted simply through choice particularly when that choice is in the context of someone finding themselves in a situation not of their choosing, that is to say ill health. I am not trying<sup>24</sup> to claim here that individualised autonomy is unworkable. I am claiming that *because* patients find themselves largely in a situation not of their choosing it is hard to see the merit of underpinning our ethical values, at least operationally, through a reliance on choice and consent. This, I would argue, is in part a result of the close relationship between the physical person and the self. The physical person and the self are inextricably linked (as would Gadow, 1980) in a way that makes medical choices that relate to the physical person particularly significant to the self. I

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<sup>24</sup> I think this point even applies to cosmetic procedures after all we don't choose to dislike the appearance of our teeth.

contend that what happens to the physical person has a greater impact on how we might describe, feel or define the self than interactions that occur externally. Some recognition of this view may be seen in the *Engle Case* (Liggett Group, Inc. v. Engle, 2003) where a duty of care relationship between tobacco companies and smokers was established (rather than a purely commercial or more properly contractual relationship) on the basis that the product purchase adversely affected the smokers' health. I do not want to develop this further here for fear of distracting from the main argument. I merely wish to claim that medical interaction has a special significance and this necessarily puts the patient in a differing position (lack of choice) than other commercial and social interactions. This leads me to question what value choice has as an ethical underpinning in the way it relates to rational autonomy in the clinical setting.

### **The value of choice**

We have seen that there are practical difficulties in helping patients make informed choices and indeed as O'Neill claims it is possible that many of the choices made by patients are individualised rather than rational, autonomous decisions (O'Neill, 2002a). I would also wish to claim that the treatment focus of that choosing means that matters of a clinical nature are automatically prioritised possibly even at the expense of those matters that are of concern to the patient. This further reduces the sphere of choosing. The result is that patients are squashed into an autonomy 'bubble' where they can choose on a take it or leave it basis but have no real influence over the priority of the information they receive nor over the situation they find themselves in.



In summary, there are a number of matters of concern that need to be addressed if we are to consider alternatives. These fall into three main groups. First, we have considered the difficulties with information giving; in a practical sense full disclosure to patients and the aim to make them what we might term 'mini-medics' is extremely onerous and may be increasingly difficult the more complex and specialised a treatment becomes. Ironically, this is also the time that patients may be making decisions of huge personal importance. The likelihood is that in some cases this matter is fudged and no real consent (according to our current understanding of the process) is gained which is both risky for the clinician and unsatisfactory for the patient. Second, an information-reliant system that identifies clinical information as the key component to patient autonomy may fail to prioritise matters of reasonable importance to patients. It would be hard to claim that the current model has a component that necessarily requires patients' reasonable preference to be prioritised. Currently the model is about the patient engaging successfully on what is offered by medicine not medicine engaging successfully with the needs and reasonable preferences of the patient. Finally, the current model gives us a misleading sense that we are delivering something that is ethically robust. It gives us the sense that we are promoting a patient's autonomy by involving or asking them to endorse what happens to them but does not require us to consider how this relates to the overall *aim* of health or make the important distinction between healthcare (the operative term being care) and delivery (*action*) of treatment. I would liken it to buying a friend a birthday gift. Can we

really claim we did the job well if we bought them what we would like rather than something that was to their taste?

### **The way forward – defining our needs**

We have considered various differing models for respecting patients as part of the clinical relationship and we have considered their shortcomings and found the alternatives also wanting. This leads us to consider then, what would be a suitable alternative? What qualities do we need to seek from a theoretical model that adequately addresses the concerns we have raised in the dentist-patient relationship? First it is contended that the delivery of healthcare, naturally leads us to a personal construction of ethical interaction<sup>25</sup>. It may be the result of empiricism in the sense that as we are dealing with an individual and our efforts are aimed at helping that individual we tend to construct the situation in an individualised manner. Indeed, as we have considered, what distinguishes the ethical challenges in dentistry often relates to the chair-side interaction between patient and clinician. That is not to say that we wish to lose sight of our overall *aim* when considering the finer detail of the dentist-patient relationship. How we construct that relationship must be reflective of our overall aim (to actively promote good through healthcare) but what is important to remember is that we are not thinking in terms of the overall good (improved health) justifying a treatment focussed model that has little regard for the process of achieving that goal. It would not be contentious to argue that in terms of interacting with the

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<sup>25</sup> Where the concept individual has some ethical value/moral weight – as opposed to classic utilitarianism

individual (for their own benefit) the means is rarely justified by the ends. In order to claim we have promoted good we are starting from the position of believing that the method or experience has a bearing on the extent to which that duty was properly discharged. We would therefore find it difficult to claim that we had discharged our healthcare duty whilst humiliating the patient or projecting our wishes onto them claiming that it was for their own good. We are already some way there in relation to recognising this key point, when we recognise the importance of a consented process of healthcare that enables patients to choose their route through the process. I am not proposing a sea change in that regard, but by relying on choice as the manner in which we mostly respect patients we are doomed to fail to discharge our duty in the right way. What then would any personal model need to account for in order to address the concerns I have raised?

I have already contended above that it is my concern that our current model of patient autonomy and its hierarchical structure directs us to construct an interaction that relies heavily on the consent process for ethical justification. As we have seen this, in practical terms, leads to a general concern that an overly medicalized interaction that may fail to prioritise the needs and desires of patients despite claiming to promote their autonomy. Any new model must adequately account for these concerns. However, as we saw in Chapter One dentistry also has specialised needs. These needs arise as a result of the differing structure of primary care dentistry from its medical counterparts, so any alternative model must also address these concerns.

We considered in Chapter One the challenges presented by the delivery of both cosmetic care and therapeutic care in the same context. As we have seen patients may well attend appointments for therapeutic treatment, make decisions and apportion weight to a clinician's advice based on their perception of a professional healthcare relationship. This relationship is formed on the basis that the dentist is duty bound to deliver treatment and advice according a strict code of practice and is responsible for the patient's welfare, as recognised by the special 'duty of care' relationship. We have considered the dangers for patients and practitioners in relation to the potential for practitioners to use the 'cloak of medicine' to unduly influence patients into opting for cosmetic treatments as a result of confusion on the patient's part between necessary healthcare and social ideals or commercial interests. We have considered the concern that a patient's choice or consent (and therefore autonomy) here might be legitimately considered to be reduced because they have been unduly influenced by the weight of clinical preference in relation to a cosmetic treatment that serves little purpose (from an ethical perspective as it is not healthcare). If a patient is influenced into a choice under the 'cloak of medicine' surely they cannot be regarded as autonomous despite the consent process? The consequence of this is two-fold, from a practical sense it shows us that the same level of patient relationship and duty of care necessarily needs to exist at any time during the clinical relationship. Second, this should not be simply confined to the delivery of therapeutic treatment because the context is too influential for patients to be able to make commercial as well as healthcare decisions. Second it shows us that we cannot refine our understanding of respect for persons to the right of patients to choose their treatment. A much more

complex interaction exists where concerns must be expressed over a patient's perception of the interaction and the roles each participant is playing as well as the outcome. As a result of this the locus of power might be said to move in relation to how we might claim to observe and promote autonomy in health. First, we need to be able to account adequately for any undue influence or manipulation that may interfere with an individual's ability to choose legitimately. Second, we may wish to consider that reliance on choice in of itself presents problems. A move away from choice as the central tenet of autonomy in medicine could perhaps address these concerns.

Similarly we have to consider the difficulties with the use of skill mix in dentistry and how this might be said to frustrate our intention to respect the individual. As we have seen the use of skill mix and the lack of knowledge on the part of the patient has occasioned them to express concern about the role of the individual who is delivering the patient's treatment. This again indicates that patients are not simply satisfied with getting what they need; the manner in which they are treated and by whom also have relevance in relation to their overall satisfaction. If we continue to contend then that the purpose of healthcare is to do good by helping patients *and* we subscribe to the view that we must respect the individual by promoting their autonomy (as we currently claim through the use of the consent process) it would seem a nonsense to claim that merely by being a patient getting what they need we have satisfied that goal. We cannot claim to have discharged our ethical duty to the patient whilst overriding their views. Perhaps this could be summarised as health as an endeavour to help patients through care rather than

through treatment; care forming a significant part of how we might assess the extent to which that process has been successful. As we can see, however, the manner in which the dental profession is structured<sup>26</sup> necessarily leads to a danger that this desire to offer care may be put at risk. Any model of ethical interaction must then be able to account for the dangers of deception.

Finally, we have considered the challenges presented by private and NHS care being offered in potentially the same appointment. We have considered how difficult it is for patients to differentiate between the two schemes and the challenges for dentists who may find themselves under commercial as well as professional pressures. Again this is a problem that is easily identifiable as deception. Further, in a dentist's desire to do the best for their patient they may wrongly assume that the patient wishes the 'best' at any cost; thus prioritising treatment (after all the reason the patient is there) over and above other considerations. Other considerations however, such as cost, may be of paramount significance to the patient. One can see here the dangers of a treatment focused and consent model here as the treatment itself and consent for such (through full clinical information) may be viewed as obscuring the need to consider other factors such as cost. Further, even if a patient would have agreed to the cost had they known about it, conduct in this manner still seems ethically problematic because it deprives the patient of the right to be self-determining and making a

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<sup>26</sup> Because primary care specialization is in its infancy the dentist currently acts as the prescriber for all care making it a presumption on the part of the patient that that is precisely who is treating them.

choice based on what they deem to be of priority even if they coincidentally happens to be the same as their dentist would have recommended.

It seems then that there are two areas of concern. First, is the general concern that reliance on a treatment focused model cannot reliably prioritise the needs and reasonable preferences of the patient; this concern may apply equally across most aspects of primary care. Second, that dentistry, owing to its highly individualised nature and traditional professional structure can lead to difficulties with manipulation and deception.

If we are not focused on promoting and protecting autonomy through the action of choosing but we still need an individualised account of respect for persons and have failed to find an adequate alternative I propose that this enables us to return to autonomy and consider an improved account of autonomy. This is because we still believe that the individual has some personal ethical significance *and* the process of medical treatment is of similar importance to them as the outcome. Therefore we cannot rely on theories that emphasise the end product of treatment and rely on that to claim that the duty of healthcare as an ethical endeavour (to promote good) has been discharged. Nor can we claim that increased or restored autonomy is achieved once the patient's healthcare is complete whilst overriding the same during treatment is justified. As patients tell us that the care they receive is of significant importance it seems a nonsense to make such a claim. We also need for our dental purposes to satisfactorily address the matters of deception and manipulation because we are claiming that the treatment process has an ethical

significance that is not outweighed by the end result. We are looking for an account that maintains a strong individualistic tone but can account for our deception and manipulation concerns.

In order to address our concerns and make my contribution to the debate I would like to propose an alternative account of clinical interaction. The account will need to ascribe value to the individual and get away from the difficulties of trying to promote patient autonomy from within the dental relationship. The account I wish to propose for this is negative liberty. The basic premise of an account of negative liberty is that it crucially requires an environment within which an individual's personal autonomy can flourish without any external obstacles. It is this principle of autonomy through freedom, that may help us to avoid some of the pitfalls with information giving and the concerns I have expressed about information and consent. However, we will need to be mindful that we must also be able to account for our specific dental concerns with deception and manipulation. In summary what I am proposing for the dental relationship is an account that protects (rather than promotes) the patient's autonomy in the relationship whilst guarding against inauthentic desires that may be a consequence of deception. In order to do this we need to start by looking at an account of negative liberty and how it may need to be moderated to fully address our needs.

### **Negative liberty – a solution**

Negative liberty is perhaps best defined by Berlin (2002) as the domain in which the question asked would be 'to what extent am I free?' 'What are the choices I



have open to me?’ It is a theory that relies on the absence of obstacles and therefore makes freedom and as a result, self-determination, an external condition. We can conclude then that negative liberty is the “absence of external obstacles” (Taylor, 1979, p.76). The obstructions must be qualified and moderated by being imposed by humans whether that be unintentional, intentional or as a result of institutional or professional constraint (Jahanbegloo, 1991, p.40). Further they must concern “alterable human practices” (Berlin, p.xxxixf, 1969). This moderates the concept of liberty and excludes those obstacles over which we have no real control or those imposed by the limitations of the natural World; for instance our inability to become invisible. So for Berlin we are free autonomous agents so long as we are not subject to artificially imposed external obstacles.

This wish to externalise the obstacles that prevent liberty forms the main objection that proponents of the ‘third way’ propose to Berlin’s theory (Taylor, 1979; Gray, 1980; Baldwin, 1984; Oppenheim, 2004 and Meskill, 2013). They conclude, there is nothing in that which Berlin proposes that would prevent us considering internal obstacles in addition. Which we will see may be important for us later in relation to deception. Indeed, Kant also similarly views the positive and negative aspects of freedom. According to Kant negative freedom was the “independency of alien causes” (Kant, 1999), those desires or immediate reactions that distract us from our true duty. If a man is to be directed by his desires or immediate reactions rather than practical reason he is no longer in control of his actions and as such would become heteronomous. Berlin categorically avoids this lapse into the world of the internal. It is understandable why he chooses to do so. The danger being

that this injects a positive liberty ideal into the world of the negative, the very thing Berlin is attempting to avoid. We could easily adjust our concept of positive liberty and attempt to express it in negative terms in the sense that we could strive to liberate oneself from the lower self rather requiring one to strive for the higher self as proposed by Frankfurt and Dworkin (Frankfurt, 1971 and Dworkin, 1988). Berlin concedes that there is nothing in his theory that prevents him from doing so. Significantly though, as we have considered with regard to the positive theories of liberty; negative theories are less prone to infinite regress, in that they require no ordering or prioritising or preferences. In this sense avoiding the internal circumvents the need to promote autonomy through external action (if we wish to promote good) and thus avoids all the associated difficulties we had with positive liberty accounts. We will consider this again later but for the moment I will attempt to expose some of the further distinctions between positive and negative liberty.

MacCallum has argued that the distinction between positive and negative liberty is confused (MacCallum, 1967). This is because negative liberty hides or obscures its structure by claiming that one is free if  $X$  is free from  $Y$ . MacCallum claims that this position is indefensible because the structure is necessarily more complex and actually requires the expression  $X$  is free from  $Y$  to do  $Z$ . Therefore, we see a fusion between the two concepts. Rather than claim that there are two distinct concepts, MacCallum asserts that the focus should rest on how these three components are apportioned significance and the manner in which they operate. The debate should look more closely at the liberties we seek to protect rather than the claims

associated with the differing concepts. MacCallum (1967) argues this point by using his to/from proposition; that is to say that the main difference between negative and positive liberty is that negative liberty could be expressed as *freedom from* something (the external obstacles as proposed by Berlin) whereas positive liberty could be expressed as *freedom to do* something (for example actions or conditions of character, MacCallum, 1967, p.314). Baldwin (1984) however has disputed this view and claims that this is not the true distinction to draw.

Baldwin (like other proponents of the 'third way') believes that negative liberty is an opportunity concept, that is to say that there is no requirement that the opportunities should be actioned. As Berlin himself describes, if a person sits on a chair and has the opportunity to stand-up if he chooses not to do so we cannot claim that his liberty is impaired (Berlin, 2002). This challenges the claim MacCallum wishes to make about the to/from distinction between the two theories. That is to say that negative freedom is the freedom to do something but it is an important feature that the something is unspecified. Negative freedom therefore is a general or over-arching approach: a state of being, whereas positive freedom becomes more reductionist and as such relates to something much more specific. Negative freedom then is almost simplistic in that the more doors that remain open for an individual, the more opportunity one has, the more 'free' one becomes. However, there is no value attached to the freedoms that we might enjoy; no ranking or ordering of which freedoms carry more value and indeed more moral weight than any other. My freedom to ride my bike without being run over, dye my hair green or vote in the next election are not, according to Berlin,

ranked in any order and as such cannot take us on any journey of self-realization because we cannot discriminate between those freedoms that we highly value and those that are relatively worthless in that they are insignificant to our selves. If we are hoping that negative liberty is the model via which we can assert an authoritative voice in complex moral situations the most we may be able to claim is that it is a necessary pre-requisite.

As we have seen in Chapter Three, positive liberty is constructed very differently and asks the question not 'to what extent am I free' but rather 'how am I controlled?' 'What governs me?' The posing of this question necessarily implies that individuals would wish to govern themselves: to be in control of their own lives.

"I would wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not other men's, acts of will. I wish to be a subject not an object; to be moved by reason, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not anybody; a doer – deciding, not being decided for, self-directed and not acted upon by external nature or by other men as if I were a thing, or an animal, or a slave in capable of playing a human role, that is, of conceiving goals and policies of my own and realising them." (Berlin, 2002, p.178)

As we can see this desire for autonomy is not too far removed from the concept of negative liberty, it shares the same characteristics (Berlin, 2002. pp.35-36). That is to say, that we wish to be free and not under the direction of others, as a result we need those conditions of freedom; the absence of external obstacles. Only then will we be able to choose our own pathway or act on (or choose not to act on) our own priorities.

It is here that we see the distinctions between the positive and negative theories start to establish themselves. Berlin, ironically, creates the environment in which the positive theories start to establish themselves by emphasising the political nature of the desire to be self-governing which may be translated into participatory self-government. This desire to be self-governed is then augmented by others to draw a distinction between ones 'true-self' or 'authentic self'. Here we see the seeds of the two-step model we have considered in Chapter Three. This is not problematic to an individual's freedom so long as he is able to overcome his own heteronomy and thus remain free. For example, as we considered in Chapter Three a smoker may be unable to overcome his own addiction to cigarettes yet there is no one (externally) that prevents him from doing so. As such, then, he remains free if we accept the negative account of liberty. Merely the smoker realises himself that he is unable to overcome his addiction and thereby achieve his goal to be a non-smoker and he is aware of the frustration.

Positive and negative values only really establish themselves as separate theories once the second element is introduced. This is where the true self becomes externally assessable. This is where we see some of the individual's desire, policies or preferences become inauthentic in that they contribute nothing to the realisation of the self at best and at worst frustrate the ability to do so (see for example the discussion of the smoke in Chapter Three). Baldwin considers this to be a key factor in the way in which we understand positive theories. He contends that positive theories construct liberty in a very specific manner and carry with them a strong normative element. As Baldwin states, "it is a typical feature of conceptions of positive freedom that an agent who is free does not merely have the

opportunity for virtue, he must be virtuous” (Baldwin, 1984, p.135). As Taylor considered, this may eventually result in the legitimate end of someone being *forced to be free*.

Despite being aware of the dangers proponents of the ‘third way’ contend that a negative account of liberty is not sufficient to address the matters of freedom (and the desire for autonomy (Taylor, 1979 and Meskill, 2013). As they outline, whilst supporters of positive theories attempt to distance themselves from the concerns relating to enforced freedom, negative libertarians cling to the notion that liberty may be accounted for simply by the reliance on opportunity (externally). Oppenheim (1979, p.56) claims that the reason proponents of negative liberty continue to subscribe to that view is because it is both simple and safe; by measuring the quantity of opportunities available and only that, positive regression is prevented. Taylor (1979) argues however that the Maginot Line drawn by negative libertarians is simply untenable. There are three main components to this position.

One of the claims of the ‘third way’ is that when we are considering opportunities we must also consider their value; clearly some opportunities are of more importance than others. We need to be able to distinguish between these matters of central importance and those that are merely peripheral to proceedings. Taylor (1979, p.218) uses the example of traffic lights. Strictly speaking traffic lights restrict our liberty in the fact that they prevent us from proceeding on our journey whenever we see fit. However, as we benefit from the operation of traffic lights it is hard to legitimately conclude that traffic lights are a serious restriction on

liberty. In fact, as we prefer safety over the speed of our journey (usually) traffic lights do not in fact restrict liberty at all. As Taylor goes on to say, if we indeed had a great multitude of traffic lights in London and no traffic lights at all in, say, Prague but in Prague we were not allowed to worship on a Sunday would we claim that the multitude of traffic lights (as they reduce our opportunity on every street corner) makes us less free? Clearly, as Taylor contends, this is not the case. Berlin's account of freedom is too thin to give us the depth of explanation when talking about what we mean by freedom. We could take this further and say that traffic lights set us free in that they enable us to continue the journey we set out on in a safe and efficient manner. This could lead us to conclude that in some cases a loss of opportunity is an increase in liberty.

Clearly proponents of a negative theory could rebut this criticism and Taylor himself recognises this problem (Taylor, 1979, p.219). The rebuttal comes in the form that negative libertarians would simply claim that any negative theory would acknowledge that some opportunities are more meaningful or valuable than others. Liberty still remains restricted if those opportunities are lost but they are of little consequence if the opportunity held no value (the loss is justified). Berlin also takes this view in that a *hangman* quite rightly ought to have his liberty restricted. This leads us to consider if context has some bearing on how we view restrictions? For instance would our view of the traffic lights change if, say, they were in our back garden, where there can be no real need for them? Taylor accords with this view in that the way in which we value opportunities is linked to the context in which we experience them. This leads to difficulty in how we might view and assess contexts or alternatively puts us at risk of making assumptions

about loss of opportunity (and therefore liberty in the negative sense); we can imagine this could be a particularly risky strategy for the medical environment. We shall return to this point later.

Connolly (1974, p.141) contends that there are also internal obstacles to freedom. Although we have considered that it is possible to incorporate an ideal of true self into a negative theory we must also guard for the frustration of that by external action or inaction (as per the second step of positive accounts of liberty). This is not contrary to Taylor's view, as we might hope, he is keen to address the concerns we might raise regarding inner obstacles because we intuitively recognise that these also may act as frustrations for self-realization. As one example to highlight this case Taylor talks of a struggle with unreasonable spiteful feelings that are spoiling a relationship that is very important to him. As much as he tries he cannot prevent himself from saying and behaving in a spiteful way that is leading to the breakdown of his relationship. Further, he longs to rid himself of these feelings but cannot overcome the impulse to behave in that way (Taylor, 1979, p.212). Because Taylor considers himself to be held back by feelings which he does not identify as his own, this prevents him from preserving the thing that is of most importance to him; this special relationship. That is to say his way is blocked from realising his desire (say to get married) from obstacles that originate from the inside. As Taylor is held back by feelings that he considers not to be his own his liberty is clearly curbed.

Negative theorists would respond to this by claiming that so long as one is aware of one's frustration we avoid the danger of external usurpation as one remains the



final arbiter of one's inner feelings. Proponents of the 'third way' have responded to this claim critically in that this undermines the very nature of the negative theorists' argument. In their view once a negative theorist admits that freedom needs closer assessment, once individuals must consider the value or relative worth of their desires against some form of context or background they are unable to prevent the practice of second-guessing (Gray, 1980, p.514). That is to say the fact that there might be a rank order for desires or indeed even a right or wrong desire necessarily implies that there must be a right or wrong. This expands the necessary context in that it reaches beyond the individual, a criteria of right and wrong that operates externally necessarily implies that the individual might not be the final arbiter on their own liberty. Further, there is no need to exclude the possibility of second-guessing.

Returning to Taylor's example then clearly his feelings of spite are inappropriate and, as he claims, irrational, his reaction and behaviour is out of proportion to the situation he finds himself in. Even if Taylor is aware of his frustrating behaviour it is clearly blocking his path to his overall aim and as such might require him to be forced to be free. Further though, and this is a key point in relation to those who have been manipulated; what if we don't know we're wrong? For instance perhaps we have acquired a desire to have the whitest teeth possible on the basis that we believe (wrongly) that it is good for our health and will make us more successful. We are now pursuing that goal but our dentist recognises that we have acquired this desire through reading various articles in Heat magazine as sponsored by a large pharmaceutical company and are grossly mistaken as to what tooth whitening can do for us. Taylor asserts that this is the point of strong evaluation in

that it requires that the individual is pulled out of themselves. It enables us to recognise that there are boundaries and criteria that relate to authentic freedom but, unlike positive theories, which are internally authenticated, are externally validated. This, therefore, allows us to overrule direct and inauthentic desires. As Taylor states: “the subject himself cannot be the final authority on the question whether he is free; the subject is not the final authority on the question whether his desires are authentic, whether they do or do not frustrate his purpose.” (Taylor, 1979, p.216)

This might be considered a serious blow for negative theorists in that once they have to relinquish the Maginot Line of sheer, mere, opportunity in need of some assessment and evaluation *and* that any internal obstacles must be assessed vigorously they may wish to return to their position of ‘half-way’ and all its difficulties with second guessing.

This is not to say that ‘third way’ theorists swing into defence of positive theories and all the difficulties we have considered as part of Chapter Three. Rather, they seek to find a mid-line that is more tenable than the one they criticises negative theorists for holding whilst avoiding some of the problems of the strong positive theories. Taylor starts by returning to the examples given where an individual is aware that he is blocked by his own desires. In that we all would acknowledge that from time to time we can be mistaken about our own motives or preferences. This is a complex legitimisation of second guessing where the final aim is for the individual who was wrong to recognise their own mistake.

If we return to our tooth whitening example; imagine that we attend the dentist who tells us that our desire to have our teeth whitened is an inauthentic desire in that we have acquired it through reading too much *Heat* magazine and that the procedure will not do what we wish it to do (augment health and makes us more successful). In fact the process is likely to do the opposite and potentially ruin our tooth enamel and by making it more porous and attract more stains in the long run. Whether or not the dentist has exposed the truth about ourselves (better health and a better job) depends on whether we can identify with the deeper self that he supposes he is appealing to. If the dentist fails to do and so the treatment fails then we shall be glad that he has no further power over us in that he might extinguish our immediate desire for the sake of promoting an inner self that we cannot identify with.

The key component of what 'third way' theorists propose is that the individual should eventually identify with being wrong and as such that he was not himself. Therefore the strong evaluation that 'third way' theorists propose appears to be in need of some personal affirmation by the individual concerned. This has been criticised by some as a "whispery shift" (Nys, 2004) and is what Berlin might have termed the "mystical moment" in Rousseau where personal judgment is changed for third person authority (Berlin, 2002, p.172). The difficulty remains then that whilst negative liberals find it hard to avoid second guessing positive liberals find it difficult to resist the lapse into externalisation.

'Third way' theorists attempt to address this difficulty of externalisation by relying on the concepts of community, strong evaluation and authenticity. Viewing the self

as being shaped by the environment in which it is experienced and having fluid and legitimately malleable boundaries (Connolly, 1974). Returning to Taylor's (1979) examples of traffic lights we may observe that in our community traffic lights are not viewed as an infringement on our freedom; we see them as a sensible compromise between that of safety and convenience. In fact the compromise becomes so entrenched in our thinking (and the justification behind it prioritised) that the use of traffic lights ceases to be an infringement at all; our boundaries of self have shifted. Taylor asserts, that this changing and shaping of the boundaries of self is an organic process in the context of community and is not the result of something imposed on an individual. For 'third way' theorists this is dependent on the contributors to society being able to recognize themselves as such (Meskill, 2013). It is not hard to anticipate that 'third way' theorists might experience some difficulties with this assertion if we consider the multiplicity of communities.

Berlin avoids this matter by subscribing to a pluralist approach tempered by the assertion that (1) negative freedom is not the *only* value (2) it is not even the *supreme* value, hence (3) it should not be *maximised* (Berlin, 1969, p.1vi-1vii). Therefore Berlin wishes freedom to be curtailed by decent values but he categorically avoids incorporating these values into his definition of liberty. To summarise, perhaps we might wish to see negative liberty as a descriptive account with a normative claim that there should be non-interference? How large this scope of non-interference should be is a question of empirical fact and moral debate. Further the sacrifice of liberty (no matter how small [compare with the case of the traffic lights]) is what should prompt us to consider the reasoning

behind it. "Freedom is what it is and should be equated with other values."(Berlin, 2002, p.178)

'Third way' theorists perhaps oppose this view on one key point and that is the idea of authenticity. We have already considered the assertion that the individual cannot be the final arbiter in the regard of what is authentic and inauthentic. Therefore the restriction of inauthentic desires is not a restriction of liberty. How we discern authenticity is an external rather than internal process as proposed by the hierarchical models. In Taylor's later work on authenticity, authenticity is described as "being true to one's own originality." (Taylor, 1991, p29) However this is not a construction that is reflective of a detached view of self that operates in a vacuum of personal reflection but rather one that is connected to community and bears contextual examination. Further by being connected it goes some way to addressing common criticisms of autonomy as being too individualised and detached from context, or requiring too much from those tasked with promoting it<sup>27</sup>.

Taylor continues by showing that any moral consideration does not operate in a vacuum; the well-known adage of "no man is an island" (Donne, 1624). Similarly a person's 'self' is also shaped by the community in which they exist by the dialogue and exchange between them and 'significant others'. The important claim is that they cannot simply decide what is significant but rather an individual must discover the changing limits of self with reference to their environment (Taylor,

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<sup>27</sup> For example the beneficent role of medicine and the burden on clinicians in matters that relate to a patient's autonomy.

1979, P39). In contrast, classic individualism gives authority to options merely because they are chosen. This, however, denies the importance of individual-transcending frameworks of significance. It could be claimed that individualism is the poor relation to authenticity in that it is ultimately self-defeating. This can be a tricky concept and third way theorist admit that it is open to criticism (Bouillon, 2003, p.2). After all how can someone who is trying to establish some form of legitimate individualism (liberty) conclude that meaning can only be found in the wider context.

I am not sure that we are able to address this in a completely satisfactory manner but it seems key to our concerns that the 'third way' theorists are proposing something that rejects the moral authority of choosing; something cannot simply be of value because it is chosen, even if it is in the 'right' way through a hierarchical process. The problem here is that the 'third way' theorists' assertion relies heavily on community agreement; a single view point of authenticity. In general this might be to the detriment of what the 'third way' is proposing despite our intuitive approval. However perhaps there are particular situations where this construct is helpful; for instance the concept of dentist and patient. Perhaps in a very general sense we can attempt to claim that patients are all from one community and as such share the same vocabulary or indeed that patients and medics come from the community of medicine together (after all they are there for a shared purpose)? We will return to this point later. Further many of 'third way's' critics do not consider the possibility that it may be reasonable to authenticate a variety of views, even if they appear to be mutually exclusive.

Clearly, as we have considered in Chapter Three, Frankfurt and Dworkin have been meticulous in their attempts to avoid defining personal autonomy with a 'second-guessing' element or external authorisation (Frankfurt, 1971 and Dworkin 1988). However, despite Frankfurt's willingness to accept that their work does not defend effectively from manipulation, Frankfurt claims that this is a reasonable trade off against the dangers of second-guessing which, it could be argued might be endemic in a way that manipulation may not. Further both Frankfurt and Dworkin recognise that manipulation in-authenticates any desire that it produces as it has not come about in the right way but nothing in their hierarchical model sets out how we might go about accounting for that in-authenticity. If an individual now holds that manipulation as a first order desire then any action resulting from that desire would seem to satisfy the requirements of the hierarchical model. Difficulties arise with relying on this approach where an individual is particularly at risk of manipulation and the effects of such would have particularly acute consequences<sup>28</sup>.

Taylor has characterised this difference with Frankfurt in terms of the distinction between 'radical self-determination' and 'strong evaluation'. This could perhaps be interpreted as radical self determination rests on the belief that it is only up to the individual which way he wants to be autonomous and supposes that he can simply *decide* to be so. Interestingly according to Shoemaker (Shoemaker, 2003), Frankfurt has gone on to emphasise the passive element of personal autonomy in later work. In his later view a person acts autonomously if he acts in a way that is

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<sup>28</sup> For example to adversely affect ones health.

reflective of what he cares about. The objects of the individuals care are clearly beyond his volitional control. Frankfurt would justify this on the basis that when a decision is upon an individual then he must reassess what is of importance to him. One cannot help but think that the use of the term 'what we care about' is more closely related to the 'third way's' proposal than one might think; it suggests a certain sense of community.

If we recall, the model we are looking for needs to serve two purposes, first to re-focus the ethical locus of health care and its choice-based claims in relation to patient autonomy and second to adequately account for the dangers in dentistry of deception and manipulation. Perhaps we could interpret this as a dual role; first to promote autonomy in the general sense through (a) the action of health care itself (improving health) and (b) by broadening the landscape of what we understand to be of importance (i.e. patient priorities versus a treatment focused model). Second, when patients are involved in the patient exchange with their clinician we may then wish to protect their autonomy (autonomy acting as a constraint). I would envisage these two ideals operating together to both constrain clinicians and enable them to promote autonomy; in practice they should both operate simultaneously and not contradict each other.

Can the 'third way' model then go some way towards addressing these needs? First we need to consider the move away from a consent based approach. For the moment I will just confirm that I am not proposing abolishing consent taking.



Rather we ought not to see this as the only way to show that we have adequately respected a patient's autonomy.

I should perhaps summarise what I am attempting to achieve with the re-evaluation of patient autonomy in the healthcare context. First I wish to better promote an individual's autonomy. I would wish to do this perhaps by the *aim* of healthcare. That is to say that restoration of health *does* promote a patient's autonomy because health is an ethical 'good' but this must always be done in an ethical environment. This is an important element that I wish to emphasise; the process. The alternative models of respecting patients as suggested in the preceding chapters, fail to emphasise this sufficiently. Much of their claim to respect patients rests on the outcome for the patient and the patient getting what they 'need'. The danger of this is two-fold, it tends to ignore the process or gives much less weight to it which might enable us to justify practices which patients would wish to object to but are justified on the basis that they give the 'right' result and second (a point closely linked to the first) that it encourages us to be treatment focused rather than healthcare focused. A good outcome is the product of treatment, say a cure, rather than a satisfied 'cared for' patient.

This I do not think is a contentious claim. Although there are differing arguments as to how we might best define health, I do not wish to lapse into them here but rather to acknowledge that a satisfactory definition of health and the restoration of such would improve a patient's autonomy because health is an ethical good and good health (however we might define that) is a pre-requisite that enables

individuals to take advantage of other goods (such as education). Second, I need to adequately account for the needs of dentistry. As we have seen it is particularly vulnerable to the dangers of manipulation and deception therefore any model of autonomy that we wish to rely on necessarily needs to account adequately for those concerns.

So what could a moderated negative account of autonomy do for us? I wish to claim that a moderated negative account of autonomy would enable us to re-focus the locus of importance when trying to discharge our duty to help the patient by promoting his or her overall autonomy through the restoration of health. The benefits would be two fold; we would be able to reject the hierarchical models of autonomy and move away from the act of choosing as the method by which we recognise a patient's autonomy. In doing so we need not look to the act of choosing a treatment as the manner in which autonomy is respected. Further by moving away from this form of ethical re-enforcement we move away from the need to rely on a treatment focused model and are then better able to re-evaluate what is of importance to patients and therefore where we should be looking in order to claim that we have promoted their autonomy.

As we have seen a negative account of autonomy or more properly described 'liberty' (presuming that by being free at least provides the conditions necessary for us to be autonomous) relies on the opportunity to be self-determining rather than the ability to authenticate desires. Berlin's account sees liberty and hence autonomy as the absence of external obstacles. Obstacles being things put in place

by other human beings – presumably on the premise that these are things over which we have practical and moral control. Already this seems like an attractive prospect. A patient could be viewed as free if obstacles are not put in his or her way by others. It would help us account for our concerns with treatment focus as Berlin sees autonomy and the absence of such as anything that happens externally. In a negative sense then we may be able to account our concerns with too much focus on treatment as almost a double negative. We might be able to claim that a treatment focused model necessarily frustrates a patient's reasonable preference to prioritise the manner in which he is treated. It is a restriction that happens outside the patient and is something that may prevent the patient having his primary concerns (for example cost or time off work) having the significance they deserve. After all it is his autonomy we are trying to promote through the *right* process; autonomy overall via health, and we accept that the process is significant in doing so we cannot take such a reductionist view of what the matters of concern are to the patient. A negative liberty model re-sets the balance. It asks the question 'what opportunities are open to me', 'what choices do I have'. The important factor here is that the question starts with the patient so the opportunities are naturally attached to the agenda set by the patient, not the agenda set by medical setting. Conversely, a hierarchical model naturally (practically) leads to the question 'which one of these options would you like to choose (in the right way)? This means that the agenda is set by the profession rather than by the patient and quite reasonably tends to be reductionist in that it relates to the context the questioner is based in (clinical setting) rather than the environment the patient originates from. If we are to accept that the process does

have a bearing on how successfully we might claim to have discharged our duty to the patient; to promote their autonomy through healthcare. Then this would lead us to reasonably suppose that questions that relate to the patient rather than the clinical context might have more ethical desirability.

It is beginning to seem then that patient autonomy falls into two main areas; one the overall aim of healthcare to improve health and as a subsidiary aim, closely linked to the first, the need to protect autonomy in relation to the process.

However we must not forget our second aim; to account for the specific concerns in relation to dentistry. We must consider if we can give a full account of what we view as autonomy by claiming that it is only related to mere opportunity. How will this account adequately for our concerns with manipulation? Berlin's account does not differentiate between the quality of one opportunity from another. As we have seen from the traffic light example as proposed by Taylor, does this mean then that closing one opportunity to a patient is no more or less significant than another? This would seem to have both practical and ethical difficulties for us. From a practical perspective as we have considered in Chapter Two through our examination of the *Redfern Report* (DoH, 2001), this would doom us to treating all procedures as the same; all must be treated with equal deference. Under our current construction this would mean giving the same amount of information about the use of a cancerous mole as it would for the disposal of a child's organ. Negative libertarians would account for our concern on the basis that all obstacles amount to restriction of liberty but individuals may recognise themselves as some

being more significant than others. This seems an unsatisfactory explanation. From an ethical perspective it would seem a rather thin account of what we mean by freedom and therefore autonomy. Perhaps it would be fair to say that Berlin's account creates the necessary conditions in which we can strive for patient autonomy. It can help us change our terms of reference so that we look more broadly rather than be reduced to the point of consent and treatment. But we intuitively feel we need more; a distinction between priorities that is ordered in some way. This is where we need a middle way between the positive and negative accounts. We shall now turn to deal with our concerns with deception.

### **Dealing with deception**

Hopefully we have addressed our re-focusing attempts and are now in a better position to consider matters of relevance and importance to the patient. However, as I stated when we started out we also need to address those matters of specific concern to dentistry; that of deception. Let us first deal with what we may call *external* deception. As I outlined earlier we are starting from the premise that external deception occurs where there is a misrepresentation or omission of a fact that is of significance to the patient. When we were concentrating on discharging our duty to the patient via the consent process we were concentrating on consent to treatment via full information. Full information, of course, relates to the prescription proposed and does not relate to wider issues that might be of concern to the patient, such as cost or the status of the clinician treating the patient. In a negative account because we are re-centring our view of medical decision-making by looking at the patient's freedom, immediately deception becomes a problem

because it prevents the patient being able to make a choice on the true facts that may be of importance to them. That is to say that the patient is prevented from being free and therefore the conditions for autonomy are destroyed because the patient is not free to decide on facts of relevance; he is prevented from seeing the whole picture. Whereas a hierarchical model only requires a patient to make a choice in the right way, a negative model requires the right conditions. This is the key to re-focusing the consent exchange to better reflect what is of importance to the patient. The founding principle being that process has an ethical significance to the patient as well as outcome and further and that a good outcome is successful care not just successful treatment. It would seem then that a negative account can potentially account for our concerns regarding external deception.

Internal deception is more difficult to address if we can agree that manipulation is a more deeply entrenched or internal form of deception. A patient has taken on a view that may be true but in conflict with other aspects of themselves. It may also be false but nonetheless a deeply held belief rather than a poor decision based on incorrect facts. Consider the example that I have been convinced into believing that women are inferior to men even though I desperately want to be treated equally and believe that is the correct thing to do. This is unlike the situation where I have been mistakenly told I am pregnant and have decided to give up drinking as a result. In the first example clearly this is a matter of inner turmoil whereas in the latter is it clearly a mistake that can be easily rectified and happens externally. In the first I will need convincing I am mistaken in my belief and must come to believe that is the case. Whereas in the second example, I will need no

convincing, merely I will need to know the facts so I can be self-determining. At first glance it may seem that we need to authenticate our desires through an ordered set of preferences and this seems like a return to the hierarchical model. However, as we have also seen, the hierarchical model cannot help because it fails to account adequately for manipulation once that belief is taken on. There is no examination of the way in which a preference is acquired; an issue that is of paramount importance here. Taylor suggests a third way in which we may authenticate desires that gives us a richer account than Berlin but attempts to avoid the shortcomings of Frankfurt and Dworkin. Taylor and others do this by claiming that there are inner obstacles to freedom as well as external ones. An internal obstacle would be one that frustrates our true purpose; a feeling that holds us back from our true self. So for example my belief that men are superior holds me back from my desire to be treated equally. It is an internal obstacle and therefore my liberty is curtailed. My preferences are not ordered then, to authenticate them as in a truly positive account, but rather they must not be constrained by *inner* obstacle. So far so good but this would require us to know that we are wrong and overcome those feelings. With internal deception it is very unlikely that we will know that we are mistaken in our belief. This is where the 'third way's' requirement for strong evaluation comes in; we must recognise that there are boundaries that relate to authentic freedom and that rather than the internal validation of the hierarchical models this relies on external validation. This would allow us to overrule inauthentic desires. In an ethical sense this is a very attractive prospect on the basis that we can question the validity of someone's claims that they are free when we are aware that although they are adamant in

their commitment to their belief they have been brainwashed into believing something is the case. Further and importantly it empowers a clinician to say 'no' when a patient requires something that is patently at odds with their overall health because it is an inauthentic desire in so far as it conflicts with their overall desire for good health. Therefore in our tooth whitening example a clinician is quite able to say 'no' to the patient without being accused of not respecting the patient's wishes. The key component here is that eventually the patient must identify with their own mistake. The strong evaluation proposed must have some personal affirmation in the end. Perhaps we can say here that this is how the 'third way' avoids the 'best interests' concerns. From a practical sense we would not want to get ourselves into a position where the clinician is able to dismiss our preferences on the basis that we are mistaken in our priorities. There must, at some stage, be an agreement that the patient was indeed mistaken as to their own belief otherwise we are in danger of a return to a paternalistic model.

It would seem then that negative theorists have a lot to offer the manner in which we might promote and defend patient autonomy. Promotion of autonomy ought to be through the creation of a free environment and negative liberty does require us to create that condition. The third way's modifications however enable us to consider authenticity and properly prioritise preferences without a lapse into ordering. There are of course difficulties with this account, as proponents freely admits the idea of contextualising and externalising authenticity leaves us open to a contradiction in terms that we look to our community to promote our own individualism. However this may well be viewed as the starting point to



developing a more authentic framework in which we can better promote and defend the rights and preferences of patients rather than teaching them to engage better with a pre-set context, the clinical setting. We ought to change the way in which we engage with patients. We ought to reject the question we currently ask 'how can we help the patient get what they want?' we ought to substitute this with the question 'how can we help them choose better than which we offer?'

Returning then to the four key components I set out in Chapter One as our aim; to respect the person through an individualised account, to enable the clinician to draw limits around their obligations, to prioritise a patient's reasonable wishes, to assure the quality of process by protecting against manipulation and deception, how does the moderated account of negative liberty (third way) help us meet these aims?

The account appears to go a long way toward addressing our concerns raised in Chapter One. Clearly the account is individualised in nature and fits closely to our aim to respect the individual. Further limits may be drawn around the relationship both in a practical and theoretical sense. Limits may be drawn owing to the separation between what we aim to do overall (promote autonomy through healthcare and protect it in the clinical setting) and what we aim to do by the chair-side. By separating the two aims we naturally limit what is expected of our duty at the chair-side. After all the chair side encounter only seeks to protect what is already there, the patient's pre-existing autonomy and this limits what is required of the clinician at that encounter. Promotion of autonomy is exercised by

the action of restoring health as we have already seen. A clinician for the purposes of consent taking then need not attempt to deliver full information and thereby discharge a duty to promote his patient's autonomy so they are enabled to make a fully informed (and therefore valid) consent. Rather a clinician is required to identify the matters of importance to a patient (by talking to them) and as such not infringe or fail to take account of the issues that concerns them be that the status of the clinician or the cost of the proposed treatment.

This then leads us on to consider satisfying our third requirement that a patient's wishes be reasonably prioritised. If we agree that the 'third way' account requires us not to ignore matters of personal importance to the patient in a negative sense. This, I wish to claim, has the effect of making them central to the exchange between patient and clinician. A dentist for fear of overriding matters of concern to the patient, must be required to consider what those matters are because he is not trying to promote autonomy through better choosing but rather protect it through considering what is of importance to the patient.

Finally as we have considered in detail that the 'third way' model is potentially more effective at protecting against our concerns about manipulation and deception. It is in this way that we may seek to avoid an overly treatment focused model as well as relying on the need to take account of patient's views. That is to say, that an objection to deception and manipulation, because it interferes with a patient's autonomy, also helps us to adequately account for our claim that a good treatment outcome (the end) is not justified by a poor process (the means). By

doing so and by taking into consideration the broader concerns of patients (as per our third requirement) we move away from a treatment focus and toward one that is more healthcare focused.

What does this mean for the clinician in clinical practice? Although it is beyond the scope of this thesis to outline a comprehensive change to the consent process without further analysis I would like to identify some key aspects of change that are likely to result. First, I wish to claim that the action of restoring health or preserving it, that is to say the action of healthcare itself is the principle ethical endeavour at hand in that health as an ethical good necessarily means that restoration of such (and the action thereof) promotes good. Therefore the action of the dentist providing treatment is the good that he or she promotes. However, that is not to say that a clinician should think in terms of treatment focus. We have learnt through careful examination that a patient expects the process and care to carry key characteristics that are reflective of their right to self-determination (such as the absence of deception); any action on the part of the dentist must adequately reflect the concept of respect for persons. We cannot claim we have promoted good if the process is flawed. A clinician then must be required to have consideration for this when they interact with a patient, particularly in relation to consent to treatment. I would claim that to some degree a change in the way in which we view consent could be important in reflecting a move away from a treatment focused model by simply requiring the clinician to approach the process in a different manner. Rather than relying on increased information relating to treatment to claim that we have both protected and promoted a patient's

autonomy we should be relying on a process of which consent forms a part but is not the sole means by which we discharge this duty. However, further work is necessary in this area to develop a new consent process for dentistry.

## **Chapter Seven - Final Conclusion and Recommendations for Future Work**

This thesis is a normative examination of the role of patient autonomy in dentistry. The intention has been to consider some of the failings of the process and manner in which we interact with patients. The aim of this examination has been to propose a theoretically robust method of respecting patients. The contribution of this thesis to dentistry is that it highlights the difficulties and complexities of the dentist-patient relationship and proposes an alternative model that better meets the needs of the modern dentist-patient relationship.

This has been achieved through first considering three hypothetical case studies. In particular this has exposed both problems with a highly medicalized approach and the problem of deception. These two issues have proved to be problematic; the first, because a highly medicalized approach fails to recognise things of wider importance to the patient impacting on our claims relating to patient autonomy. The second, because both deliberate and accidental deception destroy the authenticity of consent, the very method by which we claim to largely respect patients.

This is followed by an analysis of current accepted clinical practice. By careful consideration of the *Redfern Report* (DoH, 2001) this thesis has exposed the current reliance on a particular type of individual autonomy, the hierarchical account.

The thesis then proceeds to carefully examining the hierarchical accounts. We have concluded that such accounts do not adequately meet the needs of the modern dental relationship in two ways. First they lead to an overly medicalized view of the dentist-patient relationship and second they fail to adequately protect against deception. For this reason the thesis concludes the hierarchical account is an unsuitable model by which we might want to claim respect for patients.

The thesis goes on to consider alternatives, first looking at the concept of best interests. This is again rejected because although it does give the individualised approach we want, the model fails to protect against deception and a medicalized agenda.

The thesis then considers a second alternative; principled autonomy. This account although successful in avoiding some of the difficulties with a highly individualized hierarchical account also encounters problems. The approach is rejected because again it relies on agenda setting by the clinical profession (by adopting certain obligations) and runs the risk of a narrow medicalized approach. Although the model does attempt to deal with deception this chapter concludes that the definition is too narrow for the dental purposes that we highlighted earlier in the thesis. This model cannot therefore be expanded to meet our needs.

Chapter six summaries the position so far and re-visits some of the concerns raised in preceding chapters in detail. The chapter then goes one to propose an alternative, the moderated negative libertarian account, 'the third way'. The thesis

concludes that by relying on this account we can create an environment in which patient's own authentic autonomy can flourish. The thesis concludes that a dentist's role at the chair-side ought to be one of protecting, through non-interference a patient's pre-existing autonomy. Ethical good is confined to the action of restoring health rather than trying to augment autonomy (and therefore good) through the dentist-patient relationship. Deception is defended against as it presents as an internal obstacle but one that must be externally authenticated allowing more deeply held inner desires as the result of coercion or deception to be rejected.

The central contribution of the thesis is that it provides a road map towards where a new account of patient autonomy in dentistry may be found. The thesis does, however, not claim to be able to provide a way to implement its central findings.

### **Limitations**

Although the thesis considers problems in dentistry and the clinical setting it does so from a remove. The thesis does not incorporate practical arguments or practical evidence in the main, from the profession. The thesis instead considers these problems from a philosophical perspective and one that is normative in nature.

Despite dentistry being a practical discipline the approach has been chosen to give us vital critical distance. Normative theory and guidance are important as they are an integral part of ensuring our principles conform to rationality (Cox, 2012, p.64).

This approach allows us to legitimately avoid professional bias and to see problems and solutions for what they really are without (at this stage) moderating them to incorporate institutional or professional constraints. Normative approaches enable us to see to the heart of a matter and give us an in-depth view of our current position that is stripped bare of operational aspects of behaviour. They seek to reveal the values beneath our claims and evaluate these on their own terms through rational exploration. It enables us to judge what we do practically and the extent to which that conforms to our critical ideals.

If we wish to strive for a new approach to autonomy in dentistry that is rational and coherent a normative analysis is a key component of that aim.

### **Recommendations**

Although this thesis takes a normative approach to identifying the issues of respecting patients in dentistry and proposes a new approach to doing so it is important to consider how these ideas might be implemented in practice. However, as there is currently little or no empirical evidence in dentistry that covers the areas of concern the thesis addresses the recommendations necessarily need to address that lack of evidence as well as considering how the specific findings of the thesis might be implemented. The following are proposed as initial steps in moving towards bringing the claims in this thesis to dentistry in an applied manner:

- PhD studentship – as a consequence of this thesis a PhD studentship is being proposed to look at specific aspects of autonomy in relation to



dentistry, specifically Gillick competence and children's participation in decision making. The study will employ ethnography to explore dental clinician and DCP perspectives of Gillick competence and make detailed observations of the clinical context within which decisions are being made. The idea in this thesis will act as a normative backdrop through which to explore what we discover in our empirical analysis. This is to identify the extent and ways that children's voices are heard in a dental clinical setting, and whether the current guidance around children's participation is reflective of clinical practice. The aim is to provide an evidence base for dentistry where none exists.

- Empirical programme – A programme of empirical ethics would give us further practical insight into the issues this thesis has dealt with. The general approach to empirical ethics includes four key aims: description and analysis of the actual conduct of the group; identification of the moral issues that have escaped ethicists but are context relevant; description and analysis of the cultural and institutional aspects of the context, and; description and analysis of the actual moral opinions of the those involved (Musschenga, 2005, p.469). A programme of this kind would provide the opportunity to deal with the “translations” of the thesis's theoretical principles “into workable practice rules making them available for everyday judgements and decision.” (Birnbacher, 1999, p.321) Although empirical ethics relies both on sociological and psychological techniques to gather data in order to meet these broader aims there are two major approaches that could be employed to take this work further; reflective equilibrium and

or epistemic contextualism. Further work will be necessary to identify the appropriate methods to employ.

- Descriptive ethics – Descriptive ethics is a form of empirical ethics that measures the attitudes of individuals or groups. One of the benefits of this approach is that it seeks to measure *current* attitudes of patients. This approach would capture current patients' cultural viewpoints whilst being sensitive to generational shifts and hence can provide relevance to the implementation of theories in an applied setting. By doing so this approach could form an important part of moderating the prescriptive account of this thesis by comparing and contrasting the rational elements of the theoretical approach against the 'grass roots' views of patients at the chair-side. Again this approach relies on data collection methods from allied disciplines and further work will be necessary to identify the appropriate methods to employ.
- Consultation with the public – It would be counter-intuitive to propose a model of respecting patients in the normative sense without expecting to actively consult with patients. There are a number of approaches that could be taken at this early stage and as a consequence of an empirical programme. These could include consumerist approaches (polls and opinion surveys), traditional review of a written submission, forums (small group work with people with a shared interest). Alternatively rather newer approaches might be taken using consultative or deliberative innovations. Consultative methods would involve considering the matters put forward in the thesis via review using pre-existing groups (such as patient groups) that

will routinely consider a variety of matters and gathering their views. Deliberative innovations could be used to encourage participants to reflect on matters that affect them through a learning process where relevant expertise is made available to guide the learning and deliberative process.

- Consultation with the profession – Consultation with the professions would involve collaboration with the General Dental Council to develop professional guidelines and corporate bodies to develop corporate guidelines. Similarly to consultation with patients, it is important to gather the views and concerns of these bodies and the wider profession. Such bodies will invariably bear the burden of being subject to and delivering any new approach. Again a number of the preceding consultation approaches might be taken.

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## **Appendix**

# Why dentistry needs its own way of respecting patients

This article argues the consequence of this consent-led approach as the manner in which we respect patients can cause us to overlook matters of concern in dentistry. For that reason it may well be necessary to develop a bespoke model of patient interaction for the dental profession

There is no doubt that when we are thinking about the way in which we respect and relate to patients, no medical ethicist would engage in that dialogue without mentioning the principle of autonomy. Patient autonomy is widely regarded as the cornerstone of the clinician–patient relationship; it is through this principle that we claim we respect patients (U.S Department of Health and Human Sciences, 1979). Although not a commonly used term outside the professional arena, when we refer to autonomy we generally refer to some kind of ability or right of self-determination. Beyond this basic idea of self-determination or self-management, autonomy can be a difficult concept to grasp. In fact as yet, despite our reliance on autonomy, the clinical professions have yet to settle on a clear definition. Lack of clarity naturally leads to difficulties in accurate and meaningful application in the clinical setting and confusion as to what is required from the clinical professional. Furthermore, this general broad brush approach to understanding the term and applying it in the clinical setting works from a presumption that all clinical situations are broadly the same, and as such should adhere to a broadly similar approach to ethics; the general observance of an ill-defined principle of patient autonomy. In order to give some meaning to this difficult concept in recent times, we have attempted to promote patient autonomy through an improved consent process, which involves greater explanation of procedure and information

giving to patients. The general premise being that by giving patient's more information we can enable them to make more autonomous decisions about their care and as a consequence better respect them. I would wish to argue however that this is a far too generalised approach to be meaningful. In dentistry, particularly in primary care, the relationship between clinician and patient is more complicated than a simple permission from patients can account for. As we will see differing contexts and professional roles in primary care dentistry can lead to confusion on the patients' part or worse fail to prioritise matters of great importance to them. This makes our claims to respect patients, particularly through consent, in some cases ethically problematic. It also makes it hard for clinicians to draw accurate and meaningful limits around the duties required of them. It is for this reason that this article would like to argue for the development of new model of patient interaction, one that is specific to dentistry that adequately meets the needs of both patients and dental professionals.

## The position of autonomy in healthcare ethics

Autonomy has established itself over the last few decades as one of the primary principles that ethically underpins the clinician–patient relationship. It is the principle that some regard as the first among equals (Gillon, 2003). The paternalism of the past has been rejected in favour of an approach that recognises rights and gives authoritative weight to the voice of the patient. In principle, it affords patients the right to choose and manage their own health care experience on their assessment of the situation before them. There is much to recommend it. Autonomy helps us to understand and express our dissatisfaction with paternalistic models associated with medicine and

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dentistry in the past and provides an alternative. It is no longer acceptable for a clinician to make decisions for patients based on what they perceive to be in the patient's 'best interest'. Patients are now afforded the right to make such decisions for themselves irrespective of whether these decisions appear to be of some benefit to them. This is in recognition of the fact that as individuals it is more important to recognise our individuality than it is to derive some measurable benefit, particularly when our definition of benefit is based on the perspective of the expert clinician, not the patient.

In recent times, however, autonomy has also been subject to criticism. It is often viewed as a slippery principle that can be interpreted in many ways. It is not a term used commonly in the vernacular and indeed from a practical perspective many clinicians are unsure of what it means. There is no real agreement in moral philosophy either. Autonomy can be viewed as an acquired skill where a certain level of reflective capacity is necessary; a 'capacity of persons' (Dworkin, 1988; 1989; Frankfurt, 1971), or it can be viewed as an inalienable right to individuality; that is to say a type of personal sovereignty. This presents a problem for the clinical relationship. Medicine, although supportive of autonomy in principle, has yet to settle on a firm definition of what it is and this inevitably leads to difficulties in interpreting and translating the principle into the clinician-patient relationship. Without a clear definition we are unable to draw any limits. Depending on what view is taken of the principle, whether it be one of capacity, or a matter of individual sovereignty, this can dramatically affect the manner in which the clinical relationship is defined. Questions arise concerning when a patient may be viewed as not autonomous and therefore to what degree decisions might be made on their behalf. A clear view of autonomy is necessary in order to discern the rights of children or the mentally incapacitated and to adequately respect those groups.

### Autonomy and consent

Some clues as to our general definition of autonomy lie in our interpretation of the consent process. It is autonomy, as a principle, that is viewed as the foundation and driver of the consent. That is to say that consent is merely the method by which we observe autonomy in clinical practice rather than being an end in itself.

As such, consent is one of the most important exchanges between clinician and patient, including situations where a professional may be relying on the consent taken by another colleague as well as those taken personally (Sugarman et al, 1999). However, the makeup of consent has changed in the last 20 years. Historically, consent would be considered adequate where a patient merely agreed or declined the treatment on offer. The consent hinged on a supposition of bodily integrity; the right to decide on what happened to your own body. Consent was respected by giving patients a choice but not an informed choice. Here we might wish to suppose that this broadly implies autonomy was seen as a matter of personal sovereignty, that is to say recognition that a patient was respected in so far as they must give their permission for the treatment to go ahead, but no more. The clinician in this situation is only tasked with protecting a patient's autonomy by giving them a bare choice.

More recently, after the advent of cases such as the The Royal Liverpool Children's Inquiry Report (Department of Health, 2001) the consent process has undergone some development. We have seen much greater emphasis on augmenting the consent process by the requirement to give patients full information. Full information might be seen to imply that the definition of autonomy we are relying on has changed. Now, in order to respect autonomy a patient must be enabled, through information giving, to make a reflective and reasoned decision about their care. Autonomy would seem then to have altered its locus of emphasis from one of broadly personal sovereignty to one that requires a patient to have the capacity of personal reflection. There is a clear presumption that more clinical information means more autonomy and therefore greater respect of patients. Today the clinician is tasked with much more; they must both protect the patient's autonomy by giving them a choice, plus promote the patient's autonomy by making that choice informed.

### Difficulties with informed consent in dentistry

There are many complex philosophical and ethical consequences of such a change that are worthwhile exploring. For example, does the patient in the historical example really have less autonomy than in the second? However, there is insufficient room here to consider these questions in appropriate detail.

For our purposes, one thing that might concern us here is a practical consequence of this change. This starts with our task; we are asking patients to consent to treatment, so in general, regardless of how conscientious we are, our conversations are naturally (and legally quite rightly due to *Bolam v Friern Hospital Management Committee*, 1957) confined to the treatment proposed. There is nothing in the modern consent process that asks us to consider other factors in addition to the details of treatment and the various options. However, this seems as if it might be rather problematic. The problem arises because we are claiming that as part of respecting patients we wish to treat them as individuals and help or least support their desire to be self-determining. If the purpose of consent is to practically deliver patient autonomy because that is the way we understand respect for patients, how do we square this with the clinician setting the conversational agenda? For instance, how would we respond or how strongly would we defend our position if we knew that the details of treatment were not always what is of key concern to the patient? Are we presuming through an informed consent process that the medical choice is what drives patients and that factors, such as cost, the role and qualifications of the individual treating them, whether the treatment is private or on the NHS and even whether the treatment is cosmetic or therapeutic, are of no account to the patient?

It is hard to see how we could successfully argue this, but this is often the situation that dental professionals find themselves in. By relying on a very broad and overly medicalised model of respecting patients some of the key concerns of dental patients are, with the very best of intentions, in danger of being overlooked.

### **Dental therapists: a brief case study**

Taking one such example we might wish to look at the role of hygienists and therapists in dental treatment. There is no intention in this article to call into question the role of hygienists or therapists in dental treatment, this is in no way a criticism of the use of skill mix. However, there is no doubt that currently there is some confusion on the part of patients as to the existence or role of dental therapists and hygienists. Not only have dental patients been shown not to know the qualifications or general role of the person who is treating them, but they also are generally unaware that there are differing roles in

dentistry and that other dental professionals exist, who are not dentists, who are able to treat them (Dyer & Robinson 2008a;b). Of those patients who responded to a national questionnaire who did claim to know and be able to identify the differing roles in dentistry the majority made inaccurate or wholly incorrect distinctions (Dyer & Robinson 2008b). Perhaps of further concern is the fact that when the roles of therapists and hygienists were explained to interviewees most expressed concern and said they would be unhappy to be treated by such professionals. The concern here is not one of propriety of role rather our concern is that there does not appear to be any part of the clinical relationship as we currently deliver it that would require us to disclose the professional status of the person treating the patient. The general view implied by our approach is that we view delivering accurate and appropriate treatment with informed patient consent as the way in which we respect patients. The focus is very much on the business in hand and the delivery of treatment. The consequence of this is that potentially matters of concern to patients that fall outside of that modern consent rubric do not carry ethical weight or concern for us.

Obviously from a practical perspective, this issue is easily addressed. We can require that all dental professionals confirm their role and qualifications with patients as part of the consent process, as this clearly is of concern to them. What is important to note here is not the simple solution, but rather the way in which we construct the relationship from an ethical perspective. We need to be clear why we are doing things for patients and model ideas around patient interaction to make sure that we are indeed addressing these matters. To observe this example from the other side, we might wish to claim that it is only an examination of dental patient autonomy that might cause us to question what we are trying to achieve with patients, what role information plays, why are we giving it, and what we are trying to achieve. It is only by asking these questions that we then expose flaws in our approach.

### **Conclusion**

There are certainly some concerns in relation to what we claim to achieve through the consent process and information giving in relation to patient autonomy in dentistry. It must be counterintuitive to claim to rely on the ethical principle of autonomy as the way

in which we respect patients but to be satisfied with ignoring factors in the relationship that are clearly of concern to the patient. If we are really concerned with patient autonomy then we must model dental practice to better reflect the concerns of patients rather than to focus on the treatment agenda. Of course treatment is an important factor and quality treatment and a patient's involvement in it are not to be cast aside. But by following a generalised pattern of patient interaction set by the concerns of clinicians in differing medical situations some of the key concerns of dental patients are in danger of being over-looked. For that reason we need to consider if we do indeed need a model of patient interaction that is specifically designed for dentistry and to move away from relying on the broad brush approach to ethical clinical interaction.

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