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The Role of Autonomy in the Physician-Patient Relationship

By

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An Undergraduate Thesis Submitted in Partial Fulfillment
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I. Introduction

Euthanasia has been in the forefront of the media in recent years because of the increased attention it is receiving in government proceedings. The discussion over whether euthanasia and physician-assisted suicide should be legalized is a major topic of debate in legal circles as well as medical ethics. As medical technology advances and our ability to control our medical treatments increases to the point of extending our lives, it becomes more evident that we should also have some control over our deaths, as well. Hence the push for legalization of euthanasia has grown with emergent technological advances. But an important question to ask is whether or not euthanasia is morally permissible for both the physician and the patient. In what follows, I will investigate the important aspects of euthanasia and propose that, in at least some cases, euthanasia in the medical profession is not only permissible, but an acceptable practice.

First, some clarification on the topic of euthanasia is needed before any discussion can continue. There are many definitions and categories of euthanasia in the medical world: voluntary, non-voluntary, involuntary and active or passive. For the purposes of this paper, I am limiting the discussion to only ideas of euthanasia that are voluntary and, in particular, those that are active acts. While most of the discussion will also apply to passive acts in which treatment or life sustaining acts are withdrawn, these will not be the focus here. The importance of only considering voluntary acts regulates all considerations to those in which the patient gave their consent for euthanasia and was not forced or coerced into it.

It is also important to distinguish the difference between voluntary, active euthanasia and physician-assisted suicide. While these are related terms there are some key differences that must be noted. As pointed out by Dan Brock in *Voluntary Active Euthanasia*, one main difference between the two is who acts last. In acts of euthanasia, it is the physician who acts last as they

administer the lethal dose. On the other hand, in physician-assisted suicides, the patient is the one who acts last in administering the lethal dose themselves. (Brock, p10) Because of this distinct difference in the two cases, it can often be difficult to discuss both in the same context. However, euthanasia and physician-assisted suicide have one similarity that places them on common ground: the physician plays a major role in the death of the patient, whether actively administering the drug or prescribing the drug. When discussing these cases, it is important to keep this similarity in mind because, despite their differences, the two occurrences are related. Thus, in the course of this paper, all mention of euthanasia will be inclusive of acts of physician-assisted suicides as well.

Now that the details of euthanasia and physician-assisted suicide have been clarified, it must be discussed why these acts are permissible. The need for control is a very real concern in the lives of most individuals. We want to die with dignity and control the details of when/how we leave the world. Euthanasia provides the control that is desired by the patients during end of life decisions. With the proper regulations and requirements, euthanasia provides an alternative for patients at the end of their life. What needs to be decided, though, is whether or not there is a strong case for the permissibility of euthanasia based its consequences, both positive and negative. This can be done by not only looking at the consequences of euthanasia, but also looking at established areas with legalized euthanasia such as Oregon.

Dan Brock points out four important positive consequences of euthanasia which appear very relevant to this discussion. The first of these is interesting in nature. As mentioned earlier, Americans have a desire to control every part of life, including the end of it. Because of this desire, most people feel that we have a right to obtain euthanasia if it is wanted. However, interestingly, the majority of people who support the right to euthanasia will never seek it. It is

simply the reassurance that euthanasia is available if they desire it that is sought. (Brock 15)

Thus, the permissibility of euthanasia, without the need to even obtain it, is a benefit in itself because of the reassurance it provides to the majority of the population.

The second positive consequence of euthanasia is very common when dealing with end of life situations that are not pleasant. For many patients, the end of life experience is actually agonizing and uncomfortable. Aside from the fact that the situation is scary, this time is often filled with extreme pain and suffering. Frequently, though, this pain and suffering does not mean a hasty or easy death, and for patients who are receiving no life sustaining treatment, euthanasia may be the only option to relieve them of their suffering. This is commonly called the argument from mercy because it appeals to our feeling of sympathy for those in pain and our desire to help them in some way. This is also why it is often the strongest argument presented for euthanasia. (Brock 15) However, pain and suffering seem to be very arbitrary methods of measurements. Obviously, there is difference between pain that is treatable or manageable and pain that is too extreme to be controlled. It is the latter type of pain that qualifies for euthanasia discussions most often because once it reaches an uncontrollable point, there is little that can be done. Cases in which all options for managing pain have been exhausted and none found successful or beneficial seem to lean in favor of euthanasia because of the lack of viable options.

This leads to the third positive consequence of legalized euthanasia. Once a patient reaches a point where death is accepted, the humane decision seems to be euthanasia. This provides a death that is more peaceful and quick than the any other option, especially one that involves prolonging life needlessly. At this point in a patient's life, often it is important to them to regain some of the control that has been lost and preserve their dignity by dying in a way that they feel is acceptable. It is because we care about the way people remember us that we want to

make our death as dignified as possible. Thus, euthanasia seems to provide a method for dying with dignity and control rather than one of prolonged pain and suffering.

A final positive consequence is one that is very important for individuals. If euthanasia were permissible, the autonomy of competent, well-informed patients would be respected in every respect. The number of people who currently desire euthanasia but cannot obtain it is hard to determine. However, by looking at the established methods of legal euthanasia upheld in the state of Oregon, we can get a picture of how euthanasia works legally.

Oregon has had laws legalizing euthanasia for over 20 years. Within their established system, the Oregon Death with Dignity Act (DWDA) allows physicians to prescribe lethal doses of medication to patients who request physician-assisted suicide. Currently, the drug most commonly prescribed to patients for this purpose is an oral dose of a synthetic drug known as a barbiturate such as secobarbital. Barbiturates are synthesized from barbituric acid which is pharmaceutically inactive compound. However, by adjusting the substituents attached to this parent compound, prescription secobarbital can be produced. A look into the chemical aspects of these prescription drugs can show how they allow the positive consequences mentioned above to be put into practice in actual situations. (“Frequently Asked Questions”, 2015) In their traditional use, these drugs are used as sedatives or “sleeping pills”. Because secobarbital is highly soluble in lipids but only slightly soluble in water, along with its other chemical properties, (“Secobarbital”, 2005) once the lethal dose has been administered, the drug is absorbed into the body and “rapidly distributed to all tissues and fluids” which allows the effects to be felt shortly after. (“Pharmaceutical Information”, 2015) (For more information of the chemical nature of barbiturates, and secobarbital in particular, see Appendix A.) Thus, when used within the DWDA barbiturates can be used to sedate a patient before their death, which is assumed to alleviate any

pain or suffering, they may feel. This means that the patient will be quickly and calmly sedated, often into a comatose state, before the lethal affects occur. This in turn eases the overall suffering experienced during this time.

However, the requirements for obtaining these prescription drugs and euthanasia in general, are rigorous and meant to confirm the patient's decisions concerning the end of their lives. Thus, before euthanasia is agreed upon, the patient must be declared terminally ill with less than six months to live. They also must submit three requests for euthanasia to a physician, one written and two oral, each at least fifteen days apart. According to the Oregon Public Health Division, since the law was passed in 1997, a total of 859 patients have died from ingesting medication legally prescribed, while a total of 1,327 people have been prescribed lethal doses of medication. This number has steadily increased each year since the passing of the law. (Oregon, 2015) This is indicative of a trend in the population that suggests euthanasia is becoming more accepted and requested.

However, not everyone agrees with this proposition that euthanasia should be permissible. In order to thoroughly discuss the idea of euthanasia, we must not only look at proponents of it but also those who are adamantly opposed to its practice as well. Leon Kass is one such opponent. In his paper *Neither for Love nor Money: Why Doctors Must Not Kill*, he lays out his argument against euthanasia from the point of view that euthanasia is contrary to a physician's central role. (38-39) Kass states that the central role of physicians, and the essence of medicine in general, is to heal and not to kill. It is more than just their job; it is the goal physicians strive to achieve. According to Kass, "A person can choose to be a physician, but he cannot choose what physicianship means." (38) Thus, euthanasia is impermissible, not because the patients do not have a right to it, but because it violates the central role of the physicians.

(Kass 37-39) However, in his definition of healing, Kass seems to accept a very limited view of what ‘healing’ is. The traditional view of healing is to make well and whole. Thus, a physician’s job is to take someone who is sick or unhealthy and make them well again. This raises an issue when medical technology and methods run out. What role do physicians play when there is nothing left for them to do? When no ‘healing’ can occur?

It seems that there are parts of a physician’s job that extend outside of the traditional measures of healing and that their relationship with the patients is more complex than a consumer model would suggest. In fact, it appears that Brock would agree with this. He states that “Killing patients is not understood to be part of physicians’ job description, but some killings are ethically justified, including many instances of stopping life support.” (Brock 13) In these cases, when no traditional healing can occur, I think it necessary that a new definition of ‘healing’ is found, or at least the current one modified, to include instances in which justified killing occurs. This would mean that, in order to properly define the role of a physician, euthanasia and physician-assisted suicide become permissible under this newly defined role of physicians. Thus, it does not appear that Kass’ opposition to euthanasia, at least from this point, is substantial enough to cause significant problems.

However, he continues by discussing some additional reasons he considers euthanasia impermissible. Kass claims that, in addition to defeating the role of the physician, allowing euthanasia would have adverse effects on the physician. He states that if physicians were permitted to assist in cases of euthanasia and physician-assisted suicides, it would make it hard for them to perform their jobs. In his words, physicians need “protection against himself and his weaknesses.” (Kass 35) If euthanasia and physician-assisted suicide were made legal, physicians, in Kass’ opinion, would be too tempted to misuse their power and fall prey to their own

weaknesses. Kass uses the example of his acquaintance, who worked in hospice, to make this point, quoting: “Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.” (Kass 35) However, it is important to note that in this case, as with many other cases, the physician cannot kill their patients (as least legally) but they also would not want to. Kass seems to underestimate the willpower and professionalism of physicians. While there is always the chance that a physician could misuse their power, it is also a possibility that physicians could do the same thing without legalization of euthanasia.

Kass continues on page 35 by stating that if euthanasia were allowed it would damage the physician-patient relationship. This, Kass claims, is because the patients trust in the physician would be completely lost. How is a patient supposed to trust that a physician has their best interest at heart “once doctors are licensed to kill”? (Kass 35) Legalized euthanasia and physician-assisted suicide, however, does not have to destroy this trust. Instead, it may strengthen the relationship. Patients will feel confident that their physician will look after their wishes and respect their autonomy.

Thus, it seems that, even taking some objections into account, there is a good case for the permissibility of euthanasia. In both the good and bad consequences, there seems to be a common theme that we desire a type of control, or autonomy, over our lives and decisions at the end of life. Making euthanasia permissible respects this desire for self-control and allows us a death with dignity while still upholding the relationship between physicians and their patients. In this way, it appears that, despite Kass’ fear that euthanasia will hinder the physician-patient relationship, there is a strong likelihood it could improve it. However, what does threaten this

relationship is the type of autonomy that is awarded to patients. Kass, himself, presents a good example of when this issue arises.

In his work, Kass describes a basic model of patient care that he refers to as a “consumer view.” As the name implies, this model treats patients as mere clients or consumers. Kass explains that this model used for patient care is one of contract between patient and physician. Essentially, the doctor “sells his services on demand” to the patient. (Kass 28) The basics of the relationship work so that the patient receives their autonomy accompanied by doctor’s services; the physician receives money as well as the satisfaction of assisting the patient. (Kass 28) Thus, nothing, save the law, constrains the physician from assisting his patient in any way they desire. For example, if a patient wants to change their nose, find out the sex of their baby, or take drugs for recreational purposes, a doctor can easily provide the services desired so long as the price is right and they are willing. This also extends to end of life situations. If patients have reached a point in their life where they decide euthanasia, in whatever capacity, is their desired action, then physicians can be “hired”, for the right price, to provide this service. This is particularly applicable in places that have laws allowing euthanasia because nothing is preventing doctors from providing this service to their patients upon request.

However, despite this model’s apparent ability to respect a patient’s autonomy, it appears that it may be too relaxed in its ideas about autonomy to provide an appropriate view of the physician-patient relationship. This model seems to provide the patient with infinite freedom of autonomy. Thus, it is not the ability to obtain euthanasia that threatens the relationship; it is the definition of autonomy that is being employed. The patient has complete freedom of choice with no restrictions placed on them; they can request and receive any treatment they desire without the need or provision that they be fully informed. While this may seem desirable and appropriate

upon first glance, when the physician is restricted to following orders of the patient, especially when they are uninformed, not only does the relationship disintegrate, but the patient's autonomy is inhibited to the point of interfering their well-being. Because of this, it is important to understand what autonomy is in relation to the physician-patient relationship; it cannot be seen separately without hindering both. Thus, finding the appropriate definition of autonomy requires an understanding of the physician-patient relationship and how the two work together.

In this way, the relationship between physicians and patients is not as straight forward as it may seem. We must find the appropriate model of care that also provides an adequate view of autonomy for patients while also maintaining a priority view of their well-being. This can be complicated because while physicians have the technical knowledge and know-how to treat patients, there must be a balance between the physician's knowledge and the patient's values. Finding this balance ensures that the patient is receiving the best medical advice and treatment possible while also maintaining full autonomy. To find this point of physician-patient interactions, there are different models which can be followed that help to determine not only how the physician interacts with the patient, but also the type and amount of autonomy the patient receives. In order to guarantee the proper type of autonomy is being employed, as well as to maximize the amount of autonomous freedom a patient receives, we must investigate different types of patient care to determine the appropriate physician-patient relationship. There are several different models that we can look at that will assist in defining an ideal of patient care that is sufficient for successful physician-patient interactions and patient autonomy. Linda and Ezekial Emanuel provide us with some such models.

Emanuel and Emanuel provide four examples of patient care that can be used to improve the view of autonomy provided by Kass' model. Unlike Kass, the basic model in the work by

Emanuel and Emanuel is the paternalistic view. However, while I will briefly mention this later, this view, in general, is considered outdated and is typically assumed to be obsolete in regards to patient care; however, not only is it insufficient as a means for patient care, but it also completely fails to respect patients' autonomy in an appropriate way. For this reason, the starting point of our analysis, using their models, will be with the informative view. This will provide us with a stepping point from Kass' "consumer model" to a better, more successful view of autonomy and the physician-patient relationship.

II. Informative Model

The informative model of patient care is very similar to the consumer model in Kass' work. Both models require the physician to take a "morally neutral" approach to patient care that puts all responsibility on the patient. (Kass 28) However, Ezekiel and Linda Emanuel describe the informative model in greater detail in the article *Four Models of the Physician-Patient Relationship*. According to this model, the physician-patient interaction is very technical. The physician will provide the patient with all relevant information on their diagnosis and possible treatments. The patient will then select the intervention he or she wants and the doctor will execute it. (Emanuel 2221) There is a very clear distinction between facts and values within this model; the values and beliefs of the physician have no place in the care of patients, nor is not necessary for the physician to have knowledge or understanding of the patient's values. However, it is assumed that the patient's values are clear, well-defined, and known to them. (Emanuel 2221) Thus, the physician is effectively relegated to a technical expert and nothing more; they only provide the patient with the capability needed to maintain control and autonomy over their medical decisions. (Emanuel 2221) Under this model of care, patient autonomy

consists of complete control over medical decisions with no interference from outside parties, including the physician.

This view of autonomy and patient care is a major improvement from the outdated paternal model that was previously the norm. The Emanuel article explains that in the paternal model patients' autonomy is of less emphasis than their overall well-being. In this method, then, the physician acts as the guardian and is tasked with ensuring the overall well-being of the patient is maintained. (Emanuel 2221) Thus, the patient autonomy in this form is simply to consent to some objective value that is best for well-being. (Emanuel 2222) However, the informative model successfully provides a view of patient care that better accounts for the values and needs of the patient. The patient is free to make their own decisions about health-care without feeling pressured by the paternalistic physician. This is an important point to note. As Thomas Hill notes, autonomy is a "right that every responsible person has...to make certain decisions for himself or herself without undue interference from others." (47) In this sense, the informative model, unlike the paternalistic model, acknowledges that certain decisions are up to the patients and should be made without interference from others. (Hill 48) This seems to capture an important aspect of autonomy that the paternalistic model does not: that patients are self-governed and able to make decisions independent of others' opinions.

This can be seen clearly in the work of Dr. Jack Kevorkian. In his work with euthanasia and physician-assisted suicide, he exemplified the informative model of patient care. Kevorkian became well-known because of his work in Michigan from the 1990s until his death in 2011. During this time, he assisted over 100 individuals in their deaths. To do this, he concocted a simple machine that allowed patients to painlessly end their lives using a combination of sedatives and lethal drugs administered through an IV line. However, in each of his cases, the

patients initiated the interactions once they decided death was their chosen treatment; no previous connection to Kevorkian was needed. Thus, Kevorkian had no established relationship with any of his patients past the brief meetings to schedule the time of “treatment”. He was essentially needed only for his technical, professional knowledge and skill set. In the framework of the informative model, the patients were exercising what appeared to be their full autonomy by choosing what they wanted and Kevorkian was simply the person who could implement their desired “treatment”. In this way, Kevorkian was the perfect informative model physician because he did not interfere with his patients’ wishes or try to force objective values on them.

However, even though the informative model makes huge strides in improving the physician-patient dynamic and allows the patient more freedoms in their health-care, there still appears to be something lacking in this view of autonomy. There are actually several major issues with viewing the informative model of patient care as providing adequate autonomy for patients. Namely, the concept of autonomy that is awarded to patients is at best lacking in its applications and, at worst, it is inhibiting to both patient and physician. It seems that there should be more to autonomy than simply allowing patients complete control. In these cases, physicians cannot ensure that their patient is receiving adequate and sufficient care. However, to really see the depth of the issue and determine what it is that is lacking in this model, we must relate the informative model of autonomy to the ideas of Harry Frankfurt. This will allow us to examine what this model looks like when applied to a real life situation and the problems will become more evident. Once this is done, we will have a better idea of what constitutes an appropriate view of autonomy.

Harry Frankfurt provides a good basis for the evaluation of the informative model of autonomy. In the first part of Frankfurt’s article *Freedom of the Will and Concept of a Person*, he

makes a distinction that is very important to our discussion of autonomy: the difference between first- and second-order desires. According to Frankfurt, a first-order desire is simply the “want” to do something. They apply to the physical world and our interactions with it. For example, we have basic desires and motives that drive us such as the desire to eat, the desire to exercise, the desire to smoke, or anything else. However, humans are different from other creatures in that we are capable of “wanting to be different, in [our] preferences and purposes, from what [we] are.” (Frankfurt 7) Thus, we are capable of reflective self-evaluation and wanting to change; we are capable of forming second-order desires. These desires, unlike first-order, apply to other desires. Thus, we are capable of wanting to desire (or not desire) something (i.e. desiring to not desire to smoke). (Frankfurt 6-7) However, this distinction alone, though a bit convoluted at times, is not enough to explain why the informative view of autonomy does not work. The problems are no more illuminated than before. To help better understand this distinction and the problems created, consider instances when a person’s first- and second-order desires conflict with one another. Frankfurt does this using his “addict scenarios”.

Consider what he calls the “unwilling addict”. (Frankfurt 12) In this case, the addict has both the desire to take a drug and the desire to refrain. He struggles every day to refrain from the drug but eventually succumbs to his desire for it. As Frankfurt phrases it, “He is not neutral with regard to the conflict between his desires...” (12) This addict wants his desire to refrain from the drug to be successful, even when it is not, making him entirely unwilling in his addiction. This is a case where the first- and second-order desires are in conflict with one another and the person is a mess when it comes to the actions affected by these desires.

Now consider this same situation applied to a patient making decisions concerning end of life care. According to the informative model, patients hold all control over their medical

decisions, which includes the assumption that their values and desires are well-defined and understood. However, this could cause major problems in the informative model of autonomy if their desires are conflicting, especially if this is not explicitly understood or known to the patient. The decisions being made would not be fully autonomous because the patient does not understand their values and desires.

Imagine a patient; let's call her Ann, who is diagnosed with terminal cancer. Ann may decide, after receiving all relevant information from her physician, that euthanasia or physician-assisted suicide is her best option and chosen treatment. She feels it is best, given the small chance of survival, that she not suffer the pain caused by the cancer or burdens her family and so, she wants to end her life. However, she does not want to desire to die; actually, she wishes she wanted to live. This creates a conflict between what Ann desires (first-order) and what she wants to desire (second-order). Still, according to this first model, any decision Ann makes is completely within the scope of her autonomy because she has complete control over what treatment, if any, she wants to receive. Ann is assumed to have complete knowledge of her well-defined desires. However, there seems to be an inherent issue with this if Ann, on one level, wants to die and, on another, does not.

Consider, though, if Ann went to Dr. Kevorkian to implement her treatment: physician-assisted suicide. Dr. Kevorkian, as an informative model physician, would not question Ann's values or desires. In fact, he would not inquire about the nature of Ann's desires or whether they were aligned, nor would he interfere with her choice with his own beliefs or opinions about her well-being. Instead, Dr. Kevorkian would provide Ann with the technical assistance she needed regardless of the state of her desires and the internal conflict caused by them. Ann would get exactly what she thinks she wants. Yet, there seems to be something that is not quite right about

this scenario. If Ann is acting with full autonomy of her actions, should she not know exactly what she wants and fully understand her desires? Because she is considering only first-order desires and not the relationship between her first- and second-order desires, any treatment she receives from Dr. Kevorkian, or any other doctor, may not be the best option for her, she is simply unable to see it. In this way, it seems that Ann is not exercising full autonomy, even though she is making her own decisions. Thus, it appears that simply having the ability to make a decision does not mean that one is fully autonomous, nor does it mean that one fully understands the desires leading to the decision.

So, with the help of this hypothetical scenario of Ann, the flaws of the informative model make themselves known. It seems that this first model of autonomy does not facilitate complete autonomy. Though the informative model is a much better option than the paternalistic approach, giving patients complete control over their medical decisions still does not demonstrate a full and comprehensive view of autonomy. When this idea is put in to practice, there are still areas where the informative model is lacking in its interpretation of patient autonomy. Harry Frankfurt's insight on first- and second- order desires helps to illuminate exactly what is missing in the informative model of autonomy. Patients must fully understand both their first- and second-order desires, as well as how they align, in order to function autonomously. Accordingly, in order for patients to have a better view and understanding of autonomy, there must be a model that takes the patients desires, as well as the fact that they are not always understood, in to account. In this way, the interpretive model of patient care is a step closer to an appropriate view of autonomy.

III. Interpretive Model

The next model of patient care that is presented by Emanuel and Emanuel improves upon the informative model. Similarly to the informative physician, the interpretive physician is responsible for providing the patient with all relevant information regarding their diagnosis and treatment. (Emanuel 2221) However, they go beyond simply providing the information and accepting the patient's decision. Unlike the informative physician, the interpretive physician understands that the patient's values are not always completely understood. In fact, their values are often undeveloped and conflicting; often, they are completely unrecognized by the patient. Because of this, the physician assists in "elucidating and articulating [the patient's] values" as well as "determining what medical interventions best realize the specified values." (Emanuel 2222) Thus, in the interpretive model, the physician is not only the knowledgeable, technical expert presented by the informative physician; they also take on a role of advisor and counselor that is assisting the patient.

In this model of patient care, physicians and patients work together to connect appropriate values with treatments for the patient based on their character and beliefs. To do this, often the physician must see the patient's life as a whole from which they can specify certain values that are important to them and from this, determine what treatments are best suited to these specified values. However, it is ultimately the patient's decision to accept certain values as their own and chose a treatment method. (Emanuel 2222) The physician is analogous to a counselor, helping the patient understand their values and putting them to appropriate use within the medical spectrum. Thus, in addition to the obligations of an informative physician to ensure the patient has all relevant information, the interpretive physician also engages the patient in understanding their values. (Emanuel 2222)

Including both physician and patient in this way, provides a better type of autonomy and patient care than before because of understanding of values that results. Thomas Hill notes: “The principles and values they try to express in their decisions would be genuine guiding considerations and not mere epiphenomena unrelated to their real moral motivation... moral agents face their moral choices with awareness of both the relevant feature of the problem and effective understanding of their real values.” (Hill 51)

In this case, the moral agents would be equivalent to patients. Thus, in order to exercise full autonomy, according to the interpretive model and in Hill’s terms, one must be fully aware of the relevant information as well as have an effective understanding of their values. If this is done properly, it would appear that the patient is exercising full autonomy as well as keeping the physician-patient relationship intact. However, it must be noted that the physician does not revert to a paternalistic approach where they dictate to patient what values to hold and what decisions to make. While they are still not including their beliefs in any step of the process, they are also not judging what values and beliefs the patient chooses to hold. (Emanuel 2222)

To better understand how this model may work in a real situation. Take the same patient from earlier, Ann. She has been diagnosed with terminal cancer and her physician has provided her with all relevant information concerning her treatment options. However, Ann is having trouble deciding which treatment is best suited for her values and beliefs; in fact, she is not sure what her values would tell her to do. She wants to balance her physical well-being with her mental health as well as her personal life, but is unsure how to accomplish this. If she were to approach her physician, who practices the interpretive model of patient care, he would help her to clarify how values fit with the treatment options she is given and enable Ann to choose the most appropriate treatment option. He might say something along the lines of “I understand that

you are confused and have conflicting wishes about your treatment. It seems to me that you would like to balance your health and well-being with your personal life so that you maintain a positive attitude and self-image as well as regain your health. Given these conditions, treatment X will provide... treatment Y will provide... etc.” Thus, Ann would then take this new information and make her decision. In doing this, the physician provides assistance to the patient in understanding how the given treatment options apply to certain aspects of her values. However, he does not force a particular treatment or decision on her; he only provides clarification on how a certain treatment will apply to her values.

The interpretive model is even more clearly seen in the case of Dr. Timothy Quill and his patient Diane. In this particular case, Diane was diagnosed with a terminal type of leukemia. Dr. Quill presented her with the list of her treatment options and all relevant information including the fact that she had only a 25% chance of survival with treatment, she would spend a large amount of time in the hospital, and that without treatment her condition was decidedly terminal; action was needed quickly. Equipped with this information, Diane was faced with a decision: treatment or no treatment. Although she was relatively sure about what her values were, Diane still felt the need to discuss them with Dr. Quill. This meant that he helped to explain how her values lined up with her options, but he did not lead her to any one decision. In fact, in the end, even with a chance of survival and the desires of her family considered, the decision was Diane’s and she chose to forego treatment. Instead, she wanted to control how and when she died and requested a way to end her life when she chose to do so. Thus, Dr. Quill prescribed her medication that would allow her to do as she wished.

This example explains how the interpretive model of patient care works in a real clinical situation. Dr. Quill provided Diane with the information she needed as well as helped her align

her values with treatment. However, he did not coerce or force her in to any decisions; he merely ensured that she had a proper understanding of her values in relation to the treatment options and enacted the treatment she chose once she was fully informed. Thus, it appears that she was exercising full autonomy in her medical decisions. Because of this, this view seems to be a better model for patient care than that of the informative model. When the patient makes a decision with the help of the physician, they can have some assurance that their well-being is looked after by someone with the technical knowledge to know how to treat them properly.

However, there may yet be some hidden issues with the interpretive model that need to be illuminated. While this model seems to completely alter the definition of patient autonomy, in reality it is not much different. Like in the informative model before, the patient still maintains full authority over their medical decisions and the physician remains the technical expert. The only difference is that the physician assists the patient in understanding their values. However, there is no room for the physician to include his or her own beliefs about the best options. The only new aspect of the physician's role is to relate a particular treatment to a value held by the patient. This can lead to serious problems in the decision making process because the patient is relying on the physician to understand what they want and to help them understand how it relates to their options. Thus, the idea of responsibility enters into the equation. If the patient does not have clearly defined values and relies on the physician for clarification, can they be held responsible for their decisions? It would seem that in the interpretive model of autonomy and patient care, the responsibility of the patient is decidedly limited, but why?

To understand how the notion of responsibility affects autonomy and the physician-patient relationship, we must first understand responsibility. Susan Wolf provides a basis for what responsibility entails in her article *Sanity and the Metaphysics of Responsibility*. She pulls from

Charles Taylor's ideas that "our freedom and responsibility depend on our ability to reflect on, criticize, and revise our selves... the ability to step back from ourselves and decide whether we are the selves we want to be." (Wolf 365) Essentially, responsibility stems from our understanding of our desires and values as well as the ability to step back and reflect on them. However, if our values are unknown to us, as is the case with the interpretive model, we have no ability to reflect on or correct ourselves. This is strongly associated with Harry Frankfurt's ideas about first- and second-order desires because, as we saw with the informative model, one must be in control of both his first- and second-order desires to be constituted as autonomous. (Wolf 365) Unlike the informative model, values in the interpretive model may very well be aligned and in order, seemingly granting full autonomy; however, they are unknown to the patient, thus restricting autonomy. Responsibility cannot be a factor if the patient does not understand where the decision is coming from.

However, Wolf takes this idea a step further. She states "...the key to responsibility lies in the fact that responsible agents are those for whom it is not just the case that their actions are within the control of their wills, but also the case that their wills are within the control of their selves..." (365) This is seemingly a reiteration of Frankfurt's ideas about aligning desires. But what does this mean in relation to interpretive model autonomy? It is not enough to say that a patient has autonomy because they are in control of their decisions or making informed decisions. Autonomy must provide that the patient makes decisions based on a sound understanding of their values in relation to the information they have been provided. However, Wolf also makes the point that simply understanding your values is not enough to guarantee that a patient is exercising full autonomy; the sanity of the patient must also be considered. By this Wolf means that there can be cases when a patient's first- and second-order desires are

completely aligned and understood by the patient, but their desires are not entirely sane or rational. This can be understood as the ability of a person to (1) know what he/she is doing and (2) know that what he/she is doing is right or wrong. (Wolf 368) What is more, sanity can be defined as the “minimally sufficient ability cognitively and normatively to recognize and appreciate the world for what it is.” (Wolf 369)

This idea of a responsible and sane person is illustrated by Wolf’s example of JoJo the dictator. JoJo was raised by his evil and sadistic father who provided him with a special education, allows him to accompany him during his daily routine, and treated him as the favorite son. Because of this, JoJo took on the beliefs and values of his father, and once he assumes power, he acts much like his father before him. He knows exactly what his desires are and what he wants to do. (Wolf 367-8) However, his judgement is skewed from reality; he is not able to see whether his actions and desires are right or wrong because of his upbringing. In this sense, JoJo is insane. Thus, he cannot be counted as a responsible agent. (Wolf 368)

In relation to euthanasia, the idea of responsibility and sanity is crucial to the decision making process. Imagine if Ann, with the same diagnosis as before, was completely firm in what her values are and the treatment she desires: euthanasia. This seems like an autonomous decision. However, Ann is severely depressed as a result of her diagnosis. Because of this, the physician may refer Ann to a psychiatrist to determine if her state of mind is sufficient to make decisions about her health. (This is often a requirement for cases in Oregon, for example, where euthanasia is legal.) Thus, because Ann is depressed, she is much like JoJo with his skewed view of reality. She is unable to understand the full weight of her decisions and she is making them from a distorted view of her reality, and so, cannot be held fully responsible for the decisions she makes.

This also means that despite the appearance of full autonomy from within the interpretive model, Ann actually has a very limited autonomy.

Unfortunately, this is often seen in the interpretive view. Whether the patient lacks a proper understanding of their values or has a complete understanding, the interpretive model lacks the consideration of the patient's sanity in its definition of patient autonomy and patient care. In order to have an effective relationship between physician and patient, the model of care must provide that the physician can not only assist the patient in understanding the relationship between their values and treatment options but also that the patient is making their decisions from a sane mindset. This remains unaccomplished in the interpretive model. Thus, a third model of the patient care is needed that can capture the needed aspects of autonomy and the physician-patient relationship while ensuring that patients well-being is priority.

IV. Deliberative Model

The final model of patient care that is presented by Emanuel and Emanuel is that of the deliberative physician. This model builds on the previous two while simultaneously improving both autonomy and the relationship between physician and patient. Essentially, within the deliberative model, the aim of the physician-patient relationship is to choose "the best health-related values that can be realized in the clinical situation." (Emanuel 2222) To make this possible, though, both the physician's role and the concept of the patient's autonomy must change. Thus, while the physician's role includes many of the same qualities as the previous two models, there are also some key differences that distinguish the deliberative model of patient care from others. These differences can be seen in both the role the physician assumes and the conception of the patient's autonomy.

In this model of patient care, the physician assumes a role that is similar to a friend or teacher who assists the patient in making decisions as well as implementing treatment. (Emanuel 2222) As such, the physician must take on the responsibility of articulating to the patient which health-related values are most admirable and attainable from within a set of accepted and understood values. In this way, the physician engages in deliberation with the patient to determine which values they could, and should, hold in regards to their health. This process of deliberation can be thought of as a “process in which [the physician and patient] attempt jointly to establish a set of practical reasons that will serve as a basis for shared intention, action, and further deliberation.” (Westlund 68) However, it is important to note that the discussion between physician and patient includes only “values that affect or are affected by the patient’s disease and treatments.” (Emanuel 2222) To this end, the physician must help the patient understand which values are most beneficial and relatable to their health, while simultaneously refraining from coercing them into a decision; at the most, there is a level of persuasion on the part of the physician to convince the patient of the importance of certain values or treatments. However, the patient remains in control of the final decision and must ultimately define their values for themselves before choosing a treatment; their focus should be on “moral self-development.” (Emanuel 2222)

However, unlike the interpretive model, this model of patient care ensures that the patient is sane and capable of taking responsibility for their decisions. In her article *Autonomy in Relation*, Andrea Westlund states: “...many distinctly human capacities, including the capacity for responsible action, could not come to be but for the long, slow process of maturation during which human young remain dependent on their elders.” (59) Aside from the fact this statement is obviously not referring to patient care or the physician-patient relationship, there are some

important parallels to patient autonomy. She continues by saying that “autonomy itself must be understood in a relational capacity.” (Westlund 59) This is what is accomplished in the deliberative model: patient autonomy is viewed in more relational terms than previous models. But how exactly is a social aspect supposed to be incorporated into autonomy? We can look to Westlund for the answer.

In her article, Westlund approaches the “concept of answerability” to provide a solution to the problem of an understanding of autonomy that is both self-governing and social. (65) In its most basic form, answerability means that a patient is capable of providing rational and sane reasons for their decisions. This builds on Susan Wolf’s idea of sanity and responsibility that is considered in the informative model. Not only do patients have to be sane when making decisions, meaning they know what they are doing and know whether it is right or wrong, (Wolf 369) but they also have to be able to provide rational reasons for what they are doing. Meaning that, when asked, patients should be ready and able to provide coherent, sensible reasons for the decisions they make regarding their treatment. If they can meet each of these conditions, then it follows that they are answerable for their decisions and actions.

To better understand this idea of answerability, imagine the depressed patient from before. In the informative model, the physician was able to refer the patient to a psychiatrist who determined that they were lacking in their ability to make a sane decision. However, there is more to be said on this issue. There is a great possibility that the depressed person completely understands the decision they are making, but they are not seeing the true reality; at best, their capacities for seeing rational reasons and acting upon them is diminished. Thus, in these cases we usually say that they are not entirely answerable for their actions because the depression is limiting their ability to provide rational reasons for their action that are their own. We may say

something along the lines of “That is not Aunt Jane talking; it is the depression.” This is the concept of answerability. Because they are not able to consistently recognize and act upon rational reason, they are not seen as answerable and are not held entirely responsible for their actions. Therefore, the patient must not only understand all relevant information on their condition and options, but also be capable of making a sane decision in which rational reasons can be provided as support.

However, this answerability is not only to the patients themselves, but to others around them as well. According to Westlund, “autonomy requires a disposition to hold oneself answerable to external, critical perspectives on one’s motives and desires...” (65) Thus, when patients make seemingly autonomous decisions, they must be able to rationally justify these decisions with reason to anyone who asks, especially physicians. In order to ensure this is the case, deliberative physicians engage the patients in deliberation and discussion regarding their values, options, and decisions. This is because “the kind of reflectiveness [autonomy] requires of the agent is itself dialogical in form...” (Westlund 65) Thus, dialogue and discussion ensures that the patient is sane, rational, and responsible for their action which in turn ensures that the patient is fully autonomous in their decision.

Answerability in this type of social situation provides that the patient is making a decision that is truly theirs, not the influence or decisions of an outside agent. With the knowledge and understanding that there are numerous ways in which patients can be influenced (family, friends, society, physicians, etc.), they must be able to take these outside considerations and apply them to their own values before making a decision. If this is done incorrectly, the reasons behind patient decisions could become the decisions of others. Examples of this include: “My mom wants this treatment for me”, “My friend Suzy said this would be best”, “I couldn’t

decide so I just picked one". These are only a few responses that could result from ineffective social deliberation. However, requiring that a patient be held answerable for their decisions will help to ensure that these situations do not occur and the reasons for certain choices are grounded in the patient's own desire and rational beliefs about them.

To see this in action, we can go back to the example of Ann. Recall that Ann was diagnosed with a terminal form of cancer and has been given all of the relevant information pertaining to her treatment options. In this case, if her physician practiced the deliberative model, he would engage Ann in a discussion that begins similarly to the previous model. He would outline her diagnosis and treatment options, then assist her in understanding how certain values align with the different treatments. However, he would then continue by pointing out which treatment option would be most beneficial considering the values and options available. In this way, Ann's physician would try to persuade her to accept the treatment option that is seen as most beneficial for her health. However, it is ultimately in Ann's power to choose the treatment option she prefers and accept one set of values or another in regards to her health-care.

Thus, it appears that the deliberative model is able to most effectively provide patients with an appropriate freedom of autonomy while also ensuring that the physician-patient relationship is intact. It builds on the ideas of the previous models but includes important changes that are imperative to a working view of autonomy. Like so, the autonomy of patients is such that through deliberation with physicians, and provided they are sane, rational, and able to offer reasons, they are in control of their medical decisions and health-care. Physicians, on the other hand, are able to ensure that their patients' well-being is of top priority.

What is important to note though is the fact that this model sets very high standards for the patient as well as the physician. These standards and ideals are often unrealistic in their

perfect attainability. Because of this, the model of patient care that is practically practiced may in fact deviate from this model's often unattainable ideals. However, using the model of Oregon's established laws as a reference, it may be possible to set up a system or procedure that a patient must complete before they are considered to have met the deliberative requirements. In doing this, the goals set forth by the deliberative model are obtained to the best of our ability, considering the limitations on processes such as measuring the sanity of an individual. Thus, with this in mind, the deliberative model provides the best model on which to base such a process.

V. Conclusion

The importance of autonomy in the patient care, and the physician-patient relationship in general, is undeniably important, especially when dealing with end-of-life decisions. In order for this relationship to function properly, a model of patient care must be found that will provide adequate patient care while also providing appropriate autonomy for the patient. Each of the models previously discussed attempts to do this but is distinctly different in their approach to patient autonomy and its role the overall physician-patient dynamic. It is important to understand the benefits and drawbacks of each model to properly assess which is best suited for generally use.

Accordingly, in regards to cases of euthanasia and general end-of-life decisions, the importance of a working physician-patient relationship is crucial. Considering the growing acceptance of the permissibility of euthanasia in places like Oregon, ensuring that patient autonomy provides an appropriate amount of freedom without inhibiting patient well-being or their relationship with physicians is equally as important. An inadequate view of autonomy could not only be hindering the efficiency of this relationship, but it could also put the patient's well-

being in danger. For this reason, the different models of patient care have to be compared side by side to determine which is the most fitting.

Thus, through comparison of their different characteristics, it seems that the deliberative model provides the most adequate and complete view of patient care. While the informative and interpretive models have areas where their benefits are numerous, there are several areas in which they lack important aspects of an appropriate model of patient care such as a clear understanding of values, a standard of responsibility, and conditions of sanity. However, the deliberative model of patient care ensures each of these conditions is met and adds that the patient must be capable of providing rational reasons that of their own making for their decisions before being considered autonomous. Because of this, it appears the physician-patient relationship is best viewed through the deliberative model of patient care. This will guarantee that any decisions a patient makes concerning their medical care, especially in regards to end-of-life situations, can be viewed as autonomous and free under the physician-patient relationship.

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VIII. Appendix: A Chemical Look at Secobarbital

Since the creation of the Oregon Death with Dignity Act in 1997, over 1,300 prescriptions have been written, and over 850 patients have died as a result of these prescription drugs. (Varadarajan et al. 8) More than 80 percent of these deaths were the result of prescriptions for an oral dose of barbiturates, most commonly secobarbital. (Varadarajan et al. 14) This short-acting drug works by “suppressing...activity in the cortex, thalamus, and limbic systems.” (“Secobarbital”, 2013) Like all barbiturates, secobarbital is a central nervous system (CNS) depressant; this effect is nonselective throughout the CNS due to the decrease in the excitability of chemicals within the brain. Not only does this provide sedative and hypnotic effects, but in higher doses it can also protect the brain from intracranial pressure. Because of this, the drug can occasionally be used as a treatment for insomnia, though it becomes less effective is used longer than two weeks. (“Secobarbital”, 2013) More pertinent to this discussion, though, are the applications secobarbital has in regards to euthanasia.

Secobarbital is useful as an aid in physician-assisted suicide because of the speed it is absorbed into the body. In relation to other barbiturates, secobarbital has the highest lipid solubility, allowing it to be absorbed into the body faster than other similar barbiturates such as phenobarbital. (“Secobarbital”, 2013) This difference in lipid solubility is the result of differences in the substituents to the barbituric acid base structure. These differences in structure can be seen in figure one below where (a) displays the original barbituric acid structure with (b) and (c) displaying the different structures substituted to the five position of the ring structure.

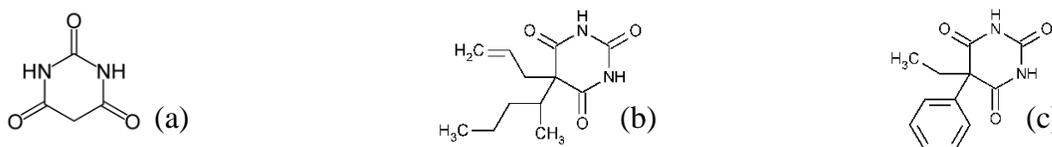


Figure 1. (a) Structure of barbituric acid. (b) Structure of Secobarbital. (c) Structure of phenobarbital

The lipid solubility is determined by the specific substituent that is attached at the five position of the barbituric acid ring. In the case of phenobarbital (c), this substituent is a phenyl group with an ethyl group. (DeRuiter 2004) This combination causes the compound to have low lipophilicity in general because it has a more polar nature than other substituents (although it is still slightly non-polar). This, in turn, means that the compound does not readily or easily cross cell membranes and the brain barrier. However, secobarbital (b), which is substituted with both an allyl and a five-carbon chain, is more lipophilic. (DeRuiter 2004) Contrary to phenobarbital, the substituents of secobarbital are more non-polar which allows them to readily cross cell membranes and the brain barrier easier.

Thus, because of its lipophilic substituents, secobarbital has an onset of only 10 to 15 minutes (DeRuiter 2004) because it absorbs into the lipophilic cells more rapidly. This is compared to the onset of phenobarbital, which is 30 to 60 minutes (DeRuiter 2004) because of its inability to easily cross membranes. Secobarbital, then, is the more useful of the two in terms of speed of absorption. In fact, literature states that approximately 90 percent of secobarbital is absorbed from the gastrointestinal tract within two hours of consumption. This time can be increased if the drug is taken on an empty stomach because of the time required for gastric emptying is decreased and the drug moves through the body faster. Regardless, the peak plasma concentrations within the blood are reached in as little as two hours, with the effects of the drug being felt only ten minutes after consumption. (“Secobarbital”, 2013) A blood plasma concentration as little as five mcg/ml can result in sedation, but concentrations greater than ten mcg/ml can result in coma and concentrations greater than 30 mcg/ml are lethal. In doses of this size, secobarbital induces death by decreasing cardiac output and causing respiratory arrest in the patient due to the severe depression of the CNS. (Varadarajan et al. 15) Thus, secobarbital is

capable of producing sedative effects, even death, quickly and painlessly while requiring relatively small doses.

These affects can be seen in real cases of patient death. One such case is described in the article “Suicide by injection of veterinarian barbiturate euthanasia agent: a report of a case and toxicological analysis”. Essentially, a 51 year-old man was injected with ten ml of pentobarbital, a barbiturate remarkably close to secobarbital; this injection resulted in the death of said individual. (Romain et al. 104) Upon analysis of “blood, urine and gastric contents” using two different analytical techniques, gas chromatography-mass spectrometry and high-performance liquid-chromatography, it was found that all samples showed presence of pentobarbital in high concentrations (21.7 mcg/ml). (Romain et al. 104-105) Unlike typical cases, this study investigated the use of veterinary grade barbiturates which are more concentrated than typical prescriptions. However, the basic principles stand: the barbiturates suppress the CNS and induce cardiac and respiratory distress while the patient is sedated.

There are, however, risks associated with barbiturates and secobarbital in particular. Several side effects are related to this drug, especially when it is used on a regular basis as a sleep aid. For example, blurred vision, dizziness, and dependency are common ones. However, there are others that are rare but more serious. Because of the amount of secobarbital that is metabolized in the liver, the possibility of it interfering with hepatic mechanisms is large. (“Secobarbital”, 2013) It also increases the metabolism of vitamins with the body so that the activity of Vitamin D and its analogs is decreased. (“Secobarbital”, 2013)

However, despite a long list of risks and adverse effects associated with secobarbital, it remains a prominent prescription drug in physician-assisted suicide. This is essentially because of its high, fast absorbance rate within the body and the relatively low dosage that is required for

effectiveness. Through depression of the central nervous system, secobarbital is able to sedate a patient in to a comatose state before death occurs. Thus, its prevalence in the world of physician-assisted suicide is the result of the chemical effects secobarbital has on the body, seemingly resulting in the decrease in the amount of suffering experienced by the patient.