# Understanding the Relationship Between Autonomy and Informed Consent: A Response to Taylor

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Medical ethicists conventionally assume that the requirement to employ informed consent procedures is grounded in autonomy.[1] Though there is philosophical debate about autonomy, most philosophers agree that the core notion is the idea of "steering the direction of one's life, determining how to behave, and deciding what projects to engage in."[2] If we focus on steering one's life as the essence of autonomy, it seems natural to think that autonomy is best protected and facilitated through the employment of informed consent procedures. When a patient consents to a procedure, he endorses the proposed course of action as in line with his intentions and affirms that it is his own decision. However, we require not just consent to medical procedures, but informed consent. Informed consent places emphasis on providing information to a patient, and making sure that it is adequately understood. The provision of relevant information is particularly important to autonomy, since this information may enable her to better steer her life. Thus, informed consent guidelines provide an appropriate means of protecting and facilitating autonomy in patients.

In his paper "Autonomy and Informed Consent: A Much Misunderstood Relationship," James Taylor questions the conventional view that informed consent finds its theoretical grounding in autonomy. Taylor claims that any attempt to ground the requirement to inform agents on

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[1] See Ruth Faden and Tom Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986); see also Joel Feinberg, *Harm to Self* (New York: Oxford University Press, 1986); Paul Appelbaum, Charles Lidz and Alan Meisel, *Informed Consent: Legal Theory and Clinical Practice* (New York: Oxford University Press, 1987); Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988); and Tom Beauchamp and James Childress, *Principles of Biomedical Ethics, 6th ed.* (New York: Oxford University Press, 2001).

[2] James Taylor, "Autonomy and Informed Consent: A Much Misunderstood Relationship," *The Journal of Value Inquiry*, Vol. 38, No. 3 (2004), p. 384; see also James Taylor, ed., *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy* (New York: Cambridge University Press, 2005); and John Christman, ed., *The Inner Citadel: Essays on Individual Autonomy* (New York: Oxford University Press, 1989).

autonomy ultimately turns out to be unrealistic and self-defeating. According to Taylor, attempts to construct a coherent notion of autonomy that could ground a physician's duty to procure informed consent, produce a notion of autonomy whose value is derivative from the value of the subjective wellbeing of patients; thus, it is ultimately wellbeing which forms the ethical foundation for informed consent. If this is the case, he argues, we must be mistaken about the real theoretical grounds for informed consent procedures. Wellbeing, not autonomy, Taylor concludes, is a more plausible theoretical basis for informed consent. It might be mentioned that in his later work, Taylor advances the weaker claim that the value of autonomy must be derivative from something, and that a plausible contender for this is wellbeing.[3] However, due to reasons of space, I will not pursue the full range of issues opened up by his later work. I will focus here on Taylor's claims that autonomy is not a plausible theoretical basis for informed consent, and that wellbeing provides a plausible theoretical basis.

Taylor's claim is bold, and its significance should not be underestimated. A survey of foundational work in medical ethics shows an overwhelming consensus around the idea that autonomy is the basis of informed consent. If Taylor's argument is successful in displacing autonomy as the accepted justification for informed consent, one of the most basic tenets of medical ethics is undermined. Yet, it is possible to show that wellbeing does not function as an appropriate basis for informed consent, and give some insight into how informed consent protects and promotes autonomy. There are two distinct lines of argument in Taylor's paper and, through showing that they do not stand up to scrutiny, I will defend the conventional view that autonomy is a plausible theoretical basis for informed consent.

**1. The Usurped Control Argument**

Though Taylor acknowledges that informing patients may initially have intuitive appeal as an autonomy-enhancing measure, he argues that, upon closer inspection, it is implausible to posit that providing information to an agent has an effect on his autonomy. To show this, Taylor argues that in order for an agent to undermine the autonomy of another agent by providing information to him or by withholding information from him, he must intend to exert control over him. Where the agent unintentionally influences the second agent, Taylor postulates, he does not undermine the second agent's autonomy. From this Taylor concludes that where an agent's autonomy is not being purposefully undermined by another, he is "fully autonomous with respect to his decisions."[4]

[3] See James Taylor, *Practical Autonomy and Bioethics* (New York: Routledge, 2009), pp. 141–156.
[4] Taylor, "Autonomy and Informed Consent," op. cit., p. 386.

Taylor illustrates his argument with an example, drawn from Shakespeare's Othello. The character Iago purposely controls the information that Othello receives in order to exercise control over Othello's actions. In doing so, he usurps control over the direction of Othello's life and Othello's autonomy is therefore undermined. Taylor next imagines an alternative version of Othello, which he deems Pseudo-Othello. In this version, Iago presents exactly the same information to Othello, but this time, instead of trying to manipulate Othello, he is a rather guileless individual who is just presenting the information as he sees it. In both cases, the information received, and the decision that Othello makes, is exactly the same. Taylor contends that while the original Othello clearly suffers from a diminution of autonomy, as his decisions are being manipulated or controlled by Iago, the Othello of Pseudo-Othello simply lacks information and thus does not face the same barriers to making an autonomous decision. Taylor concludes that Pseudo-Othello does not suffer from any diminution in autonomy, and that autonomy is only undermined when another agent attempts to usurp control over the agent's actions.

Taylor's argument here can be reconstructed as follows:

(1) For an agent to undermine the autonomy of another agent through the provision of information to him, or the withholding of information from him, the first agent must intend to assert control over the second agent.[5]
(2) One may negligently fail to provide information to an agent without intending to assert control over him.
(3) Therefore, one may negligently fail to provide information to an agent without undermining his autonomy.

Taylor then applies his conclusions to the case of the healthcare professional, with the following results:

(4) A healthcare professional who negligently omits to provide relevant information to a patient does not intend to assert control over the patient (and thus does not undermine his autonomy).
(5) Informed consent procedures require a healthcare professional to provide relevant information to the patient.
(6) Therefore, the demand from informed consent on the healthcare professional to provide relevant information cannot come from autonomy.

[5] See Taylor, *Practical Autonomy and Bioethics*, op. cit., pp. 137–138.

Suppose we were to agree, for the sake of argument, with Taylor's contention that failing to provide relevant information to an agent does not undermine autonomy. It does not follow from this premise that an obligation to provide information cannot come from autonomy. In order to see why, we must distinguish between undermining an agent's autonomy, and enhancing it. This can be illustrated by an example. One can imagine steering one's life to be like steering a ship. If someone usurps control over your actions, it is as if it is he, and not you, who is at the helm, steering the ship. Your autonomy is clearly undermined in this situation.

But let us next imagine that you are at the helm of the ship, navigating perilous waters. It is clear that if someone can provide you with a map, he will better allow you to steer the ship. Perhaps he is not undermining your autonomy by not giving you the map, but in providing you with the map, he is surely enhancing your ability to steer the ship.[6] In the same way, though withholding information may not undermine autonomy, the provision of information will surely better allow you to steer your life and will thus enhance your autonomy.

Corresponding to this distinction we can distinguish between two different obligations that can come from autonomy: a positive obligation to enhance the autonomy of the agent, and a negative obligation to avoid undermining the autonomy of the agent. It is clear that the attempt to ground informed consent on the negative obligation is vulnerable to Taylor's objection; failing to provide the agent with information does not undermine the agent's autonomy. But we can still argue that the obligation to provide an agent with information is based on a positive obligation to enhance the autonomy of the agent. Taylor would presumably reply that it is implausible to attribute this strong, positive obligation to Iago. We can accept this for the sake of argument, but it is still plausible to claim that healthcare professionals have this strong, autonomy-enhancing obligation.

How can we claim that Iago has no obligation to correctly inform Othello, where informed consent demands that healthcare professionals correctly inform their patients? We can present a coherent account of this difference by distinguishing between professional obligations and general moral obligations. We may wish to attribute special obligations to professionals that we would not wish to attribute to people generally, due to the special circumstances of the professional or the professional-client relationship. The relationship between doctors and patients is often characterised as a fiduciary relationship.[7] Marc Rodwin characterises a fiduciary relationship thus:

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[6] See Joseph Raz, *The Morality of Freedom* (New York: Oxford University Press, 1986), pp. 372–374; see also Thomas May, "The Concept of Autonomy," *American Philosophical Quarterly*, Vol. 31, No. 2 (1994).

[7] See Steven Joffe and Robert Truog, "Consent to Medical Care: The Importance of Fiduciary Consent,"

> The law defines a fiduciary as a person entrusted with power or property to be used for the benefit of another and legally held to the highest standard of conduct. Fiduciaries advise and represent others and manage their affairs. Usually they have specialized knowledge or expertise. Their work requires judgment and discretion. Often the party that the fiduciary serves cannot effectively monitor the fiduciary's performance. The fiduciary relationship is based on dependence, reliance, and trust.[8]

This well characterises the relationship between physicians and patients. Physicians have access to and knowledge of information that patients may find difficult to understand. In order to adequately steer one's life in medical situations, the patient is dependent on the physician for information and advice. Because of this special fiduciary relationship, physicians have special obligations to their patients. Once the special relationship between doctor and patient is understood, we can see why Taylor's argument does not hold in this context, even if we were to grant that it is generally plausible. While if his argument succeeds, we may not wish to attribute a positive, autonomy-promoting obligation to Iago, the special fiduciary relationship between doctor and patient grounds a positive obligation for doctors to enhance autonomy by providing information. Though Taylor might reply that this fiduciary relationship could also ground a special obligation to enhance the wellbeing of the agent, and it is upon this obligation that informed consent is based, this line of argument serves to show that Taylor's argument does not rule out the possibility that informed consent is based on autonomy.

Taylor, however, resists the premise that providing relevant information enhances autonomy. He argues that it is implausible to conceive of autonomy in such a way that can be enhanced through providing relevant information.[9] His concern is that if we require an agent to understand the implications of her actions in order to qualify as autonomous, autonomy becomes a 'success concept.' Taylor illustrates the notion of a success concept by using the success concept of recognition – an agent can be said to successfully recognise an object only if the object she recognises is the object in question.[10] Similarly, according to a success concept of autonomy, we would only call a decision autonomous if it actually leads the agent to achieve his goals. This is indeed an implausible notion of autonomy; we would not, as Ruth Faden and Tom Beauchamp

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in Franklin Miller and Alan Wertheimer, eds., *The Ethics of Consent: Theory and Practice* (Oxford: Oxford University Press, 2010), p. 352.

[8] Marc Rodwin, "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System," *American Journal of Law and Medicine*, Vol. 21, No. 2–3 (1995), pp. 243–244.

[9] See Jukka Varelius, "On Taylor on Autonomy and Informed Consent," *The Journal of Value Inquiry*, Vol. 40, No. 4 (2006), p .455; see also Taylor, *Practical Autonomy and Bioethics*, op. cit., pp. 134–135.

[10] See Taylor, "Autonomy and Informed Consent," op. cit., p. 387.

state, "want to say no action is autonomous if the actor is surprised by the outcome."[11] Autonomy cannot be plausibly construed as a success concept.

If the idea of autonomy as a success concept is indeed absurd, then, according to Taylor, autonomy cannot be enhanced through providing relevant information. Even if we were to postulate that healthcare professionals have a positive obligation to enhance autonomy, complying with this obligation will not involve providing an agent with relevant information. The obligation to inform, then, cannot come from autonomy.

However, although it is highly implausible to think of autonomy as a success concept, the idea that autonomy can be enhanced through the provision of relevant information does not necessarily turn autonomy into a success concept. To see how we might include a requirement that the agent possess relevant information in order to be autonomous without making autonomy a success concept, we can turn to Faden and Beauchamp's extensive discussion of a condition of understanding as a requirement of autonomy. Faden and Beauchamp see understanding as a necessary condition of autonomy, requiring both that an agent have relevant information, and that the information be adequately understood. Faden and Beauchamp suggest that for a decision to be adequately autonomous, only the foreseeable consequences of an action need to be recognised and understood, where 'foreseeable' means that a reasonable person could foresee them.[12] This leaves room for an agent to be surprised by unexpected outcomes of autonomous actions, as well as creating a standard that is realistically achievable by normal agents in that it does not require agents to be omniscient. Often the best evidence available will still be fallible, so we can never be certain about the consequences of an action. In addition, what will result in any given circumstance will typically depend on a lot more than the agent's actions. This approach allows us to claim that providing information enhances autonomy without turning autonomy into a success concept. Informed consent could thus be coherently based upon the theoretical foundation of autonomy.

Taylor also neglects the idea that an agent can have information about and an understanding of several possible outcomes of an action without knowing which will result. In these cases, although the patient does not know what the outcome of the action will be, we would still want to say that she has an understanding of the implications of that action. For example, we may have a patient who wishes to undergo surgery to relieve chronic pain. In order to have the operation, she

[11] Faden and Beauchamp, op. cit., p. 253.
[12] See ibid., p. 252.

understands that a general anaesthetic will be used, which in her case has a 10 percent chance of serious complications. There is also a 30 percent chance that the operation will be unsuccessful. She wishes, however, to take this risk in order to achieve her goal of reduced pain. If the operation is unsuccessful, it still seems as though she had an understanding of the possible implications of her actions, although they did not lead her to achieve her goals. This just provides a sketch of some routes that could be taken to avoid turning autonomy into a success concept, but it nonetheless shows that providing information to an agent may enhance her autonomy, and that autonomy could thus provide a good ethical basis for informed consent.

We can see then that it is plausible to attribute a positive autonomy-enhancing obligation to healthcare professionals, and to claim that this obligation will involve providing an agent with information in order to enhance her ability to steer her life. Informed consent is thus an appropriate autonomy-enhancing measure.

**2. The Wellbeing Argument**

We can also extract another line of argument from Taylor's paper, which I will refer to as the wellbeing argument. In the wellbeing argument, Taylor contends that if autonomy is seen to involve providing an agent with information in order to enable her to steer her life towards her goals, what we are ultimately aiming for is the satisfaction of an agent's desires or values. Taylor posits that the satisfaction of desires or values constitutes subjective wellbeing. Therefore, if we take the view that enhancing autonomy involves the provision of information, we are ultimately aiming to promote the agent's subjective wellbeing, thus wellbeing becomes the ultimate basis for informed consent.

We can reconstruct Taylor's argument as follows:

(1) Informed consent procedures are grounded in autonomy only if the purpose of enhancing autonomy cannot be reduced to the pursuit of another value.
(2) Enhancing autonomy (by providing relevant information) is simply a matter of helping others to satisfy their desires or act in accord with their values.
(3) Desire satisfaction or acting in accord with values is constitutive of subjective wellbeing.
(4) Informed consent involves providing relevant information to the agent.
(5) Therefore, informed consent procedures are not grounded in autonomy (but in subjective wellbeing).

Two problems with this argument are immediately apparent. One concerns Taylor's notion that subjective wellbeing amounts to desire satisfaction or acting in accord with one's values. It seems clear that it is very possible for people to desire something that even they think is bad for them; the desire to smoke would be a prime example of such a desire. The second concerns the link between informing someone and helping them to pursue their subjective wellbeing. It has been empirically demonstrated that in some cases informing patients will impede the satisfaction of their desires.[13] Some patients do not want to make decisions about their treatment, or even to know their prognosis. The idea that informing a patient will generally contribute to her subjective wellbeing, when informing itself will sometimes go against her wishes, and failing to inform will in many cases maximise subjective wellbeing, seems quite tenuous. However, even if we put these problems aside, Taylor's argument is still unsuccessful.

The plausibility of Taylor's argument hinges on the ambiguous use of the word 'values'. Depending on how this word is interpreted, premise (2) or premise (3) becomes implausible. This presents a dilemma for Taylor's argument. As long as we interpret the term consistently, the value of autonomy cannot plausibly be seen as derivative from subjective wellbeing. There are two ways we could interpret Taylor's use of the word 'values.' Values could be seen as essentially the same as, or as always tracking, desires, or they could be seen as involving something more. If we take the first interpretation, premise (2) becomes implausible. Autonomy needs to involve more than just desire satisfaction. If we focus solely on satisfying the agent's desires, we are neglecting other essential aspects of their character. Normative beliefs provide a good example of this.

Taylor may claim that where a person has a normative belief, he will always have a corresponding desire to act according to that belief, so we are always able to account for autonomy purely in terms of desires. However, it is not difficult to imagine cases where normative beliefs and desires might come apart. We can imagine a case where someone thinks something is wrong, though he really and wholeheartedly desires to do it. Let us take the case of an ethical vegetarian, who thinks that it is wrong to eat meat. A delicious meal is put in front of him, which he wholeheartedly desires to eat. We may feel as though we should tell him there is meat in the meal so he will be able to act according to his normative convictions, not because this will change his desire to eat the meal. Upon hearing that there is meat in the meal, the ethical vegetarian might feel as if it is

[13] See Carl Schneider, The Practice of Autonomy (New York: Oxford University Press, 1998); see also William Strull, Bernard Lo and Gerald Charles, "Do Patients Want to Participate in Medical Decision Making?," The Journal of the American Medical Association, Vol. 252, No. 21 (1984).

simply wrong to eat the meal, though he still wholeheartedly desires to eat it. If we ignore this aspect of the ethical vegetarian, and provide him with information based only upon what will best allow him to pursue his desires, it seems as though we are ignoring a crucial aspect of his selfhood. If we understand values to be essentially the same as, or as always tracking desires, and as long as it is plausible to imagine a case in which normative beliefs and desires come apart, (2) becomes implausible.

Alternatively, by 'values' Taylor could mean something different from desires; something that can capture these other aspects of our character. However, if this is what Taylor means it is implausible to maintain that this will secure our subjective wellbeing; that is, premise (3) is false. Let us accept, for the sake of argument, that desire satisfaction is identical to subjective wellbeing. What is far less plausible is that acting in accordance with one's values will always secure wellbeing. If we return to the example of normative beliefs used earlier, it becomes apparent that acting according to our moral scruples seems very unlikely to secure our wellbeing, indeed, acting morally will often involve self-sacrifice. Hence, if values are taken to be something more than desires, it becomes highly implausible to claim that (3) is true.

Thus, no matter which view we take of what it is to act according to our values, the value of autonomy cannot be seen as derivative from wellbeing. The interpretation that captures what it is to be autonomous leaves us with an implausible notion of wellbeing, and if we try to interpret the account to give us a plausible notion of wellbeing, we are left with an implausible notion of autonomy. Taylor is unable to give a single definition that adequately captures what it is to be autonomous, and what it is to act in accordance with our wellbeing; therefore he cannot maintain that the value of autonomy is derivative from subjective wellbeing.

It is also worth pointing out an additional problem with Taylor's notion of wellbeing, which highlights what an unusual notion of wellbeing it is. The strangeness of his account of wellbeing leaves it unable to support the subsequent claim he makes based upon it. If the value of autonomy is based upon the value of subjective wellbeing, Taylor argues, then wellbeing becomes the pre-eminent value in medical ethics. If this is the case, Taylor suggests that the case for medical paternalism gains strength.[14] However, Taylor's notion of wellbeing is not able to support a notion of paternalism as it is conventionally understood. For example, Taylor's notion of subjective wellbeing would be unable to support paternalistic action that involved overriding an agent's

[14] See Taylor, "Autonomy and Informed Consent," op. cit, p. 391.

desires or values for his own good (that is, what would most conventionally constitute the most clear-cut case of paternalism.) An example of this kind of paternalism would be where a doctor approves a blood transfusion for a Jehovah's Witness against their wishes. As the agent's own good is identical with her desires and values under Taylor's view, this type of paternalism would be paradoxical and self-defeating. A paternalism based on Taylor's notion of wellbeing would be quite atypical, and wellbeing as Taylor understands it is unable to provide a theoretical foundation for paternalism in a conventional sense.

**3. Conclusion**

Upon reviewing Taylor's arguments, it becomes apparent that he fails to discredit autonomy as a theoretical grounding for informed consent. Though I have for the sake of argument accepted Taylor's premise that an agent may need to intend to control another agent to in order to undermine his autonomy, it is still the case that providing information to an agent promotes his autonomy, and it is upon this positive autonomy-promoting obligation that informed consent finds its theoretical basis. Though we may not wish to ascribe a positive autonomy-promoting obligation to agents generally, the special professional role of healthcare professionals makes it plausible to posit this positive obligation rather than simply the negative obligation not to undermine autonomy that we might wish to ascribe to agents in general. Providing information to an agent to increase her autonomy need not turn autonomy into an implausible success concept, as long as we acknowledge limits on the amount of information that one is obligated to convey. Finally, the contention that an agent's autonomy can be promoted by providing information does not produce a notion of autonomy whose value is ultimately derivative from subjective wellbeing; the two values remain distinct. Once we have addressed Taylor's objections to the conventional view, it is easy to see that autonomy, conceived as steering one's life, will plausibly be promoted through the provision of information, and that it is plausible to ascribe an obligation to provide this information in medical ethics to healthcare professionals. For all that Taylor has told us, autonomy remains a plausible theoretical basis for informed consent requirements.[15]

[15] I would like to thank James Taylor, Nic Southwood, Jeremy Shearmur, and the anonymous referees from *The Journal of Value Inquiry* for their helpful comments on an earlier draft of this paper.