

# Value of choice

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## ABSTRACT

Accounts of the value of patient choice in contemporary medical ethics typically focus on the act of choosing. Being the one to choose, it is argued, can be valuable either because it enables one to bring about desired outcomes, or because it is a way of enacting one's autonomy. This paper argues that all such accounts miss something important. In some circumstances, it is having the opportunity to choose, not the act of choosing, that is valuable. That is because in many situations whether one has, or is denied, that opportunity conveys how one is seen. In particular, it conveys whether or not one is seen as an equal and competent member of society. Adequately recognising this fact has implications for what healthcare professionals should do, ones that require a move away from the current focus on autonomy. The paper draws out these implications by focusing on patients who may struggle to be recognised as competent and equal members of society, and whose autonomy may thus itself sometimes be in question.

## INTRODUCTION

While patient choice plays a central role in contemporary healthcare, differences about its role and extent remain. These differences stem in part from different ways of characterising the value of choice (or, what is slightly different, the opportunity to choose). According to one prominent account choice is valuable because it is by choosing that individuals make their life their own.<sup>1 2</sup> As such, choosing is necessary for autonomy (in one sense of that term). Healthcare professionals' obligation to respect autonomy thus means they should give their patients a choice about what is to be done and respect that choice once it has been made (assuming the patient has the capacity to act autonomously). A different, equally prominent, account takes it that choice is valuable for instrumental reasons.<sup>3 4</sup> If suitably informed patients are better judges of what is in their interests than anyone else, then their choosing makes it more likely they will get what is in fact best for them. In that situation, healthcare professionals' obligation of beneficence means they should give their patients relevant information in an understandable form and defer to the patient's subsequent choice.<sup>5</sup> On this account what matters is not that the patient is autonomous, but that (once informed) she is a better judge than her doctor of what will benefit her.

Each of these accounts captures something important, but they do not (either alone or in combination) capture everything that matters ethically. To see why, we need to take the patient's perspective. A patient will only value having a choice for instrumental reasons where they think they are the best judge of what will promote their ends. If they think (as they may well) that their doctor is both better

placed to make that judgement and has their interests at heart, they should on instrumental grounds prefer to leave the choice to her. Similarly, a patient who values choosing because it enables them to shape the way their life goes may nevertheless not value choosing for this reason in all cases. They may not, for example, value having a choice between two very similar antibiotics on these grounds. However, even in these cases, patients may value having the opportunity to choose (an opportunity they will not take up). To explain why, a different account of the value of choice is needed—what Scanlon calls the 'symbolic' account.<sup>6</sup> It is this that will be the focus of this paper. I will start, in the next section, by introducing that account and showing how it differs from those outlined above. Then, in the following section, I will explain why this matters when considering the obligations of healthcare professionals. Before beginning I want to stress that the account presented here is intended to supplement existing accounts, not replace them. Because choice is valuable for more than one reason no single account can capture everything that matters.

## THE 'SYMBOLIC' VALUE OF CHOICE

According to Scanlon, one reason choice is valuable is that choosing, and who gets to choose, has a communicative role.<sup>6</sup> To be denied a choice that other people would be allowed or expected to make reveals that one is seen as either less competent or less important than them. That is, it marks one out as inferior—at least in the eyes of those determining who gets to choose. Scanlon argues that being treated in this way can be both demeaning and stigmatising. It reflects a judgement that one lacks the standing normally granted competent members of one's society. Not all choices are like this, and sometimes being denied a choice carries no message about one's standing or competence. But where it would carry such a message, individuals will value having the opportunity to choose.

Contemporary healthcare is one area where choice frequently has this kind of symbolic value. Whether or not a patient is given a choice about treatment, for example, communicates something about how the healthcare professionals concerned see them. In particular, it communicates whether or not they are recognised as competent members of society with the same standing as others (including the healthcare professionals themselves). In this situation, it would be wrong for healthcare professionals to deny patients a choice. To do so would be to fail to treat them with the respect they are due. It would also be to treat them in a way that is potentially demeaning—something that healthcare professionals, just like everyone else, should not do. While this concerns treating patients with respect, it



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is not best captured using the language of respect for autonomy (at least if ‘autonomy’ is characterised as it was earlier). It is not the patient’s autonomy that needs to be respected, but their equal standing as competent members of society.

Where choice is valuable for symbolic reasons what matters is having the opportunity to choose, not being the one to choose. Should a patient prefer not to take up that opportunity—for example, if once things have been explained to him, he prefers his doctor to choose for him—making that choice would neither constitute a failure of respect nor be demeaning. As such, it would not be wrong on these grounds. This marks a significant difference between this account and at least some of those that conceptualise the value of choice in terms of either enacting autonomy or promoting well-being. For example, if the value of choice is conceptualised in terms of enacting autonomy, as the way in which patients make their life their own, having the opportunity to choose is not enough. Being autonomous requires both that other people are not choosing for one, and that one is in fact choosing for oneself.<sup>4</sup> That suggests that respecting autonomy (in this sense of ‘autonomy’) means healthcare professionals should not choose for their competent patients, even where those patients would prefer that they did. They should instead insist that the patients choose for themselves. Similarly, if it is argued that patients should have a choice on the basis that they, the patients, are in general the best judges of their own interests,<sup>7</sup> having the opportunity to choose is not enough. To obtain those benefits, the patient must in fact choose.

The account developed here is not alone in prioritising the opportunity to choose. Arguments for informed consent policies that focus either on the ways in which they protect patients from being coerced into having treatment<sup>8,9</sup> or on the ways they can protect patients’ ability to choose and follow their own conception of the good life<sup>10</sup> would seem to do the same. However, the argument developed here is not best thought of as concerning informed consent. Its focus is on the wrong of denying patients a choice, and informed consent policies are not always the best means to avoid that wrong. That is partly because, as advocates of shared decision making have pointed out, some choices that matter to patients (such as the choice of where care will be delivered) fall outside the scope of such policies.<sup>11,12</sup> But it is also because to avoid the wrong of demeaning patients by denying them a choice healthcare professionals must both refrain from giving patients treatments they have not chosen, and give them those treatments they have chosen. Patients do not have a genuine opportunity to choose for themselves if their choices can be overridden by others. While informed consent regulations can ensure the former (by ensuring that treatment is not imposed on patients without their consent), they cannot ensure the latter.

However, in at least some contexts, this requirement might seem problematic. It suggests that healthcare professionals should do what their patients choose even where, in the opinion of the healthcare professional, this would not benefit, and may even harm, the patient. As such, it fails to capture the importance of healthcare professionals exercising their own judgement, instead reducing them to information providers and obedient servants. But, as Jackson has argued, this is not the right way to conceptualise the healthcare professional/ patient relationship.<sup>13</sup> Any account that argues that healthcare professionals should give their patients a choice over what happens must address this issue. This is relatively straightforward where our concern is with the symbolic value of choice. That is because, as we saw earlier, denying someone a choice does not always communicate a negative judgement about either their competence or their standing,

and is thus not always even potentially demeaning. For example, failing to give a patient the opportunity to choose whether to have a treatment that is ineffective given their condition would not communicate this kind of judgement. Not providing such an option reveals neither a negative judgement about the patient’s competence nor a failure to recognise them as an equal member of society. If the patient nevertheless asks for the ineffective option, there would thus be no requirement on the account developed here to give it to them (unless other people in their position would be given it in these circumstances). Such a refusal would mean the patient did not have a genuine opportunity to choose that option. But as we have seen there is no requirement to give him such an opportunity. As a result, this account places significant limits on when healthcare professionals are required to do what a patient chooses.

Finally, it is worth noting that while the account developed here has some affinities with shared decision making, there are also important differences between the two approaches. In particular, where our concern is with the symbolic value of choice, there is nothing wrong with a patient opting out of the decision-making process entirely should they choose to do so. All that matters is that they have had a genuine opportunity to choose. In that case there would, on this account, be nothing wrong if the healthcare professionals involved make the choice on their own. This would not, however, be a case of truly shared decision making.

#### IMPLICATIONS FOR MEDICAL ETHICS

As we have just seen, conceptualising the value of choice in symbolic terms highlights the value to patients of having a genuine opportunity to choose. In this it differs from some other accounts, which focus on the act of choosing. It also differs from those accounts in the way it determines when it would be wrong to deny patients a choice—focusing on the message communicated by such denials, rather than on whether the patient is either autonomous or the best judge of their own interests. It is now time to draw out the implications of these differences for medical ethics.

The message conveyed by being denied a choice, and whether that denial is likely to be experienced as demeaning, is not fixed by features of the patient as an individual. It is instead heavily dependent on context. As such, recognising that choices can have symbolic value requires taking account of that context when determining what healthcare professionals should do. Of particular importance here is the extent to which societal features mean members of some groups find it particularly hard to be recognised as competent and equal members of society. That includes members of groups subject to discrimination (such as members of minorities, migrants and those with some forms of mental illness). It also includes those who are in what we might call transitional groups (such as teenagers struggling to be recognised as competent, or those with declining cognitive abilities struggling to hold onto that recognition). In all such cases, healthcare professionals need to be particularly sensitive to the messages conveyed by denying some people a choice others would automatically be given.

To illustrate some of the issues here it will be useful to focus on patients who fall into the transitional groups. Standard approaches to determining whether such patients should have a choice focus on whether either the individual or their choice is autonomous. But where our concern is with the symbolic value of choice this is largely irrelevant. Instead what matters is whether denying the patient a choice would be demeaning and/or fail to

treat them as a competent and equal member of society. And that does not map neatly onto the autonomous/non-autonomous divide on any account of 'autonomy'. On the one hand, it is clearly possible to treat those who are not autonomous in ways that are demeaning. On the other, as we have already seen, it is not always demeaning to deny a choice to those who are autonomous. Questions about whether a particular patient is, or is not, autonomous are thus beside the point when determining if they should have a choice about what happens to them.

Things might appear different when it comes to questions about whether they are competent. It would not normally be demeaning to treat someone as unable to do something that they are in fact unable to do—though it must be remembered that competence is decision specific and in the cases we are concerned with here both varies over time<sup>14</sup> and is affected by the amount of support available.<sup>15</sup> Given that competence is standardly taken to be a requirement for autonomous choice that might suggest that whether a patient's choice is autonomous matters when our concern is with its symbolic value. However, such a suggestion is problematic for two reasons. The first concerns the choice's independence. Suppose a patient is given a choice about what treatment to have. He discusses it with his adult daughter and says he does not know what to do, she should make the choice for him. She does so, choosing the option to forego any active intervention. If choice is valuable for symbolic reasons there is nothing wrong with this, and nothing wrong in the patient's healthcare provider proceeding on the basis of this choice. However, it is much less clear that this is acceptable if the reason patients should have a choice is that this is a way to enact their autonomy—the patient here is arguably not governing himself and so is not acting autonomously. It might be objected that there is nothing problematic here as long as the choice to delegate to his daughter is autonomous.<sup>16</sup> But, for all that has been said, it might not be—for example, the patient may not have adequately understood the risks and benefits involved (something standardly required for a choice to count as autonomous in this context). How we deal with this kind of case will thus vary depending on how the value of choice is conceptualised, and the relative weights we give to different conceptualisations of that value. For example, recognising choice's symbolic value will tend to act as a counterweight to arguments for supported choice that focus on support as a way to help patients make more autonomous choices—choices that better express their self.<sup>17</sup> That is because, at least in some situations, the provision of such support can itself be demeaning—as when only some people are deemed to require it, while others are allowed to make an unsupported choice. In such cases a single minded focus on how autonomous (in this sense) a patient's choice is would be problematic. There are competing values here that healthcare professionals must negotiate in order to avoid wronging their patients.

The second reason focusing on autonomous choice is problematic is that there is no obvious link between the amount someone understands and whether denying them a choice would be demeaning or would fail to recognise them as an equal member of society. Indeed, restricting choice to those who have what one judges to be the required level of understanding can itself constitute such a failure (particularly where those in marginal or transitional groups are required to demonstrate their understanding while members of other groups are not). However, a choice would standardly only count as autonomous if it is made with substantive understanding.<sup>18 19</sup> The normal way to proceed here would be to give patients relevant information along with the opportunity to choose. But for this to be a genuine opportunity, the choice made must be taken seriously and acted on even

if the patient does not use the information provided. That is, to avoid wronging the patient healthcare professionals must be prepared to respect choices that are not autonomous (in the sense outlined above). That includes choices they consider counter to the patient's interests. To do anything else is to say 'we will give you a choice, but will only act on it if you either make what we think is the right choice or make your choice in what we think is the right way'. Where denying patients an opportunity to choose is wrong for symbolic reasons, acting in this way will also be wrong for those reasons. For example, if patients are generally allowed to forego beneficial treatments or stay at home where doing so poses increased risks to their health, then older patients with declining capacity should also have those opportunities. Anything else communicates that other (younger) people are competent to make that choice, or are important enough to be taken seriously, but the older adult is not. That is a failure to recognise the latter as an equal and competent member of society. Here, too recognising choice's symbolic value adds an additional dimension that can be missed by too narrow a focus on autonomy (in the sense of expressing our self and/ or shaping our life in accordance with our values, aims, and commitments). The latter is surely important but it is not the only thing that is important.

Two things need to be stressed at this point. First, what we are concerned with here is patient choice, not consent. For all that has been said, it may be that only an autonomous act can constitute consent—that is, can make permissible something that was previously impermissible. But consenting is not the same as choosing, and some things patients might choose do not require consent (most obviously where the patient chooses not to have treatment). Second, as described above, a concern for the symbolic value of choice does not require healthcare professionals to do, or offer, things they believe would harm their patients. The 'bad' choices that matter here are those where patients reject something those treating them believe would be beneficial. To avoid wronging the patient it is these choices that must be respected. In most cases that does not require the healthcare professionals concerned to act; it requires them to refrain from acting.

## CONCLUSION

This paper has argued that contemporary accounts of patient choice, with their focus on enacting autonomy and promoting well-being, miss something important. This is that the opportunity to choose, and even more so being denied that opportunity, reveals something about how healthcare professionals see their patients. It communicates that they either see those patients as competent and equal members of society, or that they do not. Where patients are in fact competent the latter is demeaning and hence wrong. Avoiding that wrong requires recognising the communicative role of practices of enabling or denying choice. That in turn requires moving away from a narrow focus on the features of individual patients (such as whether or not they are autonomous) to take account of the context of choice. Doing so is particularly important when dealing with patients in marginal or transitional groups because discriminatory attitudes towards these groups make it more likely they will be wronged in this way. It also requires moving away from a focus on the features of the choice made (such as whether it is independent or autonomous). What matters here is the opportunity to choose, not the choice itself. Giving patients a genuine opportunity to choose means that some of their non-autonomous choice must be respected in just the same way as some of their autonomous choices. That

can be missed if we focus too narrowly on autonomy and beneficence alone.

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