Autonomy in the Intensive Care Unit: The Refusal of Treatment

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The right of competent adults to refuse treatment, whether in a physician's office or an intensive care unit, is now firmly established in American medicine. Nonetheless, discussions of autonomy in a critical care environment are too often like ballet lessons in a fracture ward—demonstrations of impracticality and wishful thinking. This is a pity. Freedom of choice, which is highly valued in this society, is nowhere more important than in matters of life and death—whether and how we live or die. Such questions are the stuff of critical care units.

Despite its inherent complexities, in terms of the care of patients, autonomy is another way of saying self-determination—the choices people make in their own best interest.[6, 7, 10, 11] The equivalent legal doctrine was clearly stated by Justice Cardozo in 1914, "Every human being of adult years and of sound mind has a right to determine what shall be done with his body" (Schloendorff v. Society of The New York Hospital). The problem is simply stated. How are we to act in intensive care environments so that whatever we do for our patients will be seen by them, at that time or in the future, to be in their own best interests?

Although the issue is easy to phrase, its solution is difficult for several reasons. The first reason is the difficulty physicians have in achieving the state of mind that places the patient's freedom of choice above almost any other value in an intensive care unit. The second reason is the subtle change that has taken place in the nature of critical care medicine. Third is the difficulty of knowing what patients believe to be in their own interests, and fourth is that a patient's situation can change very rapidly.

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THE PHYSICIAN'S ATTITUDE TOWARD THE PATIENT'S FREEDOM OF CHOICE

Underlying this discussion is the presumption that the physician understands, right to the center of his or her heart of hearts, that doctors are meant to act to promote the best interests of the patient *as defined by the patient* unless the patient is a minor or legally incompetent, an illegal action is entailed, or the physician cannot in good conscience concur. I am well aware that such a state of mind is not arrived at easily. One of the wonderful things about being a doctor is that one can go about doing good, and even aspiring to be good, with a fair probability of success. However, since the physician works with understandings about disease and medical science that are completely remote from concepts of good (or compassion or caring), what it means to do good is largely derived from general cultural notions and what has been learned by precept and experience. Here there is nothing like the precision of science that exists in other facets of medicine. Further, since doing good in medicine often, paradoxically, involves causing pain, doctors must, out of self-defense, learn to hold fast to the belief that what they think is good for a patient is indeed good for the patient. It is usual and largely necessary that sick people have the same belief because of their inability to think everything through for themselves as they might if they were well. The result of all this is a common presumption on the part of doctors that they really do know what is best for their patients. If physicians act primarily on the presumption that they know what is good for patients or on general rules such as "a doctor's job is to protect life at all costs," conflicts about self-determination in the intensive care unit will arise.

The beliefs—that doctors know what is good for patients and that they should preserve life at all costs—come from earlier times in medicine. Since both notions served medicine well, even though they have now outlived their utility, it is useful to examine them more closely. Changes in the knowledge held by patients, changes in the nature of society, changes in the concept of person (what do I mean when I say "myself"), and increased medical efficacy have outdated the comfortable precept that the doctor knows best.

There was a time when only doctors knew anything about medicine and the body. In those days, physicians' authority about disease and treatment was usually accepted without protest. Modern patients know, or believe they know, a great deal about science, the body, diseases, and treatment options. Whether their knowledge is accurate or not, they are now in the position of having an informed opinion about what should be done for them or their relatives. For this reason, in the decision-making climate of acute care, the opinions of patients must be taken into account. If they are wrongly informed, they must be given correct information; if they lack information, it must be provided in terms understandable to the patient. On no account can patients' opinions be brushed aside or dismissed without chancing enmity or encouraging an adversarial relationship.

In those earlier times, as now, physicians had authority and status and were responsible for the care of persons largely like themselves. In addition,