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Patients, Agents, and Informed Consent

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In a recent edition of *Psychiatric News*, the newspaper of the American Psychiatric Association, the question was raised whether the term "client" should replace "patient" in the vocabulary of health professionals. Proponents of the change felt "patient" connotes passivity and fosters the illusion that one has little or no responsibility for one's actions in the therapeutic setting. Opponents of the change felt that the issue was one of mere semantics, and that in any event, the term "patient" is so deeply entrenched in how physicians relate to those who seek help as to make replacing it impractical.

I fully agree the term "patient" is deeply entrenched in how physicians relate to those who seek help — but I do not think that the issue is merely semantic. In fact, I shall argue that because the term "patient" is so deeply entrenched, replacing it is a moral desideratum. My thesis is that the elimination of "patient" from the medical vocabulary would serve the articulated purpose of informed consent. That purpose is to further decisional authority over one's own medical fate. By placing the issue within the context of informed consent, I hope to show how the term "patient" disguises certain value judgments which might otherwise be apparent to speakers of the language.
In Part II of this article, I develop the “patient”/agent distinction from the vantage point of humanistic ethics. This is the view that the knowledge of man is the basis for establishing norms and values. In Part III, I argue that the “patient”/agent distinction correlates with the Kantian notions of heteronomy/autonomy, and disrespect for autonomy/respect for autonomy. In Part IV, I show that the “patient”/agent distinction also correlates with the standards of disclosure the courts have adopted in deciding informed consent cases. Finally, in Part V, I show how the family of notions associated with “patient,” although deeply entrenched in the medical profession, fails to do justice to those values which informed consent is designed to further, and in Part VI, I give my reasons why the term should be replaced.

First I must explain what I mean by informed consent. Informed consent refers to the duty of a physician, before treating a “patient,” to explain the procedure to the “patient” and to warn him of any material risks or dangers inherent in or collateral to the procedure, so as to enable that “patient” to make an intelligent and informed choice about whether to undergo treatment. This definition is uncontroversial. Nevertheless, as Jay Katz points out, the doctrine of informed consent is both “confusing and confused.” Therefore, I will attempt to clarify my proferred definition.

First, I have defined informed consent as a duty of the physician to provide relevant information. I might equally have defined it as the right of the “patient” to receive this information. In this respect, the duty and the right are correlative, a point to which I shall later return. For now, it should be observed that informed consent is a two-step process: the physician discloses, and the “patient” consents. The disclosure requirement ordinarily obligates physicians to reveal the diagnosis, the nature of the contemplated treatment, the risks inherent in such treatment, the prognosis if the proposed treatment is not undertaken, and the alternative modalities of treatment, if any. The consent requirement presumes “patients” to be competent, intelligent, and to be consenting to treatment voluntarily. This, at least, is the paradigm model and I am assuming it without further qualification.

Second, I have spoken of “material risks and dangers” inherent in or collateral to the treatment. There is some confusion as to the amount of information a physician must disclose. It has been suggested that since the physician/“patient”

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3 See infra note 49 and accompanying text.

4 Miller, Informed Consent (pt. 2) 244 J. A.M.A. 2,100 at 2,101 (1980).


6 There are, of course, many interesting, albeit difficult, issues inherent in any definition of informed consent. Some are: how do we assess competency and understanding?; how do we apply the doctrine to in-patients vs. out-patients, or to the chronically ill vs. the critically ill? How compatible is the so-called “therapeutic privilege” with informed consent? For purposes of this Article, none of these issues needs to be discussed.
relationship is a fiduciary one, the "patient" is entitled to full disclosure. This has rarely been accepted in the case law; in any event the better view is that "material" means the probability of harm multiplied by the magnitude of harm. For instance, when a "patient" undergoes a myelogram, the probability of developing foot drop is so remote as to be statistically insignificant; because foot drop is not a critical illness, the physician need not disclose the possibility of it occurring.

Finally, I have assumed a situation in which the proposed treatment is specifically and exclusively directed to the benefit of the "patient." There are, however, other applications of informed consent. The doctrine applies to a therapeutic situation in which the proposed treatment exclusively benefits another (e.g., the living kidney donor); to a purely experimental situation in which the objective of the procedure is entirely unrelated to the welfare of the individual but may prove beneficial to "patients" generally, or add to the common fund of medical knowledge (e.g., to what we already know about the transmission of hepatitis); and to a hybrid situation in which treatment of unknown efficacy is administered both for the possible benefit of the "patient" and for the potential increase in medical knowledge (e.g., new chemotherapeutic agents for the treatment of carcinoma). Much of what I say applies, pari passu, to each of these situations.

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8 See Miller, supra note 4, at 2347 ("It is generally recognized that a physician may not be required to disclose a risk if there is an extremely small probability of its occurrence or if it threatens only minor harm."). See also Brahams, Informed Consent Does Not Demand Full Disclosure, 2 The Lancet 58 (1983).

9 See, e.g., Holland v. Sisters of St. Joseph, 270 Or. 129, 137-138, 522 P.2d 208, 212 (1974) ("If a serious injury might occur from a given method of treatment, the physician must inform the patient of all but extremely remote risks. However, if the potential injury is slight, then the patient need be informed only of those risks which might well occur.").

10 Contra Berkey v. Anderson, 1 Cal. App. 3d 797, 82 Cal. Rptr. 67 (1970) (failure to disclose possibility of developing foot drop from myelogram held to violate duty of disclosure).


12 It should be observed, however, that while I am specifically interested in autonomy as the moral foundation of informed consent, there are other foundations which have been invoked as well. Veatch has mentioned three and possibly four bases for informed consent: 1) the maximization of good to the patient and the minimization of harm to the
II. THE "PATIENT" AND THE AGENT

"Patient," from the Latin pati meaning "to suffer," implies passivity. "Agent," from the Latin agere meaning "to act," implies activity. These two cognates, activity and passivity, have meanings today different from those they had in classical antiquity through the Middle Ages and up until the beginning of the Renaissance.13

In modern usage, activity refers to the expenditure of energy. Thus, farmers who cultivate land are called active, and so are workers on an assembly line, salespeople who persuade customers to buy their wares, etc. Activity refers to overt behavior and not to the person behind the behavior. It does not differentiate between activity and business in the sense of being busy.14

Even so, there is an important distinction between activity and business. This distinction correlates with the terms "alienated" and "non-alienated" with respect to activities. In alienated activity, I do not experience myself as the acting subject of my activity. Rather, I experience the outcome of my activity as something separated from me, as standing over and against me. In alienated activity, I do not really act; I am acted upon by external or internal forces (I am passive). In non-alienated activity, however, I am the author of my thoughts and actions; each of these I experience as my own.15 It follows that alienated activity, in the sense of business, is in essence passivity; and passivity, in the sense of non-business, may in essence be activity.16

Historically, philosophers such as Aristotle did not distinguish between activity and business. For Aristotle, alienated work was performed largely by slaves and was excluded from praxis, a term denoting the kinds of activities only free persons performed.17 The highest form of praxis, i.e., non-alienated activity, was the contemplative life. He considered the contemplative life the activity of nous and eudaimonia (well-being): "an activity of the soul in accordance with virtue."18


13 E. Fromm, To Have Or To Be, 61 (1982).
14 Id. at 78.
15 Id. at 78-79. See also L. Crocker, Positive Liberty 36-43 (1980) (distinguishing autonomous behavior, "things which I can do," from non-autonomous behavior, "things which happen to me." Id. at 36).
16 E. Fromm, supra note 13, at 79.
18 Aristotle, Nichomachean Ethics, 1177a (J.A.K. Thomson trans. 1981). Aristotle uses the term "soul" since on his view, eudaimonia for a rational being must involve more than bodily pleasure. Ingredients fitting to his cognitive faculties must also be
Spinoza, too, regarded activity as intimately connected with reason. To the extent that we act in accordance with the conditions of our existence (our conatus), we are aware of these conditions as real and necessary, i.e., we know the truth about ourselves. Thus, "[o]ur mind is in certain cases active, and in certain cases passive. In so far as it has adequate ideas, it is necessarily active, and in so far as it has inadequate ideas, it is necessarily passive."\(^{19}\)

Spinoza also distinguished between activity and passivity (to act and to suffer) as referring to the two fundamental aspects of the mind's operation.

I say we act when anything takes place, either within us or externally to us, whereof we are the adequate cause; that is, . . . when through our nature something takes place within us or externally to us, which can through our nature alone be clearly and distinctly understood. On the other hand, I say that we are passive as regards something when that something takes place within us, or follows from our nature externally, we being only the partial cause.\(^{20}\)

In sum, in the philosophical tradition of pre-industrial society the distinction between being active and being passive was the distinction between being and not being the author of one's own thoughts. In contrast, the modern distinction is between one who is busy and one who is idle. This should not surprise us, since the alienation of labor had not yet reached proportions comparable to that existing now.\(^{21}\) By and large, activity today means socially recognized behavior that results in corresponding socially useful changes.\(^{22}\) It is for this

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\(^{19}\) Spinoza, The Ethics, 130 (R.H.M. Elwes trans. 1951).

\(^{20}\) Id. at 129.

\(^{21}\) E. Fromm, supra note 13, at 80. This view is not unique to Fromm. Marx gave it its most notorious expression and Albert Schweitzer, in many of his writings, saw modern man as unfree, incomplete, unconcentrated, and "absolutely passive." See generally A. Schweitzer, Die Schuld Der Philosophie An Dem Niederlang Der Kulter (1923); Verfall Und Wiederaufbau Der Kulter (1923); Civilization and Ethics (rev. ed. reprint of 1923 ed., 1973).

Willard Gaylin recently made an analogous point about human dignity: "For the most part, human dignity was not redefined until modern times. However, the Reformation did produce one important if subtle change. The concept of dignity was gradually extended to encompass not just the species, but each individual member of the species." Gaylin, In Defense of the Dignity of Being Human, Hastings Ctr. Rep., Aug. 1984, at 18. Gaylin also quotes Axel Stern as saying:

The problem of human dignity, not in the sense of that of human beings versus that of other animals, but in the sense of the dignity of each human being as a person, has come to the fore with the rise of mercantilism and capitalism and an increasing individual self-awareness. A very clear manifestation of it can be found in the assertion of the protestant reformers that each Christian has to face his God directly and without mediation.

Id. citing Stern, On Value and Human Dignity, Listening, Spring 1975, at 78.

\(^{22}\) E. Fromm, supra note 13, at 78.
reason that philosophers, for instance, have typically been viewed as not being very active in contrast, for example, to attorneys or laborers.\textsuperscript{23} It is unlikely this view would have occurred to Aristotle or Spinoza.

III. Heteronomy and the Autonomous Agent

If we attend to the philosophical origins of "activity" and "passivity," it is clear that activity refers to the person behind the behavior, i.e., to the agent, and not merely to the behavior itself. The same holds true of passivity; it applies to the person, i.e., "patient," and not merely to his behavior. What follows from this is that it is etymologically wrong to attribute actions to "patients;" only agents can act, in the best sense of the term.

To give informed consent is to perform an action of some sort. It is an affirmative action whereby the one being treated determines for herself her own best interests (medically as well as psychologically, socially, and financially),\textsuperscript{24} according to what the competing risks and benefits are,\textsuperscript{25} and so on. Although the one being treated makes this determination in consultation with the physician, the one being treated and not the physician ultimately decides her own medical fate.

The moral basis of informed consent is generally thought to be the concept of autonomy. Our understanding of this concept was shaped by Kant's \textit{Fundamental Principles of the Metaphysic of Morals}.\textsuperscript{26} Autonomy, said Kant, means

\textsuperscript{23} Typically viewed, that is, by laymen and some non-philosophers. Of course, it is entirely possible for a philosopher to be passive in the relevant sense and for a laborer to be active. The neurotic behavior of intellectualizing one's thoughts, frequently found in clinical narcissists, is an instance of passive philosophizing. See, e.g., the discussion of Tolstoy's character Levin in A. Rothstein, \textit{The Narcissistic Pursuit of Perfection}, 121-55 (1980).

\textsuperscript{24} The doctrine of informed consent, in addition to furthering the autonomy of individuals, also furthers an objective of tort law. To the extent that tort law seeks to achieve an efficient allocation of resources, it aspires to place the responsibility for particular decisions upon those best able to avoid the costs arising from those decisions. Thus, while the physician can best determine a "patient's" medical needs, the "patient" can best determine her non-medical needs. The cost to the physician of discovering the "patient's" psychological, social, and business needs is simply too great. Only the "patient" sufficiently knows her own value preferences so as to determine the desirability of a particular course of treatment. See Note, \textit{Informed Consent and the Dying Patient}, 83 \textit{Yale L. J.}, 1632 at 1645-46 (1974), citing G. Calabresi, \textit{The Cost of Accidents} (1969).

\textsuperscript{25} See Superintendent v. Saikewicz, 370 N.E.2d 417 (Mass. 1977), which held that the general right to refuse medical treatment exists in the incompetent as well as the competent patient. Saikewicz, a mentally retarded resident of a Massachusetts state institution, suffered from acute and incurable leukemia. A guardian ad litem, appointed by the probate court after petition by the institution, recommended that chemotherapy not be administered to Saikewicz. On balance, the guardian ad litem concluded that the patient's inability to understand the treatment, and the fear and pain he would undergo outweighed the limited benefits of treatment. The court found that since the value of human dignity extends to both the competent and the incompetent, \textit{id.} at 427, the same choice concerning treatment vel non exists. It is not "the unvarying responsibility of the State to order medical treatment in all circumstances involving the care of an incompetent person." \textit{Id.}

\textsuperscript{26} (T. Abbott trans. 1949).
governing oneself, including making choices in accordance with moral principles which are one's own and which are universalizable. Hence, his first formulation of the categorical imperative is: "Act only on that maxim whereby thou canst at the same time will that it should become a universal law."²⁷

Kant also shaped our understanding of what it means to respect an autonomous person. Kant said that to respect an autonomous person is to take seriously²⁸ a person's considered value judgments even when it is believed such judgments are mistaken. Hence, his second formulation of the categorical imperative is: "So act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as a means only."²⁹

It is important to realize that Kant distinguished autonomy and respect for autonomy from heteronomy and disrespect for autonomy. Under heteronomy, Kant included both external and internal determinations of the will, but not in-dwelling moral principles. Thus, one is heteronomous when one acts from desire, impulse, habit, or in short from any motive other than respect for one's own moral principles which are universalizable.

Similarly, to show disrespect for an autonomous person is either to reject that person's considered value judgments or to deny him the freedom to act on those judgments. This, for Kant, is what it means to treat a person as a means to an end; it always involves a violation of autonomy. To treat any person in accordance with principles not of his own making shows a lack of respect.³⁰

It is no coincidence that Kant, as well as subsequent moral philosophers, considered autonomy a property of moral agents. To be a moral agent, one must be free and responsible, with a certain amount of maturity and rationality. One who is busy but who lacks these qualities (an infant, an acute psychotic), is not considered a moral agent (is not autonomous) and we do not ascribe to him moral qualities (show respect for his autonomy) and treat him accordingly.

The notions of autonomy and heteronomy, of respect for autonomy and disrespect for autonomy, correlate with the terms "agent" and "patient." While Kant had no term for one who is heteronomous and one whose autonomy is not respected, the term "patient" would certainly suffice. We might say, in the Kantian spirit, that a "patient" is one whose considered value judgments are not his own but which come from without (it makes no sense to speak of "moral patients" if morality requires autonomous agents). Similarly, not to respect an autonomous person is to view that person merely as a "patient," i.e., as one whose judgments about what is of value to himself are not taken seriously.

²⁷ Id. at 38.
²⁸ I have borrowed this phrase from Ronald Dworkin: See R. DWORKIN, TAKING RIGHTS SERIOUSLY (1977).
²⁹ E. KANT, supra note 26, at 46.
³⁰ For an excellent discussion of autonomy in medical ethics, see T. BEAUCHAMP & J. CHILDEESS, PRINCIPLES OF BIOMEDICAL ETHICS, 56-85 (1979).
IV. Two Standards of Disclosure

The distinction between agent and "patient" occurs in law as in morality. I have previously alluded to the standards of disclosure governing the amount of information a physician must reveal. There are two relevant legal standards: the professional custom standard, which is a "patient"-oriented standard, and the material risk standard, which is an agent-oriented standard.31

The professional custom standard requires a physician to disclose only such information as is customarily disclosed by physicians similarly situated in the medical community.32 This standard is based on the proposition that the scope of a physician's duty of disclosure is determined by the standards of the medical profession. From this perspective, it is the physician who determines the balance of treatment harm over benefits and who establishes the topics to be discussed and the amount and kinds of information to be disclosed about each topic.33 A good illustration of this approach is DiFilippo v. Preston.34 The "patient" in DiFilippo had suffered injury to the recurrent laryngeal nerves and paralysis of the vocal chords following a thyroidectomy. The physician had not disclosed the risk of such injury to the "patient." The evidence, however, showed "that it was not the practice of surgeons in the Wilmington area to warn patients of the possibility"35 of such injury. Therefore, the "patient" was unable to recover on a lack-of-informed-consent theory.36

The material risk standard requires a physician to disclose all information an individual needs to make an informed decision about whether to undergo treatment.37 This standard is based on the principle of self-determination (autonomy) originally articulated by Judge, later Justice, Cardozo in Schloendorn v. Society of New York Hospital: "[E]very human being of adult years and sound mind has a right to determine what shall be done to his body."38 From this perspective, the relevance of a piece of information is measured not

31 These are not the only standards of disclosure—only the most ubiquitous. For another standard, see T. Beauchamp & L. McCullough, Medical Ethics: The Moral Responsibilities of Physicians, 67-70 (1984). See also N.Y. St. Ct. 28, § 2805-d.1 (McKinney 1975) Health Law § 2805-d.1 which is a hybrid of these two standards.
33 See T. Beauchamp & L. McCullough, supra note 31, at 68.
35 Id. at 336.
36 Id. at 339.
38 211 N.Y. 125, 105 N.E. 92 (1914), overruled on other grounds, Bing v. Thung, 2 N.Y. 2d 656, 143 N.E.2d 3 (1957).
by a professional judgment, but by the significance a reasonable person would attach to a risk in arriving at a decision. In theory, therefore, a physician may be found liable for negligent failure to disclose even if her behavior conforms to recognized and routine professional practice.\textsuperscript{39}

*Cobbs v. Grant* well illustrates this approach.\textsuperscript{40} The "patient" in *Cobbs* had undergone surgery to cure a peptic duodenal ulcer. Subsequently, he began to bleed internally from a severed artery at the hilum of his spleen. This complication occurs in approximately five percent of such operations. Because of the seriousness of the bleeding, the "patient" had to undergo a second operation for removal of his spleen.\textsuperscript{41} Later, it was discovered that Cobbs was developing a new ulcer, another risk inherent in an operation to remove a peptic ulcer. After four months of attempting to treat this ulcer with a restricted diet and antacids, the physician performed a third operation, a gastrectomy, with removal of fifty percent of the "patient's" stomach.\textsuperscript{42} After this operation, the "patient" was rehospitalized because of internal bleeding owing to the premature absorption of a suture.

Before the first operation, Cobbs' personal physician had advised him of the risks involved in undergoing general anesthesia, and the surgeon had explained the nature of the operation. Neither physician had disclosed the risk of injury to the spleen, the possibility of developing a new ulcer, or the potential for premature absorption of a suture.\textsuperscript{43}

The "patient" brought suit against the surgeon for negligence in performing the operation and failing to obtain his informed consent to the procedure. The jury returned a general verdict for the "patient," but on appeal, the California Supreme Court held that there was insufficient evidence to sustain a verdict based on lack of informed consent. Since it was unable to determine on which ground the jury had relied, the court reversed judgment and ordered a new trial on the informed consent issue.\textsuperscript{44}

The *Cobbs* court rejected the professional custom standard in favor of the material risk standard. First, it expressed doubts as to whether a discernable professional standard regarding disclosure actually exists; the court feared that to rely on a vague or nonexistent professional standard would vest physicians with virtually absolute discretion as to what information to deliver.\textsuperscript{45} Second, and more important, it reasoned that a standard requiring disclosure of all information material to the "patient's" decision is more consistent with the "patient's" right of autonomy than is a standard that allows information to be withheld on the basis of medical custom.\textsuperscript{46} Furthermore, the court opined that

\textsuperscript{39} This was the basis for liability in Natanson v. Kline, 187 Kan. 186, 354 P.2d 670 (1960).

\textsuperscript{40} 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

\textsuperscript{41} *Id.* at 235, 502 P.2d at 4, 104 Cal. Rptr. at 508.

\textsuperscript{42} *Id.*, 502 P.2d at 5, 104 Cal. Rptr. at 508.

\textsuperscript{43} *Id.*

\textsuperscript{44} *Id.* 234, 502 P.2d at 4, 104 Cal. Rptr. at 508.

\textsuperscript{45} *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

\textsuperscript{46} *Id.*
the decision about which risks are relevant to the “patient’s” own decision to undergo treatment is not one that brings the physician’s medical knowledge and skill peculiarly into play and that there is, therefore, no reason to judge by a medical standard the doctor’s decision not to disclose.

V. The Physician’s View: The Heteronomous “Patient”

The previous sections have described the total connotations of agent and “patient” as demonstrated by the family of notions surrounding these terms. “Agent” correlates with non-alienated activity, autonomy, respect for autonomy, and the material risk standard, while “patient” correlates with alienated activity (passivity), heteronomy, disrespect for autonomy, and the professional custom standard. This can be represented schematically as follows:

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<thead>
<tr>
<th>AGENT</th>
<th>PATIENT</th>
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<tr>
<td>Moral Agent</td>
<td>Heteronomy</td>
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<tr>
<td>Autonomy</td>
<td>Disrespect for Autonomy</td>
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<tr>
<td>Respect for Autonomy</td>
<td>Alienated Activity (Passivity)</td>
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<tr>
<td>Non-alienated Activity</td>
<td>Professional Custom Standard</td>
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<tr>
<td>Material Risk Standard</td>
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These are what the terms connote (or should connote) when employed in the relevant senses.

Clearly, if the person being treated is an autonomous moral agent, he has the right to his own considered value judgments providing such judgments are not detrimental to others. Conversely, if the person being treated is not an autonomous moral agent, such rights and duties may not arise. Thus, the way in which physicians relate to those who seek help is paramount in determining their duties and obligations. In this section, I shall argue that physicians have typically viewed their “patients” as something other than moral agents, and in the following section I shall suggest that calling people “patients” shows a disrespect for their autonomy, and ought to be replaced by a more suitable term.

As medical ethics has developed over the past 2,500 years, the family of concepts associated with “agent” has been conspicuously absent. The Hippocratic Oath, for instance, does not oblige the physician to obtain consent before treatment. Rather, Decorum XVI of the Hippocratic Corpus suggests that physicians would be wise to conceal most things from their “patients,” since when given information “many patients . . . have taken a turn for the worse.”

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47 Id.

48 Id.

49 See supra note 3 and accompanying text. I am assuming that a “patient’s” right to be respected as an autonomous agent entails the correlative duty of the physicians to respect that right. Of course, not all rights entail correlative duties. The list of human rights such as the one proclaimed by the United Nations may not oblige governments to provide for these rights. See BIOMEDICAL ETHICS, 10-11 (T. Mappes & J. Zembaty eds.).

The Hippocratic Oath lays down only one comprehensive responsibility — to promote health and abstain from doing harm. Thus: "I will apply dietetic measures to the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice." Strictly construed, this obligation binds the physician to treat his "patients" for their benefit, but according to what he, not they, perceive that benefit to be, and to what he, not they, think will most promote it. Hippocrates further admonished physicians to

[perform (these duties) calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort him with solicitude and attention, revealing nothing of the patient's future or present condition.

Nowhere in his writings does Hippocrates suggest that the physician actively engage the "patient" in dialogue so as to effectuate his autonomy rights. What Beauchamp and McCullough have called the principle of beneficence directly conflicts with our notions of autonomy.

It is clear, then, that at least in the earliest manifestation of Western medical ethics, physicians viewed those who sought help as "patients," with all that this implies. As Katz points out, in a recent work, physicians held the same view during the Medieval period, through the age of Enlightenment, and up to and including the twentieth century. They have perceived themselves as committed to the welfare of "patients," and anything that impedes the promotion of their welfare is viewed as a denial of their professional responsibility. That many physicians still feel this way is evidenced by more modern authorities on medical ethics and the fact that the Hippocratic Oath is still taken by graduating physicians throughout the United States despite the strictures against it.

It hardly needs stating that health is a value that we all desire and it is certainly admirable that physicians promote it. Nevertheless, the principle of beneficence to which physicians appeal clashes with our strong intuitions about being autonomous and being respected as autonomous agents. For instance, consider the following exchange which took place between a physician and

54 T. Beauchamp & L. McCullough, supra note 31, at 28.
55 See J. Katz, supra note 7, at 7-29.
57 See, e.g., T. Beauchamp & L. McCullough, supra note 31, at 29.
plaintiff’s attorney in the 1961 case of Moore v. Webb. Moore is a poignant example of how physicians underevaluate their “patient’s” autonomy.

Moore had consulted an oral surgeon about a toothache. She was told that extractions would be necessary and gave her consent, at the same time indicating that she did not think all her teeth needed to be removed. After an X-ray examination, the surgeon unilaterally decided that a complete extraction would be beneficial and proceeded to extract all of the “patient’s” teeth. The “patient” brought suit on the grounds that her teeth were extracted without her informed consent. At the trial the following transpired:

PHYSICIAN: . . . I think you should strive to do for the patient what is the best thing over a long period of time for the patient. We tried to abide by that.

ATTORNEY: Isn’t that up to the patient?

PHYSICIAN: No, I don’t think it should be. If they go to a doctor they should discuss it. He should decide . . .

ATTORNEY: Isn’t that up to the patient? . . . If I want to keep these teeth, can’t I do it?

PHYSICIAN: You don’t know whether they are causing you trouble.

ATTORNEY: That’s up to me, isn’t it?

PHYSICIAN: Not if you come to see me it wouldn’t be.

This virtually parodizes the idea of the physician/“patient” relationship and its basis in informed consent to treatment. Why is this a parody? Why do we find the attitude of the physician abhorrent? The answer is that the physician in this case treated the plaintiff as a “patient,” i.e., as one who is not an autonomous agent and has no right to be respected as such. Szasz and Hollander have described this type of physician/“patient” interaction as the “activity-passivity” model. The behavior characterized by this “oldest conceptual model” is “based on the effect of one person on another in such a way and in such circumstances that the person acted upon is unable to contribute actively, or is considered inanimate.” According to the model, the “patient” resembles a helpless infant, and the physician an active parent.

That the “activity-passivity” model persists is demonstrated by a recent survey for the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research. Many physicians (fifty-five percent of

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58 345 S.W.2d 239 (Mo. 1961).
59 Id. at 241.
60 Id.
61 J. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 649 (1972).
63 Id. at 586.
64 Id.
those polled) think the primary purpose of informed consent is to avoid lawsuits.\textsuperscript{65} In another survey conducted by a research team from the University of Pittsburgh, similar findings were made:

Most of the physicians we observed did not view informed consent as an integral part of good patient care. Although they generally supported the idea of giving patients more information, few physicians gave it much attention. Most physicians who were interested in informed consent seemed primarily concerned with it as a legal problem. Indicative of this attitude was a senior member of the house staff who, when asked how the presence of observers had changed the service, said that he was more inclined to discuss the patients' treatment with them on rounds when he knew the observers would be there. Ordinarily, he said, he would often discuss patients' treatment with them privately because "[t]he intern(s) think it's real boring to stand there and listen to me tell somebody about what their treatment is going to be." Even at this early stage of their careers, the interns found the dialogue with the patient uninteresting.\textsuperscript{66}

Similarly, the results of a study by Christie and Merton found that "the medical student's image of the Ideal Physician was one of high extroversion, slight emotionality, thorough dominance, and a handsome appearance . . . [while] . . . the patient was envisioned as introverted, emotional, weakwilled, and ugly."\textsuperscript{67}

VI. Purging the Medical Vocabulary

We see then that "patient" and all this term implies is in fact deeply entrenched in how physicians relate to those who seek help. As in Moore v. Webb, physicians continue to view "patients" as passive recipients of their knowledge and expertise, as the beneficiaries of their clinical judgments.

Part of the persistence of the physician's attitude may be due to the fact that the term "patient" straddles two distinct notions. On the one hand, the term "patient" refers to someone who undergoes some action, who is acted upon. This is the sense contrary to "agent" implying freedom, competence and power to act. On the other hand, the term "patient" refers to someone who suffers or who is in need of medical help. The two notions may interact in the sense that the more we become "patients" in the latter sense, the more we become "patients" in the former.\textsuperscript{68} But there is no necessary connection between the

\textsuperscript{65} See, President's Ethics Commission, Medical World News, Nov. 22, 1982 at 7.

\textsuperscript{66} Lidz, Barriers to Informed Consent, 99 ANNALS INTERNAL MED. 541 (1983).

\textsuperscript{67} Christie & Merton, Procedures for the Sociological Study of the Value Climate of Medical Schools, 33 J. MED. ED. 247-56 (1958).

\textsuperscript{68} See Bok, Round Table Discussion, in 3 PHILOSOPHICAL MEDICAL ETHICS—Its Nature and Significance 230-31 (S. Spicker & T. Englehardt eds. 1977).
two notions. It is both conceptually and factually possible to be an autonomous agent requiring medical attention. Once the term is dissected in this way, the weakness of such a medical attitude becomes apparent. Physicians have failed to separate these two distinct notions.

All of this is changing, however. "Patients" have become acutely aware of their long-ignored autonomy rights. Such awareness is fueled by the media, which are publicizing the ethical dimensions of health care, as well as the proliferation of medical malpractice actions. In the literature, too, there is widespread concern with improving the physician/"patient" relationship by engaging the "patient" in active dialogue. As Alan Stone asserts:

[L]et there be no mistake: there is a growing demand to transform the doctor-patient relationship . . . [t]he traditional doctor-patient relationship is seen . . . as one in which the doctor and the patient are unequal bargaining partners in a contract for services. It is the doctor's special knowledge that creates the advantage. Informed consent is meant, then, to force the doctor to give the patient knowledge that will make him or her an equal bargaining partner. Thus informed consent is meant to transform the essence of the doctor-patient relationship from status to contract.

Thus, informed consent is the means by which the "patient's" autonomy rights are to be actualized. That the doctrine accomplishes its intended purpose only deficiently is evidenced by the attitudes of the physicians in the surveys mentioned above. I submit that one way to accomplish the objectives of truly informed consent is to eliminate the term "patient" from the medical vocabulary. Linguistic change per se is not a necessary or even sufficient condition for achieving this purpose. Eliminating "patient" and replacing it with a more suitable term will serve to sensitize physicians to the issues underlying the doctrine of informed consent and the end it is designed to achieve.

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69 It should be observed, however, that there is a sense of "to suffer" meaning "to undergo or be subjected to an action." In Plato’s Crito, for instance, Socrates asks Crito "[W]hether we shall do rightly either in escaping or in suffering others to aid in our escape..." The Works of Plato 98 (I. Edman ed. 1956).

70 See, e.g., Lidz, supra note 65, at 543; Cross & Churchill, supra note 50, at 112. The clearest manifestation of this is the interpretation of informed consent by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. According to the Commission, this principle “incorporates at least two basic ethical convictions: First, that individuals should be treated as autonomous agents; and second, that persons with diminished autonomy and thus in need of protection are entitled to such protection.” The Belmont Report, supra note 12, at 4 (DHEW Pub. No. (OS) 78-0012).


72 Katz has persuasively argued that the doctrine of informed consent is certainly less than solidly founded and has yet to be fully realized. See generally Katz, supra note 7, at 7-29.
The term "client" is a fitting replacement, though it may seem odd after having contrasted "patient" with "agent" that I urge the adoption of "client" instead. I do this for two reasons. First, the term "client" is already in use by some psychiatrists. Second, it is unrealistic to expect use of the term "agent" to gather momentum. "Agent," of course, is the preferred term, but will of necessity remain in the halls of philosophy departments. In any event, the term "client" does adequate justice to the values in question and is preferred over "patient."

Here, we may take a cue from the feminist movement, which in recent years has insisted that the term "man" (as in "chairman" and "mankind") be expunged from ordinary language. Feminists have argued that "man" is indicative of an underlying bias against sexual equality and should be replaced by terms which are gender-neutral (e.g., "chairperson" and "humankind"). They do not suggest that this change alone will accomplish a shift in attitudes or will effectively promote sexual equality. Clearly, a woman can be chairperson of the board and still be the subject of gross inequality (e.g., she might receive less compensation than her male counterparts). Rather, feminist theoreticians have argued that linguistic change together with social, educational, and legal reforms will correct the power structure which has long been unbalanced.

The feminists' efforts have not been for naught. We are beginning to witness the opening of doors that have long been closed to women. Concomitant with this, we are seeing etymological changes in various disciplines. Hardly an article is written in philosophy journals today which does not alternate, in successive paragraphs, the use of gender pronouns. The same is true of legal journals. These linguistic changes sensitize readers to the social reforms for which feminists have been pressing.

What we call people is vitally important, since names have a meaning beyond their denotation. It is easier to incarcerate a "parasite of the state" than it is to jail a "conscientious objector;" it is easier to deny a "queer" employment than it is to deny a "gay person" employment. The Nazi extermination of Jews became easier once they had been called "vermin" sufficiently often to strip them

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73 Also, it should be noted that some psychologists refer to their "patients" as "clients" since they do not employ a medical model.

74 Telephone interview with Gertrude Ezorsky, Professor of Philosophy, City University of New York (Jan. 29, 1985).

75 "Denotation" is "the direct, explicit meaning or reference of a word or term," WEBSTERS NEW WORLD DICTIONARY 377 (2d College ed. (1970)), while "connotation" refers to an "idea or notion suggested by or associated with a word, phrase, etc., in addition to its explicit meaning." Id. at 301.
of their human-ness. In this sense it is easier to dismiss a "patient's" value judgments than it is to dismiss a "client's" value judgments.

There is also a sense in which all social reform must be accompanied by linguistic reform. One of the developments of the civil rights movement, for instance, was the rejection of the word "Negro" and its replacement with the term "Black." This linguistic change accompanied the rejection of second-class citizenship. The linguistic analog within the homosexual rights movement is the insistence on the use of the term "gay." There is nothing intrinsically discriminatory about "Negro" or "homosexual;" these words are different from "chairman" in an important sense. But these terms have so long had pejorative connotations, that linguistic change has been perceived as a vital component of social equality. It is in this sense that linguistic reform is important whenever we are concerned with protecting and upgrading the status of a particular class of people.

Now I think I have shown that "patient" is value-laden in a non-trivial sense, and that it ought to be replaced in the medical vocabulary. Still, I am prepared to defend the weaker thesis that even if such change is ultimately a matter of semantics, it is still not merely semantics. A change in terms, together with social, educational, and legal reforms, will further the purpose of informed consent. Such reform might consist in lobbying for the legislative adoption of the material risk standard. Since the early 1970's, an increasing number of courts has adopted this particular standard though, unfortunately, in a majority of jurisdictions (seventy-five percent) the professional custom standard is still adhered to. In medical schools, reform is already taking place with the addition of courses on medical ethics to the curriculum; and the American Association of Medical Colleges has called for pre-med students to be more broadly exposed to the humanities. The proliferation of hospital medical ethics committees is part of the same trend.

By replacing the term "patient" with the term "client," I am not suggesting that clients do not suffer or that they have no need for the advice of health professionals. I am simply saying that linguistic reform would increase respect for "patients'" autonomy rights. It is important to choose terms carefully and to avoid terms that imply inadequate values. In the physician/"client" relationship, the physician's superior knowledge is still recognized, but the client retains significant authority and responsibility in decision-making. Compare this

76 Conversely, Hannah Arendt has noted that while Nazi executioners defiled Jews prior to exterminating them, some Jewish prisoners deified their executioners to mitigate their fate. See generally H. ARENDT, EICHMANN IN JERUSALEM: THE BANALITY OF EVIL (1963). Katz too has noted the tendency in "patients" to deify physicians. See Katz, supra note 7, at 100-01.

77 One need only to ponder the emotive significance of this sentence to appreciate its force.

78 "Chairman" wears its bias on its face. 'Negro," however, does not. My strong thesis is that "patient" is more like "chairman" than like "Negro."

79 See T. BEAUCHAMP & L. MCCULLOUGH, supra note 31, at 68.


81 See M. BAYLES, PROFESSIONAL ETHICS 68 and passim (1981).
to the attorney/client relationship. The attorney’s expertise is surely acknowledged but it is the client’s judgment that is ultimately binding.\(^8\)

**VII. Conclusion**

Moral philosophy since Kant has been almost exclusively concerned with “act/rule” morality. A preoccupation with the basis of ethical choice and conduct has dominated scholarly activity in the area. “Agent” morality, and a thoroughgoing examination of the moral actors behind act/rule, has largely been ignored. Most of this essay is in the tradition of the latter, emphasizing, as it does, what it means to respect autonomous agents. These notions recall a remote passage from an essay by William James, entitled “What Makes A Life Significant.” According to James:

> Every Jack sees in his own particular Jill charms and perfections to the enchantment of which we stolid onlookers are stone-cold. And which has the superior view of the absolute truth, he or we? Which has the more vital insight into the nature of Jill’s existence, as a fact? Is he in excess, being in this matter a maniac? or are we in defect, being victims of a pathological anaesthesia as regards Jill’s magical importance? Surely the latter; surely to Jack are the profferer truths revealed; surely poor Jill’s palpitating little life-throbs are among the wonders of creation, are worthy of this sympathetic interest; and it is to our shame that the rest of us cannot feel like Jack.\(^3\)

At a time when the medical division of labor significantly detracts from viewing persons as autonomous agents, in a world where time is in short supply and detracts from paying too much attention to any particular “patient,” it is important to be reminded that “patients,” like Jack’s Jill, are people who have intrinsic worth. They surely are not “interesting cases” or “specimens of diseased biology;” neither are they “just patients.”

In 1983 Elie Weisel addressed the graduating class of Mt. Sinai Medical School. After seeing the evil to which medicine can be put, having been a victim of the Nazi concentration camps, Weisel told the new physicians that at one time or another over the course of their careers, they would be confronted with a “patient” who would demand to be treated as if he were the only person that physician could treat; as if he were the center of the universe. And, said Weisel, he is.

\(^{82}\) See *ABA Model Code of Professional Responsibility*. Canon 7, EC 7-8 (1979): A lawyer should exert his best efforts to insure that decisions of his client are made only after the client has been informed of relevant considerations . . . . In the final analysis, however, the lawyer should always remember that the decision whether to forego legally available objectives or methods because of non-legal factors is ultimately for the client and not for himself.
