The different faces of autonomy. A study on patient autonomy in ethical theory and hospital practice

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Citation for published version (APA):
CHAPTER 10

Mr. Boskoop and Mrs. Huisman - control, trust and autonomy

10.1 The case of Mr. Boskoop

Mr. Boskoop is a retired businessman and managing director of a medium-sized company. He is 65 years old, married, and has two grown-up children who are doing well in their respective careers. Mr. Boskoop's medical history started about eight years ago, when he got heart problems. He has had a number of heart attacks, and one bypass operation. He is also a diabetic, and his remaining heart function is very bad, limiting him in his daily activities. He feels he cannot develop himself any further because of his physical condition, and because he feels that now he is retired, he cannot use his intellectual energy any longer.

Mr. Boskoop was admitted to the hospital for treatment of his heart failure, which caused severe oedema and shortness of breath. The treatment proved to be rather difficult, and he improved only slowly. Apart from this, he suffered a severe attack of gout in his toe, which caused him a lot of pain. Unfortunately, the medication for the heart failure worsened the gout, and it was difficult to find a proper treatment for it. Since his diabetes appeared to be very mild, his insulin therapy was replaced by oral medication.

For the staff, Mr. Boskoop was a rather demanding patient, who, in their opinion, was a little too actively involved in his own treatment. In a staff meeting a nurse introduced him as: "a gentleman who thinks he knows a lot about medication and wants to enter into a discussion about everything." On the daily rounds, the visit to Mr. Boskoop was always the longest, lasting ten to fifteen minutes, since he would always have a lot of questions about the medication and the treatment policy. He frequently proposed different lines of treatment himself and so was regularly engaged in discussions with his ward physician, Dr. Bernard, about the pros and cons of certain medication. For example, one day Mr. Boskoop told Dr. Bernard he wanted to talk about changing the medication for the diabetes. The oral medication he was on nauseated him, but insulin was disadvantageous because it had to be administered by injections. Dr. Bernard said that because he only needed a very low dose of insulin, oral medication would do. Mr. Boskoop was of the opinion that his insulin dose was not that low, but Dr. Bernard insisted that it was. Mr. Boskoop said he wanted to take another oral anti-diabetic, one he had used before and that had not caused nausea. Dr. Bernard replied: "That's fine, if you would rather like it like that..." to which Mr. Boskoop replied: "It is not a matter of liking, but of what gives the best results." The medication was changed according to Mr. Boskoop's wishes. On some other occasion, however, when Mr. Boskoop wanted to have a certain diagnostic test performed, Dr. Bernard refused...
because he believed the test would not contribute to the treatment in any way. Dr. Bernard readily admitted to his colleagues and to me that he found the way in which Mr. Boskoop behaved rather unpleasant. He was willing to comply with a patient’s wishes, and tried to listen carefully to what Mr. Boskoop was saying, so that he could take that into account. He found it useful that Mr. Boskoop knew a lot about medication, for that made it easier to discuss things with him, but he also found Mr. Boskoop too stubborn at times, not willing to accept the physician’s account of matters he actually did not understand himself. Besides, he found his long-winded way of talking irritating. Still, Dr. Bernard said he tried hard not to let his irritation come in the way of his decisions, and tried to reason with Mr. Boskoop on a rational basis.

One of the nurses, Paul, had a similar opinion about Mr. Boskoop. He stated he was generally glad when people showed some initiative, and that he understood it might be hard for patients to leave everything to others, but he also found Mr. Boskoop too self-assertive. “Taking the initiative, like, ‘Is it really necessary to take this medication?’ I believe that’s very good, but not simply refusing medication on your own initiative, that’s going too far. [...] He does not have an view of the whole situation, he just absolutely does not know... He has his reasons, but the doctors’ thoughts behind it go deeper than he can imagine. ... I think, he does not discuss it, and that’s important to me. It must come from both sides, it is an interaction. I inform him, and he has to do that with us, too. Yes, simply discussing things, like ‘How are we going to go about this’. But that’s what’s missing with him, he just does it, really, without discussion.”

Paul believed Mr. Boskoop’s behaviour originated from the fact that he had always been on top of the hierarchy, whereas now he was really at the bottom. He believed Mr. Boskoop found it hard not to be in control any more, and to have to accept things from others. He had tried to talk to him about this, but without success.

Mr. Boskoop himself was well aware of the fact that the staff probably thought him pigheaded, but was very clear on his own position. He realised there was a difference in knowledge between himself and the physicians, but he thought himself quite capable of understanding their explanations and arguments or of asking for scientific publications on the subject. He told me to see it like this: “In my company I also buy specialised knowledge, and I have to trust that the knowledge I buy ... I want to know about it, but in some way, it must be there as a given. And right here this means: if a doctor says ‘you should do this’, then I do want to know why. If I should not take certain medication because of certain complications, then I am given an explanation, and most of the time this explication is sufficient. Well, and then I will have to acquiesce in it.” Still, he would not call this a matter of trust, or of surrendering himself to others. He believed he himself remained responsible at all times for the decisions that were made, even if he had delegated the decision-making to someone else. After I interviewed him he asked me to fetch him some scientific information on a certain drug Dr. Bernard and the cardiologist had been deliberating about putting him on, because he wanted to form his own opinion.

Two weeks after he was admitted, the treatment finally seemed to have
success, and a planned transfer to the cardiac unit was cancelled. However, a few days later Mr. Boskoop died in his sleep; the autopsy revealed that his death had probably been caused by a cardiac arrest.

10.2 The case of Mrs. Huisman

Mrs. Huisman is 73 years old. She is married and has four grown up children and five grandchildren. Before her marriage she used to work as a maternity assistant, and afterward she took care of the house and the children. Her husband used to work as a salesman. They have lived in their own house in a medium sized village all their life. Mrs. Huisman has diabetes, chronic obstructive pulmonary disease (COPD) and hypertension, but is still able to manage the household by herself, something in which she takes pride. She has been in the hospital twice before because of a pneumonia. This time Mrs. Huisman was admitted to the hospital because she had passed out in the course of an acute illness. On examination it turned out that she had a mild pneumonia, an atrial flutter and too high blood sugar levels. She received antibiotics and oxygen, the atrial flutter was treated with digoxin, and the diabetes was regulated by changing her medication. At home she had used both oral medication and insulin which, according to the ward physician, was a rather strange and somewhat 'old-fashioned' regimen. He also changed her hypertension medication. Mrs. Huisman herself had always disliked taking "all these pills", as she put it, and was glad that most of them were stopped during the hospital stay.

After a few days she felt much better, and said she wanted to go home before the weekend, because she had her birthday coming up. The atrial flutter had disappeared and the digoxin was discontinued, she could do without the oxygen and her diabetes was regulated with insulin twice a day, so her physician, Dr. Burger, said she could probably go home before the weekend. Later on he discussed her case with his supervisor, who wondered whether she suffered from paroxysmal atrial flutter, because she had had complaints of palpitations before, and whether they should give her preventive medication. "Maybe she passed out because of a TIA, and maybe she will have a CVA in the future. And then it will be too late", he remarked. It was decided to make a 24-hour ECG.

One afternoon, I talked with Mrs. Huisman. She told me she was pleased with the way in which they, the doctors, told her everything. "Because I always thought I had to come here because of the sugar, but it was because of my lungs. I didn't know that! [laughs] But I am glad they tell you, because then you know what you are up against, and you can take your measures." I asked after the changes in her medication and she answered: "Well, they told me I had been taking too many pills for the sugar. And they stopped a

1 This case was already mentioned briefly in Chapter 6.
2 A TIA is a transient ischaemic attack, a temporary deficiency of blood and oxygen in a part of the brain, causing temporary symptoms resembling stroke. A CVA is a cerebrovascular incident, a stroke or a cerebral haemorrhage.
lot of them, and also of the other ones ... they had given me too many." She was content with the decision to reduce the medication. She said: "Yes, I approved of that, because you swallow them and you swallow them and you think it is right what a doctor prescribes you, but you see it was not all right. Actually, I always wanted to get rid of them, I said: I take far too many pills." Later on she said: "I haven't really ever asked doctors many questions. Not really. You just accept everything they say, and you suppose it's OK. That's how I feel about it. But perhaps that is wrong." I asked her why, and she answered: "Well, it's obvious, when my family doctor prescribed all these pills ... 'Yes, you need them', he said. Perhaps I should have talked to him about that."

She went on to tell me about her life in general, and how she resented her husband always meddling with her. He wanted to move, because he believed that would be better for her, but she did not want to move at all. "Maybe he's over-anxious, but he had better leave me alone. That's much better. And not meddle with me, and that goes for other people as well. That they decide things for you, I don't like that." She said she had never really felt this way before, but: "Lately I've recognised that, that you had better do things your own way, not as other people want it. Because that's what I have always done, really, my husband decided everything and that's not right. A woman must be able to decide for herself what she wants and what she does not want." I asked her what had made her change her mind in this respect and she answered, a little puzzled: "I don't know why that is, actually. I don't know, why I suddenly want to make my own decisions for myself. ... You don't want to be treated like a child now do you, that's not necessary. But I've realised now that this should improve".

The next day, during rounds, Dr. Burger told her she could go home after the weekend. Mrs. Huisman said: "Oh, that's a disappointment. But well, I don't mind." Dr. Burger explained that he was still waiting for the results of the ECG. "And if that's OK, we won't have to change your medication again", he said. Mrs. Huisman answered that she agreed with everything he proposed and added in a soft voice, "But maybe that's not good either, is it?" It was not clear whether Dr. Burger heard this remark - in any case, he did not respond to it.

The ECG showed no abnormalities and so Mrs. Huisman did not receive any additional medication. On Monday, her birthday, Mrs. Huisman went home.

10.3 Between self-willed control and docile trust

I have put these two cases one after the other because they represent two ends of a spectrum - the assertive businessman who buys his medical knowledge and uses that knowledge to make his own treatment decisions, and the docile housewife who does not even know what she's in the hospital for and fully trusts her doctors to do the right things. These cases differ from one another in a number of respects. First, the nature of the physician-patient relationship, ranging from an informative-contractual relationship in the case of Mr. Boskoop to an old-fashioned fiduciary relationship in the case of Mrs. Huisman. Secondly, the issue of patient control - both the need
for control and the actual degree of control exercised by the patient differ considerably between these cases. Finally, the willingness to trust the medical professionals and the actual amount of trust between professionals and patient ranges from great in the case of Mrs. Huisman, to nearly absent in the case of Mr. Boskoop.

In an interesting qualitative empirical study Stüssgen (1997) has found similar differences between patients. He found that patients could be classified in three groups on a dimension that ranged from self-willedness and obstinacy to obedience and docility. According to Stüssgen, with regard to medical decision-making and compliance with the physician's orders and prescriptions, the self-willed patient relies primarily on his own ideas, experiences and wishes. He follows medical advice or guidelines only in as far as they fit in with his own preferences and experiences. He is not inclined to discuss things with his physician since he is convinced of his own ideas and experiences. In cases of conflict between the physician's orders and his own ideas he holds on to his own wishes and does not discuss or negotiate these with the physician.

The obedient and docile patient, on the other end of the spectrum, relies primarily on the medical knowledge, advice and guidelines of the physician. He follows doctor's orders because he has a blind faith in his expertise and he relies more on the physician's professional expertise than on his own ideas, wishes or experiences. Consequently, there are no differences of opinion that need to be discussed. Besides, the docile patient does not feel capable of discussion or negotiation with his physician anyway.

The third group Stüssgen distinguishes is that of the balancing patient. He relies both on his own ideas, experiences and wishes, and on the knowledge, advice and guidelines of the physician. He is prepared to be obedient as long as the physician recognises him as a subject. He acts according to medical norms and guidelines, as long as the physician founds these on arguments and is willing to discuss them with him. The balancing patient finds discussing and negotiating with his physician important because he values equality and cooperation. If the physician cannot convince him with arguments, this patient balances between acting in either an obedient or a self-willed manner.

Stüssgen remarks, rightly I believe, that the balancing patient conforms most to the ideal of the autonomous patient who enters into a cooperative relationship with his physician on the basis of equality. This type of patient fits best into models of informed consent, patient participation and shared decision-making. A more docile patient like Mrs. Huisman does not seem to fit very well in this picture. She is not involved in decision-making or in other aspects of her (medical) care. In this sense, she appears to fall short of the ideal of the self-determined sovereign patient. This raises a number of questions. Does a docile and trusting patient like Mrs. Huisman really fall short on autonomy, or can autonomy express itself in other ways than in involvement in medical decision-making? Is trust really the opposite of autonomy? And, finally, how should physicians respect the autonomy of patients who entrust decision-making to them?

A more self-assertive and stubborn patient like Mr. Boskoop does not con-
form neatly to the ideal of the autonomous patient either. Although he is, and makes an effort to be sovereign and in control, his behaviour does not always fit in with the ideal of shared decision-making, because he finds it difficult to leave anything to the staff, to accept their expertise and experience and to be convinced by their arguments. Is Mr. Boskoop more autonomous than Mrs. Huisman because he is more involved in decision-making about his own treatment? Is a certain degree of trust not necessary to maintain a good and fruitful physician-patient relationship, and if it is, how can this trust be earned or sustained? How should health care providers deal with self-willed and stubborn patients?

This chapter will further explore the issues of control and trust in the medical encounter in order to answer these questions. I will start by arguing that having control over one's daily life is also an aspect of autonomy (Section 4). Section 5 will then continue to analyse and discuss the concept of trust, on the basis of the work of Annette Baier and Olli Lagerspetz. Section 6 will examine the relationship between trust and autonomy in the medical encounter and discuss how physicians can deal with trust and autonomy in the physician-patient relationship.

### 10.4 Control and autonomy

**Autonomy in different domains**

While for Mr. Boskoop it seemed very important to retain control, to influence the course of events and to make medical decisions for himself, the issue of control did not seem all that significant for Mrs. Huisman. Apparently, it was not difficult for her to leave decision-making to the physician and to agree with his proposals without understanding much of her medical situation or the medical arguments involved. In this respect, and in others too, she was an easy and non-demanding patient. An interesting aspect in the case of Mrs. Huisman is that while she seemed content with her own docility towards physicians, she resented the way in which her husband and other family members had always made, and still tried to make decisions for her. She apparently held a different standard of how 'self-determined' she should be in different domains of her life. With some other patients it was even more obvious that on some issues they clearly made their own decisions and found it important to do so, while in medical issues they left decision-making to physicians and nurses.

Obviously, one reason for this is that patients feel incompetent and lacking in knowledge regarding medical matters. Patients may still receive too little information and explanation to allay their sense of ignorance and incapacity. Another reason may be that (especially older) patients still strongly feel that the proper roles of patient and physician require the physician to decide and them to obey. Patients may be too little aware of their rights

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3 Though Mr. Boskoop himself might classify himself as a balancing patient, the staff would probably think of him as a self-willed patient.
and entitlements and believe they have no option but to comply. However, some patients may simply want to hand over these decisions to their physician. They may gladly entrust one aspect of their life, namely their health, to others who are better positioned to take care of it than they are themselves. They may not feel the need to control or monitor everything that is going on but instead acknowledge and accept their dependence on others’ expertise and skills and leave decision-making to their physicians. This need not take anything away from their self-determination and control, actual or desired, at other times or with regard to other aspects of their lives. Autonomy is not monolithic but can be present by degrees, and by different degrees in different situations or with regard to different subjects.

**Autonomy with regard to matters of daily life**

Although Mrs. Huisman was not actively involved in decision-making, she did appreciate being informed about what was going on and about what was going to happen to her because, as she said, it enabled her to “take her measures”. Other patients expressed the same idea.

Information, even if it is not used to make decisions, does give patients a sense of control over their situation. First, if one knows what tests the physician plans to do, or what procedures or therapies he is going to prescribe, one has the opportunity to refuse. Information enables patients to use their right to refuse, which is an important aspect of the right to self-determination. Even when a patient is not actively involved in decision-making, and only assents to the proposed treatment, information about what is going to happen is essential for a sense of control. It makes the difference between feeling one could refuse if one wanted to, or feeling one is at the mercy of others. Secondly, information enables people to mentally prepare themselves for pain, discomfort and the like and this also gives a sense of control. Moreover, information can help a person to come to terms with an illness or to give it a place in her life, which is also a way of regaining control.

Finally, if one knows what is going to happen, one can ‘take one’s measures’ and prepare oneself in a very practical sense. Planning one’s daily activities, for instance, knowing when visitors can be invited, when to be on the ward and when one can safely go off to have coffee or take a walk. This means that in the hospital, information about the day’s schedule, about the content and direct implications of tests and procedures is necessary for one’s freedom of movement and opportunities to arrange one’s daily activi-

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4 For example, one patient, who had a fluid restriction of 500 cc a day, said she did not care to understand the decisions concerning her treatment, but she wanted to have detailed information on what she was allowed to drink, and how much and at what times, because this information enabled her to ‘plan’ her drinking during the day.

5 See for example how Mr. Tas (Chapter 6) felt unpleasantly surprised by the fact that his groin was shaved before the angiography.
ties for oneself. In contrast, if people do not have that kind of information, it is others who arrange their day-to-day lives for them - their daily lives are then run completely by physicians, nurses and institutional arrangements. As one of the nurses I interviewed expressed it: "In the hospital, patients are actually at the disposal of the physicians and the various diagnostic departments."

This shows that control and sovereignty over one's own life is not only important with regard to far-reaching decisions, but can also be important in day-to-day matters (cf. Collopy, Boyle & Jennings 1991, Agich 1993). Of course, this is not only a matter of being informed about what is going to happen and being able to adapt oneself to it. As Agich has argued, it is also important that patients be enabled to make certain daily choices for themselves and to be given a range of options that are meaningful to them. According to Agich, this means that the options made available should make sense in light of a person's biography - they should fit into the way a person has lived her life and should be an expression of her identity and self-perception. Agich argues that as long as one is autonomous in a global sense, that is, as long as one has a developed identity and holds values and goals that have gone through a process of critical reflection, one's everyday routine choices and actions are autonomous as well. As mentioned in Chapter 2, Agich asserts that a person does not have to deliberate and reflect critically on every choice or action for them to count as autonomous. As long as one acts out of a 'developed identity' and experiences one's actions as 'one's own', they are autonomous and deserve respect. At this point, however, I believe that Agich stretches his notion of autonomy a bit too far. His model does not seem able to distinguish between everyday or routine actions that stem from compulsions, addictions or (bad) habits, and actions that are more freely chosen. However, I do not believe it is necessary to claim that such everyday and routine choices or actions are autonomous (in the sense of authentic) in order to claim respect for them. I believe such choices deserve respect simply because they are that patient's own choices. As long as they do not obviously hurt the patient in question, the right to sovereignty protects such choices from interference, whether they are truly authentic or not.

The idea that sovereignty is important because it enables a person to make her life her own, which was discussed in Chapter 2, not only applies to decisions involving important values, goals or life plans, but also to the more frequent and perhaps equally pervasive 'small' choices and decisions of everyday life. For example, Mr. West (see Chapter 7) was used to taking a shower in the morning before he had breakfast. That was how he had always done it, and how he had always insisted his children should do it. In the hospital, however, the daily routine was to have breakfast first and to have a shower or be washed after that. After one of the nurses had suggested they would try to provide daily care in accordance with Mr. West's own wishes, to set aside hospital routines if necessary (and possible), and to let him have his shower before breakfast, Mr. West became much more accessible. According to one of the nurses, this was the first time he felt someone really listened to him and respected his wishes. Especially when patients are admitted for a longer period of time, control over simple daily things such as personal care, meals, activities and compa-
ny become very important. Leading one's own life is not only a matter of making important choices for oneself, but also of arranging one's own daily life. More concretely, this means that patients should be allowed and enabled as much as possible to make their own choices with regard to matters of daily life. Routines of daily personal care should be handled with flexibility and more effort should be made to tailor daily care to the patient's own wishes and preferences. Patients should be informed about the day schedule, about when exactly procedures and tests will be performed, how long they will take, what they involve and what they require of the patient. Recommendations like these could easily become trivial and most health care professionals will undoubtedly agree that they are, of course, important. Besides, one might argue that it is already common practice to inform patients about such things, or to give them more freedom and options with regard to arrangements of daily life. I do not want to claim, therefore, that control over one's daily life is a completely new issue, or something that has not received any attention. I do believe, however, that it is important to make it an explicit point of attention and make sure that it remains that, both for policy makers and for practitioners, as it tends to be something that is easily gone by the wayside.

Control and trust

For Mr. Boskoop, control over matters of daily life was clearly not all he was concerned with. Being involved in medical decision-making and making his own decisions on the basis of information and professional advice were clearly also important to him. He wanted to actively exercise his right to self-determination with regard to medical matters. For him it was not as easy as it was for Mrs. Huisman to entrust one aspect of his life and well-being to others. He wanted to keep decision-making in his own hands, both because he felt it concerned his own life and body and consequently was his own responsibility, and because he wanted to make sure the proposed options were indeed best for him. He found it difficult to leave things to others, probably also because being in control and making his own choices were strongly connected to his self-respect. Mr. Boskoop was aware that because of the difference in knowledge between him and the physicians he was dependent on them, and would have to accept their authority on certain issues, but found that hard to do. "With regard to medical therapy I will have to surrender myself to the physicians. However much I regret that", he remarked. Later on he stated that it was not really a matter of surrendering himself, but of accepting the physician's advantage in knowledge and of being convinced by the physician's arguments. However, he was of the opinion that he remained responsible for the decisions that were made: "Because if I let someone else make a decision for me, or on behalf of me, then I have authorised him to do so and so it is my decision. I have delegat-

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6 A lack of opportunities to do so can elicit a feeling of not being respected as a human being, a subject, but rather being seen as a thing, an object to be shoved around with by others at their will. This is also a matter of respecting people as competent and sovereign individuals, as was discussed in Chapter 9.
ed it to him, he is no more than an extension of me." This attitude was difficult to cope with for some of the nurses. They were of the opinion that Mr. Boskoop should accept that the physicians and nurses sometimes simply knew better and that he should entrust himself more to their care. Although I have argued that medical decision-making is not all there is to autonomy, the question remains whether it is not more autonomous and more desirable for patients to make such decisions for themselves. Making medical decisions for oneself is opposed to entrusting decision-making to others and the former is often considered to be more autonomous than the latter. Moreover, once it is recognised that medical decisions not only require technical knowledge and skills but also involve goals and values, it can be argued that it is simply impossible to trust others to decide for us (Veatch 1991). Was Mr. Boskoop not right in assuming that he himself was the best judge of his own well-being, and was the claim of some of the nurses, that he could trust them to do what was good for him, not mistaken? On the other hand, is it not also true that trust is necessary for a cooperative relationship, and that autonomy without trust leads to self-willedness and isolation and can become counter-productive to good decision-making? In order to find an answer to these questions, I will first further explore the concept of trust.

10.5 The concept of trust

The subject of trust has received surprisingly little attention in health care ethics. On the one hand, trust and the fiduciary relationship between physician and patient are traditionally deemed important and valuable, the moral basis of medical practice. On the other hand, the 'new' medical ethics has treated them with some suspicion, stressing the potential dangers of trust and instead advocating the use of contracts and rules. However that may be, trust, trustworthiness and trust-relationships have scarcely been a real topic for ethical analysis. The same lack of attention can be observed in moral philosophy in general (Baier 1986, Lagerspetz 1998).

Vulnerability and the presumption of good will

In one of the few important articles on the subject, Annette Baier (1986) explores various forms and varieties of trust. She observes that trust is a very basic element of all our interactions and dealings with others - both intimates and strangers, both individuals and institutions, both in a private setting and in the public sphere. Trust is important, but not necessarily (morally) good or harmless and therefore it is necessary to distinguish between different varieties of trust and to examine its various (morally) relevant qualities.

After a first exploration, Baier defines trust as the "accepted vulnerability to another's possible but not expected ill will (or lack of good will) towards one" (1986, p. 235). Trust is a form of reliance, in which the other's good will is the ground for depending on him. When we rely on things, or on other persons, we depend on certain (legitimate) expectations we have about
their actions and attitudes. There can be various grounds for relying on others' behaviour, such as their dependable habits, their fear of sanctions, or their predictable reactions. In trusting others, we rely on their good will towards us - we trust a surgeon will not unnecessarily mutilate us, not because he fears a lawsuit or because the operation team will prevent him from doing so, but because we expect a surgeon to have a basic good will (or at least no ill will) towards us.

When trust in others is understood as dependence on their good will toward us, it also implies some degree of vulnerability and risk, since the other may not live up to our expectations. By trusting another person we put ourselves in a (potentially) vulnerable position. The exact nature of this vulnerability varies with the kind of goods, or things one values or cares about, that are left or put within the power of the other. This is so because trusting someone can be construed as entrusting. On this analysis, trusting another person means entrusting him with something we value or care about. When I trust another to keep my secrets, or to look after my children, or not to steal something from me in an unguarded moment, I entrust to him my secrets, my loved ones and my goods. To entrust something to another person means giving him access to it, putting it under his control, or letting him take care of it, while expecting him to use and exercise this access, control or care rightly. This requires some discretionary powers on the part of the trusted other and part of the trust given is a trust in the judgement and capacities of the other to do what has to be done in order to care for the good he is entrusted with. As Govier (1992) expresses it, the expectations that trust entails are open-ended - what is expected is not (and cannot be) spelled out in detail. Moreover, we also rely on the other’s understanding of what it is exactly that is entrusted to them. For example: a good-willing gynaecologist, who sterilises a woman during a uterus operation because he believes that is better for her, has ‘taken care’ of more than he was entrusted with, and in doing so failed, if not betrayed, the patient’s trust.

Another interesting distinction Baier makes is that between trust as a renunciation of guard or defence, which is the kind of trust we show when we allow others to come close to us, and trust as a renunciation of intelligence, the kind of trust we show when we allow others to take what matters to us out of our sight (Baier 1994, pp. 157-158). Trusting close up entails a vulnerability to immediate harm and invasion of ourselves. Baier appears to interpret this vulnerability in a very physical sense, but I believe psychological closeness and forms of intimacy that are both psychological and physical can (and should) be added to this. The closeness of a physical examination, for example, not only makes a person vulnerable in a physical sense - one could be hurt - but also in a psychological sense, as it can be a shameful or

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7 According to Lagerspetz (1998), the analysis of trust as entrusting is mistaken. However, I believe the kind of trust I am concerned with here (that of patients entrusting their health and decision-making about their health to physicians) can be analysed in those terms - which is not to agree with Baier that all instances or manifestations of trust can.
humiliating experience. Trusting others away from us, “out of our vigilant
gaze”, makes us vulnerable to more indirect kinds of harm. Baier does not
spell out what these are, but I think harm to our goods, our loved ones or
our reputation are examples of this. In the medical context, these two forms
of trust seem to be interconnected in a complex way. If patients trust their
physicians to make the right decisions and give them the right treatment,
they refrain from monitoring and checking the decision-making, and let the
physician come physically close to them in administering the treatment,
or, indirectly, by taking the prescribed medication. Trust can thus be characterised as “letting other persons [natural or artificial,
such as firms, nations etc.] take care of something the truster cares about,
where such ‘taking care of’ involves some discretionary powers” (Baier
1986, p. 240). “Caring for” should be understood here as ranging from leav­
ing alone, to safeguarding, to active interference, and as something that can
require either closeness or distance. The fact that trust is in part a reliance
on the discretionary powers of the trusted also reflects on the vulnerability
which is inherent to trust. When one trusts another person, one is not only
vulnerable because the other may prove to harbour less good will towards
one than one expected, but also because he may fail to use his discretionary
powers in the proper way. The gynaecologist mentioned above did not nec­
essarily lack good will towards his patient but he did fail in his judgement
and misused his discretion.

Reflected and unreflected trust

Trust can exist in various degrees of consciousness, intentionality and ex-
plicitness. We can be more or less conscious of who we trust, what we
entrust them with, or what risks we take in doing so. In everyday life, trust
is so omnipresent that most of the time we hardly realise it is there. As
Baier says: “We inhabit a climate of trust as we inhabit an atmosphere and
notice it as we notice air, only when it becomes scarce or polluted” (1986,
p.234). According to Lagerspetz (1998) this shows that trust is basically
unreflective. It is part of our normal world, part of what we take as given.
In a sense, unreflective trust is the absence of any thought (about what
might happen), attitude or state of mind. It expresses itself as simply acting
- in a way that can only be described as trusting from an outsider’s perspec­
tive. When I trust, Lagerspetz argues, I typically do not think I am trusting.
I do not feel I am taking any risks, or even think about my vulnerability,
because from my perspective, there is no risk or vulnerability. It is only
from a third-person perspective that my behaviour can be described as tak­
ing a risk, or putting myself in a vulnerable position and, consequently, as
trusting. So, trust is not something that goes on within us, but rather a way
to describe what we are doing from a third-person perspective. Lagerspetz
criticises Baier and other authors for taking conscious trust as the basis for

8 This is very clear when we trust a surgeon to operate on us under total anaes-
thesia. We allow him to come very close physically, while at the same time we
allow him to take our body and health out of our own sight.
analysis, whereas in his view "trust as a conscious undertaking is logically secondary to unreflective trust" (1998, p. 31) and hence we should analyse unreflective trust as such. Its unreflective character is not accidental, but constitutive of what it means to trust.

Still, there is nothing incomprehensible in stating that we can and do trust consciously or intentionally as well, being aware of our vulnerability. We can take a third-person perspective to look at our own actions and see the possible risks we take. However, Lagerspetz's point is not so much that we cannot do so, but that once we do it we do not really trust anymore. As soon as considerations of risk and vulnerability are taken into account and once these are weighed against the advantages of trusting, he speaks of reliance, not trust. Although I see Lagerspetz's point, and would agree that what he calls trust is important, I do not believe it is very useful to focus only on this aspect and leave more conscious acts of entrusting or acts of reliance out of the analysis. In everyday language, trust is used to refer to all of these. Moreover, Lagerspetz's analysis seems to rule out the possibility that we can trust by degrees. In practice however, trust does admit of degree - we can trust a person more or less, in more or less calculated ways, and we can trust him in some respects but not in others. For now, I believe Baier's analysis is helpful to understand what is going on when a patient trusts his physician to 'do the right thing', and whether this should properly be called reliance rather than trust is not my primary concern.

Pathologies and dangers of trust

Trust is often seen as something desirable and good, because it is a precondition for intimate relationships as well as for cooperation between strangers. Without trust, it is often remarked, cooperation, society, and daily life as we know it would not be possible (Gambetta 1988, Mechanic 1996, Govier 1992). Though Baier also mentions these positive sides of trust, she does not assume that trust is always good, virtuous or morally 'decent'. She recognises that trust can help smooth enterprises, institutions and schemes that are morally wrong in themselves and that it can coexist with contrived inequality and exploitation. She also distinguishes a number of 'pathologies' of trust, ways in which trust can degenerate and lead to unwelcome situations. Trust can be faked and it can degenerate into mutual predictability. Trust can be endangered by misuse of discretionary powers, but also by the truster's bad timing of a demand for an account of the use that the trusted has made of them. Trust implies some deference of one's desire to understand what is going on. When the truster cannot to some degree let go of his urge to check and monitor what is going on, the area of trust may shrink, while the area of constant checking distrust expands. In the case of Mr. Boskoop,
it may be argued that his desire to understand and check up on all decisions made by Dr. Bernard and the nurses exhibited a kind of distrust which they felt as an insult to their professional pride. Some of the nurses in particular felt it as a denial of their knowledge and skills and as a denial of their good will towards Mr. Boskoop. Though they tried (mostly successfully) not to let this interfere with their professional attitude, it did create some tensions in the relationship between Mr. Boskoop and the staff. Although the disappearance of trust may be regrettable because it also takes away the advantages that trust can bring (distrust can lead a patient to reject a therapy that would have helped him) it can also be wise and justified not to be too trusting. The fear of insulting others by checking up on them may be so exaggerated that it leads to complete trust without any vigilance. As a result, the chance of misuse or abuse of discretionary powers may become unnecessarily great. Mrs. Huisman's remark that maybe she should have trusted her family physician less with regard to the amounts of medication he prescribed is a rather innocent example of how trust without vigilance can lead to less than desirable outcomes.

Trust in social institutions and arrangements

Whereas Baier's analysis is primarily about interpersonal trust, a distinction can be made between interpersonal trust and social trust, the trust we have in social institutions, arrangements and the like (Mechanic 1996). Trust in persons, however, cannot be detached from this kind of social trust. Although trust can be based on personal experience and knowledge of a specific person, we also trust individuals as representatives of certain social roles. We can trust a physician as a person, because we like him and know him well, but we can also trust him as a physician, because we trust the medical profession in general. Baier rightly remarks that, in practice, trust (as the reliance on the other's lack of ill will) is often mixed with other species of reliance on persons - and this reliance is often based on the social arrangements in which our lives are embedded. We rely on institutions of certification, on procedures for inspection, and on the sanctions of law. All of these serve to diminish the risks of trust and to limit the dangers of abuse of trust, and thus facilitate and enhance both interpersonal and social trust. The reliance on the good will of professionals can be strengthened by institutional arrangements that promote and protect this quality in the representatives of a profession, and it can be weakened by arrangements that fail to do so. For example, trust in the medical profession can be undermined if the assumption that physicians are primarily concerned with their patients' well-being becomes doubtful due to arrangements that put other interests higher on the physician's priority list. The rise of managed care has elicited much discussion on the decline in public trust that it might cause, should utility and budgetary concerns become as important for physicians as their patients' well-being (Mechanic 1996, 1998, McCullough 1999). Medical research can also undermine trust in the profession if there is a conflict between the research (or researcher's) interests and the interests of patients which is not clearly and explicitly resolved in favour of the latter and if no arrangements exist to ensure this is done (cf. Kass et al. 1996).
Confidence in the knowledge, skills and judgement of professionals is enhanced by arrangements to monitor and secure the quality of medical training and guarantee the value of medical certificates. Disciplinary rules and disciplinary committees also function to maintain and enhance trust by putting sanctions on those who fail to behave and perform in the way that is expected of members of a profession, or, in other words, who fail to behave in a trustworthy manner, thereby undermining the trust in the profession as a whole. At the same time, disciplinary rules (and law) also make it possible to rely on professionals and professional behaviour in the absence of real trust.

**Contracts and trust**

It is often assumed that trust relationships and contracts do not go together (Cense 1991, Legemaate 1991). However, contracts or agreements can also be seen as devices that enhance and ensure trust. Agreements or contracts serve to make mutual expectations explicit and install (legal) sanctions and safeguards that facilitate trust. While the contractual model of the physician-patient relationship is often criticised because it assumes an equality that does not actually exist according to the critics, it also gives the patient certain rights and offers him certain safeguards against an abuse of power on the part of the physician. The contractual relationship between physician and patient not only assumes a certain measure of equality but creates it as well. In as far as the patient is dependent on his physician and has no choice but to trust him (or perhaps better: to rely on him), the contract is a means to limit the risks inherent in this trust.

From a legal point of view, the relationship of Mrs. Huisman with her physician was just as much contractual as was that between Mr. Boskoop and his physician. The legal framework by no means rules out the possibility of a trust relationship, however. Mr. Boskoop said he had delegated some decisions to the physician and saw this as a contractual arrangement in which mutual expectations were relatively clear and in which sanctions were present to minimise the risks involved in putting himself in the physician's hands. Mrs. Huisman, however, did not delegate decision-making - she simply trusted the physician. For her, it was not necessary to make expectations explicit, to ask for additional warrants and safeguards, or to rely on sanctions.

Medical contracts and the accompanying legal sanctions and regulations are part of the social warrants for trust in physicians, and in cases in which there is no real trust, they make reliance possible. Baier warns, however, that by analysing trust only in its contractual form, we may lose sight of important aspects of trust, such as the fact that it is generally not something one can give at will and the fact that, due to the role of discretion and discretionary powers, trust can never be made completely explicit, nor risk-free. We may forget that contracts do not capture all there is to say about

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10 A marriage is a contract as well, but this does not mean that spouses have a contractual relationship (Legemaate 1991).
trust and that actually only a very small part of our moral relations and expectations can be modelled after the contract. At some level, real trust will always be necessary to keep cooperation and relationships going, even if they are covered by a contract.

Moreover, I believe there is yet another reason to caution against looking at trust only in its contractual form. Rules and regulations intended to diminish the risks of trust can start to function in a way that undermines rather than promotes or warrants public trust. A system that is inspired by distrust and is based exclusively on control, safeguards and sanctions may undermine real trust rather than sustain or enhance it. For example, the current practice in the United States of having patients sign informed consent forms for many medical procedures seems to have weakened rather than promoted trust in the medical profession. Harris et al. (1982) found that most patients believed these consent forms to be primarily intended to safeguard physicians against malpractice suits, not to protect their rights or interests.

10.6 Trust and autonomy in the medical encounter

After the general exploration of trust in the previous section, I will now discuss trust within the physician-patient relationship, especially with regard to medical decision-making. I will first discuss the relationship between autonomy and trust and examine how autonomous a trusting patient can be. Then I will examine what moral claim a patient's trust puts on the physician and discuss the question of how physicians should deal with patients who entrust decision-making to them.

The trusting patient

Above, I wondered whether Mrs. Huisman was less autonomous because she trusted the physician to make the right decisions, or whether Mr. Boskoop was more autonomous because he tried to keep decision-making in his own hands. Are autonomy and trust each other's opposites? I believe not. If autonomy is understood as the right to self-determination, it is obvious that both Mrs. Huisman and Mr. Boskoop possessed this right - in that sense they were equally autonomous, however much they trusted or distrusted physicians. A person is not obliged to make use of his right to self-determination. This right does not require patients to make their own decisions, it just requires that they be given the opportunity to do so. However, if self-determination is seen as a normative ideal, as good, valuable, and desirable, it can be said that leaving decision-making to others is less 'good' or desirable than making decisions for oneself. Being self-determined and self-directing can be seen as part of the condition and ideal of autonomy. From that perspective, a patient who leaves decision-making to the physician, who trusts the physician to do what is right, is less autonomous than a patient who makes the decisions himself. Still, we clearly cannot make all the decisions that affect our lives ourselves. We do and need to trust others to do certain things for us, to provide us with information, to help us deliberate or to make some decisions for us.
At some point, autonomy as an ideal of self-sufficiency with regard to decision-making becomes incompatible with the reality that we are also social beings, embedded in social structures and relationships and for a large part dependent on others.

When we trust others to make a decision for us, however, we can do so in a more or in a less autonomous way. We can feel more or less compelled to trust others because we are dependent on them. As mentioned above, patients may feel they should leave decision-making to the physician because they lack the knowledge and competence or because of their ideas about a proper physician-patient relationship, not because they really want to do so but because they feel they have no choice [cf. Chapter 6, note 15]. However, patients may also leave decision-making to physicians because they want to do so and because they trust their physician. Such trust need not be given automatically and it need not be blind - it can be given intentionally, reflectively and with good reason, based on evidence that the trusted is indeed trustworthy.

What does a patient need to know and what information does he need to have in order to be able to put a well-founded trust in his physician(s)? First of all, a patient will need some reason to believe that the physician harbours good will towards him, or at least bears him no ill will. In general, this does not seem very problematic, since medicine as a profession is devoted to helping, curing and caring for patients. The presumption of good will (or lack of ill will) seems warranted, especially when social institutions and arrangements are functioning to filter out and sanction the occasional malevolent professional. Secondly, a patient must have some evidence that his confidence in the physician’s knowledge, skills and powers of judgement is justified. This is a more complicated issue. In general, as long as medical education, certification and inspection are present and working well, we have reason to trust that physicians know what they are doing, and can do it well. However, the growing complexity of medical knowledge, the existence of many sub (and sometimes sub-sub-) disciplines in medicine, the availability of medical knowledge to the public (through the media and, lately, the internet) and stories of mistakes and faults made by physicians can undermine trust. Sometimes, these may be good reasons not to be too trusting, to check up on decision-making or to request a second opinion. However, trust in medical professionals not only requires confidence in their technical skills and knowledge, but also in their powers of judgement, and these do not only concern medical-technical matters, but also the goals and values to be served and respected by medical actions. It can be argued that it is impossible to trust physicians to make medical decisions for a person because these do not only involve medical knowledge and skills, but also knowledge of his personal well-being. Veatch [1991] has discussed the question of whether we can trust health care professionals to know what is best for us. He argues that since a person’s interests are personal and depend on his goals and values, professionals cannot know them. According to Veatch, then, we cannot give physicians the discretionary power to make decisions for us since this element is necessarily lacking in their knowledge. Some patients, like Mr. Boskoop, recognise this and do not entrust decision-making to their physician but try to keep it in their own hands. The next
question Veatch poses, however, is whether we can trust professionals to give us objective information and so enable us to make our own decisions. He concludes that since purely objective facts do not exist and because facts cannot be presented in a neutral way, professionals cannot be trusted to present the facts objectively "not because of their shortcomings as professionals, but because of the inherent limits in the process of reporting professional knowledge" (1991, p. 166). Mr. Boskoop, who seemed aware of this too, in fact did try to check up on the information he received from his physician by asking for publications and references on a proposed therapy. Although I do agree with Veatch's argumentation, I do not share his conclusion that we cannot trust physicians to make decisions for us, because I believe that his conception of trust is mistaken. The emphasis in Veatch's discussion of trust is very much on the element of confidence, which is an epistemic attitude (Cooper 1985). Having confidence entails having certain beliefs about the other - his skills, knowledge or abilities - that can turn out to be true or false. According to Veatch, the nature of personal well-being and that of medical knowledge are so different that confidence in physician's abilities to know what is the best course of action for their patients is unwarranted because they cannot know their patients' interests. However, Veatch does not recognise the elements of vulnerability and risk that are inherent in trust. That we can never know with certainty whether the other will take good care of what we entrust him with does not mean we cannot trust anyone anymore. On the contrary, to trust means to accept a certain amount of risk and vulnerability (Baier 1986, Collopy 1999). The question is how much uncertainty and risk we are willing to accept, and how much evidence we require that the risks are within limits. We may not be able to trust physicians to know all our deepest values, preferences and goals or to give us completely objective information, but perhaps we can trust them to try to understand our personal interests as best they can in making decisions for us and selecting the kind of information that we need to be able to make up our own minds. And perhaps this can be enough to base our trust on - not the infallible certainty that physicians will know best what to do, but the grounded belief that they will do their best and come close enough (to providing the information that we need or to making decisions that fit our values and goals) for us to accept the remaining uncertainty and vulnerability.

Reasons for believing that physicians can indeed be trusted to do this, and have the skills to do this, can be found both in institutional and social arrangements, but also in the performance and behaviour of the individual physician. As Mr. Boskoop remarked, a physician can earn trust by his attitude and performance (cf. Stüssgen 1997). By showing his interest in the patient's own point of view he can confirm the presumption of good will and by setting the right diagnosis and informing patients about the expected side-effects of a treatment he can enhance trust in his medical

11 Of course these tasks, too, require specific knowledge, skills and powers of judgement, as was discussed in Chapter 6.
knowledge and skills. By taking into account the patient’s own values and preferences in the presentation of information and treatment options he can confirm trust in his understanding of the patient’s personal interests (Thom & Campbell 1997, Mechanic & Meyer 2000)\(^\text{12}\).

It can be concluded that patients can have good reasons to leave some decisions regarding themselves and their lives to physicians on the basis of trust, and that this does not necessarily diminish their autonomy. This does not mean that the evidence must always be weighed and judged explicitly and consciously to warrant trust, or that risks and benefits of trust must be weighed in such a way. As Baier says: “Trusting is taking not-so-calculated risks, which are not the same as ill-judged ones” (1994, p. 196). The warrants for trust, or the evidence that trust is well-founded, can be so much a part of our ‘normal’ world, that it enables us to trust unreflectively, as Lagerspetz calls it. The fact that we usually do not really think about these warrants does not mean we cannot take the third-person perspective and see that they are there, but that usually we will only do so in cases in which our trust is in some way challenged and not self-evident anymore. Trusting others also involves a degree of trust in one’s own powers of judgement - in that sense it seems we need to be autonomous to some degree (that is, have some values, goals and standards of judgment that are our own) to be able to trust at all.

**The moral claim of trust**

Until now, the argument has been put forward mainly from a third-person perspective. As Lagerspetz stresses, considerations of risk and vulnerability only enter the discussion of trust when we trade the first-person perspective for an outsider perspective. From the first-person perspective I am, as a trusting patient, not taking any risks by leaving decision-making to my physician. I simply know he will do the right thing, or rather, the thought does not even enter my mind that he would not. From this perspective I do not need evidence to justify my trust. On the contrary, the fact that I trust determines my outlook on what I regard as evidence. If I truly trust my physician to do the right thing, this means I believe that whatever he does is the right thing, not because of any additional evidence, but because it is he who has done it.

In the same way, I may not believe my physician knows what is best for me, but I can trust him to provide me with information and accept that information as true and right, because it is he who gave it to me. I may not

\(^{12}\) Thom and Campbell (1997) found that, apart from structural and predisposing factors such as age, patients’ trust in physicians is influenced by their thoroughness in evaluating problems, the adequacy of the treatment they provide, their understanding of the patient’s individual experience, clear and complete communication, by their expressing care, building a partnership and sharing power, and demonstrating honesty and respect for the patient. Mechanic and Meyer (2000) found both physicians’ interpersonal competence (involving caring, concern, compassion and listening) and technical competence to be very important for patients’ trust.
believe other pieces of information that go against what my own physician told me, because I do not trust the source of that other information (for example, a television programme). I choose who to believe, which is the same as saying that I choose whom to trust (this choosing need not be conscious, of course, it is simply that my believing one piece of information and not another shows that I trust one source but not the other). This shows, according to Lagerspetz, that reasoning or making rational judgments always involves taking some facts and beliefs on trust. As he argues, “this taking on trust will not in its turn be based on reasoning since it is itself a part of reasoning” (1998, p. 96). In other words, “a certain preparedness to take other people’s testimonies on trust is constitutive of what we mean by rationality” (1998, p. 96)

Lagerspetz sees trust not as a cognitive but as a moral relation. The point is not that we can be wrong in expecting others to behave in certain ways (they may fail to meet our expectations) but that when I trust someone, he wrongs me if he does not take account of my expectations. He does not necessarily have to fulfil them (he may not be able to do so, for various reasons), but at least he should take them seriously. Trust is more than confidence - it is not just an epistemic attitude but a moral claim on the trusted person to behave in a certain way. Perhaps this is where the notion of good will, or lack of ill will, comes in again. When we trust we do not only expect others to have good will towards us, we also claim a certain right to their good will towards us. Although Baier says that the phrase: “I trust you!” can be more like a warning or a threat than like an expression of trust, it may actually be a perfect expression of what trust (also) is: the claim on an other to show me good will, to respect my expectations and not to take advantage of me. This analysis shifts the perspective from the question of how our trust can ever be warranted to the question of what the trusted should do not to betray our trust.

If a patient says he trusts the physician to make the right decisions for him, the physician must realise that in many cases he cannot do so unless he knows at least something about the patient’s values, goals and preferences. So, in order not to betray the patient’s trust, he will have to try to learn something about them and to base his proposals or decisions on them. In more complex cases, in which values and goals are more prominently present, he may even have to insist that he cannot make the decision for the patient, because what the right thing to do is depends heavily on the patient’s own views on life. It may be a betrayal of trust to make a decision for the patient knowing that you are not in the position to do so in the way the patient expects you to. In such cases the physician will, first of all, have to make it clear to his patient that the decision at hand hinges on highly personal norms and values. If a patient understands that very personal views on life are at stake but still wants the physician to make the decision, it is no longer a matter of trusting the physician to make the right decision, but of letting the physician decide.

However, it is conceivable for some patients to trust their physicians to make the right decision because they have more confidence in the physician than they have in themselves. They may feel they do not know (anymore) what their goals and preferences are, and believe the physician will know better.
For example, they may be at a loss about what it is they really want and let themselves be guided by what the physician believes to be best, or by what the physician knows (most) other patients believe to be best. As discussed in the previous chapter, disease may disrupt a person’s value pattern and priorities. However, as I have argued, the response to this should be to try to support the patient in redefining himself and his values and goals. Moreover, in situations such as these, trust in family or friends to help one with decision-making or to make the right decisions for one may be more warranted than trust in physicians [cf. Veatch 1991]. Others who know the patient well are usually in a better position to help him in his search for suitable goals and values than are physicians or other ‘strangers’. Moreover, the fact that one trusts one’s intimates may be grounds for adopting the courses of action or the goals and values they propose as one’s own. Only if this does not work should the physician make decisions for the patient — not because he can be trusted to know best, but because some decision must be made.  

10.7 Summary and conclusions

In this chapter I have argued that being autonomous does not entail that one should make all decisions concerning one’s life for oneself. First of all, since we are all social beings embedded in relationships with others and are all in some ways dependent on others, it is impossible to make all decisions that affect our lives ourselves. Secondly, although we may consider autonomy to be valuable because by making decisions for ourselves we make our lives ‘our own’, this does not entail that we must make each and every decision ourselves in order to have our own life. In different domains of his life, or with regard to different issues, a person can choose to either make his own decisions or to leave decision-making to others. Although people can be said to be more autonomous in the degree that they make more decisions, in more areas of their lives, for themselves, it is impossible to be completely autonomous in the sense that one makes all decisions concerning one’s life by oneself. Moreover, I believe this is not desirable as an ideal either, because it precludes cooperative relationships.

Whether or not we accept it as an ideal that people should make as many decisions as possible themselves, such an ideal should not be forced upon people. People should be allowed to choose for themselves how many and what decisions they want to make on their own and what decisions to leave to others. In this sense, the right to autonomy also implies a right to choose for oneself how autonomous one wants to be.

In the medical context, these conclusions mean that autonomy need not express itself exclusively in (participation in) medical decision-making. Having control over one’s daily life and being allowed and enabled to make

13 This does not mean the physician will have to make a blind guess - if he knows the patient he will have some idea of what will be best for him, and if not, his experience with other patients may guide him.
'small' non-medical decisions for oneself is also part of autonomy. Patients who do not want to participate in medical decision-making may still want to retain control over daily matters, and respect for autonomy requires that they should be allowed that control. Furthermore, the right to self-determination does not entail that patients should make all medical decisions themselves - they should be allowed and enabled to do so, but they can also choose to leave decisions to physicians.

It is a matter of personal choice whether or not one places trust in a physician and leaves (part of) medical decision-making to him. Some people have a greater need for control while others find it easier to hand over some of their sovereignty to others. There is a difference, however, between being forced to trust because one has no other options, and choosing to trust. Moreover, there is a difference between blind and unreflected trust and trust that is based on reflection and backed up by warrants. Although trust need not be conscious and calculated to be reasonable, it can only be given unreflectively against a background of largely self-evident warrants and safeguards. Consequently, when patients trust their physicians to make the right decisions for them, this does not necessarily mean they are less autonomous. As long as they are enabled and allowed to be more involved if they want to, it can be an equally autonomous choice to entrust decision-making to others, to delegate it, to share it, or to do it all by oneself.

A patient who trusts his physician does not give him a licence to do whatever he sees fit. Trust as a moral relationship puts a claim on the physician to take the expectations of the patient seriously and to respect them. This means that he should do his best to understand what will be conducive to the individual patient's well-being, but also that he should say so if a decision involves such personal values and goals that he cannot make the 'right' choice without at least having discussed it extensively with the patient.