

To the Graduate Council:

I am submitting herewith a dissertation written by Christopher Meyers entitled "Freedom, Autonomy, and Responsibility: An Analysis of Autonomy in Applied Settings." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Glenn C. Graber
Glenn C. Graber, Major Professor

We have read this dissertation
and recommend its acceptance:

Ron B. Edwards

Charles H. Reynolds

Betsy C. Poston

Accepted for the Council:

Lew Minkel
Vice Provost
and Dean of The Graduate School

FREEDOM, AUTONOMY, AND RESPONSIBILITY:
AN ANALYSIS OF AUTONOMY IN APPLIED SETTINGS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
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Christopher Meyers

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DEDICATION

This dissertation is dedicated to the memory of my father, Ian Henry Meyers. His teachings and his philosophy are evident in this work and in the person I have become.

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It is an overworn cliché to note that no scholarly work is the product of one person alone. However, as with most clichés, this one is founded on a great deal of truth. Thus I would like to thank the following people, without whose help this work could not have been managed.

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student often is a miserable experience. Michael Burgess, Brian Hilliard, Gary Levvis, Cy Anders, Peter Lazzara, and especially Michael Watkins made my experience not only tolerable but frequently a joy.

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Finally, to my wife, Cynthia: your love and your continuous and unqualified support provide the foundation for all of my work.

ABSTRACT

While it appears that respect for autonomy has become the fundamental principle in medical ethics, it is not clear what various authors have in mind when they use the term "autonomy." Accounts range from an equation of autonomy with negative freedom to a Kantian emphasis on self-governance.

My goal here is to characterize that status in persons which we call autonomy and which demands our respect in such applied settings as medicine. What types of behavior must be present for us to honor persons' decisions as autonomous? And what kinds of factors can constrain that behavior?

My answer is that being autonomous means being as much responsible for one's life (i.e., being negatively free, engaging in reflective deliberation, and identifying with one's decisions/actions) as the situation allows and warrants. In explaining what these various claims entail, I note that autonomy is an exercise concept and that it admits of degrees. Being autonomous requires more than simply having the capacity to engage in certain kinds of behaviors; the autonomous person exercises those capacities. Furthermore, persons are more or less autonomous in different situations, and different types of decisions demand varying

levels of autonomous behavior in order to warrant our respect.

In addition to explaining what it means to be autonomous, I discuss the broad range of factors which can constrain autonomy. I extend the traditional analyses of constraints and show how such factors as illness, socio-economic and institutional realities, and interpersonal communication can constrain persons' ability to be autonomous.

I conclude with an argument that persons have an obligation to be autonomous. This argument is based both on a position of self-respect and on avoidance of harms to others.

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INTRODUCTION

Respect for autonomy has become the fundamental principle in the vast majority of approaches to medical ethics. The principle is used as a guide for any number of issues, ranging from informed consent to legitimate levels of governmental regulation in professional practice. However, as Gerald Dworkin points out,¹ "It is . . . apparent that the term [autonomy] is used in very different ways by different authors. It is not at all clear that they are referring to the same concept . . . " (Dworkin, 1981, p. 203). In Chapter I of this work I hope to show that there are a number of concepts at work. And, as a result, that there is a large discrepancy between ethical recommendations (both in case-by-case analyses and policy determinations) that use the principle of autonomy as a foundation.

Is there one correct use of "autonomy"? I suspect there is not. It seems to be a paradigm case of what W. B. Gallie² has termed "essentially contested concepts"; i.e. concepts which have no clearly definable use that can be deemed the accurate use. Within the philosophical tradition

¹Gerald Dworkin, "The Concept of Autonomy" in Science and Ethics, Rudolph Haller, ed. (Amsterdam: Rodlopi Press, 1981).

²W. B. Gallie, "Essentially Contested Concepts," Proceedings of the Aristotelian Society, Vol. 56, 1955-56, pp. 167-197.

there are two broad categories of ways "autonomy" is used. The first use refers to the status one has as a moral agent and attempts to delineate the conditions necessary for being such an agent. The second use refers to one's status as a self-governing, independent agent who chooses her own policies, decisions, and actions and is thereby self-determining. And within these two categories there is a wide range of interpretations as to which conditions satisfy the proposed requirements of moral agency or self-determination.

Although my project is oriented toward the second category, this is not because I think this is the only correct way of using "autonomy." My approach, instead, has been to look at the way the principle of autonomy is used in medical ethics literature and in clinical practice; to determine what values we are attempting to confirm in our respect for and promotion of autonomy, and thereby to determine what kinds of decisions we are willing to honor as autonomous and why. This perspective--what conditions must be present for us to honor decisions--is the primary focus of this work. However, there is a clear connection between those conditions and the respect we have for the person making the decision. I do not mean by this the kind of respect we have for persons qua moral agents; rather, the respect I have in mind is an aretaic judgment of the sort: "She is a responsible person." Thus, although my main goal is to determine

what need be present for us to honor decisions as autonomous, such a determination should also give us insight into the related respect we have for responsible persons.

In using the described approach (i.e., of looking at the way "autonomy" is used), I have two goals. First, I hope to capture many of the normative concerns that underlie our use of "autonomy" in applied situations. In this process I hope to make explicit what is often assumed and thereby often unclear. Second, I hope to ease some of the confusion that surrounds the range of uses of "autonomy." That is, if I do in fact exhibit a common theme in the various uses of "autonomy" then communication among ethicists and health care personnel can be greatly facilitated.

What is the "common thread?" My claim is that the decisions we honor as autonomous are those in which the agent is dispositionally responsible and negatively free. A major portion of this work will be devoted to cashing out this notion of autonomy. In Chapter I, I will critically examine three popular contemporary accounts of autonomy--those of Robert Veatch, Tom Beauchamp and James Childress, and Terrence Ackerman. I will borrow from each ideas which are useful and show how their accounts come up short. In Chapter II, I will provide my positive characterization of autonomy. In doing this I will analyze the notions of self-governance, of deliberation and practical rationality, and of the agent's identification with her decisions/actions.

However, my goal in this work is more than simply providing a characterization of autonomy. I think that one of the major failings of contemporary literature is that it often at least implicitly assumes that any individual of sound mind and mature years is fully able to make totally autonomous decisions. This sort of assumption, though, ignores the enormous range of illness-related, social, institutional, and economic factors which can constrain our ability to be autonomous. Thus, Chapter III will be devoted to explaining some of those factors, showing how they can represent a constraint on autonomy.

Finally, in Chapter IV I will show how autonomy must be understood within the the specific context with which the agent is concerned. In the process I will give an explicit defense of the idea that autonomy admits of degrees as well as address the issue as to whether our obligation is to promote, as opposed to merely respect, autonomy.

At this point I would like to set out some preliminary clarifications of the ways in which I will be using certain crucial terms.

First, throughout the paper, I use the terms "freedom" and "liberty" for the most part interchangeably. Both terms will be used in the sense of "negative liberty" suggested by

Isaiah Berlin.³ That is, one is at liberty when there are no external constraints (using "constraints" here in the sense to be explained in pp. 6-8 below) upon a person doing as she would were those constraints not present. Although there are a number of convincing arguments that the distinction between negative and positive liberty is suspect,⁴ I maintain it because of the way the term "liberty" is ordinarily used. That ordinary usage is more often affiliated with political liberty and is primarily concerned with whether there are legitimate interferences with one's liberty and if so what kinds. For example, when President Reagan says (in the 1985 State of the Union Address), "Every dollar the federal government does not take from us, every decision it does not make for us, will make . . . our future more free," he clearly has in mind the sense of negative freedom described above.

I grant that I have based the distinction on somewhat arbitrary reasons; i.e., if, for example, MacCallum can

³Isaiah Berlin, Four Essays on Liberty (New York: Oxford University Press, 1969). I also distinguish between "positive freedom" and "autonomy," despite many similarities in the notions, for much the same reasons I distinguish positive and negative liberty. My only hesitation with this second distinction is that some of the authors with whom I will be working--most notably Howard Waitzken and Frithjof Bergmann-- use the term (positive) freedom in quotations wherein I will be referring to autonomy. I will again note this when the situations arise.

⁴See, for example, Gerald C. MacCallum, "Negative and Positive Freedom," Philosophical Review, Vol. 76, 1967.

successfully show that his "triadic" account of freedom captures all the concerns we would want to include under both negative and positive freedom, then the distinction does not seem valid. However, on MacCallum's account we are forced to use "freedom" in ways which run counter to the way we ordinarily use the term.⁵ And while that usage may make a (somewhat strained) sense to those of us trained in philosophical jargon and analysis, it would not make much sense at all to the woman on the street, or more important for my purposes, to the ordinary clinician or patient. I have already stated that part of my goal is to facilitate communication between the ethicist and health care personnel. In doing this it will sometimes be necessary for us to use concepts that are familiar, even if those concepts rely on relatively artificial distinctions. However, I advocate this kind of approach only if there are concepts which adequately capture all of our concerns. In this case there are. By referring to both negative freedom and self-governance (or being responsible for one's life) we use terms that are relatively familiar and that, when carefully explicated, capture all we need for full moral analysis.

⁵Since MacCallum's concern is with specific actions (the freedom from constraint to do x), we will have situations in which individuals are constrained from doing anything but a specific, possibly mundane, action. I will return to this criticism of MacCallum's account in the first part of Chapter II.

Given my use of negative liberty--when one is not externally constrained from doing what one would without those constraints--it is clear that we need an understanding of "constraint." I will be arguing more fully later that the notion of autonomy entails but is not identical with freedom. Part of the way this is revealed is by looking at what constitutes a constraint on freedom as opposed to what constitutes a constraint on autonomy.

One of the more plausible accounts of the former is presented by David Miller in his essay, "Constraints on Freedom."⁶ Miller, consistent with most other writers on this topic,⁷ distinguishes between constraints which are the result of human agency and natural physical obstacles. To this effect, Miller distinguishes between that which causes someone to be "unfree" and that which causes someone to have the "inability" to perform a given action (Miller, 1983, pp. 68-75). That which renders someone unfree is a constraint and "the appropriate condition for regarding an obstacle as a constraint on freedom is that some other person or persons can be held morally responsible for its existence" (Miller,

⁶In Ethics, Vol. 94, #1 (October, 1983), pp. 66-86. For similar accounts see: Cheyney C. Ryan, "The Normative Conception of Coercion," Mind, Vol. 89, pp. 481-498 and Robert Nozick, Anarchy State and Utopia (New York: Basic Books, 1974), pp. 162, 163-164.

⁷A possible exception might be John Rawls' discussion of natural assets and physical attributes in A Theory of Justice (Cambridge: Belknap Press of Harvard University Press, 1971) especially section 77.

1983, p. 72). By including the clause that other persons "can be held morally responsible" for the existence of the constraint, Miller allows for constraints which are not deliberately imposed, which exist either because an agent imposed it or because she failed in her obligation to remove it, and which exist regardless of whether an agent is causally responsible for it (Miller, 1983, pp. 72-73).

Miller's inclusion of moral responsibility, however, does not entail any necessary claim as to the justificatory status of the constraint. There are, he notes, justified constraints on freedom (e.g., I can justifiably constrain your freedom to harm me). Unless we acknowledge such justified constraints, he points out, we are forced to accept a "moralized" concept of freedom, with the attendant problems that go along with such a concept.⁸ Also, in appealing to his moral-responsibility clause Miller argues that "some other person or persons" can include institutions or corporations, so long as it is "possible in principle to point to

⁸For an account of those problems see, G. A. Cohen, "Capitalism, Freedom and the Proletariat," in The Idea of Freedom A. Ryan, ed. (Oxford: Oxford University Press) and Cohen, "Illusions About Private Property and Freedom," in Issues in Marxist Philosophy, Vol. 11, John Mepham and David-Hillel Rubin, eds. (Sussex: Harvester Press, 1981). In the latter article Cohen mistakenly attributes a moralized definition of freedom to Nozick (Cohen, 1981, p. 228), whereas Nozick, like Miller, actually has a moralized definition of constraint.

one or more individuals who contributed to the outcome intentionally or in dereliction of duty" (Miller, 1983, p. 81).⁹

Thus Miller's definition of "constraint on freedom" is narrow enough so as not to include natural physical obstacles to a chosen end, yet broad enough to include acts of omission as well as acts of commission. In these latter cases (primarily, but not exclusively associated with negligence) the responsible actor need not have intended the result. Her responsibility is due, rather, to an obligation she has to bring about or maintain a given end.

Miller's definition, however, is not broad enough to account for all elements which constrain a person's ability to deliberate effectively and to identify with her decisions/actions, i.e., to be responsible for her life and thereby autonomous. Other constraints I have in mind include such things as social, institutional, and economic factors as well as the constraints which result from illness. With none of these need there be any "person or persons who are morally responsible for their existence." Social, institutional, and economic factors often have little or no direct connection to a specific person or

⁹For a more extensive defense of this position see my article, "The Corporation, Its Members, and Moral Accountability," Journal of Business and Professional Ethics, Vol. 3 #1, Fall, 1983, pp. 33-45.

persons.¹⁰ And with constraints of illness (though involving human activity and thus distinct from physical obstacles) there is neither another person or persons involved (unless one intentionally or negligently infects another), nor is there any real sense of moral responsibility (unless one claims that there is a general moral responsibility to cure all illness, a position I find untenable). Nevertheless I hope to show in Chapter III how these elements do represent constraints on autonomy, even if we would not want to call them constraints on freedom.

What then is an adequate definition of "constraints on autonomy"? I doubt whether precision in this area is possible, for such a definition would have to be so broad as to be unhelpful (e.g., those conditions which prevent persons from deliberating effectively and from identifying with their decisions/actions). However, such constraints must have some human involvement (so as to distinguish them from obstacles) and some moral component, in the sense that their existence impedes the achievement of a moral good--i.e., being more fully autonomous. It is also important to stress that constraints, either on freedom or on autonomy, need not render one completely unfree or completely nonautonomous.

¹⁰In chapter III, I will provide a more extensive explanation of this "structuralist" approach to certain social and/or economic entities.

As I will be arguing in Chapters II and IV, both of these concepts admit of degrees.

A third and final point of clarification involves the difference between respecting and promoting autonomy. Are or should or need we only be doing the former? It might be argued that promotion of autonomy, in the sense of directly encouraging or requiring persons to be autonomous, represents a contradiction. In promoting one's autonomy we necessarily are interfering, in at least a loose way, with that person's decision-making. But I will be arguing, contrary to such writers as Robert Veatch, that the concept of autonomy is not defined as non-interference. Thus, that objection falls aside. Nonetheless, the issue remains a potential problem. While there clearly are morally significant differences between the claim that persons have an obligation to promote, as opposed to respect, another's autonomy and the claim that we ought to respect autonomy, it is not always clear how those differences are or should be revealed in applied settings. In some situations we seem to have an obligation to respect, in others to promote. The focus of this work will orient around respect rather than promotion of autonomy. However, in Chapter IV I will argue that in some contexts persons do have an obligation to promote others' autonomy as well as that persons have an obligation to attempt to become more fully autonomous.

CHAPTER I

CONTEMPORARY ACCOUNTS OF AUTONOMY

The predominant theme in contemporary medical ethics seems to be a form of mainline liberalism. There is considerable emphasis placed on patient autonomy and its related requirement of informed consent. In this chapter I will first analyze two popular versions of this liberalism, the negative libertarianism of Robert Veatch and the more sophisticated views of Tom Beauchamp and James Childress, and the control-based position of Terrence Ackerman. I hope to show that while both accounts are helpful, neither sufficiently takes account of self-governance or of the political realities of contemporary health care. Second, I will turn to work by Terrence Ackerman, who takes a positive shift in the analysis by looking at what it is we are trying to accomplish in our respect of autonomy.

Veatch and the Libertarian Tradition

In his book, A Theory of Medical Ethics,¹ Robert Veatch argues for a contractual relationship as the moral foundation for medical ethics. In spelling out this foundation he devotes considerable attention to the conditions that need

¹Robert Veatch, A Theory of Medical Ethics (New York: Basic Books, 1981).

be present for two parties to enter into such a contractual relationship. A necessary, though not sufficient, condition is that both parties be free agents. He states, "Freedom of the contractor must be acknowledged prior to the contract. It is a necessary condition for contracting . . . " (Veatch, 1981, p. 193).

This emphasis on freedom carries over into his discussion of autonomy. In fact, throughout this chapter he seems to want to identify autonomy with the sense of negative freedom/liberty discussed in my Introduction. I qualify my claim ("seems to want") because Veatch presents two, ultimately incompatible, approaches to the concept of autonomy. In explicating these two positions I will explain why I interpret him to be endorsing the "negative freedom" view. I will conclude the section with some criticisms of that view of autonomy.

Autonomy as negative liberty. Veatch's first analysis of autonomy reveals a clear identification of autonomy and liberty:

Would rational people taking the rational point of view find it necessary to include the principle of autonomy² as one of the basic principles for the society in addition to the principles of beneficence and promise keeping? Time and time again,

²Veatch never gives an explicit definition of the principle of autonomy but the general nature of his arguments suggests that he holds that persons have a right to autonomy; i.e., a right to non-interference in their decisions/actions.

the answer to this question has been in the affirmative. Liberty is a fundamental principle, either an inalienable right endowed by the creator or simply a rational necessity for founding a moral system (Veatch, 1981, p. 194, my emphasis);

Those who have reflected on this problem have concluded that individual autonomy is very basic As [Rawls] puts it, rational contractors from behind a veil of ignorance would agree that 'each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others.' The implication is that liberty is basic . . . (Veatch, 1981, p. 194, my emphasis).

This identification is further established in his treatment of "positive" and "negative" rights. In his discussion of the two types of rights he associates positive rights with "entitlement rights" which "require some action on the part of others in order for one to be free to act" (Veatch, 1981, p. 195). While he says that both positive and negative rights "are related to the fundamental principle of autonomy" (Veatch, 1981, p. 195), his examples of positive rights (rights of access to medical care, Medicare, and "courteous treatment") are on the whole related to issues of distribution of economic goods. But, rather than showing the ways in which such distribution is important to respect of autonomy,³ he leaves consideration of them to his chapter on justice and devotes all but one page of his chapter on autonomy to negative rights.

³The relation between distribution of economic goods and respect for autonomy will be one of the issues addressed in Chapter III of this work.

Further, in that chapter on justice he presents the primary conflict as being between rights of individuals to choose, and the need for an egalitarian system of health care. In coming down on the side of egalitarianism he says that this will often result in the constraining of autonomy. That is, the kinds of positive rights one would have to claim in order to assure equal access to health care are presented by Veatch as being in conflict with autonomy (Veatch, 1981, pp. 250-287, especially, pp. 274-275).

By relegating positive/entitlement rights to his discussion of justice Veatch reveals that his use of "autonomy" is almost exclusively involved with negative rights; i.e., one's autonomy will be fully respected if one's negative rights are respected. He equates negative rights with "liberty rights" and includes under them "such medical notions as the right to refuse medical treatment, the right to control one's own body (assuming that only one's body is at stake), and the right to consent to treatment" (Veatch, 1981, p. 194).

Although Veatch does not hold these negative rights to be absolute, he only acknowledges two types of constraints on one's autonomy as being justified. The first are those designed to protect the liberty of others. Accepting the traditional Millian argument he says, "Even liberty in this

restricted [negative] sense must be constrained when it interferes with the like liberty of others" (Veatch, 1981, p. 195).

With respect to the second type of justified constraint Veatch again appeals to Mill and the traditional debate as to whether one may freely give up one's freedom and, for example, sell oneself into slavery. He sides with Mill and says, "society might reasonably place some limits on the surrender of freedom, even if it is surrendered voluntarily" (Veatch, 1981, p. 197). He says "some limit" in order to account for a previous discussion in which he argues that while "society as a whole cannot justify forced control of behavior . . . , [it] is willing to accept voluntary, partial surrender of freedom on the part of the individual himself" (Veatch, 1981, p. 196). But even in these kinds of cases (his specific example is of the "substantially voluntary individual" who commits herself to a mental institution [Veatch, 1981, p. 196]), it is still necessary that the actor freely (autonomously) choose to surrender part of her freedom (autonomy).

Even with these provisos it is clear that Veatch's emphasis is on non-interference. Each of the specific negative rights falls out of the general right of negative freedom or autonomy; i.e., the right not to have one's voluntary

choices constrained.⁴ So long as one's actions do not represent a harm to another, he argues, it would be a violation of one's autonomy (and hence of the moral contract) to interfere with their being carried out. He stresses the importance of non-interference in his closing comment on negative rights: "They [negative rights] all involve claims of autonomy in the sense of an individual's choosing to act without interference from others" (Veatch, 1981, p. 194). And he concludes his theoretical discussion of the nature of autonomy with a strong comment on the near absolute status this principle of non-interference should carry:

. . . Mill himself recognized what those in the natural rights and Kantian traditions have affirmed all along: Autonomy, independent of the good it will normally produce, is by itself a right-making characteristic of actions. Although it might be surrendered voluntarily in carefully specified situations of limited duration and limited stakes, the principle of autonomy itself remains unscathed as a right-making characteristic of action in a moral community. For those who are known to possess autonomy (and have not surrendered it), the principle takes precedence over any moral obligation to produce benefit for them (Veatch, 1981, p. 197).

It is clear, then, that in his first approach to the concept of autonomy Veatch identifies autonomy with the non-interference associated with negative freedom. His emphasis is placed on the individual and her ability to act freely.

⁴He never gives an explicit explanation of what he means by "constraint," but the overall discussion suggests something akin to the Millerian sense described above in my Introduction.

The end of this section and much of the work as a whole will be devoted to showing that such a position is simplistic and does not adequately account for the wide range of constraints on autonomy. But first we need to take a look at the remainder of Veatch's analysis, as it seems to suggest a broader notion of autonomy. I think it will be clear in what follows that Veatch ends up with an inconsistent position⁵ and it will then be our task to speculate, based on his emphases, which of the views he favors.

The placenta case and the obligation to be autonomous.

In addition to the theoretical examination of autonomy outlined above, Veatch also looks at autonomy through an analysis of a case study which he uses to start the chapter. The somewhat unusual subject matter of this case is typical of Veatch's approach. He often chooses examples where our intuitions are pressed, in the hope that agreement here will lead to agreement in less controversial areas.

The issue in the case is whether it is a violation of a patient's autonomy to obtain placentas associated with normal childbirths, without receiving the consent of the delivering mother. To a large degree his response falls into his libertarian perspective. He argues that the women should be questioned and

⁵Whether there is in fact an inconsistency depends on how one reads some ambiguous passages. I hope to show that my reading of them is supported by the surrounding text.

If more than five percent (my arbitrarily chosen cutoff point) would want to be informed, then the group as a whole should be. To do so would inconvenience the researchers and possibly the women, but it would preserve the principle of autonomy (Veatch, 1981, p. 204).

If (at least five percent of)⁶ the women view the lack of informed consent as constraining their freedom, then, because of the obligation to respect their autonomy, the whole group should be informed and given the option to consent--even if no risk will be involved for the mother and even if doing so will result in "inconvenience" for all concerned. Not informing them represents a potential "interference" of the decision-making abilities of the future "five percents" and is thus prohibited by his conception of the principle of autonomy with its libertarian emphasis on non-interference.

Veatch's conclusion in the placenta case also reveals, however, a possible switch in emphasis regarding his views on autonomy. As was just noted, even if only five percent of the women asked expressed an interest in being informed, the entire group should be told. In addition to revealing Veatch's emphasis on free choice-making, the conclusion serves as a bridge to another point he seems to claim about

⁶Veatch does not discuss the problem of whether the women approached represent a valid sample from which to make future decisions. It appears as if he presumes it will be, a presumption that is not at all supported by the description of how the sample will be selected.

what it means to be autonomous. While there is some ambiguity as to whether Veatch is endorsing this additional position, as opposed to suggesting it as a possible interpretation of autonomy, I hope to show that he does want at least in part to defend it, even though in doing so he ends up being inconsistent.

Immediately following his direct discussion of the placenta case, Veatch says:

If autonomy is not only a right, but an inalienable right,⁷ then it seems that there is something dehumanizing about refusal to face important decisions affecting one's future. It is more noble, more responsible, to take an active part in making these decisions. That seems to imply that individuals have not only a right but an obligation to get . . . critical information (information that is neither trivial nor irrelevant because it is known that other decision makers will use values that are the same as the primary decision maker). The principle of autonomy, then, if it is a right-making characteristic of actions,⁸ generates at least a prima facie obligation to get information that would be material to responsible decision making (Veatch, 1981, pp. 205-206).

This argument suggests, however, that Veatch also associates autonomy with something more than freedom. Relating it back to the placenta case, Veatch seems to be saying that

⁷In his discussion of the right to life Veatch argues that "inalienable rights" are "nonsurrenderable," such that one cannot give up, for example, one's right to life (Veatch, 1981, p. 356, n.20). The ambiguity noted in my previous paragraph largely rests on the term "if" which starts this long quotation. Although Veatch never explicitly says autonomy is an inalienable right, I think what follows clearly shows that (at times) he thinks it is.

⁸Note the additional use of "if" preceding a proposition that we already know he does endorse (see p. above).

if having and understanding the information is necessary for making a responsible and, by the above argument, autonomous decision, the women have at least a prima facie duty to seek it and to attempt to take reasonable means to understand its significance for their case. It is crucial to clarify here a distinction between levels of information and of understanding, and unfortunately Veatch's arguments are quite muddled. Pulling claims from a number of different places throughout the chapter seems to show Veatch to be arguing that a certain, quite minimal, level of understood information is necessary for any free action. Without that minimal level, though, persons' actions are not competent and paternalism is justified (Veatch, 1981, pp. 195-196).⁹ However, understanding more extensive information, even "critical" information (his example is the full nature of the risks involved in a given procedure) is necessary for making responsible (and, seemingly, autonomous) decisions, though it is not necessary for free decisions. And since, by the above argument, he thinks persons have an obligation to be autonomous, persons also have an obligation to seek that additional information. By this argument, then, Veatch has moved beyond his original position of "to be autonomous is to be (negatively) free."

⁹Veatch is also unclear as to how extensive that paternalistic interference may be. It would seem to range from imposing information on persons to forcibly preventing persons from engaging in certain kinds of activities.

However, the argument also lands him in an inconsistency. If I am correct in interpreting him to be endorsing, rather than reporting, this more extensive view of autonomy (i.e., that autonomy is inalienable and that it is linked with being responsible), then persons have a duty to do what is necessary in order to act responsibly--e.g., to obtain information. On the other hand, the principle of autonomy justifies the "right of the individual" not to do what is necessary in order to act responsibly. This view (from his first approach) tells us that being autonomous means choosing freely, i.e., without constraint. If one chooses freely not to act responsibly, then the principle of autonomy demands that we must respect that freely chosen decision and not interfere with the autonomous agent. Hence the contradiction: how can the same principle of autonomy require that a person act in a certain way and require that her decision not to act in that way be respected as autonomous? That is, Veatch's second analysis claims that one must be responsible in order to be autonomous; yet, if the person is being irresponsible (nonautonomous) we must, according to the first analysis, respect her choices, for otherwise we would be violating her autonomy.

Why must we read this as an inconsistency on Veatch's part? It might be argued that he is simply expanding his

view; that he is moving beyond the simplistic non-interference view his first approach suggests, in favor of the second more sophisticated position. Unfortunately the text does not bear out such a reading.

Directly after presenting the "autonomy as being responsible" argument Veatch returns to his original libertarian position:

That same principle of autonomy that generates a right to be informed gives humans the freedom to act in a less than responsible manner. Imposing information on a person would violate the individual's autonomy just as withholding information would (Veatch, 1981, p. 206).

The principle of autonomy, this quotation suggests, ultimately is for Veatch the principle of choosing freely. When the (never fully explicated) minimum conditions necessary for free choices are present, the agent is autonomous and must be respected as such, even when she is not informed enough to make a responsible decision. Hence, the principle of autonomy would,

justify the right of an individual to waive access to what seems like a reasonable amount of information. In all but the [undefined] extreme situation the autonomous surrender of free and active control over one's life is not analogous to Mill's example of selling oneself into slavery where it is argued that the autonomy principle itself prohibits such ultimate surrender of freedom (Veatch, 1981, pp. 206-207).

Veatch further confirms his affirmation of autonomy as negative liberty in his treatment of an extreme issue--the right to refuse treatment:

The question of the right to refuse treatment . . . is reduced to little more than an aside. It makes no sense to talk about getting a patient's consent to nontreatment, whether that patient be terminally ill or not (Veatch, 1981, p. 207).

The overriding concern is with not interfering with the patient's free decision, a decision based on "voluntary consent" which any free, competent adult is capable of giving. If the patient consents to treatment, it is morally appropriate. If she does not, it is not. The complexities of determining levels of autonomous decision-making are simply ignored. Further, the brief appeal to responsible decision-making is lost in the cut and dried libertarian analysis. By returning to this simplistic position, Veatch avoids acknowledging that what constitutes free, unconstrained decisions is not in all cases what constitutes autonomous decisions.

Summary and additional criticisms. To summarize quickly, despite the section on "acting responsibly," Veatch ultimately defends the view that being autonomous is equivalent to having negative liberty, to not being constrained ("interfered with") in one's free choices. Setting aside the inconsistencies in his arguments, is his minimalist libertarian view itself defensible?

The answer to this question will be one of the aims of the remainder of this work. For now, suffice it to note that the position is naive and simplistic with respect to the way persons actually go about making decisions and with

respect to the kinds of considerations that can constrain autonomous decision-making. Veatch does not take into account such considerations as power asymmetry, illness-generated constraints, and institutional coercion. In this account Veatch simply does not acknowledge the social, political, psychological or institutional realities of illness and of health care delivery.

Despite these problems, Veatch does point to at least two claims that I take to be crucial to the concept of autonomy. The first is the linking of autonomy with responsible decision-making. Although he vacillates between accepting and rejecting this link, Veatch seems to recognize the relevance of a crucial connection between the concepts. A defense of this and the related notion of the obligation to be autonomous will be my major affirmative theoretical argument in this study. I will argue that given its intended use in applied ethics contexts, autonomy is best understood as "being as responsible as possible for one's life." Chapter II of this work will be devoted to unpacking and defending this claim.

The second claim of value, and it is closely allied with the first, is never explicitly defended by Veatch, though there is much to suggest that he holds the view. That is, that there is a range of autonomous behavior, from the minimally autonomous to the fully autonomous.

The suggestion that Veatch holds this view lies in his use of such qualifying terms as "substantially" and "essentially." In his defense of weak paternalism he states,

It must be conceded that society has the right to intervene to protect the welfare of individuals who are substantially nonautonomous, whose actions are essentially nonvoluntary [T]he real problem comes when the person is substantially autonomous or when we do not know whether he or she is autonomous (Veatch, 1981, p. 195).

Elsewhere he comments that "the mentally ill, but still substantially voluntary [autonomous] individual" should have her status as an autonomous individual respected (Veatch, 1981, p. 195). By including these qualifiers, Veatch (possibly without explicit awareness) is suggesting that respect for autonomy involves respect for various degrees of autonomous behavior. The interesting issue, and it is one Veatch does not address, is what minimal level of autonomous behavior should be respected. We must also ask whether these minimal levels differ in different therapeutic settings; i.e., whether the same level of autonomous behavior should be respected in a terminal cancer unit as in a family practice clinic. I hope to show in this work that these questions are the ones with which the applied ethicist must be concerned. As it now stands, most theoretical analyses do not account adequately for morally significant situational variables.

Beauchamp and Childress

Despite its defects (as shown by my criticisms), Veatch's appeal to negative liberty is important and valuable to a thorough discussion of autonomy. Most of contemporary medical ethics literature at least implicitly acknowledges this in its arguments, for example, that constraints should be removed so that valid informed consent can be achieved. However, of at least as much importance to understanding the nature of autonomy is the Kantian notion of self-governance.

Tom Beauchamp and James Childress are two of many contemporary writers who include self-governance in their analysis of autonomy. In the second edition of their Principles of Biomedical Ethics¹⁰ they state:

The most general formulation of autonomy . . . is that a person is autonomous if and only if he or she is self-governing. Autonomy as governance in the absence of controlling constraints points to the individual able to legislate norms of conduct (Kant) and able voluntarily to fix a course of action (Mill). Only if these conditions are present is a person autonomous (Beauchamp and Childress, 1983, p. 61).

As this quotation suggests, Beauchamp and Childress defend a view of autonomy that includes the notion of negative freedom. But unlike Veatch they do not identify autonomy with negative freedom. They recognize that a full account

¹⁰Tom Beauchamp and James Childress, Principles of Biomedical Ethics, 2nd edition. (New York: Oxford University Press, 1983).

of autonomy must also include the notion of self-governance. For them the autonomous person must be free (in the sense of negative freedom on which Veatch focuses) and must be an agent who chooses her own principles. However, as we will see in their discussion of authority and autonomy, their sense of self-governance is in fact quite weak. I hope to show that this weakness in part evolves out of their relative misreading of Mill's On Liberty.

In formulating their concept of autonomy, Beauchamp and Childress make brief appeal to the classical roots of both components. For self-governance they appeal to Immanuel Kant and for liberty they appeal to J.S. Mill. In this section I will outline their interpretations of Kant and Mill, showing ways in which their accounts are either misguided or inadequate. I will also criticize their overall account of autonomy by briefly discussing their views regarding the compatibility of being autonomous and complying with authority figures. Their views here reveal their misreading of Mill, the inadequacies of applying their account of autonomy to practical settings, and their naivete regarding clinical realities.

Before we jump into the specific interpretations, a quick look at the similarities and differences between Kant and Mill is helpful. They are similar in that both, at least in their moral philosophy, emphasize freedom and the

autonomy of persons.¹¹ The difference is that Mill emphasizes liberty or freedom of action while Kant emphasizes freedom of the will. David Ost¹² draws the distinction nicely:

[L]ibertarians like J.S. Mill emphasize liberty, freedom from external constraint, as autonomy in the primary sense, while others, like Kant, emphasize freedom from internal constraint (i.e., freedom to be rational) and minimize the factor of external constraint--though there is in each, to be sure, a strain of the other (Ost, 1984, p. 304, his emphasis).¹³

Clearly an adequate concept of autonomy would account for both inner and outer constraints and Beauchamp and Childress do right to develop a concept that borrows from both camps. I will argue, however, that they, consistent with traditional readings of Mill, under-emphasize Mill's discussion of "inner" constraints on liberty as well as his related arguments concerning self-governance. But first let us turn to the elements they do borrow to determine whether they are

¹¹Although Mill does not, to my knowledge, use the term "autonomy," I think it will become clear that his numerous discussions on "being an individual" are dealing with the same basic issues.

¹²David Ost, "The 'Right' Not to Know," The Journal of Medicine and Philosophy, Vol. 9, No. 3, August, 1984, pp. 302-312.

¹³While Ost does a nice job of delineating the differences in emphasis between Kant and Mill, he makes the common error of equating in Mill the concepts of autonomy and liberty. I will argue that though liberty is, for Mill, a necessary element of being autonomous, it is not equivalent to it.

faithful to Kant and Mill and whether the account of autonomy which emerges is satisfactory.

Kant. For the most part Beauchamp and Childress' interpretation is consistent with that presented in contemporary medical ethics literature:

In analyzing autonomy, Kant contrasted it with heteronomy (rule by other persons or conditions). To be autonomous is to govern oneself, including making one's own choices, in accordance with universalizable moral principles, i.e., principles that can be willed to be universally valid for everyone (Beauchamp and Childress, 1983, p. 60).

To be autonomous, for Kant, is to choose one's own principles. But, as his emphasis is on the will, the constraints on such choices are potentially of a different nature than are the constraints on one's liberty. Beauchamp and Childress do not acknowledge that for Kant the will is unconstrained only when it is acting in accord with pure reason.¹⁴ The non-autonomous individual is one whose will

¹⁴Their failure to acknowledge this is the first of two areas in which their interpretation of Kant is less than optimal. Emphasizing the role of reason is not crucial to their account of autonomy. But given their appeal to Kant and given the fundamental role reason played in his views, they should at least acknowledge that their position is leaving out this aspect of his thought. This becomes especially problematic when we see the difficulty of reconciling obedience to reason with self-governance.

is under control of any non-rational influence, including internal coercion (such as emotions, desires, etc.).¹⁵

Hence for Kant the term "rationally-autonomous" would be redundant. The autonomous person is, by definition, rational; decisions based on non-rational considerations--his principal example is seeking happiness--are not autonomous decisions.

This demand for rational decision-making raises a potential problem for the second element in Kant's conception of autonomy--self-governance. How is it that we freely choose our principles of self-governance if those principles must be rational? Kant argues that any truly rational person will necessarily see the validity of the categorical imperative. Hence, any autonomous (rational) person necessarily will choose the categorical imperative as the principle of moral self-governance. How can we reconcile the seemingly contradictory requirement that in order to be autonomous we must freely choose a moral dictum that any autonomous (rational) person must choose? On this view, is not the autonomous person being required to give absolute allegiance to principles "outside" of herself?

¹⁵There is a considerable problem for Kant here. Since the will is of the noumenal realm and cannot be affected by anything in the phenomenal realm, it is very unclear how it could be subject to any form of coercion, either internal or external. However, a full exploration of these metaphysical underpinnings of Kant's view lies outside the scope of the present study.

Kant avoids the contradiction with a crucial step: he argues that the principles are not "outside" us because essentially and finally we are rational persons. In choosing the necessary truth of the categorical imperative we have succeeded in overcoming our gross "inclinations" and appeal to our true, rational selves. As Marvin Fox puts it,¹⁶

Reason is for [Kant] far more than a power with which man happens to be endowed. It is the highest element of man's being, the ground of his uniqueness as human. Kant believes that man's moral life is a continual striving to become more perfectly rational (Kant, 1949, p. xi).

Thus even though the categorical imperative must eventually be chosen by the autonomous (rational) person, the choice of it is for Kant still an act of self-governance. In choosing it we are simply recognizing our final nature as rational beings.

Beauchamp and Childress are sensitive to this problem in their argument that persons are autonomous even while necessarily realizing the categorical imperative. They note that Kant did not want to suggest that each individual must "author" her own moral principle. Rather, he seemed to suggest that in being purely rational the categorical imperative will, in a sense, be revealed. As they put it,

"Acceptance by the agent" needs emphasis. Kant is often interpreted as holding that each individual

¹⁶From the introduction to: Immanuel Kant, Fundamental Principles of the Metaphysic of Morals, translated by Thomas K. Abbot. (Indianapolis: Bobbs-Merrill, 1949).

must make (author or originate) his own principles --a strained interpretation in light of Kant's view that purely personal or subjective principles are morally unacceptable. Moreover this subjectivist perspective denies much that we know about the moral life, and thus we understand Kant to mean only that each individual must will the acceptance of his or her principles (Beauchamp and Childress, 1983, p. 61, their emphasis).

While this quotation represents an accurate interpretation of Kant, it should be noted that Beauchamp and Childress again underemphasize the role of reason in the "acceptance" of moral principles. They would do better to say the individual must first recognize the principle as being based in pure reason and then as an autonomous (rational) individual she will accept the principle for herself.

My second criticism of Beauchamp and Childress' use of Kant is related to the first. They are much too brief in their discussion of how for Kant the recognition of one's status as an autonomous being is a recognition of one as a moral entity, as a being

whose existence has in itself an absolute worth, something which, being an end in itself, could be a source of definite laws, then in this and this alone could lie the source of a possible categorical imperative, that is, a practical law (Kant, 1945, p. 45, his emphasis).

Beauchamp and Childress acknowledge this (Beauchamp and Childress, 1983, p. 62), but they do not discuss why it is

that autonomous beings, persons,¹⁷ are unique in this respect.

Kant's ethical theory, it is crucial to keep in mind, is based on his metaphysical theory of personhood. For Kant a person is of unconditional worth because she is a rational self-determining being. But she is a rational self-determining being because she has the capability to reason, to think in terms of time and space and causality, to gain understanding of the world through the twelve categories, etc. and because she has a noumenal will. In short, a person's moral status is based on her metaphysical status, on her capability to think, to reason. It is because of this capability that persons are able to be autonomous, to be bearers of rights and obligations, and, hence to have unconditional worth.

Neither of these clarifications conflicts with Beauchamp and Childress' account; each merely represents an extension of their position. However, the issues range beyond scholarly interpretation. They carry over into such concerns as to whether, as Veatch at times suggests, one has an obligation to accept information necessary to making responsible decisions. Ost presents a compelling argument

¹⁷Many contemporary writers use the Kantian model as a definition of personhood; i.e. of a being who has rights and obligations and who exists as an end in itself. Although in discussing autonomous agents Kant says "man and generally any rational being," it is clear that he considers humans to be the only known entities who qualify as rational beings.

that if one need be rational to be autonomous and if one need be autonomous to be a bearer of rights, "then to refuse information is ipso facto to claim that one is not autonomous, i.e., not a bearer of rights" (Ost, 1984, p. 304, his emphasis). In other words, Ost argues, one cannot have a right to refuse important information. I will be dealing with these issues in greater detail later. My concern here is to show that by leaving these issues out of their discussion Beauchamp and Childress do not deal adequately with some important elements involved in the analysis of autonomy.

This is not to suggest, however, that their discussion of Kant is not important to understanding autonomy. Most of what they say is accurate and when it is combined with their use of Mill an engaging notion of autonomy emerges.

Mill. As I noted earlier (p. 16, note 9) Mill does not use the term "autonomy." However, in his chapter, "Of Individuality" in On Liberty¹⁸ he presents arguments concerning the development of what he calls individuality and of what he calls character. Using those arguments as a basis, this section will be devoted to two claims. First, I will show that in his discussions of the nature and limits of liberty Mill paid considerable attention to the conditions which need be present for a person to have liberty.

¹⁸John Stuart Mill, On Liberty, ed. by Currin V. Shields (New York: Bobbs-Merrill, 1956).

His discussion of these conditions, I will argue, shows his position to be considerably more complex than the strict libertarianism generally associated with his thought. Second, I will argue that, contrary to many contemporary readings, Mill was not defending a view which presents liberty as the final good which society must enhance or protect. Although at times he presents liberty as an intrinsic value, I will show that he saw it also as a means to other goals--the enhancement of individuality/character which in turn improves society.¹⁹ Further, I read his concept of individuality/character to be of the same nature as our concept of autonomy. Hence, throughout this section I will be using the terms interchangeably. All of the analysis will revolve around Beauchamp and Childress' use of Mill in their formulation of autonomy.

Keeping in mind Ost's distinction between "internal" and "external" constraints as a distinguishing characteristic between Kant's and Mill's thought, we can better understand the way in which Beauchamp and Childress incorporate Mill into their conception of autonomy. They emphasize Mill's concern that persons have the liberty (i.e., not to be externally constrained) to make choices and to act on

¹⁹Berlin is one of the few authors I have seen who read Mill in a similar way. See Berlin, 1970, pp. 128-131 and especially p. 160.

those choices, so long as those choices/actions do not represent significant harm to another. They accurately present Mill's conception of the moral status of liberty as being such that the only justified interferences are those designed to protect the liberty of others. But they do not include in their discussion Mill's analysis of the conditions which need be present for a person to be at liberty, to make free, unconstrained²⁰ choices. Further, they make the mistake of extending Mill's arguments for the protection of liberty to his understanding of autonomy. That is, they do not acknowledge that Mill saw protection of liberty as being valuable in part because it brought about the development of individuality. They do provide a brief description of Mill's use of "individuality" and "character" and they note that development of these traits serves to produce the greatest overall good for society. However, their analysis clearly emphasizes his libertarianism, resulting in a greatly simplified account of his thought.²¹ Devoting more attention to Mill's analysis of "individuality" shows his position to be considerably richer and, I think, more useful.

In explicating the conditions necessary to be at liberty Mill presents, in addition to the commonly noted views,

²⁰Mill's sense of "constraint" seems to be comparable to the Millarian sense described in my Introduction.

²¹Veatch's use of Mill makes this same mistake.

some surprisingly non-libertarian thoughts. The first and most obvious condition, as Beauchamp and Childress emphasize, is that persons must not be externally constrained. This obviously was Mill's principal emphasis and it is the position on which most authors focus.

But Mill also argued that not all persons are competent to make free decisions. In the Introduction to On Liberty he states:

It is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury. For the same reason we may leave out of consideration those backward states of society in which the race itself may be considered in its nonage Despotism is a legitimate mode of government in dealing with barbarians, provided the end be their improvement and the means justified by actually effecting that end (Mill, 1956, pp. 13-14).

He is never explicit as to why children and "barbarians" should be excluded, but we can conclude it is because they have not adequately developed the faculties necessary for making free choices--"observation to see, reasoning and judgment to foresee, activity to gather materials for decision, discrimination to decide, and . . . firmness and self control to hold to his deliberate decision" (Mill, 1956, p. 71). And part of the reason these faculties have not been fully developed, especially in the

case of "barbarians," is that they have not had the opportunity to be properly educated. Hence, Mill argues, the state has the right and the obligation to assure that its citizens be educated.

At the end of two lengthy volumes (Principles of Political Economy)²² in which he extols the virtues of laissez faire economic systems and disparages governmental interference in citizens' lives, Mill argues:

There are certain primary elements and means of knowledge, which it is in the highest degree desirable that all human beings born into the community should acquire during childhood. If their parents, or those on whom they depend, have the power of obtaining for them this instruction, and fail to do it, they commit a double breach of duty: towards the children themselves, and towards the members of the community generally, who are all liable to suffer seriously from the consequences of ignorance and want of education in their fellow citizens. It is therefore an allowable exercise of the powers of government, to impose on parents the legal obligation of giving elementary instruction to children (Mill, 1909, p. 575).

Mill goes on to argue that while it is "desirable" that parents pick up the expense of this obligation themselves, and even though "compulsory taxation" should be avoided at all costs, there will be situations in which,

I hold it therefore the duty of the government to supply the defect by giving pecuniary support to elementary schools, such as to render them accessible to all the children of the poor, either

²²J.S. Mill, Principles of Political Economy, Vol. II, (New York: Appleton & Co., 1909). This argument is also presented, in a less complete form, in the final chapter of On Liberty.

freely, or for a payment too inconsiderable to be sensibly felt (Mill, 1909, p. 576).

The implicit argument that justifies this governmental interference is: 1) There is intrinsic as well as instrumental value in persons being at liberty to make free choices; 2) The ability to make free choices is dependent on having developed, mature character; 3) Some minimal amount of education is necessary for such development; 4) Society as a whole will be improved, the greatest good for the greatest number will be enhanced, when persons develop their individual character; 5) Restraints on the ability to develop individual character represent a harm to both individuals and the society as a whole; 6) Government has the right and the duty to prevent such harms; therefore, government has the right and the duty to secure those conditions necessary for the development of individual character, including the education of its citizens.²³

²³There are some obvious problems with this argument. Mill extends, without argument, the claim that it is intrinsically valuable that persons be able to make free choices to the claim that it would be harmful if they are in some way prevented from doing so. In other words, Mill seems to be equating here, without supporting argument, the positive duty of beneficence with the negative duty of non-maleficence. While it would not be difficult to clean up Mill's argument so as to make it more acceptable, such is not my goal here. Rather, I merely wish to show that Mill was aware of the kinds of conditions that need be present for persons to be able to make free, unconstrained choices. His arguments show him to support a wide range of governmental interferences.

By not including these discussions, many contemporary writers, Beauchamp and Childress among them, simplify Mill's views to such an extent as to ignore much of the rich value in them.

In a related vein, Beauchamp and Childress make the common error of not distinguishing Mill's arguments on the nature and limits of liberty from his discussions of "individuality" or "character." In doing this they again over-emphasize the libertarian quality of Mill's work. A thorough reading reveals Mill to be suggesting that liberty is a means to other goals. To see this we need to understand what Mill meant by his use of "individuality" and "character." I think it will be clear that his use is similar to contemporary notions of "autonomy."

Mill defines "character" as follows:

A person whose desires and impulses are his own--are the expressions of his own nature, as it has been developed and modified by his own culture--is said to have a character. One whose desires and impulses are not his own has no character, no more than a steam engine has a character (Mill, 1956, p. 73).

The person of character is for Mill the person who chooses "his plan of life," who does not blindly accept the dictates of others. It is only by making these active choices that we are able to engage our moral nature. Without them we are "ape-like," (Mill, 1956, p. 71) simply responding to our social/cultural environment:

The human faculties of perception, judgment, discriminative feeling, mental activity, and even moral preference are exercised only in making a choice. He who does anything because it is the custom makes no choice (Mill, 1956, p. 71).

But this extends considerably beyond simply calling for no unjustified external constraints. One could be unconstrained, or negatively free, on this model and not have a developed character. Character development for Mill involves a process of identifying one's own values, goals, principles, etc. all of which could be studiously avoided by a person who was in no way externally constrained. This should become more clear when we look at why Mill considered character development to be valuable.

He presents two arguments. The first appeals to the intrinsic worth of individuality (autonomy). He says:

It is not by wearing down into uniformity all that is individual in themselves, but by cultivating it and calling it forth, within the limits imposed by the rights and interests of others, that human beings become a noble and beautiful object of contemplation (Mill, 1956, p. 76).

Pushing this same point to its end, Mill presents the status of individuality as the epitome of what it means to be human:

Having said that the individuality is the same thing with development, and that it is only the cultivation of individuality which produces, or can produce, well-developed human beings, I might here close the argument: for what more or better can be said of any condition of human affairs than that it brings human beings themselves nearer to the best thing they can be (Mill, 1956, p. 77).

Thus individuality/character/autonomy is presented by Mill as being valuable in and of itself, worth pursuing regardless of the social values which may extend from it.

But Mill also presents a second, utilitarian, argument. In the above quotation regarding the "cultivation of individuality" he goes on to say:

[B]y the same process human life also becomes rich, diversified, and animating, furnishing more abundant aliment to high thoughts and elevated feelings, and strengthening the tie which binds every individual to the race, by making the race infinitely better worth belonging to. In proportion to the development of his individuality, each person becomes more valuable to himself, and is, therefore, capable of being more valuable to others (Mill, 1956, p. 76).

The emphasis placed on deliberative choice-making, on not blindly following the values, dictates and precepts of one's social/cultural environment, combined with the discussion of the conditions necessary for being at liberty, begin to break down the traditional distinction, as presented by Ost and accepted by Beauchamp and Childress, between Kantian and Millian thought. Both Kant and Mill were concerned, in admittedly different ways and with different emphases, that persons have the capability to "reason" (Kant) and to "make full mature use of their faculties" (Mill) so as to be able to choose for themselves the values, goals and principles which define us as moral beings. In other words, both Kant and Mill emphasize a strong sense of self-governance in their work. This feature is overlooked in interpretations

of Mill which do not distinguish his discussions of liberty from those of individuality/character. By not acknowledging this common (and I think central) element in Kantian and Millian thought, writers like Beauchamp and Childress end up under-emphasizing the importance of self-governance in their own work, as will be evidenced in the next section.

Autonomy and Authority. Beauchamp and Childress explicitly acknowledge that self-governance is a necessary element in formulating the concept of autonomy. We need now to look at how Beauchamp and Childress incorporate it into their recommendations. One of the principal issues revolves around the relationship between autonomy and authority. Beauchamp and Childress question whether, as R. P. Wolff argues,²⁴ being autonomous is incompatible with unquestioning acceptance of authority. They ask, that is, whether one can be self-governing while obeying authority simply because it is authority.

They argue that the concepts are not incompatible. But in saying this they qualify their notion of "unquestioning" acceptance by stating that they are talking about "legitimate," "non-dictatorial," authoritative command. Such command, they argue, is ultimately based on "justifying

²⁴Beauchamp and Childress make reference to Robert Paul Wolff's In Defense of Anarchism (New York: Harper and Row, 1970) and his article, "On Violence," Journal of Philosophy, No. 66, October 2, 1969.

reasons." That is, they claim that these authoritative figures have reached their position because they have not exceeded "the limits set by those who delegated the authority to command in the first place--the autonomous citizens" (Beauchamp and Childress, 1983, pp. 64-65). These "autonomous citizens" "delegate" and continue to respect authority because they have "justifying reasons" for doing so, e.g., reasons for acknowledging that the authority figure is the relevant expert in a given area. Beauchamp and Childress suggest that accepting such authority is therefore comparable to accepting the recommendation of a more technically competent advisor. And the implication is that one qualifies as self-governing if one is careful about whose advice one accepts. I will return to this in a moment.

A more immediate problem is the naivete Beauchamp and Childress reveal regarding political realities. Even if we restrict our analysis to the politics of medical care delivery, we can see that positions of authority are neither established nor maintained by citizen approval. Such authority is established and maintained by the institutional structure of medical care whereby power, in the forms of knowledge and technology, is held by a few and desired by many. The "autonomous citizens" have little or no say about who gets trained to be a medical practitioner or about how that training takes place. Hence, although there often are

"justifying reasons" for medical practitioners having authority (i.e., they often are the relevant experts), a percentage of medical decisions clearly have as part of their basis motivations other than "justifying reasons." Medical practitioners are not unknown to seek to maintain authority, with or without direct, immediate, medical justification.²⁵ Thus to assume that all medical practitioner/patient interactions are based on patients deliberately choosing to heed the "justified" advice of the practitioner is simply to have a naive and mistaken view of such interactions.

This is not to suggest that all health practitioner/patient interactions must be grounded in at-least implicit attempts to acquire and/or retain power. It is possible to establish solid "fiduciary" relationships in which the "weaker" party (in this case the patient) can be supremely confident that the "stronger" party (her medical practitioner) will be acting in the best interests of the weaker. Unfortunately, such fiduciary relationships are becoming the exception rather than the rule. Much of the immediate care in major hospitals is provided by residents and interns who may or may not be familiar with the particular patient and who may or may not even remain on the same rotation for the

²⁵In fact it has been convincingly argued that much of the very structure of American medical care is oriented toward the maintaining of authority. See Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982).

entire length of a patient's hospital stay. Since Beauchamp and Childress either do not recognize these political/medical realities, or choose not to acknowledge them, it remains unclear how or whether they think acceptance of medical practitioner authority can be justified. Either way, their exclusion of these practices suggests a naive view of medical care.

But what of the situations in which such a fiduciary relationship has been established? Is it consistent with the concept of self-governance (and thereby of autonomy) for a person to turn over the making of decisions to a more technically competent authority figure? It is if we understand autonomy to be a concept which is context-dependent.²⁶ That is, in some situations (e.g., emergency situations which demand immediate decision-making by the most technically qualified persons) the wisest, most responsible/autonomous decision will be to engage in a lesser degree of personal deliberation and to give up some personal control, placing faith in the authority figure. On the other hand,

²⁶I will argue in Chapter IV that understanding autonomy as being context-dependent also means understanding autonomy as admitting of degrees. Beauchamp and Childress, like Veatch, seem to recognize (without discussion) this latter element of the concept of autonomy. Their account is also sprinkled with such qualifiers as "sufficiently autonomous," "clearly non-autonomous," and "substantially non-autonomous." It is worth noting that they include a section of determinations of competence and acknowledge a wide range of competence, but then do not directly apply that to their concept of autonomy.

less immediately crisis-oriented circumstances would seem to demand that autonomous persons question the directives of authority figures in all significant aspects of life.²⁷ In other words, and this seems somewhat obvious, the optimal level of self-governance will vary within situations, though saying this does not detract from its importance to being autonomous.

Summary. By including self-governance in their formulation of autonomy Beauchamp and Childress have improved on the definition suggested by Veatch. However, partly as a result of their misreading of Kant and especially Mill, the sense of self-governance they incorporate into their final version of autonomy is quite weak. This weakness is compounded by a lack of a (stated) appreciation for the kinds of medical, social, economic, and institutional constraints that can greatly inhibit an individual's capacity for autonomous activity. Omission of this analysis--identifying the nature and impact of these constraints--is a predominant flaw in most contemporary accounts of autonomy and I will be addressing it in the following chapter. For now we need to continue our analysis of the nature of self-governance.

²⁷I want to stress the "significant" qualifier in this claim. I am not suggesting that the autonomous person need agonize over every decision. The more important the decision, the more critical deliberation is necessary. Further, many of our decisions fall into defined categories so that critical deliberation over certain issues will carry into other decisions. I will return to this issue in Chapter II.

Ackerman and "Control"

If we are going to incorporate self-governance into our conception of autonomy we clearly need a better understanding of what it involves. Does it mean the autonomous individual must choose all of her moral principles? Must that choosing be done alone, without the advice of authority figures? Where is the line between providing advice so that another may choose and being coercive?

Terrence Ackerman, in his article, "Why Doctors Should Intervene,"²⁸ approaches these issues from a different direction than the discussion heretofore.²⁹ He switches from a definitional project to a discussion of what it is we are trying to accomplish in respecting a person's status as an autonomous being. He argues that by making this switch our focus changes from non-interference with patient decision-making to a recognition of those considerations which constrain (or aid) decision-making. He states:

²⁸Terrence Ackerman, "Why Doctors Should Intervene," Hastings Center Report, August, 1982, pp. 14-17.

²⁹Since publication of this article Ackerman has substantially altered his position. Instead of focusing on autonomy and on those elements which constrain autonomous behavior, he now emphasizes "personal growth." Following Dewey he argues that such growth is what all persons naturally seek. He claims that the tradition of liberalism has attempted to promote this growth through respect of the principles of autonomy, beneficence, and justice. He now argues that when elements (e.g., the debilitating effects of illness) constrain personal growth, the duty of beneficence requires us to attempt to remove those constraints, even at the cost of violating a person's autonomy (personal correspondence, including an unpublished manuscript, July, 1984).

When respect for personal autonomy is understood as noninterference, the physician's role is dramatically simplified. The doctor need only be an honest and good technician, providing relevant information and dispensing professionally competent care. Does noninterference really respect patient autonomy? I maintain that it does not, because it fails to take account of the transforming effects of illness (Ackerman, 1982, p. 14).

Despite the shift in emphasis, Ackerman maintains a fairly standard definition of autonomy; one similar to that provided by Beauchamp and Childress:

First, autonomous behavior is governed by plans of action that have been formulated through deliberation or reflection. This deliberative activity involves processes of both information gathering and priority setting. Second, autonomous behavior issues, intentionally and voluntarily, from choices people make based upon their own plans (Ackerman, 1982, p. 15).

However, his project, as noted, is considerably different from Beauchamp and Childress'. He views autonomy as valuable primarily because it serves as a means to other goods and he greatly emphasizes the nature and extent of illness-related constraints. That latter emphasis will make up the bulk of my third chapter. Here we need to look at how his first project differs from those of Veatch and Beauchamp and Childress.

What respect for autonomy accomplishes. A primary confusion exists in Ackerman's article, revolving around the nature of the end for which we are striving in our respect of autonomy. He gives at least three answers, ranging from, at one extreme, the substantially libertarian position that

interference is justified only if it will allow for more patient liberty ("physicians should actively seek to neutralize the impediments that interfere with patient's choices" [Ackerman, 1982, p. 16]), to, at the other extreme, a substantially paternalistic position ("The goal of the therapeutic relationship is the 'development' of the patient In this sense, the doctor-patient interaction is not unlike the parent-child or teacher-student relationship" [Ackerman, 1982, p. 17]).

While that latter claim is given more prominence in some of his other writings,³⁰ Ackerman's emphasis in this article is on the desirability of patients having control in the medical interaction. He quotes Eric Cassell's argument that the loss of control is the most destructive element of illness and claims that the returning of control is "the doctor's job" (Ackerman, 1982, p. 16). Part of Ackerman's goal in this analysis is to remove some of the adversarial character of the doctor-patient relationship that is often portrayed in philosophical writings. His claim is that while there obviously will be particular doctor-patient interactions that are adversarial--as one will find in any sort of interpersonal interaction--the doctor-patient relationship is not by nature adversarial. Instead, the mutual goal is to return patients' ability to maintain control

³⁰For example, the above cited unpublished manuscript, especially Chapter Three.

over their lives, control that has been reduced as a result of the debilitating effects of illness.

Although Ackerman does not explicitly draw it, there clearly is a link between his use of "control" and self-governance. In seeking to retain control by the patient, we would be seeking to promote a situation in which patients make the decisions concerning their medical treatment; a situation in which they choose and are able to act upon the principles by which they wish to govern their lives as they are affected by the medical situation. But the problems here are the same as when we explicitly appeal to self-governance. For example, what are the nature and limits of control? What levels are we saying must be present in order for a person to be considered autonomous?

Ackerman's approach to these issues turns out to be considerably different from the traditionally argued approach as represented by Veatch and Beauchamp and Childress³¹. They seem concerned with patients having control within the immediate interaction and pay less attention to the patients' control over more general and long-term aspects of their lives. Ackerman, on the other hand, places almost all of the emphasis on the latter concern. He is willing to sacrifice some immediate control of

³¹Elsewhere, in Medical Ethics: The Moral Responsibilities of Physicians (Englewood Cliffs, New Jersey; 1984) co-authored with Laurence B. McCullough, Beauchamp argues for this long-term conception of control.

decision-making powers (e.g., in the overcoming of patient denial) in order to give the patient more overall control of her life. In other words, his goal is not necessarily concerned with creating an equal relationship between physician and patient: "When people are sick, the focus upon equality is temporarily misplaced" (Ackerman, 1982, p. 16).³² In fact, he claims such inequality may temporarily be necessary for the patient to retain general control of her life. As such, the emphasis of most writers, he believes, is misguided in that it limits its focus on control to the immediate interaction and either ignores or underrates the importance of long-term control of a person's life-plans.

Ackerman has hit on an important and difficult notion here; namely, what is it we feel the obligation to respect: the individual's immediate control over specific decisions, or the person's chosen life-plans which determine the general nature of her life? Is the self-governance that we have been linking with being autonomous of an immediate nature or does it relate to the general principles which determine who we are in the long run? The easy answer, of

³²It may be implicit in his argument that the ultimate goal is the creation of an equal relationship. If so, his position would need to be expanded to include ways of dealing with the institutional and economic constraints I will be discussing in the following chapter.

course, would be to say both immediate and long-term decisions are crucial ingredients of self-governance. Unfortunately the immediate and long-term often conflict. In medical situations, that conflict frequently centers around decisions of withholding treatment. What is the appropriate response to a patient whose general principles include a love of life and a desire and willingness to work for important elements of her life who nonetheless appears to make a competent, rational decision, for example, not to undergo difficult cancer treatment?

Ackerman's approach clearly is to appeal to the general nature of her life and use those principles to override the immediate, apparently inconsistent one. But while this position is in many ways attractive, I shall argue that it implies the problematic conclusions: a) that the physically infirm individual is in some important way a different person than the one who has made the long-range decisions;³³ and b) that the latter person is the one to whom we owe our moral obligation to respect autonomous control. This conclusion results from the view that decisions which promote immediate control are less deserving of moral respect and/or protection than are those decisions which promote long-term

³³I will argue in Chapter II that when one changes a crucial life-plan or "fundamental project" one, in a sense, does become a different person. However, I will argue against the view that this "other person" is less deserving of our moral respect and/or protection.

control. That is, when these types of decisions conflict, Ackerman holds, we have a stronger obligation to respect those decisions which promote long-term control. In fact, it seems that according to Ackerman we may sometimes have an obligation not to respect those conflicting short-term decisions.

The obvious objection to Ackerman's position is that we feel an obligation to respect a "well" person's decisions that are inconsistent with her long-range goals; we do not consider her to be another (morally second-class) person. We may disapprove of that decision and attempt to convince her to alter the decision.³⁴ However, so long as we regard her as competent we respect her right to have autonomous control over her life. Even if her immediate decisions are in conflict with the general principles around which her life has been oriented, we feel morally obliged ultimately to respect them.

Why, then, should this moral attitude be altered in situations of illness? Obviously we could declare the patient incompetent. This is the frequent move in cases of mental illness or physical illness with a substantial mental component. As we will see in the next chapter, Ackerman

³⁴As we will see in a moment, Ackerman's final recommendation is not much stronger than this, although there is considerably more implied by his argument.

moves in this direction by paying close attention to illness-generated constraints on autonomous decision-making. However, even accepting, as I will, that degrees of illness can represent corresponding levels of constraint on autonomy does not allow us to declare the ill patient incompetent.³⁵ Clearly the effects of some illnesses will be severe enough effectively to overwhelm any autonomous decision-making. But unless one advocates the position that I have been specifically arguing against, viz., that being autonomous does not admit of degrees, then it is not the case that every constraint on autonomy would render the patient non-autonomous. In our daily lives we constantly face varying degrees of constraint on our autonomy all the while retaining our status as autonomous persons. And Ackerman gives no evidence that he supports the all-or-nothing conception of autonomy. When he discusses the impact of constraints on autonomy he avoids use of terms like "prevent" or "prohibit," using instead the weaker notions of "impeding" and "interfering." Further, his examples do not portray individuals devoid of autonomy. Instead, he presents patients who are capable of some, although in most

³⁵Ackerman does not distinguish adequately between catastrophic illnesses and less severe ailments, nor does he discuss the differing ramifications of varying degrees of illness. This represents a serious, though correctable, problem and I will be returning to it later.

cases not enough, autonomous control.³⁶ Of course one could sensibly argue that competency, like autonomy, admits of degrees and that the ill person is in varying degrees incompetent. While I would be sympathetic to such a move, it does not help us out of our original quandary--how do we justify overriding immediate decisions which are inconsistent with chosen long-range principles.

One possible move is to argue that self-governance, and thereby autonomy, is defined as formulating and adhering to long-range principles, or "life-plans." A number of people have defended this position, among them John Rawls and Charles Fried.³⁷ I do not think, however, that this view ultimately can be defended and a section of my second chapter will be devoted to criticizing it.

A second option is to claim that respect for autonomy is superseded by a respect or promotion or achievement of some further goal; e.g., happiness, fulfillment of cherished goals, etc. But why must we conclude that long-range principles will better promote those goals? We can appeal to analogous cases and determine whether overruling immediate decisions facilitated the achievement of long-range goals.

³⁶He has confirmed this reading in personal discussions (November, 1983).

³⁷See John Rawls, A Theory of Justice (Cambridge: Belknap Press of Harvard University Press, 1971), especially Section 78, and Charles Fried, An Anatomy of Values (Cambridge: Harvard University Press, 1970), especially Section 10.

But arguments by analogy are notoriously suspect. Even if we could engage in the considerable work necessary to determine that the situation was relevantly analogous, can we be confident that the persons are relevantly analogous? With either choice there will be a risk of error. Respect for immediate choices may involve a disrespect for current or future long-term goals. On the other hand, respect for long-term goals--assuming they are inconsistent with immediate choices--will represent a disrespect for immediate choices. Further, it may deny the patient the option of changing her long-term goals. In short, even if we decide that respect for a broad goal like "happiness" should supersede respect for autonomous decision-making, there seems to be little justification for assuming that the patient's happiness will be best promoted by respecting her previously chosen life-plans over her immediate decisions.³⁸

Clearly this is an exceedingly difficult issue which cannot be settled in one short paragraph and much of this work will be involved with finding its solution. The direction I will take is based a shifting of focus. That shift is, again, not to think in terms of only two alternatives:

³⁸One possible justification would be provided if it could be convincingly shown that the life plan resulted from careful deliberation and that the immediate decision was made somewhat carelessly, without sustained thought. I suspect, however, that the very attempt to attain that evidence would result in the patient's giving the immediate choice more careful deliberation. (I am indebted to Betsy Postow for her suggestions here).

being either autonomous or non-autonomous. It is implicit in Ackerman's article³⁹ that the choosing of some goals is such an important and complex process that persons need to be in as sound and rational a mental state as possible. The constraints of illness, though often not severe enough to render one incompetent, can affect our judgment enough to draw suspicion on illness-related decisions. While most illnesses do not nullify the possibility of some level of autonomous behavior, many can place enough constraints to render that level minimal. Hence certain important and difficult decisions resulting from such constraints may not be sufficiently autonomous to require our respect. Our level of respect needs to reflect the types of decision being made as well as the severity of the illness and the type of constraint associated with that illness. Thus, there is no clear-cut general answer as to whether we must always respect long-range goals or immediate decisions. The obligation will depend on the type of decision being debated, the type of illness, and the strength of the individual involved.

This issue will be a recurrent theme in this work. For now, I just want to note that acceptance of the third option requires at least two supporting arguments. The first is

³⁹Ironically, as I noted in an earlier footnote, Ackerman's most recent position is close to the second option outlined above.

that autonomy does in fact admit of degrees. As noted, this is one of the major affirmative points of this work and will receive its most thorough defense in the fourth chapter. The second is that illness can represent the kind of constraint on autonomy suggested above. This second claim is the heart of Ackerman's article and discussion of it will make up the bulk of the third chapter.

Summary and future concerns. By shifting emphasis from non-interference to an understanding of what respecting autonomy accomplishes--restoring "personal control"--Ackerman succeeds in raising some of the issues crucial to understanding the nature of self-governance. While his answers to these issues are either incomplete or unsatisfying, they give us a starting place from which we can develop an adequate formulation of autonomy.

CHAPTER II

AUTONOMY AND SELF-GOVERNANCE

As we saw in the preceding chapter, both classical and contemporary accounts of autonomy include the notions of negative liberty and self-governance. A considerable amount of work has been done on the former so that there is a good deal of agreement as to what constitutes negative liberty as well as what counts as a constraint against it (see pp. 4 - 9, above). No such agreement exists with respect to positive liberty or self-governance and/or what counts as a constraint against persons' ability to be self-governing. Given the widespread reliance on this concept in definitions of autonomy it is clear that we need to gain a better understanding of these matters.

In what follows I will assume two components of self-governance. First, self-governance is a continuing process. It involves not only the choosing of principles but also determining what options are most consistent with those chosen principles. This latter element is the one we are most often engaged with in our attempts to obtain, for example, informed consent. This is not to suggest that the first element, the choosing of principles, is static. As we encounter situations in which given options do not fit with established principles of self-governance, new ones must be

added and/or old ones changed. (There is considerable debate over how much weight should be given established principles or goals, especially those which provide long-term or life plans, as opposed to principles or goals which satisfy only short term preferences. We touched on this at the end of the last chapter and will be returning to it in greater detail later in this chapter.)

Second, self-governance is distinguished from negative freedom. As I explained in the Introduction, I make this distinction primarily because of the way the terms "freedom" and "self-governance" are ordinarily used. "Freedom" is generally understood in the negative sense of, freedom from constraint. And "constraint" is generally understood in a way similar to the Milllerian definition described in the Introduction; i.e. "those restraining conditions for which some person or group of persons has direct moral responsibility."

But this definition of "constraint" is too limiting for self-governance. Persons clearly can be negatively free and nonetheless constrained in their choosing of principles of self-governance and/or in choosing actions consistent with chosen principles.

To see this we need only consider factors which impair our ability to make decisions or which impede our achieving cherished goals but for the existence of which there is no person or persons who have a direct moral responsibility.

This will be one of the central claims of this work and the primary focus of Chapter III: that autonomy can be constrained by such things as illness or institutional structures. Given our definition of constraints on (negative) freedom, this clearly represents a point of distinction. This is Berlin's principal point in his distinction between positive and negative freedom (Berlin, 1970, especially pp. 121-135).¹ Negative freedom is concerned with the kinds and extent of constraints which impede persons from doing as they wish. Positive freedom is concerned with who is the source of governance and what kinds of factors impede and/or promote self-governance. Given this difference in types of constraints,² a person may be negatively free yet not self-governing (and, consequently, not fully autonomous). Gerald Dworkin³ echoes this same sentiment when he says:

¹Berlin's explication of "positive freedom" is quite similar to many accounts of autonomy, including my own. Given his goal of clearly distinguishing between the two concepts, it seems he would do better not to give the more inclusive, richer notion the same appellation (i.e. "freedom"). By referring to both concepts as "freedom," he gives the impression that they are different conceptions of the same concept rather than two distinct concepts.

²Although, as I noted in the Introduction, MacCallum is critical of the distinction between negative and positive freedom, he notes that what counts as a constraint against each is one of the possible ways of distinguishing between them (MacCallum, 1967, p. 322).

³Gerald Dworkin, "The Concept of Autonomy," in Science and Ethics, Rudolph Haller, ed. (Amsterdam: Rodopi Press, 1981).

People mind being motivated by false beliefs, by manipulation, by being kept uninformed of relevant information. But not all of these are considered interferences with a person's freedom. . . . [Yet,] just as a deprivation may count as an excuse or partially relieve a person of responsibility, so may these interventions. Just as a person may feel used, may feel that he is the instrument of another's will, when his freedom is interfered with, so may he feel when he is deceived or manipulated or tempted. It is his autonomy which is threatened (Dworkin, 1981, p. 210).

There need not be any person or persons directly responsible when one is "deceived or manipulated or tempted." One can be deceived by, e.g., the psychological constraint of denial; manipulated by, e.g., the advertising structure of a capitalist economy; and tempted by, e.g., false beliefs. And in each case we would want to say that the person's ability to be self-governing has been constrained, even though she was negatively free.

Thus, in contrast to Veatch's primary analysis, autonomy is not equivalent to negative freedom. Yet there obviously is some relation between negative freedom and autonomy; it seems that negative freedom must be included in the concept of autonomy. That is, even if we view being autonomous as a dispositional state, as I do, the autonomous person must have a reasonable opportunity to act upon her chosen decisions. This frequently is how the dictum of informed consent is viewed in the clinical environment. Patients must give informed consent, it is thought, for otherwise we would be violating their liberty. This suggests

that freedom is a necessary, though not sufficient, condition for being fully autonomous. While I think this is true, it does not say enough. It does not say enough because there are situations in which one is negatively constrained (to a very great extent) and yet still substantially autonomous. The kind of situation I have in mind is that of political prisoners who, though imprisoned and thereby having their liberty greatly constrained, still engage in such autonomous activities as hunger strikes.⁴ The obvious response to this claim is that first, their liberty has been only partially constrained and second, they correspondingly are only partially autonomous. Both of these responses are accurate, yet they also seem to be incomplete. They are incomplete because the high degree of constraint against their liberty should be reflected in their level of autonomy. Yet we unhesitatingly declare their decision as autonomous and we honor it as such; i.e., if we are family or friends of the strikers we do not attempt to override their decision and, for example, force-feed them.

⁴It is true that the prisoners are free to engage in this specific activity, a hunger strike. And on McCallum's type of triadic account of freedom this is all that is needed; i.e., they are free from constraint to engage in hunger strikes. My claim is that most persons would find such an evaluation off-base, that despite the ability to engage in this one particular activity, the prisoners are not free.

This suggests two important points about the concept of autonomy. First, it reveals that autonomy is a global concept.⁵ That is, elements which we take to be crucial to being fully autonomous may be constrained (e.g., our liberty is constrained), yet enough of the other elements (i.e., there is full enough deliberation and identification) exist so as to demand that we honor the decisions as being autonomous. We honor these decisions because the actor is relatively unconstrained in determining whether the options at hand coincide with her chosen principles of self-governance. She may be completely constrained from making an autonomous choice with respect to another decision; however the context of this choice is such that she is able effectively to deliberate over and identify with her decision/action. This clearly is linked with my claim that autonomy admits of degrees. Our level of autonomy is reduced either by an overall reduction of all of the components of being autonomous or by a significant reduction in either of them.

The above example reveals a second point. If we are willing unhesitatingly to honor the prisoners' decision, as I suggest we are, then we clearly are willing to accept some less-than-fullest degree of autonomy as sufficient for demanding our respect. A section of the fourth chapter will be devoted to arguing that the degree of autonomy necessary

⁵I am indebted to George Brenkert for his suggestions here.

for demanding respect depends on the situation. The significance of the decision being made, the factors which allow for or which impede one's ability to deliberate, the values which compete with autonomy all contribute to a determination of what level of autonomous behavior is necessary to demand respect.

I do not mean to suggest by the above example that achieving a fuller degree of autonomy which included negative freedom would not be desirable. Being totally negatively free is a necessary condition of full autonomy; yet, depending on the context and on the decision being made, it need not be fully present for an individual to make decisions which demand our respect as autonomous.

The range of constraints I will be discussing in Chapter III is quite broad. How can autonomy be preserved in the midst of those constraints? If, as is suggested by much of the literature and practice in medical ethics, autonomy means the lack of constraints,⁶ then it cannot be preserved. The range of constraints is so extensive that it will be the

⁶The sense of autonomy as non-interference is even more pervasive in clinical practice than it is in the literature. This in part leads to a suspicion of autonomy-based medical ethics on the part of many medical practitioners since they at least implicitly realize that strictures of non-interference are not realistic. But while such practitioners often identify the use of the term "autonomy" with non-interference, the patient decisions they feel most obliged to honor are those which meet the criteria of deliberation and identification described below. This of course suggests the need for greater communication between health care practitioners and ethicists.

rare exception when one is not in some way and to some degree constrained. This suggests three alternatives: 1) either we give up on the goal of preserving/promoting autonomy; 2) we recognize that autonomy admits of degrees and that we do not always hope to achieve the fullest degree; or 3) we understand the concept of autonomy in such a way that constraints do not always represent a threat against it. I will be suggesting a concept of autonomy which adopts alternatives two and three.

What, then, are the conditions in addition to being negatively free which identify the autonomous choice, remembering that those conditions must account for the broad range of constraints on autonomy to which I have been alluding throughout and which will be described in Chapter III? The following initial formulation provides a first step: the autonomous person is the person who is self-governing and who is negatively free to carry out her decisions.

This formulation, however, adds little to the previous discussion as it has the same substantive content as the formulation provided by Beauchamp and Childress (pages 13-14, above). It does add to their account in that I provide a definition of negative freedom and of constraints against it, but like them I have to this point said nothing about what is involved in being a self-governing individual. Cashing out this crucial notion will be the primary focus of this chapter.

The tradition in ethics is to claim that being rational is a necessary (and sometimes sufficient) condition for self-governance. Within that tradition, however, there are at least three senses of "rationality" at play. In the following three sections I will briefly outline those senses,⁷ adopting ideas which add to our current discussion.

Kantian Self-Governance

The traditional understanding of, and importance given, self-governance can be traced to Kant and his is the first sense of rationality we should explore. His formulation of autonomy essentially is the description of a self-legislating person: "Autonomy of the will is that property of it by which it is a law to itself (independently on any property of the objects of volition)" (Kant, 1945, p. 57). But, as I noted in the section on Beauchamp and Childress (pages 16-20, above), that description is of a person choosing her moral principles guided only by the light of pure reason. An understanding of what Kant meant by his dictum to be "guided only by the light of pure reason" will better fill out his use of autonomy/self-governance as well

⁷By reducing the volumes of work in this area to the following brief pages my account necessarily will only touch the surface of these issues. Analyzing the concept of rationality, however, is not my project. My goal instead is to provide an outline of three of the more popular views of practical rationality so as to determine the relationship between that concept and autonomy.

as reveal the problems with appealing to such a strict guide as the basis of autonomous decision-making.

Any decision which is founded on a true morality, for Kant, must be chosen from duty and more importantly for our present purposes, cannot be based on the "vulgar;" i.e., it cannot be based on experience, empirically grounded examples, or "appetite." Rather,

it is clear that all moral conceptions have their seat and origin completely a priori in the reason, and that, moreover, in the commonest reason just as truly as in that which is in the highest degree speculative; that they cannot be obtained by abstraction from any empirical, and therefore merely contingent, knowledge (Kant, 1945, p. 29).

To accomplish this a priori moral knowledge based on pure reason it is necessary that we, in a sense, forget ourselves. We must make our moral decisions as if they were decisions which would hold for all rational creatures as such. That is, we must strive to make our will "a will which in all its maxims gives universal laws" (Kant, 1945, p. 49, his emphasis).

For Kant, such a will is by definition the only sort of an autonomous will. It is purely self-legislating in that it issues from our true self, our rational being. Andrew Levine⁸ puts it as follows:

For in enjoining that we act only on a maxim through which we can at the same time will that it become a universal law, Kant points out, we have

⁸Andrew Levine, "Rawls' Kantianism," Social Theory and Practice Vol. 3, No. 1, Spring, 1974.

already supposed that a rational will is its own law-maker; that it is, in other words, self-legislating or autonomous (Levine, 1974, p. 51).

Thus Kant clearly has a special sense of self-governance in mind. We must not only choose our moral principles, we must do so with no influence other than pure reason. And given Kant's claim that the moral law which results will hold, "not merely for men, but for all rational creatures generally" (Kant, 1945, p. 26, his emphasis), we must choose those principles after having, as I suggested above, "forgotten ourselves". In analyzing whether Rawls' original position is "Kantian," Levine describes Kant's sense of rational autonomy as follows:

It is not enough to be left with our common humanity. We would need, indeed, to be left ignorant of all attributes distinguishing us from reasonable beings as such, of all aspects of our persons and situations not derived from pure practical reason alone. In short, we would need to be made ignorant of [our] very humanity (Levine, 1974, p. 51).

Is this sense of self-governance helpful for our purposes in applied ethics? I think it is clear that a demand that persons strive for this type of objectivity is not practical, given the myriad of decisions we must make on a daily basis.⁹ Granted, Kant does not argue that all our decisions must be chosen from such a stance, only that our

⁹Stephen Darwall makes a recent attempt to revive this form of Kantianism in his book Impartial Reason (Ithica, New York: Cornell University Press, 1983). I think it is unsuccessful for much the same reasons that Kant's attempt fails.

general moral principles must be so chosen. However, one of the more common and telling criticisms of Kantianism is that there is no way to know how to apply those general principles to particular decisions; the method of application is dependent on how the situation is described and on which factors are being emphasized. Achieving this kind of objectivity in our decision-making might represent an ideal goal, for which we should strive but could achieve rarely if ever. But even this suggestion assumes that one can, in fact, "forget one's humanity". Kant does not¹⁰ provide adequate guidelines for how one accomplishes this task.

Further, I doubt that such guidelines can be provided. My skepticism is founded on two metaphysical/epistemological points: First, that there is no rational essence of persons which carries across all social/historical/cultural contexts and second, (the admittedly controversial view) that appreciating other "forms of life" requires a paradigm switch that can be achieved only, if at all, by immersing oneself in that form of life, not just by pure rational reflection. A defense of that metaphysic/epistemology is far beyond the scope of this work. However, even assuming some rational essence, the most purely rational reflection could give us is agreement on the highest level principles or preferences.

¹⁰Nor does Darwall.

It could not tell us what particular values or goals an individual carries into a given decision. As will be evident in the sections on deliberation and identification, those subjective values and goals are of utmost importance to being autonomous.

Further, and at least as important, this is not how persons ordinarily go about making decisions. The sense of autonomy I am defending is a relatively common and readily achievable state. Such a Kantian ideal state, by definition, is neither common nor readily achievable.¹¹

Self-Governance and "Rational Coherence"

An alternative to the extreme Kantian position has come to be known as the "Hume-Ramsey Theory."¹² This position combines Hume's skeptical claim that ends are beyond the

¹¹A third criticism of Kant's view is that his sense of rationality commits one to particular moral content. That is, as I noted in the first chapter, Kant believes that all persons who base their moral analysis on pure reason will determine the same moral law--the categorical imperative. The categorical imperative is a necessary result of purely rational thought. This conclusion implies a metaphysic and an epistemology that is, at the very least, highly controversial. In fact, without appeal to reason being a method for reaching divine truths (a position I reject) one can make little sense of the appeal to this kind of objective moral principle. It is not my point to question whether some sense of rationality has some normative, or as Alan Gibbard will put it "endorsing," quality. My claim is that the sense of rationality which is important for autonomy does not. A defense of this will come out later in the chapter.

¹²See Alan Gibbard, "A Noncognitivist Analysis of Rationality in Action," in Social Theory and Practice, Vol. 9 #'s 2 and 3, 1983, p. 201.

purview of rational criticism, that reason is the "slave of the passions," with Ramsey's appeal to "coherence." The second component of this theory--coherence--has recently come back into favor and is often defended as a necessary element of practical rationality.¹³ While most authors who appeal to coherence in their characterizations of practical rationality also include additional elements, my concern in this section is simply to explain what is meant by "coherence" and to show some problems with appealing to it as a condition of rationality.

A version of the coherence account often appealed to is the one provided by Norman Daniels in his article, "Wide Reflective Equilibrium and Theory Acceptance in Ethics."¹⁴ Daniels' goal in this paper is to provide an alternative to foundationalism in ethical theory. No single ethical judgment or set of them, he believes, serves as a foundation upon which all other ethical judgments, principles and theories are built. In effect, Daniels is claiming that we need

¹³Darwall appeals to something like the version described below and considers it to be a necessary though not sufficient condition of practical reason.

¹⁴Journal of Philosophy, Vol. 76, 1979. (Daniels notes that the notion of coherence he is defending has its roots in the first part of Rawls' A Theory of Justice.) Daniels does not present his account as an explanation of practical rationality; instead, he presents it as a method of justifying acceptance of normative theory. However, if the account works in its described goals it can be well transferred to our purposes and, as noted above, Darwall attempts to do just that.

to analyze and evaluate our individual contextual web of moral beliefs and determine the ways in which such beliefs are held together. Daniels' account is much too extensive to give due consideration here, but I will attempt to outline its basic points.

Daniels argues that we need to move beyond mere coherence between principles and judgments--"narrow reflective equilibrium"--to,

coherence in an ordered triple of sets of beliefs held by a particular person, namely, (a) a set of considered moral judgments, (b) a set of moral principles, and (c) a set of relevant background theories (Daniels, 1979, p. 258).

Extending coherence in this way is necessary, he thinks, because neither the initial judgments nor the principles have epistemic priority; they too must be critically evaluated. And in order to do this, he claims, one must compare those judgments and principles to higher level (using "higher" as a reference only to the theory's complexity, as opposed to its inherent acceptability) set of beliefs--relevant background theories (e.g. a theory of the person, a theory of procedural justice, etc). The goal is first, to determine what the various higher and lower beliefs are and then to bounce them off one another, reformulating and rejecting

them when there is conflict, until there is an overall coherence among the beliefs.¹⁵

Why would this type of coherence be important for rational decision-making? It has long been held that consistency is the benchmark of rationality. Through achieving this type of wide coherence, persons' decisions will never be morally inconsistent, so long as their decisions never conflict with the achieved equilibrium.¹⁶ Thus a person who had achieved wide reflective equilibrium and who based all her decisions on it would lead a life of ultimate consistency. This would, it seems, provide at least the foundation of a life based on practical rationality.¹⁷

Is achieving this kind of coherence what we would want to demand of the self-governing, autonomous individual? It seems that coherence among judgments, principles and theories would provide the ultimate backdrop against which individual decisions, e.g. whether to undergo surgery, could be

¹⁵This characterization greatly simplifies Daniels' method; he includes a number of constraints on how to reach coherence (e.g. the "independence constraint," holding strong moral intuitions to be only "provisionally fixed points," etc.). These details are not important for our purposes here.

¹⁶I am using "achieved" somewhat loosely here. As we will see, Daniels does not demand that each (rational) person actually go through the extensive process of achieving an all-inclusive coherence.

¹⁷For some, it would be both necessary and sufficient. For those who want to have rationality include a moral content, one would need to formulate the coherence from an impartial, egoless standpoint.

made. The agent would have all of her moral values, principles and theories established so that all that would remain would be to determine how various options coincide with that backdrop.

What would be involved in achieving such a coherence? The ideal case would be where each individual actually worked out an all-inclusive coherence. But this clearly is not possible and Daniels does not require it.

The other alternative is to borrow from others' established coherences in particular areas. For example, let us say that I, like Daniels, think that Rawls' principles of justice are in coherence with considered judgments and background theories. Let us also say I think Beauchamp and Childress' principle of autonomy is in similar coherence. Are Rawls' and Beauchamp and Childress' principles in coherence with each other? And let us add Sartre's theory of the self and my considered judgment that it is generally immoral to steal. What grounds do I have for saying that these various positions are, or ever could be, in coherence? Are there any good reasons for going against the historical tradition of conflict among philosophical theories and accepting that they are or ever could be in coherence? What could those reasons be, other than actually working out the all-inclusive coherence, something we have already suggested cannot be done. In short, on the coherence view "good reasons" are in part defined as such because they cohere with

other accepted principles, theories, and judgments. But what "good reasons" do I have for accepting Rawls' principles when I do not know whether those principles are in coherence with other principles, judgments and theories I think I have "good reasons" for accepting?

To push this point home, consider the extensive number of theories for which we need good reasons (and hence coherence among) in order to accept them as valid. In his defense of a coherence view similar to Daniels', Dan W. Brock provides a partial list:¹⁸

Besides the usual specification of the general moral principles, and the particular judgments they imply, a coherence account of a theory of practical reasoning should include at least the following: a framework of justification (as in the ideal observer view, or Rawls' original position); a theory of moral psychology, that is, an empirical account of how persons will come to desire to act in accordance with the normative principles of the theory; the identification of particular emotions or feelings, such as guilt and shame, logically or empirically related to acceptance of the system of practical reasoning in question; the identification of particular social practices, such as praising and blaming, giving or seeking moral advice, etc., consistent with or precluded by the theory of practical reasoning in question; the identification of certain beliefs, e.g., the metaphysical belief that we are one person among many equally real persons in a single world, that commit us to practical principles of a certain sort (Brock, 1977, pp. 77-78).

But what of less extreme versions of coherence; i.e., versions that simply require the agent to identify the most

¹⁸Dan W. Brock, "The Justification of Morality," American Philosophical Quarterly, Vol. 14 #1, 1977.

important and immediately relevant values, principles, and theories and to establish life plans around them? To be rationally self-governing, this reduced version claims, one need only achieve consistency or coherence between immediate choices and long-term life plans. We touched on this issue in the final section of Chapter I and I will be returning to it in greater detail in the section on identification.

Brandt and Gibbard on Practical Rationality

This brings us to the third candidate of practical rationality. In his article, "The Concept of Rational Action,"¹⁹ a revision of a similar view spelled out in his book, A Theory of the Good and the Right,²⁰ Richard Brandt provides the following "approximation" of the concept of rational actions:

I hereby recommend that X do A, while taking as my objective maximizing satisfaction of the transitive mood-independent ultimate desires of X, as they would be if they had been subject to repeated vivid reflection on relevant facts, and having as my beliefs about options for actions and consequences those which are justified on X's evidence--a recommendation made because A is that one among the options justifiably believed to be open, choice of which exemplifies a strategy for decision-making which we know will in the long run satisfy the (as above) corrected desires of X as effectively as any other strategy can be known to do (Brandt, 1983, p. 161).

¹⁹Richard Brandt, "The Concept of Rational Action," Social Theory and Practice Vol. 9, #'s 2 and 3, 1983.

²⁰(Oxford: Oxford University Press, 1979).

Is this an adequate characterization of practical rationality? There is some confusion as to what Brandt has in mind by the words, "I hereby recommend that X do A." Alan Gibbard claims that despite these opening words of the quotation, Brandt's characterization misses "the element of endorsement that the term 'rational' connotes" in our ordinary language (Gibbard, 1983, p. 207). It misses because Brandt's formulation has the result that in cases where, despite "mood-independent, repeated vivid-reflection" persons' desires are nonetheless "crazy"; e.g., the hand-washer who, despite receiving and clearly understanding information regarding the nature of the microscopic creatures who crawl on our skin as well as the social and health costs connected with constant hand-washing, persists in his behavior (Gibbard, 1983, p. 204). Although the hand-washer meets many of the requirements we have for rationality, Gibbard thinks, we would not endorse her behavior and thus, in our ordinary use of "rationality" we would deem that she falls short.

My project here is not to determine exactly what Brandt has in mind with his characterization and/or whether Gibbard's claims against it are valid. The sense of autonomy I wish to adopt, however, is the weaker sense, the sense which does not include the recommending flavor. While I agree with Gibbard that our ordinary use of "rational" includes "endorsement," I do not think endorsement need be

included in our use of "autonomy." It will become clearer in the next two sections that if a person engaged in the kind of deliberation Brandt describes and felt no alienation²¹ from her related actions/decisions, then we would respect those actions/decisions as autonomous. We might not think those actions/decisions smart, or the best thing to do, but we would honor them as autonomous.²²

But Gibbard also makes a related criticism. What is to count as "relevant information" on Brandt's account? Being told about the microscopic creatures obviously affected the hand-washer's higher level desires. Does that make the information, by definition, relevant? I am willing to grant, as I think Brandt must, that almost any information potentially is relevant if when the individual is informed of it, the information will have a significant effect on an individual's higher level desires and, thereby, her decisions.

²¹I.e., if she identified with her actions/decision in the sense to be explained below.

²²An obvious problem here would be if the particular obsession disrupted other important elements in the person's life. In such cases I think one would be hard pressed to show that such an obsession was not alienating to the individual. That is, such obsessions most often result in a tension between related actions/decisions and who we want to be and how we would like to act. In short, our identification with such actions is quite limited. This kind of situation would fall under my category of psychological constraints on autonomy to be discussed in Chapter III. Further, Brandt would probably question the likelihood of such an obsession surviving "cognitive psychotherapy."

In his book, Brandt deems information relevant "if its presence to awareness would make a difference to the person's tendency to perform a certain act, or to the attractiveness of some prospective outcome to him" (Brandt, 1979, p. 12, my emphasis).

Does this represent a problem for our purposes? I think not. Remember that our primary goal here is to determine what types of decisions should be honored as autonomous. We are seeking a practical account of adequate decision-making in actual situations. In such situations what is relevant is determined by what persons have wanted to be informed of in the past, by what "the reasonable person" would want to know, by what the health care practitioner would want to know in a similar situation, etc. Obviously this is not an objective standard, but I do not think an objective standard is attainable, given the plurality of value structures that exists among patients and among

health care practitioners.²³ Granted, such a "loose" standard will allow for situations in which information that a particular patient might deem important will not get conveyed. But unless we accept an objective standard of rationality (with its consequent, and I think undesirable, views about the nature of persons--e.g., that persons have a rational essence), such "looseness" is a necessary component of practical decision-making.²⁴

²³It is important to note that acknowledging that there is no objective standard of relevancy does not mean that the standard which is currently in practice is not open to revision. Frequently new information surfaces which was not previously deemed important (e.g., that such trappings as lab coats are seen as symbols of authority by patients) and such information is either included in what the patient is told or it alters the way in which information is conveyed. In other words, both our conception of the "ordinary" or "reasonable" person and what that person would want to know are dynamic. Also, I do not wish to suggest that the reasonable person standard alone is sufficient. Rather, it serves as a starting point from which further determinations of relevancy are made.

²⁴The focus of the above discussion has been on the patient receiving important information. But, as I will argue in Chapter IV, the responsible, autonomous person is the one who also seeks information she deems may be relevant to her decision-making process. Shifting the focus in this way can alleviate much of the problem of plurality. Those persons who recognize that their value structure differs from that of the health care practitioner and/or from that of the "reasonable person" and who consequently feel they may not be receiving all important information, can and should endeavor to find such additional information on their own.

Practical rationality and self-responsibility. Is, then, practical rationality a necessary component of being autonomous? Well, what do we mean by "practical rationality?" I have tried to show that at least three popular versions (Kant's, Daniels' and Gibbard's) are not. But if what we mean by "practical rationality" is the much weaker sense that Brandt defends, then it is a necessary element.²⁵ I hesitate to adopt the term in this way because as Brandt admits it is not the way it is used in ordinary language. But, as he puts it,

[W]e could of course use some other term, like 'fully informed', but the choice of 'rational' seems as good as any, and I do need a term which I can use regularly to refer to actions (etc.) which have this status (Brandt, 1979, p. 10).

However, in adopting this account of practical rationality I wish to suggest a conceptual shift: When we feel obliged to honor persons' decisions as autonomous it is because we recognize those persons as taking responsibility

²⁵I do not mean to suggest here that I accept Brandt's view part and parcel. His notion of "cognitive psychotherapy" is quite weak and cannot account for some of the constraints I will be discussing in the next chapter. Further, he seems to hold that what he describes as rational action is all that is necessary for demanding our respect; whereas I see it as one of number of necessary elements.

for their own lives. Thus I would like to link self-governance and autonomy with being dispositionally responsible for one's life.²⁶

I think this is a common, if often only implicit, theme in much of the literature and clinical practice. I hope this commonality will be more explicit when I describe what being dispositionally responsible entails.

Why not, then, simply define autonomy as being dispositionally responsible and negatively free, leaving out all appeal to self-governance? I think it can be so defined. Nevertheless, the concept of self-governance is so rooted in the historical approaches to discussions of autonomy, that it is is a fundamental concept in our understanding of autonomy. However, as with "rationality," the notion of self-governance is rife with a range of interpretations. I am suggesting that the elements of those interpretations which are important to autonomy are the same as those which one would use in describing the dispositionally responsible person.

²⁶By "dispositionally responsible" I mean the sense of "responsibility" in which we make aretaic judgments of the sort, "She is a responsible person," or, "She led a responsible life." Thus we can respect (honor) the person for being responsible as well as honor (respect) the responsible decision being made. Although my primary focus is on the latter, the former should not be excluded in our understanding of what is involved in being an autonomous person.

Deliberation

The first of those elements is "deliberation." There is nearly unanimous agreement in medical ethics literature that in order to be autonomous, persons must be able to deliberate carefully over (at least important) decisions. Beauchamp and Childress note that one of the consequences of having "diminished autonomy" is that it leaves persons "at least in some respect incapable of deliberating or acting on the basis of such deliberations" (Beauchamp and Childress, 1983, p. 60). In characterizing the autonomous person Dworkin²⁷ states that such persons "are able to reflect on their decisions, motives, desires, habits, and so forth" (Dworkin, 1981a, p. 275). My claim is that such a capability provides the foundation and that one must exercise those capabilities in order to be autonomous. What then is involved in deliberation?

The first condition is that one must have adequate information over which to deliberate. But mere access to information obviously is not sufficient. In order to be self-governing, persons must give thought to that information, considering how the various available options coincide or conflict with chosen principles or goals. To do this the agent must be capable of a special sort of reflection:

²⁷Gerald Dworkin, "Autonomy and Behavior Control," in Thomas Mappes and Jane Zembaty, eds. Biomedical Ethics (New York: McGraw-Hill, 1981a) pp. 273-280.

second-order reflection. Borrowing from Harry Frankfurt,²⁸ David A. J. Richards says,²⁹ "these capacities [of reflective self-evaluation] enable persons to establish various kinds of priorities and schedules for the satisfaction of first-order desires" (Richards, 1981, p. 6).

The ability to evaluate reflectively allows us to engage in four activities which are important to being autonomous.³⁰ First, it allows us to establish a prioritized system of higher-order values, goals, beliefs, etc. Second, as Richards notes, it allows us to consider whether a particular first-order desire (e.g., to smoke) fits with higher-order desires, principles, etc. (e.g., whether I want to be the kind of person who smokes). Third, it allows us to analyze new information (with the options inherent in it) with respect to higher-order desires, principles, etc. (e.g., information that smoking contributes to cardiovascular disease may lead to such higher-order desires as, "I don't want to be the kind of person who smokes"). And,

²⁸Harry Frankfurt, "Freedom of the Will and the Concept of a Person," Journal of Philosophy, Vol. 68(1971) pp. 5-20.

²⁹David A. J. Richards, "Rights and Autonomy," Ethics, Vol. 92, #1, Oct. 1981 pp. 3-20.

³⁰I argue elsewhere ("Freedom, Autonomy, and Responsibility," Master's Thesis, University of Tennessee, Knoxville, pp. 87-89) that at least a part of the value we ascribe to autonomy comes from this distinguishing capability.

fourth, it allows us to consider others as moral agents deserving of our respect (e.g., in deliberating over my first-order desire to smoke, I consider whether doing so will be harmful or offensive to others).

This last element--the ability to consider others as moral agents--clearly is a different type of deliberation from the first three. In order to consider others as moral agents I need not reflect on my own higher-order preferences; I merely must consider others as intentional agents. Daniel Dennett, in his definition of personhood,³¹ gives a nice explication of this element (which he calls "reciprocity"):

Let us define a second-order intentional system as one to which we ascribe not only simple beliefs, desires and other intentions, but beliefs, desires, and other intentions about beliefs, desires, and other intentions. An intentional system S would be a second-order intentional system if among the ascriptions we make to it are such as S believes the T desires that p, S hopes that T fears that q, and reflexive cases like S believes that S desires that p (Dennett, 1978, p. 273).

Why is this type of deliberation important to being autonomous? Much of the reason we hold persons responsible is that they are capable of considering others as intentional agents capable of feeling pain, sorrow, joy, etc. This capability distinguishes between moral agents (i.e., agents capable of being responsible) and other types of entities.

³¹Daniel Dennett, "The Conditions of Personhood," in Dennett, Brainstorms (Bradford Books: Montgomery, VT, 1978) pp. 267-285.

Given my linking of autonomy with dispositional responsibility, reciprocity must be included in those capabilities an autonomous person has.

But as Dennett notes (Dennett, 1978, p. 270), reciprocity is not equivalent with being a morally good person; one could take into consideration the beliefs or fears of another while engaging in great violence against her. As this suggests, the sense of self-governance and autonomy I am adopting does not include that autonomous decisions necessarily have a normative component. A decision can be made autonomously even if it leads to a morally heinous choice. In this respect, autonomy is morally neutral. Of course, we need not honor such decisions; we may rightly decide in such cases that protecting other moral values will override respecting a person's autonomous decision. I will be returning to this theme in the section on identification.

The above characterization of deliberation reaffirms that adequate and accurate information must be present for a person to be self-governing. Without such information it is impossible rationally to generate a prioritized system of principles, to determine if an immediate desire is compatible with that system, to evaluate options, or to judge accurately how our decisions/actions will affect others.³²

³²Although I have little to add to the vast literature on the "informed" component of informed consent, I will briefly return to these issues in Chapter III.

This emphasis on having adequate and accurate information points to another condition of adequate deliberation: In order to deliberate effectively, one must have a thorough understanding of the context in which the decision is being made. One of the consistent themes of the Kantian perspective is that the empirical details surrounding a given decision are not as important as the rational process by which one appeals to a principle. This view is, I think, one of the major failings of the Kantian position. It is only by taking such empirical details into account that we can fully understand our place in the web of interactions which surround our decisions. That is, an understanding of the context--the persons involved, the nature of our relationship with those persons, the short- and long- term ramifications of our decisions/actions, the factors which may be influencing our deliberation, etc.--are of utmost importance. Without this contextual understanding we cannot fully appreciate either the myriad ramifications which result from our decisions or the range of factors which have influenced our decisions. Being a responsible decision-maker entails appreciating these elements. Although he does not say this, I take it that this is similar to Brandt's requirement that persons have "full and vivid awareness" of relevant information. For Brandt, the only way we can appreciate how we would respond to a given piece of information is to have it

before us as vividly as we would were we actually experiencing it. While I have doubts that, to borrow from Hume, the idea will ever be as vivid as the impression, the point is that we need to understand as much as possible how the information stands in relation to its context.

I do not mean to suggest that we can ever fully understand the context. We can understand it to greater and lesser degrees, just as we are autonomous to greater and lesser degrees. We can, however, often gain an understanding of the factors which are most central to the decision at hand. The more we are able to take these factors into account, the more we are able to be more fully autonomous. Further, part of what is involved in being a responsible agent is recognizing that we cannot always know all pertinent information. Our responsibility comes from our willingness and our attempts to seek relevant information and from accepting the resulting decision as our own decision. This latter component, of identifying with our decisions/actions, will be the focus of the next section.

The type of deliberation then which is necessary for making responsible, self-governing decisions includes second-order deliberation over adequate and accurate information which describes the context in which the decision is being made. The self-governing person must engage in that deliberation in as full a way as the situation allows and

warrants.³³ It is only through such deliberation that we can discriminate between "significant" and "trivial" choices. As Charles Taylor points out³⁴ we do not feel threatened when we are constrained by such trivial things as traffic lights. However, when significant concerns, e.g., our religious beliefs, are constrained we feel a serious threat (Taylor, 1979, pp. 182ff). And, as Taylor notes, the only way we can discriminate the significant from the trivial is through second-order deliberation (Taylor, 1979, pp. 187-190).

But surely it is possible for a person to engage in such a deliberation and then simply follow blindly the dictates of others. Mere deliberation does not guarantee self-governance. Yet, we have already acknowledged that one rarely if ever can be the sole source of a decision; our nature as social creatures guarantees that our decisions will be motivated from a wide range of sources. Thus another component of responsible decision-making must be included:

³³This caveat, "in as full a way as the situation allows and warrants," will be the theme of a section in Chapter IV.

³⁴Charles Taylor, "What's Wrong with Negative Liberty?" in The Idea of Freedom, Alan Ryan, ed. (Oxford: Oxford University Press, 1979). Taylor's goal is to convince us that the kind of freedom associated with negative liberty is not of the sort we want and that we should adopt the positive concept instead. For reasons noted in the Introduction, I think we do better to subsume elements of positive freedom under autonomy.

the self-governing individual is the one who identifies with her decisions.³⁵

Identification

The process of identification has two goals: to identify who we are and to identify with the decisions/actions we have made. The rationalist tradition has held that the first goal must precede the second; i.e. we cannot know what we identify with until we know who we are. This presumes, however, a sense of a static, essential self, a true self to which our authentic actions must correspond. But as the sense of a transcendent substance, soul, or essential self has fallen into philosophical disfavor, so has the idea that authentic actions must correspond with our "true selves." The position I will be defending, instead, is that the process of identification is bilateral; i.e. we come to know our selves by the decisions/actions with which we come to identify and we identify with our decisions/actions by appeal to our current conception of self. This obviously suggests that our conception of self and of authentic decisions/actions can change over time. But this is a problem only if we confuse identification with identity. I

³⁵While I have divided the processes of deliberation and identification into two separate categories, there is considerable overlap between them. The process of identification clearly involves that the agent deliberate and aspects of deliberation include the agent's identification with what is being deliberated.

will be returning to this distinction in the section on long versus short term identification.

The process of identification involves two components: making a choice and calling what was chosen one's own. Let us start with the first of these components.³⁶

Benn's notion of autarchy. S. I. Benn³⁷ provides an excellent characterization of "the chooser" and we can use it as our guide. "The condition of being a chooser . . . I shall call autarchy--a self-governing condition . . ."
(Benn, 1975-76, pp. 112-113). He notes that "[A]utarchy is normal, both in the statistical sense and in the sense that human beings who fail to qualify are held to be in some measure defective as persons" (Benn, 1975-76, p. 113).

What does being autarchic entail? Benn provides six conditions, each of which is necessary and which are together sufficient.³⁸ These conditions provide an excellent starting point in our analysis.

³⁶As we will see, the notion of being "a chooser" primarily is a capacity concept; in describing what is involved in being a chooser I will be describing capabilities such agents must have. Many of these capabilities also serve as prerequisites for the kind of deliberations described in the previous section.

³⁷S.I. Benn, "Freedom, Autonomy, and the Concept of a Person," Proceedings of the Aristotelian Society Vol. 76, 1975-76, pp. 109-131.

³⁸Note that these also are at least some of the conditions we generally take to be necessary for saying an individual is responsible. This helps strengthen my conceptual shift toward understanding autonomy as being responsible for one's life.

Benn's first condition is that "it must be possible to identify a single person corresponding over time to a single physically acting subject" (Benn, 1975-76, p. 116). While this condition has intuitive appeal--we like to be able to identify agents as holding a single identity over time--it does not seem to be a valid condition of autarchy. The condition clearly holds at one extreme; if we were unable to identify a single person from moment to moment, if there was no consistency, no point of referential recognition, we would be unable to relate to this entity as an agent to whom responsibility ascriptions are appropriate. If there were no identifiable individual, we would not know to whom such responsibility should be ascribed. Such a situation, I think, would press our intuitions as to appropriate definitions of personhood. Many would be unwilling to call such an entity a person.

But on the other extreme, we can easily imagine one person (who we would call autarchic) inhabiting a body for a long period of time only to have that body taken over by another (autarchic) person who inhabits it for a subsequent long period of time.³⁹ Any number of science fiction scenarios describe situations where we are not aware that a

³⁹This example can easily be reversed with the same conclusions. We can imagine a person meeting all the conditions necessary for being autarchic being transferred to another "physically acting subject" and still being recognized as autarchic.

person's body has been "taken over," where there is not a single person corresponding to a single physically acting subject, yet where we recognize the new agent as autarchic. (Recall the character Leonard Nimoy plays in the remake of "Invasion of the Body Snatchers." His behavior has us convinced that he is the same person, whereas in fact his body has been inhabited by an alien.) While these scenarios admittedly are far-fetched, they reveal that there is no logical or meaningful inconsistency in not requiring that a single person must correspond with a single physical subject.

Obviously the more difficult cases are those which fall somewhere between the described extremes. Part of what makes cases of split personality disorder so fascinating is that we do recognize the "other" personality as a real personality. Persons who are not familiar with the original personality treat the other as they would any individual. Although our sympathies (moral and emotional) lie with the original personality, this is not because we do not recognize the other personality as satisfying the conditions of being autarchic. Often the other personality displays other forms of behavior which we find unacceptable, or the original personality is clearly dominant. However, I suspect that our sympathies also result in part from something like

"squatters rights;" the original personality was "there first" and thus deserves our respect and/or protection.⁴⁰

However we judge these kinds of cases, it is clear that there is no necessary link between being autarchic and "corresponding over time to a single physically acting subject." What of Benn's other conditions? Each of them is, I think, necessary to understanding what is involved in being a chooser. In what follows I will describe them, make some slight variations in the way Benn presents them, and add one or two others.

Benn's second condition is that the autarchic person "must recognize canons for evidence and inferences warranting changes in his beliefs" (Benn, 1975-76, p. 113). That

⁴⁰Many would argue that I have conflated "person" with "personality" in the above example. They would argue, per Kripke, that a person's identity is linked with her genetic origin (Saul Kripke, Naming and Necessity (Cambridge: Harvard University Press, 1972, pp. 110-113). Thus in the case of the individual with the personality disorder, Kripke would argue that it is the same person displaying different personality characteristics. While this may be true--I do not intend to challenge Kripke's theory of naming and identity here--I am not at all sure that what we respect and want to protect about a person is her Kripkean essential identity. It seems our primary respect is for the moral agent--the capabilities, personality characteristics and the physical entity which we identify with that individual, all of which reveal the entity as an individual capable of taking and of being ascribed responsibility.

This issue will come up again in the section on long- vs. short- term identification. Even if we accept Kripke's view, though, it says nothing about the second extreme case described above. In that case Kripke would say that the original person no longer exists, only her physical body remains.

is, the autarchic person must recognize the kind of information described in the preceding section. While I obviously think this is a necessary condition, I would make it a little stronger. Not only must the autarchic person be able to recognize such evidence and inferences, she must at least be open to the possibility of that evidence altering her beliefs. Without this addendum we could have persons who willingly acknowledge new information that would change their beliefs if duly considered, but who do not give it such consideration. Some fundamentalist religious sects seem to at least partly display this type of behavior towards certain kinds of scientific information. Further, as I will discuss more fully in Chapter III, the psychological constraint of denial can prevent persons from adequately considering important information. Thus the condition should read, "the autarchic person must recognize canons for evidence and inferences warranting changes in his beliefs and he must be able to consider seriously the possibility that this information will necessitate a change in his beliefs."

Benn's third condition is that the autarchic person "must have the capacity for making decisions when confronted by options, and for acting on them" (Benn, 1975-76, p. 113). The only point worth noting here is that the first part of this condition logically precedes my addendum to the second condition. That is, in order to consider the possibility

that new information will alter our beliefs, we must be capable of making the decision to change them.⁴¹

The fourth condition is that "changes of belief must be capable of making appropriate differences to decisions and policies" (Benn, 1975-76, p. 113). This condition is very similar to my addendum to number two. There the claim was that the autarchic person must be "open-minded" enough that information could alter her beliefs. Here the claim is that she must be open-minded enough that such changes in beliefs could have the subsequent effect of altering her goals, values, preferences, etc. and thereby alter her actions.

Benn's fifth condition, that the autarchic person "must be capable of deciding in the light of preferences" (Benn, 1975-76, p. 113), is somewhat unclear. It is not clear whether the phrase "capable of deciding in the light of" implies the following prerequisites: that the autarchic person must be capable of first, holding preferences (elsewhere Benn makes it clear that he means higher-order as well as first-order preferences), and second, recognizing or understanding what those preferences are. Whether or not they are implicit in Benn's characterization, they clearly are necessary. Like the ability to recognize others as intentional agents, the ability to hold and recognize higher and

⁴¹While there probably is a difference between changing a belief and making the decision to change a belief, I do not think that difference is important for our purposes.

lower preferences is a distinguishing characteristic of responsible agents. Thus this condition should read, "the autarchic individual must be capable of holding higher and lower order preferences, have some clear understanding of what those preferences are, and be capable of deciding in the light of them."

Benn's sixth and final condition is especially well put: the autarchic person "must be capable of formulating a project or a policy so that a decision can be taken now for the sake of a preferred future state" (Benn, 1975-76, p. 113). This captures two crucial elements of being a chooser. First, it captures the idea that being a chooser means being able to integrate complex information, desires, goals, values, etc. into some kind of (more or less) general plan. Second, it captures the idea that the autarchic person must be at least partly future-oriented. It does not say that all autonomous decisions must be based on future goals; it simply says that the person must in principle be able to orient decisions in such a way and that she must thus be able to conceive of herself as existing in the future. This condition has been included as a distinguishing characteristic of responsible agents by many authors and

finds one of its most powerful defenses in Heidegger's notions of "for-having" and "fore-conception."⁴² The challenging question is how much of one's decision-making needs to be future oriented. And how extensive a future orientation is needed? In other words, do our autarchic decisions have to correspond to life-plans? Or is it sufficient that we simply consider the immediate ramifications (to self and others) of our actions? We have been running up against variations on this issue in a number of places and once again I must postpone my response a bit longer.

All of the above conditions are capability conditions; they appeal to capacities the agent must have to be autarchic. Are they sufficient? Is being "a chooser" simply having the (quite sophisticated) capabilities described above? Benn makes an interesting move at this point. He argues that they are sufficient for being a chooser and that any entity who has such capabilities deserves our respect (much as we respect persons as persons even if they do not act autonomously or morally). However, he goes on to say that in order to be autonomous one must exercise these capabilities:

⁴²Martin Heidegger, Being and Time, translated by John Macquarrie and Edward Robinson (New York: Harper and Row, 1962), see especially section 32. Interestingly, many of Benn's ideas have an (unacknowledged and possibly unrecognized) Heideggerian bent.

The autonomous man is not merely capable of deciding for himself, he does so; he is not merely capable of considering reasons, he does consider them, and he acts on them. He is therefore the man who realizes what the autarchic man has merely in potentiality (Benn, 1975-76, p. 124).

I am in full agreement with Benn that the autonomous person must realize her potential of autarchy. One of the themes I have been suggesting throughout this work is that being a self-governing, autonomous person means taking responsibility for important decisions in one's life. Taking such responsibility clearly means exercising the above noted conditions. I have not been suggesting that one need be the original author of decisions; I question whether this is possible in any but rare circumstances. Rather, my claim is that the autonomous person is the one who engages in the kinds of deliberations described above and who identifies with her decisions/actions.

Thus I clearly am in agreement with Benn's view that autonomy is an exercise concept.⁴³ However, Benn goes on to claim that being autonomous is an ideal. Understanding what he means by this and what its significance is for being autonomous takes us into the next section of this chapter.

⁴³Taylor makes a similar appeal to an "exercise-concept" in his explication of a sense of positive freedom quite similar to mine of autonomy. (Taylor, 1979, p. 193).

Identification. Benn lays out the distinction between being autarchic and being autonomous and begins an explanation of the sense of autonomy as an ideal in the following quotation:

Now I take autonomy to be an ideal in this sense. To be a chooser is not enough for autonomy, for a competent chooser may still be a slave to convention, choosing by standards he has accepted quite uncritically from his milieu. He assesses situations, adapts means to ends, and so on, but always by norms of propriety and success absorbed unreflectively from parents, teachers, or workmates. It is not that he is incapacitated from making independent judgments, like the heterarchic man; it is only that he has little inclination for making them and rarely does so. Such a person is heteronomous: unlike the heterarchic man, he governs himself, but by a nomos or set of standards taken over from others (Benn, 1975-76, pp. 123-124, his emphasis).

This quotation also captures my own hesitations with restricting the characterization of autonomy to rational (i.e., means-end) deliberation and negative freedom and thus provides the motivation for my appeal to identification. The remainder of this section will be devoted to describing what is involved in governing oneself by appeal to one's own nomos. And although Benn makes too much appeal to (unexplained) notions of "consistency" and "coherence," I will continue to borrow much from his account.

How does one establish one's own nomos; i.e. how does one avoid blindly following the dictates of others? The immediate, and partially correct, answer is through the type

of second-order deliberation described in the previous section. I noted there that such deliberation allows us to create a rational higher-order prioritized system of values, goals, preferences, etc.; i.e. a nomos. As we are faced with new options, this nomos guides our choices; through it we determine our preferences toward a given decision/action.

Why is this answer only partially correct? Throughout this work, and this will come out even more explicitly in the next chapter, I have been referring to social influences that prevent individuals from being "islands unto themselves." Who we are is very much a product of the "life-world"--the people, values, technologies, etc.--in which we find ourselves. Benn puts it nicely:

Are we not all governed by the basic presuppositions of a society which has provided the very conceptual structure of our world, the traditions into which we have been inducted, the demands of roles we have internalized? One's range of options is as much circumscribed by such mental furnishings as the highest speed at which one can travel is governed by the state of its technology (Benn, 1975-76, p. 126).

Now one need not accept this admittedly controversial epistemology to recognize that the process of socialization is quite pervasive and powerful and that persons often simply accept the values and goals of the immediate authority figures. One of the more obvious examples of this is the prevalent attitude of "whatever you think is best, doctor."

How can we escape this socialization so as to be independently self-governing and autonomous? If our goal is to

be the original and sole author of our decisions then, given our nature as social beings, that goal will be unreached the vast majority of the time. However, we can shift our emphasis from being the original and sole author of our nomos to the goal of identifying with that nomos and with our decisions and actions; to (metaphorically) seeing ourselves in our decisions, actions and their products in the world.

Benn puts it as follows:

It is a feature of the active life of [an autonomous] person that he is conscious of himself as an author of changes in the world. Admittedly, the man who has a place on an assembly line, so far as concerns this role alone, is not likely to see himself in this way. The total product is remote from his performance, and he is unlikely to feel much personal responsibility for it--to feel that he is, even in small measure its author. But of course his whole life is not like that. If he fries an egg for breakfast, he can recognize that this at least is his work, and he can judge whether he has done it well or ill (Benn, 1975-76, p. 124).

Benn is not suggesting here, nor am I, that all of one's life need be subjected to a strict process of careful deliberation and identification. Benn describes one who appeals to such a requirement as "an existentialist gone mad"

(Benn, 1975-76, p. 127).⁴⁴ In fact, I take it that one of Marx's primary goals was to shift the process of production so that persons would be able to identify with the more important aspect of their lives. So that instead of identifying with how one's egg has been fried, one can identify with one's product from the assembly line. Describing how those kinds of economic and production changes could be managed is not my project here. My point is that in order to be self-governing and autonomous one must have a great degree of identification with one's important decisions/actions and therefore with one's nomos.

None of this suggests, either, that through the process of identification one removes oneself from the influences of society. But this is no longer a problem, as our goal has switched away from original authorship of decisions/actions. Frithjof Bergmann puts it as follows:⁴⁵

⁴⁴Benn goes on to note rightly that "[Mo]st of the autonomous man's actions would be appropriate but non-deliberate responses to situations falling into fairly standard, readily recognizable categories" (Benn, 1975-76, p. 127). The appeal to such categories, combined with a recognition that decisions range in levels of importance and thus require greater and lesser levels of deliberation and identification, does much to allay the criticism that this sense of autonomy requires individuals to be in such a state of critical reflection that they will be unable to take any actions, that they will be reduced to a Dostoevskian "Underground Man."

⁴⁵Frithjof Bergmann, On Being Free (Notre Dame: University of Notre Dame Press, 1977). Like many of the other authors I have quoted, Bergmann refers to the condition I have been describing as "positive freedom," rather than "autonomy."

For it is of course a fact that I can identify with my deliberations, and with the acts to which they lead, in spite of their being influenced, and their not being under my complete control, just as I can disassociate myself from them. And this would lead to the plain and understandable position that choices are [positively] free if I identify with them (i.e., with the deliberations involved and with the later action) and [positively] unfree if I do not (Bergmann, 1977, p. 63).

Throughout this section I have not provided an explicit characterization of the process of identification; I have hoped that the reader has had some recognition of what I have meant by the term. But to appreciate fully what I mean, it is necessary to fill in the idea. Simply put, identification is the recognition of one's self in one's decisions and actions. The following section will attempt to spell this out more completely.

Self-conception and long- vs. short-term identification. I noted earlier that I reject the sense of a static, essential self to which all authentic actions must correspond. Yet I just defined identification as "the recognition of one's self in one's decisions and actions." So what is this "self"? The self is not the source of authentic actions; rather, it is the product of our decisions and actions, of living in the world. In deliberating over values, preferences, goals, etc., and in making choices and taking actions we create and confirm our selves. Benn puts it in the following Heideggerian way:

I began with the apparently undemanding conception of a person who cares about his ontological status

as a chooser, and has projects that structure his activities and his perceptions not only of his world but of himself too. With growing understanding of his activities he learns to appraise not only his performance, but also the very standards he uses for the appraisal. And this applies not only to the standards for appraising deeds and artefacts, but to his standards for appraising himself too. For he now emerges as the author of his own personality, conceiving his own ego-ideal, modifying it in the light of his successes and failures, much as the potter learns by experience the potentialities as well as the limitations of his material. . . .

[T]he principles by which the autonomous man governs his life make his decisions consistent and intelligible to him as his own; for they constitute the personality he recognizes as the one he has made his own (Benn, 1975-76, pp. 128-129, his emphasis).

This conception of the self has its roots in the existential phenomenology of many 20th century Continental writers. It finds one of its more extensive explications in Sartre's The Transcendence of the Ego.⁴⁶ Sartre stresses here, as do all writers who hold this view of the self, that the "creation" of the self is not an active process; one does not make a deliberate decision to create one's ego. (If it were such a deliberate decision there would have to be some "deeper" self which was deciding to create this particular ego and so on ad infinitum.) Rather, the self, in a sense, emerges from our interaction in the world. Bergmann puts it as follows:

⁴⁶Jean Paul Sartre, The Transcendence of the Ego, translated by, Forrest Williams and Robert Kirkpatrick (New York: The Noonday Press, 1957).

An analogy might bring us closer to it: numerous writers have remarked that in the case of the emotions a peculiar intimacy, a special connectedness exists between our investigating judgment on the one side, and the object of this judgment (that which it purports to describe) on the other. We think that we are in love, or angry, but our opinion is not a detachable and separate fact. That thought or conviction is itself a part of the event. Our believing that we are in love is itself a proof of the actuality of our love, just as a doubt also does not remain apart, but itself can be an indication that our feeling has begun to cool (Bergmann, 1977, p. 81).

This quotation also reveals the response to a common objection to this position. If the self is the product of our living in the world, why does it not constantly change, resulting in something like the person described in my discussion of Benn's first condition of autarchy (pp. 32-33, above)? In a sense the self does constantly change; we constantly make alterations in our beliefs, values, etc. However, our (as Sartre puts it) "fundamental project" rarely changes. That is, as we grow into adults we formulate fundamental goals of who we want to be and what we want to accomplish (e.g., to be a professor of philosophy). With these goals come a set of crucial values and beliefs (e.g., that advanced education is intrinsically worthwhile and that attending a reputable graduate school will best bring about the desired goal). While subsidiaries of these values and beliefs will become altered, the fundamental ones rarely change. If they do, if, to continue with the same example, I decide that academia in our culture tends to stifle rather

than promote creativity and that I would rather sell real estate than teach philosophy, then in an important sense I will have become a different person. One of the aspects of who I am, of how I define myself and of how others recognize me as that same person, has changed. If the change is even more fundamental, if for example I decide that gratuitously harming others is morally good, the alteration of self is likewise more radical. There is a connection between who we are, between our fundamental values and beliefs, and that aspect of the world we are experiencing. Bergmann notes this in his claim that there is a "connectedness" between our judgment (that we are in love, for example) and the object of that judgment. But, it must again be stressed that this connection is bilateral. I come to understand my self through my formulation of a nomos and through how I react to elements of the world and I come to understand the world through my conception of self.⁴⁷

With this understanding of "the self" we can better make sense of my characterization of identification: identification is the recognition of one's self in one's decisions and actions. It is the recognition of one's fundamental project and of one's constantly changing subsidiary beliefs, values, goals, etc.

⁴⁷The above represents a necessarily condensed explication of this view of the self. For a more complete summary see Bergmann's chapter, "Freedom and the Self" (Bergmann, 1977, pp. 79-103).

This characterization of the self (and thereby of identification) also provides us with an answer to the question that has been vexing us throughout: must our decisions/actions cohere with rational life-plans for them to be autonomous?⁴⁸ My hesitation with such views is that it appears that they often confuse identity with identification. That is, it seems in some of these accounts as though the goal has shifted from identifying with one's decisions/actions to preserving the same sense of self. While I readily admit that an alteration of one's fundamental project brings about a change in self, I do not see why such a change negates one's status as autonomous. Altering one's sense of self represents the most serious of decisions and should not be taken without careful, well-considered deliberation. But there is nothing to suggest that such a deliberative decision is any the less autonomous than other deliberative decisions.

Using the above described conception of the self as a base, my claim differs from the "coherence to life-plans" view in two ways. Autonomous decisions/actions need not

⁴⁸Rawls is the most often quoted proponent of this view (Rawls, 1971, especially pp. 409-415), although a number of medical ethicists have been associated with it as well. See, for example, Bruce L. Miller, "Autonomy and the Refusal of Lifesaving Treatment," Hastings Center Report, Vol 11, # 4, August, 1981, p. 24). Beauchamp and Childress have also been interpreted as holding such a view. See: Alfred Beasely and Glenn Graber, "The Range of Autonomy: Informed Consent in Medicine," Theoretical Medicine, Vol. 5, 1984, p. 31-32.

cohere with a life-plan or fundamental project; instead, they either must not conflict with one's fundamental project (life-plan), or there must be a well-considered recognition that conflicting decisions/actions represent an alteration of that project, including a recognition of the subsequent ramifications which follow such a change. The first break from the life-plans view lies in the shift from the stronger requirement of "cohering" to the weaker one of "not conflicting." This allows for decisions which, although not in direct conflict with a fundamental project, may not promote that project. Such decisions, however, may conflict with some of the values and beliefs which are subsidiary to the fundamental project.⁴⁹

The second break from the life-plans position is that I allow for changes in one's fundamental project. However I do not say this lightly. Such a change is one of the most significant decisions a person can make. And for the clinician attempting to preserve a patient's autonomy, honoring

⁴⁹I admit that it may not always be easy clearly to distinguish a patient's fundamental project (with its fundamental beliefs and values) from the subsidiary beliefs and values. Sartre claimed that persons are so often in "bad faith" that a type of psychoanalysis ("existential psychoanalysis") is often necessary to determine one's fundamental project. I am not so pessimistic as Sartre. Further, since I allow for alteration of one's fundamental project, given adequate considered deliberation and identification, the risk is not so great as one might suppose. In those cases where we are unable to make the distinction, we can simply seek the extensive level of deliberative identification described below.

such a decision is an especially difficult choice, especially given the power of such psychological constraints as denial (as described in Chapter III). When a clinician (or, for that matter, a family member or friend) is faced with the choice of whether to honor such a decision, it would not be an unjustified infringement on autonomy to demand evidence that the decision in fact is the result of careful, considered, deliberation and identification. This will involve extensive questioning as to whether the patient understands the full significance of her decision--of the alteration of life-plans (and therefore of self-conception) which will follow, of how her decision will affect others, of the possibility that her decision may be the result of fear or denial, etc. Acquiring such evidence obviously will take time; time that sometimes neither the patient nor the practitioner is willing to give. However if we respect autonomy as highly as we say we do, such time needs to be taken.⁵⁰

A Characterization of Being Autonomous

A final characterization of being autonomous now emerges: The fully autonomous person is the one who is self-governing and thereby dispositionally responsible for her life--i.e., she is "a chooser" who exercises those capabilities by carefully deliberating over important decisions

⁵⁰The pessimistic tone of the preceding is offset by the fact that the vast majority of decisions in the medical setting do not involve a possible alteration of life-plans.

and who identifies with her decisions and actions by appeal to a fluid self--and who is negatively free to carry out her chosen actions.

While I think this characterization best captures the normative goals associated with appeals to autonomy in clinical and other applied settings, it does not fully avoid the types of fears expressed by Berlin in his rejection of positive freedom (Berlin, 1969, especially pp. 135-166). His concern there is with the tyranny of the majority deciding what is appropriate and/or sufficient deliberative self-governance. We avoid some of these problems by not including any normative content in our idea of autonomy. Much of Berlin's concern was with the idea that the "right kind" of rational deliberation will give us the same moral principles. Further, in spelling out deliberation and identification in the way I have, we are able to counter much of the socializing influence which Berlin finds threatening. However, as I have repeatedly noted we cannot counter all of it. Thus there remains the danger that what we come to identify with is the result of the predominant values and belief structures of our "life-world." But unless we adopt an epistemology and a metaphysic which allows for the possibility of complete individual independence (a view I reject), this danger will always be present. Our best response is to engage in as much critical deliberation and

identification as is possible and as the situation allows and warrants.

Note also that the above characterization is of the fully autonomous person. This again implies what I have been suggesting throughout: that being autonomous admits of degrees. We clearly can be more or less responsible: we can exercise greater or fewer of our capacities as choosers, we can engage in fuller or lesser levels of deliberation, we can indentify with our decisions/actions in greater and lesser degrees, and we can be more or less negatively free to carry out our actions. This element of being autonomous is crucial to my argument that different situations demand different levels of autonomous behavior and I will be returning to it in Chapter IV.

Our task now is to look at the variety of factors which can constrain one's ability to be autonomous. As I noted in Chapter I, most contemporary accounts do not acknowledge such constraints as illness, institutional structure and economic realities. Explaining the nature of these constraints as well as their impact on being autonomous is the goal of the next chapter.

CHAPTER III

CONSTRAINTS ON AUTONOMY

Much of the work in medical ethics, both in the literature and in clinical practice, seems to assume that persons who are of mature years, who are not made incompetent by mental illness, and who have access to pertinent information are fully able to be fully autonomous. That is, such work assumes that these described impediments (i.e., lack of information, incompetence and immature faculties) are all that constrain our ability to be autonomous.

Brandt, however, has already taken us beyond this point with his requirement that rational deliberation include "repeated vivid reflection." In including this requirement, Brandt is recognizing that constraints on rational decision-making (and thereby on autonomy) are more extensive than is often recognized.

But is this additional requirement sufficient; i.e., is it the case that if negatively free persons engage in this kind of reflection over all relevant information they will then be fully autonomous? That is, Brandt's account suggests that persons have the inherent capability, given access to relevant information, to determine for themselves through repeated vivid reflection whether their original understanding of that information has been clouded by false

beliefs. Such repeated vivid reflection, he argues, will put the information in its true perspective with respect to our hierarchy of values and desires. Part of the goal of this chapter is to show that Brandt's account does not represent a realistic assessment of the kinds and extent of constraints against autonomy or of our ability to counter those constraints.

In defending this view I will present a partial account of those factors which can impede our ability to deliberate effectively and which can alienate us from our decisions/actions. In the process I hope to substantiate my claim from Chapter II about, as Robert Young puts it,¹ the "social nature of our existence" (Young, 1980, p. 565). By listing only a partial survey of the wide range of constraints, I think it will be clear that any adequate characterization of autonomy must account for this social aspect of our nature. At the end of the chapter I will explain how it is that the characterization I have suggested provides this account.

A second goal of this chapter is to substantiate my distinction between autonomy and negative liberty. I suggested in the Introduction that a characteristic distinguishing between these concepts is the type of constraint which counts against each. With many of the factors discussed below the agents may be negatively free (i.e. there

¹Robert Young, "Autonomy and Socialization," Mind, Vol. 89, 1980, pp. 565-576.

are no restraining elements for the existence of which some person or persons are morally responsible), yet their ability to deliberate effectively and to identify with their decisions/actions has been constrained. So let us turn to some of those factors to see how they in fact constrain autonomy.

Ackerman and the "Constraints of Illness"

In discussing how illness impedes autonomous behavior Terrence Ackerman² makes reference to three traditionally named constraints--physical, cognitive, and psychological--and adds a fourth often not included in philosophical literature--social constraints. But even his discussion of the first three goes beyond most accounts to show how the effects of illness can at least reduce the ability of patients to be autonomous.

Physical constraints. With respect to physical constraints Ackerman quotes Edmund Pellegrino:³ "'In illness, the body is interposed between us and reality--it impedes our desires and actions and is no longer fully responsive'" (Ackerman, 1982, p. 15). The result of this is an,

²"Why Doctors Should Intervene."

³Edmund Pellegrino, "Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness," The Journal of Medicine and Philosophy, #4, 1979, pp. 44-45.

obstructing [of] attempts to act upon cherished plans. An illness may not only temporarily obstruct long-range goals; it may necessitate permanent and dramatic revision in the patient's major activities, such as working habits (Ackerman, 1982, p. 15).

The interesting and insightful aspect of this claim is that Ackerman includes in his notion of physical constraints considerably more than confinement or other external restriction of action. What Ackerman and Pellegrino have recognized is that as persons we are intimately associated with our bodies. The achievement of goals, just getting along in our daily activities, require proper physical functioning. While this does suggest a form of dualism, it need not be a strict Cartesian, mind/body, dualism. Richard Zaner suggests an alternative that is compatible with Ackerman's claims and yet does not appeal to such a dualism. He describes what he calls an "embodied self"⁴; a self which is distinguishable, but not dissociable, from its body. Since we are not dissociable from our bodies, our decision-making abilities, goal-planning, etc. are inextricably dependent upon a relatively healthy functioning of those bodies. Fatigue, fever, and pain can impair our ability to deliberate thoughtfully over important decisions. Restricted movement may impair our ability to engage in desired activities, such

⁴Richard M. Zaner, The Context of Self: A Phenomenological Inquiry Using Medicine as a Clue (Athens, Ohio: Ohio University Press, 1981).

as athletics. At the extreme, as Ackerman argues, physical impairment resulting from serious illness can require a drastic revision of one's overall lifestyle. This is obvious in such instances as paralysis; but less severe impediments--e.g., chronic back pain--can also result in the overhaul of a physically active person's lifestyle.

It must be noted that not all of these will always represent constraints upon autonomy. Instead, they sometimes will simply represent an alteration of the environment in which decision-making takes place, much as climatic or population changes represent alterations. That is, in many cases these physical impediments are elements which should be seen as being given factors needing to be taken into consideration in any decision. But when they prevent effective deliberation or when they create an alienation between the agent and her decisions/actions then they are constraints.

Along similar lines, I do not mean to suggest that, for example, the paraplegic cannot be substantially autonomous. Rather, the point is that these kinds of physical impairments can bring about substantial change for the patient and when that process is in its most acute stages her decision-making abilities will be constrained. She will be unable to place the same kinds of values on factors (e.g., she may previously have placed considerable value on mobility-oriented exercise); she will not know what value certain factors will hold because she has to this point not had to deal

with those factors; she will not be clear on how certain cherished activities will fit into her altered condition; she will inevitably have to change some cherished activities; etc.

This does not suggest, however, that the possibility of autonomous behavior will be nullified (except maybe in extreme cases, during the most acute periods of change). Rather, the level of autonomy will be limited, in degrees corresponding to the type of illness and the extent of impairment. However, autonomy can be substantially restored as the person develops identification with the new principles, values, projects, etc. which come with the impairment.

Cognitive constraints. There are two broad categories of cognitive constraints--direct and indirect. Direct cognitive constraints involve a reduction in the patient's cognitive processes. This reduction produces a corresponding impairment of the patient's ability to understand and respond to her predicaments. Obvious examples include the effects of organic brain syndrome, Alzheimer's disease, schizophrenia and other forms of mental illness, etc. In each of these cases the patient may suffer a substantial diminution of ability to comprehend both the immediate situation and long-term effects. Hence her ability to formulate goals or to evaluate how chosen principles can be maintained is seriously impaired.

Other forms of direct cognitive constraints include the results of therapy--primarily the use of pain-killing and/or sedative chemotherapy. The immediate effects of such commonly prescribed drugs as morphine and demerol obviously can effectively prevent the patient from engaging in the kind of deliberation necessary for autonomous decision-making. But the long-term effects of codeine, for example, can also result in a serious impairment of decision-making abilities. In these latter types of cases the amount of impairment (and, thus, the level of autonomy) will vary among patients. Because of this variation we can assume neither that the patient is autonomous nor the reverse. Instead, careful analysis of the patient and the situation are required in each case.

Indirect cognitive constraints, in the form of inadequate knowledge and understanding of medical care, have long been the concern of medical ethicists and have provided the foundation for the emphasis on the "informed" side of informed consent. Ackerman sums up the source of the concern as follows:

[W]ithout adequate medical understanding, the patient cannot assess his or her condition accurately. Thus the choice of goals is seriously hampered and subsequent decisions by the patient are not well founded (Ackerman, 1982, p. 15).

Enough has been written and said about the need to provide patients with the information necessary to understand

the medical/technical aspects of their condition. I have only two points to add to that extensive body of work.

First, the medical/technical information is not the only information needed for making informed, autonomous decisions. For example, persons also need information regarding the way in which illness results from hazards present in the workplace or in the surrounding environment. I will be discussing this in much greater detail in a later section of this chapter.

Second, it is a frequent claim of health care practitioners that for patients to be truly informed of medical/technical information they would need to go through medical school. In short, this claim is simply false. Although the workings of both the body and medical technology are indeed complex, neither--when informatively simplified--is beyond the comprehension of most patients.⁵ The all-too-frequent lack of such patient comprehension is due to three factors. The first, and most common, is a lack of time and energy on the health care practitioner's part, especially

⁵See Making Health Care Decisions, Vol. II (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; Washington, D.C.: U.S. Government Printing Office, 1982). The authors of this volume state, "Numerous recent studies suggest that through the use of simplified language and written and audio-visual aids as adjuncts to discussion, lay people can understand health-related information" (President's Commission, 1982) p. 12.

when those health care practitioners are overworked residents, to do the extra work required to provide such an understanding. The second is an at least implicit desire to keep a certain aura of mystique surrounding the practice of medicine. When knowledge is shrouded in mystery, those who possess it maintain a distinct power advantage over those who need/desire it. The third reason why patients are frequently under-informed is directly related to the next two forms of constraint--psychological and social. For a variety of reasons, ranging from depression to an acceptance of a particular status associated with the "sick role," patients sometimes do not want to become informed. To understand why this is sometimes a cognitive constraint, rather than just a willful decision to remain uninformed, we need to look at the psychological and social components of illness.

Psychological constraints. First, there is no clear demarcation between psychological and cognitive constraints. The common types of cases, e.g. insanity defenses and incompetency hearings, generally appeal to the client's inability to deliberate rationally over actions. However, the claim often is that psychological problems lead to the cognitive impairments and that a distinction can be helpful for both legal and medical purposes. This in part explains the long

history of appeal to psychological constraints in both medicine and law. Although specific cases are often controversial, there is general acceptance in legal, medical, and philosophical communities that psychological impairments represent genuine constraints on autonomy.

Ackerman and others are attempting to extend that agreement to a recognition of a broader range of psychological constraints. Again responding to Pellegrino, Ackerman says, "[He] mentions the anxieties created by illness, but psychological constraints may also include denial, depression, guilt and fear" (Ackerman, 1982, p. 15).

Of those listed constraints, the majority of work has been focused on the effects of denial. Elisabeth Kubler-Ross' famous work, On Death and Dying,⁶ carefully details the ways in which denial (as well as other "stages" of reaction to terminal illness) affect our ability accurately and effectively to deliberate over important decisions. And Jean-Paul Sartre's discussions of mauvais fois and existential psychoanalysis⁷ have led to an entire branch of psychological theory and treatment.

Despite the extensive work in this area, little has been said about it in the literature on autonomy. Ackerman

⁶(New York: Macmillan Publishing Co., 1969), pp. 38-50.

⁷Being and Nothingness: A Phenomenological Essay on Ontology, Hazel Barnes, translator (New York: Pocket Books, 1956), pp. 86-112 and 712-765 respectively.

makes some inroads in his analysis of examples. He discusses the case of a young adult whose cancer had metastasized extensively enough to create complications for future chemotherapy. Despite repeated attempts to inform the patient adequately of the increasingly grave situation, he "would say only that he wished to do whatever was necessary to get better. Denial prevented him from exploring the alternatives" (Ackerman, 1982, p. 15). I would state it more strongly. Denial not only prevented him from exploring the alternatives, it prevented him from fully understanding the important elements and changing factors of his illness and life. Without that understanding he was unable to deliberate effectively over decisions and determine whether particular options were consistent with his chosen principles of self-governance.

Denial can also affect the ways health care personnel view situations. This in turn affects the kind and amount of information they communicate to patients or other decision-makers. While on a rotation at an intensive care nursery dedicated to performing all possible procedures to protect life, I had the opportunity to study the staff's reaction to a three-month-old infant who had been born to a mother unknowingly infected with herpes.

The herpes had attacked the child's liver, effectively destroying its ability to excrete bile and metabolize necessary vitamins. As a result of the liver failure the child

was severely jaundiced with dark yellow coloring. This unattractive aspect of his illness, coupled with a fatal prognosis, resulted in a general avoidance of him on the part of both staff and family. The staff kept him nourished and clean but in the three weeks I spent in the ward I saw him held only once. And though I was told his mother visited, I never saw her. In short, the child was suffering a slow, lonely death extended over a five to sixth month period.

Interestingly, when discussing the technical details of his ailment and prognosis the staff was forthright and blunt about his assured death. But in less formal conversations I brought up the possibility of saving all concerned parties considerable hardship and grief by taking a range of measures--extending from nontreatment of future infections to cessation of nourishment--to hasten his death. However, when faced with direct acknowledgement of the child's eventual demise the staff invariably denied its inevitability and would consider nothing but the most "heroic" of measures. This denial was translated into the information they conveyed to the patient's mother which, coupled with her own denial, had the effect of causing her to continue to maintain hope in a hopeless situation. All of this resulted in enormous emotional and financial cost to the mother at a time when she needed reserves of both as she attempted to divorce her husband (the source of the herpes). Simply put,

the staff ultimately denied the gravity and inevitability of the situation. This brought about a conveyance of misinformation that prevented the decision-maker from being able fully and accurately to assess the situation and determine how various options fit with her chosen principles and those she chose/would choose for her child.

Both these examples show the significant effect denial can have on one's ability to deliberate carefully and accurately over a situation. Thus when denial obstructs deliberation in this way, one's ability to make decisions consistent with chosen principles of self-governance will be constrained.

Similar examples are available for the effects of depression, fear, and guilt: the patient informed of a potentially fatal illness becomes so depressed as to be unable to make any decisions regarding her treatment; the cancer patient's unrealistic fear of the effects of chemotherapy prevent her from understanding fully the ramifications of non-treatment; one's guilt at not doing everything possible to preserve life can result in subjecting oneself or another to indignities and costs one would not otherwise endure; etc.

Obviously, the range and impact of these constraints will vary among patients and across situations. But the above examples reveal that these concerns must be a part of our process of attaining valid informed consent. William C.

Thompson, a consultant to the President's Commission,⁸ concurs and says:

[P]eople often draw strikingly inaccurate conclusions about the risks they face on the basis of relatively simple information. . . . These studies suggest that subtle biases in the way people process and use information must be taken into account by those who seek to "inform" patients of risks. Further empirical research is needed to determine the best way to avoid these biases and to ensure that patients draw accurate conclusions about risks (Thompson, 1982, pp. 114-115).

Thompson's emphasis again reveals the thin demarcation between cognitive and psychological constraints. But the issues raised above clearly are consistent with his recommendations. Further, his call for additional empirical research fits with my claim that the extent of the constraints will be situationally variable. If our goal is to allow persons to be self-governing and autonomous then such research is imperative. In the meantime concerned parties must be sensitive to the potential impact of such psychological factors.

Social constraints. One of the more insightful aspects of Thompson's article is that he recognizes that in addition to the effects of illness the very institutional nature of health care delivery can represent a social constraint on autonomy. He states:

⁸Cited in footnote four, above. This reference is from Volume III in an article entitled, "Psychological Issues in Informed Consent."

Psychological research also suggests that . . . physicians hold the power to exert a manipulative influence over patients' decisions. This sort of manipulation undermines patients' autonomy and, arguably, their welfare as well (Thompson, 1982, p. 115).

While Thompson does a good job of explaining what kinds of techniques physicians use to manage this manipulation (e.g. "framing or couching disclosures") he fails to discuss adequately either how it is that physicians have this power or why it is they may sometimes wish to exert it.⁹ I will be returning to these issues in a moment.

In his discussion of social constraints Ackerman speaks first of the family as a social unit. He cites a common example which shows how the family can represent a constraint on an individual's decision-making. A twelve year old boy with terminal cancer was asked to enter a phase one clinical trial. Phase one trials are carried out with the primary goal of determining toxicities and have no anticipated benefit for the subject. All the previous therapies had failed, making the boy a candidate for this experimental trial. These trials often have very unpleasant effects and can be physically debilitating.

The patient's course had been very stormy and he privately expressed to the staff his desire to quit further therapy and return home. However,

⁹One of the more difficult aspects of these discussions is the degree to which the above noted manipulations and/or power exertions are intentional. While clearly much (probably most) of it is done without active awareness, it is also clear that much is reflective and calculated.

his parents denied¹⁰ the hopelessness of his condition, remaining steadfast in their belief that God would save their child. With deep regard for his parents' wishes, he refused to openly object to their desires and the therapy was administered. No antitumor effect occurred and the patient soon died (Ackerman, 1982, p. 15).

Clearly there are two conflicting desires at stake here--pleasing his parents and choosing his own style of death. But without the expectations and ensuing constraints of the familial social structure that conflict would never have arisen. This is not to suggest that familial expectations will always represent a constraint on autonomy. Rather, my claim is that we need to recognize and take these expectations into account when attempting to determine whether a patient is autonomously choosing her own course. Are they disrupting her ability to make responsible decisions? In this case the patient is clearly alienated from his decision; he would not have made the choice he did had his parents been holding a realistic assessment of the situation; the decision he made did not fit with his own chosen principles of self-governance. It was not his choice; rather, it was a choice he felt constrained to make, constrained by his parents expectations. As this case reveals, our attention often will need to focus on the family's expectations and on whether they are consistent with the patient's own chosen principles of self-governance.

¹⁰This example provides a third way in which denial can affect decision-making.

Ackerman also broadens his discussion of social constraints to include what he calls "various social and cultural expectations" (Ackerman, 1982, p. 15). By these he means the forms of acceptable behavior that are dictated by our cultural and economic realities. As he points out in his reference to the sociologist Talcott Parsons,¹¹ one of those forms of acceptable behavior has been dubbed the "sick role". Parsons convincingly, if incompletely (for reasons I will discuss in a moment), argues that this sick role "tells" us such things as when we truly are sick and should seek help and to whom we should go for that help. The "sick role," as well as other social determinants, "tell" us what are proper modes of behavior when seeking out the help of the health care practitioner. They "tell" us to respect and defer to the authority of the professional to the point that,

many patients relinquish their opportunity to deliberate and make choices regarding treatment in deference to the physician's superior educational achievement and social status ('whatever you think, doctor!') (Ackerman, 1982, p. 15).

As Ackerman points out, Parsons explains how the "sick role" is ingrained in us from childhood. The doctor is nearly always perceived and presented as the authority who has the patient's best interest at heart. Deference to this

¹¹The Social System (Glencoe, Illinois: The Free Press, 1951).

authority becomes so natural as to often result in decision-making being transferred from the patient to the physician or other health care practitioner.

But an account of the "sick role" clearly does not present the complete story. Parson's and Ackerman's accounts fall short in that they do not discuss such broader constraints as: the fact that restricted availability of health care services makes it more difficult for lower economic classes to receive quality care for their illness and thereby are more likely to be constrained by those illnesses; the standard objectification of patients in hospital settings; the training processes for health care practitioners; the ways in which profit alters health care policy, etc. As I will be showing in a moment, these economic, institutional, and political realities shape the ways in which a precious commodity is made available and, thereby, the ways in which authority will be delegated and acceptable consumer behavior defined.

Parsons' complete social theory assumes that it is desirable to preserve the status quo and the analyses which follow will be in conflict with this aspect of Parsons'

work. Ackerman's position, on the other hand, could be consistently expanded to include the broader economic, institutional, and political considerations. As I noted in the Introduction, I think he would be at least partially sympathetic to such an expansion.¹²

Social and Economic Constraints and Routine Care

One of the more serious flaws in medical ethics literature is the way in which discussions of broader socio-economic issues are almost studiously avoided. There is some, quite good, theoretical work done in the area of justice and distribution of health care. But for empirically-grounded analyses of institutional structures--e.g. the effects of the capitalistic economic structure on health care delivery, or the nature of power displacement in medical practice--one must turn to sociologists.

Further, a large majority of the work being done in medical ethics focus on extreme situations--who should be chosen for scarce but lifesaving resources, when is it appropriate to "pull the plug," when if ever does the fetus take on personhood status, etc. To an extent Ackerman's article has a similar bias. His examples focus on crises, where the decision in question will determine whether the patient will live or die, and they do an excellent job of

¹²He has confirmed this in personal communications, November, 1983.

showing the constraints on autonomy which can inhere in such situations.

But what of less obvious examples? Are there constraints present in common, routine interactions with health care practitioners? If I have a flu and go to my family physician, is there anything currently inherent in that situation which could constrain my ability to be a self-governing autonomous individual?

There is in fact quite a bit. The remainder of this chapter will be devoted to discussing the nature of these constraints and to showing how they range from the immediate interactional (micro) level to the broader economic and political (macro) levels. While there is much to suggest direct connections between these macro and micro level constraints, I will not be attempting to draw those connections in this work.

Micro-Level Constraints

Extensive work has been done on informed consent. Some of that work (see the above cited Thompson article) has included discussions of the constraints imposed by the institutional nature of medical care. But little has been written on the constraints inherent in the health care practitioner/patient relationship. Given that the vast majority of medical decisions orient around conversation, we need

thorough analyses of the ways those conversations are conducted. I hope to show that those conversations typically are conducted in such a way as to represent a constraint upon the patient's ability to make autonomous decisions.

Discourse analysis has a relatively extensive history in linguistics, psychology, and sociology. Based on theoretical foundations as diverse as John Searle's work on speech acts, Ludwig Wittgenstein's appeal to meaning as contextual use, and Aaron Cicourel's cognitivistic psycholinguistics, its practical application is to disclose meaning in conversations that is not normally subject to our active appraisal. The general claim is that much of what is expressed in conversations takes place on an "implicit" level. That is, that the meaning of a particular conversation is given through more than just the spoken words. It is given in the way words are stressed, who asks questions and when they are asked, who interrupts more often, etc.

This method has been applied to such contexts as educational techniques, manipulations of legal/courtroom processes,¹³ and fortunately for us, conversations between health care practitioners and patients. Two good sources for these analyses are J. Coulter's The Social Construction

¹³A recent broadcast of 60 Minutes profiled a sociologist who advised attorneys on the choice of jurors based on an analysis of the conversation between potential jurors and questioning attorneys.

of Mind¹⁴ and Sue Fisher and Alexandra Dundas Todd's, The Social Organization of Doctor-Patient Communication.¹⁵ The former provides a thorough theoretical structure, based on a "Rylean/Wittgensteinian" approach, while the latter anthology combines a number of examples of discourse analysis with sociolinguistic and cognitive theory bases. I have neither the space nor the expertise to fully lay out the theoretical foundations so I will focus on a few of the examples mentioned in the Fisher-Todd anthology. I would direct readers interested in the theoretical foundations to Coulter and to Cicourel.¹⁶ Although I will not provide those theoretical foundations, much of what is involved in these analyses appeals to common sense, as I hope will be revealed in what follows.

What is there about conversations that could represent a constraint on autonomy? First, it must be remembered that health care practitioner/patient conversations are of a special sort. The patient is appealing to someone with greater knowledge and expertise for help with something of crucial

¹⁴(London: Macmillan, 1979).

¹⁵(Washington, D.C.: Center for Applied Linguistics, 1983)

¹⁶Cicourel has a number of respected publications in this area. One of the most referenced is his, "Discourse and Text: Cognitive and Linguistic Processes in Studies of Social Structure," Versus: Quaderni de Studi Semiotici No. 12, 1975, pp. 33-84.

importance--her health. Further, that expert is in turn attempting to gain information. This can often be an exceedingly difficult task as she must be able to elicit all information pertinent to the patient's case. Then she must be able to convert that information into possible diagnoses and treatment plan options, doing so in a way that the patient will have enough understanding to deliberate effectively over those options. Ideally then, the patient, in continued consultation with the expert, voluntarily determines how those options fit with her chosen principles of self-governance and chooses the option she deems best. When the communication is not effective, when various elements prevent the effective transfer of information, the patient ultimately will be constrained in her ability to choose autonomously.

Roger Shuy discusses three ways in which this communication can be "interfered" with.¹⁷ First, there is the often-noted problem of jargon. Shuy's response to it, however, is atypical of those of most ethicists. He says,

Jargon is perfectly acceptable and useful within the groups that know it When jargon goes wrong is when it is used outside the group that knows it, resulting in either a lack of comprehension for the outsider or a social one-upmanship on the part of the insider (Shuy, 1983, p. 190, his emphasis).

¹⁷"Three Types of Interference to an Effective Exchange of Information in the Medical Interview," The Social Organization of Doctor-Patient Communication, pp. 189-202.

We all use some form of jargon, Shuy is claiming.¹⁸ This becomes a problem when we maintain our use of jargon with persons who do not understand it. It becomes a serious problem when the jargon "infected" communication is about something as important as a patient's health.

Medicine is especially liable to this type of interference in communication. Further,

[Ph]ysicians have felt the need to communicate their knowledge considerably less than those in most other fields, largely because their clients are often in trouble or pain and willing to be told rather than eager to know. As client relationships go, that of the doctor and patient is maximal for control and minimal for needing to learn how to communicate information to the client (Shuy, 1983, p. 190).

The second type of interference is "cultural differences." Shuy's work is primarily done with the black community but his findings can easily be extrapolated to other non-Standard American English speaking groups.¹⁹ After considerable study (at Georgetown University Hospital) of patients who speak Vernacular Black English, Shuy concludes that the problem does not primarily lie in the area of understanding.

¹⁸He notes, in fact, that patients often have their own jargon but that in his studies he has yet to find a physician who attempts to pick up the patient's jargon while nearly all patients attempt to pick up the physician's.

¹⁹As part of her dissertation Sue Fisher (one of the editors of this anthology) worked with hispanic groups in the San Diego area. She found the problems there to be at least as severe as Shuy describes. (Personal communication, May, 1984).

[T]he person who hears a vernacular dialect spoken tends to devalue the speaker of that dialect. Consciously or unconsciously, dialect speakers tend to get worse treatment, wait longer for service, are considered ignorant, and are told what to do rather than asked what they would like to do (Shuy, 1983, p. 192).

While I think there is danger in making such judgments as, the person who hears a dialect "tends to devalue the speaker," the other claims are grounded in his empirical research. (The former judgment, of an individual's belief, needs considerable supporting evidence. Shuy often does not provide this evidence.) It is obvious how those reactions will constrain a patient's ability to choose autonomously an option consistent with chosen principles of self-governance. "Being told what to do," getting "worse treatment," etc. all represent clear constraints on autonomous decision-making. The fascinating aspect of this research is that these constraints result from the way in which the patient is speaking. Again we see how elements of communication can represent constraints on autonomy.

Shuy's third type of constraint is one that is receiving a considerable amount of attention in applied linguistic research. It is the way in which the medical interview is structured. Shuy first describes the structure of "normal" conversations noting that

[Of] particular interest in most conversations is who introduces the topic, who switches it to another topic, how an introduced topic is responded to by other participants in the conversation,

[and] how interruptions take place . . . (Shuy, 1983, p. 193).

He then goes on to describe how the structure of medical interviews differs from the norm. He notes that, unlike normal conversation the medical interview is unbalanced. The physician asks the vast majority of questions, is the only one to initiate a new topic, and frequently interrupts the patient. Shuy draws an analogy with student/teacher interactions. He points out that those conversations have many of the same unbalanced characteristics and notes that the children "perceived as troublesome are often those who have unconsciously made use of conversational rules that are perfectly acceptable elsewhere but not acceptable in the school" (Shuy, 1983, p. 193).

Shuy's primary claim is that this unbalance represents an interference because patients are not accustomed to this type of conversational interaction. As a result they "bring along a great deal of fear" to the interview (Shuy, 1983, p. 193). This fear contributes to the imbalance and leads to a stilted conversation in which control is maintained by one party--the health care practitioner. Again it should be clear how this kind of interference in communication can represent a constraint on the patient's ability voluntarily to choose options consistent with her principles of self-governance. If the health care practitioner is in control, if she leads the conversation in such a way as to impart and

receive information that she considers important, it becomes quite difficult for the patient to gain information and understanding needed to deliberate effectively and to make an informed, voluntary decision.

These three types of interferences in communication are only a few examples of micro-level constraints. Sue Fisher points to such elements as whether the physician is relating to a patient referred from another private physician or is coming from "the public" into a community clinic.²⁰ She convincingly argues that the former patients are treated with considerably more respect and are given more input into the decision-making process. Alexandra Dundas Todd discusses the ways physician attitudes about sexual relations can affect communication and treatment decisions.²¹ (By pointing to the connections to societal structures, both Fisher and Dundas Todd also begin to draw a bridge between micro and macro level constraints.) The element common to all of these examples is that they reveal how communication between health care practitioners and patients can be affected by a wide range of considerations. Given that we are

²⁰"Doctor/Patient Talk: How Treatment Decisions Are Negotiated in Doctor/Patient Communication," The Social Organization of Doctor-Patient Communication, pp. 135-157.

²¹"A Diagnosis of Doctor-Patient Discourse in The Prescription of Contraception," The Social Organization of Doctor-Patient Communication, pp. 160-187.

taking self-governance to be a crucial element of being autonomous, anything which constrains an individual's ability to make carefully informed, deliberative decisions is of great importance. The considerations discussed above clearly show how biased communication of information with the often related alteration of treatment can constrain a patient's decision-making powers.

Macro-Level Constraints

The extent of macro-level constraints is enormous. They range from societally based racism/sexism that physicians (and patients) carry into the medical interview²² to such institutional constraints as the way the "clinical mentality" determines treatment decisions²³ to the effect a profit-based economic system has on health care delivery.

While I am fascinated by the nature and extent of institutional constraints, limitations of time and space restrict me to looking at two general areas: the effect of technology on medical and patient decision-making and the effect of capitalism on American health care. I hope to show how each of these (negatively) affects individual

²²See Elizabeth Fee, "Women and Health Care: A Comparison Thesis," Health and Medical Care in The U.S.: A Critical Analysis, ed. by Vincente Navarro (Farmingdale, New York: Baywood Publishing Co., 1973), pp. 115-132.

²³See Eliot Friedson, Profession of Medicine: A Study of the Sociology of Applied Knowledge (New York: Harper and Row, 1970), especially Part II, pp. 85-202.

decision-making abilities and thereby constrains personal autonomy.

This is a good place to reinforce one of the general points of this chapter. As we move into more abstract levels of constraint we see the inadequacy of appealing only to constraints on freedom. While in many situations there will be some person or persons who have moral responsibility for the existence of a given constraint, such is not the case with the kinds of constraints being discussed here. With illness-generated constraints there rarely is anyone directly responsible for the existence of the constraint (a counter-example would be knowingly exposing a partner to a sexually transmitted disease without telling her or him). Unless one appeals to some version of a "conspiracy theory" the direct connection to a person or persons is even more

tenuous with respect to social and economic constraints.²⁴ Nonetheless, I hope to show how these broader considerations can in fact represent constraints on autonomy, keeping in mind my general claim that autonomy admits of degrees. As with the constraints of illness, the following considerations will constrain autonomy in varying degrees among various persons.

It should also be noted that the primary source for the type of analysis to follow is socialist literature. While I am only in partial sympathy with many of the socialists' claims, I think writers like Howard Waitzken provide some of the more sophisticated accounts of the way health care is practiced in the United States and I will be relying heavily on Waitzken's The Second Sickness²⁵ in what follows.

²⁴Throughout this work I will be assuming a "structuralist" account of certain social and economic entities. That is, I hold that some of these entities have an identity that supervenes over the individual persons who make them up. Hence those entities can affect (and, I hope to show, constrain) autonomy without there being a direct connection between those effects (constraints) and an individual or individuals who cause them. This is not to suggest that the persons within these entities (the typical example is of corporations) are immune from ascriptions of responsibility for actions taken. The claim is simply that such things as corporations or social attitudes can have influence over and above that of the individuals that make up the corporation or society. And that for many of those influences there is no person or persons who can be held morally responsible for their existence. For a fuller defense of this view, see my article, "The Corporation, Its Members, and Moral Accountability," Journal of Business and Professional Ethics, Vol. 3, No. 1, Fall 1983.

²⁵(New York: The Free Press, 1983).

A few introductory notes. Individuals working within the socialist perspective typically hold that capitalism, by its nature, is an immoral economic structure and that most, if not all, of our societal ills follow directly from it. In short, they believe that by changing this economic structure we can eliminate the traditional problems that have historically plagued society. With specific reference to medicine, they argue that it is only by changing the general economic nature of the society that we can have an effective health care delivery system. While I agree that many of the problems in health care delivery are a result of an abusive profit motive, I do not believe that the profit motive is itself immoral or that it will always lead to abuses. Neither do I think that an alteration of the economic structure will solve all our difficulties in health care delivery. Although many of those problems are a result of power asymmetries, not all power asymmetries are the result of economic inequities. The motivations for our behavior, both positive and negative, are far too complex to be so directly connected to economics. But, those difficulties aside, much of what many of the socialists have to add to our discussion is of great value and its omission from most accounts of autonomy has led to those accounts being over simplified.

Technology and decision-making. In his monumental critical history of American medicine,²⁶ Paul Starr discusses the rise of technology and how it affected the doctor/patient relationship. Until the early 1800's, he notes, medicine depended upon a patient's communicating her ailments. Thus, the physician needed good communication skills so as to be best able to determine the nature of the disease. By the mid-1800's a range of new diagnostic tools came unto the medical scene--stethoscopes, ophthalmoscopes, laryngoscopes, etc.--which allowed the doctor to rely on manual observation more and on communication less. This resulted in a "strengthening [of] the authority of internal medicine and radically altering the doctor-patient relationship" (Starr, 1982, p. 136). The relationship was altered, he explains quoting Stanley J. Reiser²⁷ because such tools as the stethoscope

required the physician, at least momentarily, to "isolate himself in a world of sounds, inaudible to the patient," and encouraged him to "move away from involvement with the patient's experiences and sensations, to a more detached relation, less with the patient but more with the sounds of the body." These sounds the patient could neither hear nor interpret. Similarly, the other instruments that gradually assumed a place in the doctor's bag reduced dependence on the patients' statement of symptoms and increased the asymmetry of information (Starr, 1982, p. 136).

²⁶The Social Transformation of American Medicine (New York: Basic Books, 1982).

²⁷Medicine and the Reign of Technology (Cambridge: Cambridge University Press, 1978), pp. 43, 38.

I include these quotations because they show, first, how even such seemingly innocuous tools as the stethoscope can negatively affect important communication (and, hence, the patient's decision-making abilities). Second, they reveal the seriousness of the technological gap today. As increasingly sophisticated technology came to pervade medicine, the patient became further and further removed from doctor/patient interactions. The new tools could be used to study the bodily mechanism directly. The person was important only for pointing the tools in the correct direction and for when the tools came up short in the doctor's interpretation of the ailment. The physician, consequently, became increasingly a technician, adept at analyzing the data provided by the tools as opposed to being adept at reading her patients. And as a technician the physician held information and a language foreign to the patient, further adding to what Starr aptly calls "the asymmetry of information."²⁸

With sophisticated technology comes a medical mind-set that frequently produces greater alienation between provider and consumer. The consumer feels alienated from the sophistication and mystery of the technology and those who work with it. The consumer feels herself dependent on a system

²⁸Alfred D. Beasley and Glenn C. Graber provide a similar analysis of current technology in their article, "The Range of Autonomy: Informed Consent in Medicine," Theoretical Medicine, vol. 5, 1984, pp. 31-41.

of people and machines she knows little about. Whether or not a power asymmetry actually does follow from this alienated dependency (all evidence suggests it does), the consumer generally feels such an asymmetry. Our feelings of helplessness at not being able to cure our illnesses are exacerbated by our alienation from those who we hope can cure us. With this alienated dependency comes a strong disinclination to question, to have responsible involvement in decision-making. And, as Ackerman points out, this alienated dependency is ingrained in us from a very early age. It becomes a natural part of our understanding of the medical part of our lives. The doctor has the knowledge and with that knowledge comes power--power such that questioning of his medical authority is quickly learned to be inappropriate.

Clearly the advanced technology on which medicine is so dependent has a deleterious effect on balanced interactions between health care workers and patients. It adds to the view of the patient as a mechanism which needs fixing, it worsens the information gap, and it adds to the perception that the physician is the figure of authority. All these results make it considerably more difficult for the patient to be an active, responsible decision-maker.

But the prevalence of technology in medicine also has broader ramifications. First, as Waitzken explains, technological advancements in part dictate the training of new

medical workers. As hospitals strive to maintain a competitive edge in their local markets they often place top priority on acquiring the latest technological advance. With these acquisitions comes a need for workers skilled in their use, at the cost of more general knowledge about medicine.²⁹ Seeing this need for technically competent health care workers, medical schools train their students accordingly (Waitzken, 1983, pp. 23-24).

Second, "The proliferation of technology increases the costs of medical care and diverts attention from simpler services that are sorely needed" (Waitzken, 1983, p. 234). Because of the competitive nature of hospital care there is little coordinated effort to avoid duplication of expensive technologies in a given area. Thus already scarce resources of medical care get focused into highly expensive equipment and tests. This leads

to some bizarre contrasts. In many North American cities, one sees densely concentrated hospitals in specific geographic areas. These hospitals often contain the world's most advanced medical technology, with duplicated and overlapping equipment located in a perimeter of several city blocks. On the other hand, nearby urban and rural areas frequently lack clinics and hospitals altogether, and patients--usually poor and often from minority backgrounds--must travel miles for primary services (Waitzken, 1983, p. 23).

²⁹The emergence of Family Practice programs is a direct response to this technologization and consequent specialization. Despite this positive step, Family Practice physicians have not and will not make a significant impact on the problems described above.

The proliferation of advanced medical technology thus has a direct connection with the quality and level of medical care many persons enjoy. If illness represents a constraint upon autonomy in the ways described above, then that constraint is exacerbated for those unable to get relief from their ailments. Such persons clearly will have their autonomy more constrained than those wealthy enough and/or fortunate enough to live in an area with quality medical care. And even the latter persons must receive their care from practitioners trained to use tools, rather than trained to work with people.

Capitalism and medical care. The effects of a profit-motivated socio-economic structure are obviously quite encompassing. I do not claim to understand more than a fraction of those effects and I will attempt only to describe a couple of those which have an obvious detrimental effect on medical care and on persons' ability to be self-governing and autonomous.

Waitzken describes two pervasive "social contradictions"³⁰ in medical care practiced in a profit-motivated

³⁰He defines a social contradiction as:

antagonistic or opposing characteristics that arise among social groups, within organizations and institutions, across nations, and in the realm of ideas. . . . If a specific feature is necessary for a system's accomplishments, a contradictory feature is one that undermines those accomplishments (Waitzken, 1983, p. 5).

socio-economic structure--the contradiction between profit and health and the contradiction between profit and an equitable distribution of health care.

The contradiction between profit and health results, in part, from the conflict between the dual needs of profit and safety in the workplace. "Safety in the workplace, in almost all instances, means increased cost of production and, as a result, decreased profits" (Waitzken, 1983, p. 9). And in a capitalistic system profit is given a high enough value that safety will suffer with a consequent reduction in worker health. Increased emphasis on worker health would require a substantial augmentation of product and equipment safeguarding. Such an augmentation often results in higher costs and reduced worker efficiency. Hence, "the constraint of private profit is a structural basis for resistance to changes in production that would assure occupational health and safety" (Waitzken, 1983, p. 9).

Further, this contradiction is found in our involvement in the environment as a whole. "Considerations of profit . . . also encourage the dumping of waste products of the production process into the wider community" (Waitzken, 1983, p. 9). They also encourage the wasteful abuse of resources precious to the health and well-being of society. I agree with Waitzken to this extent: so long as profit, especially short-term profit, is among the strongest motivating factors in the way the workplace is run and the

way the environment is used, there will be a high rate of health problems.³¹

Related to this profit/health contradiction is the realization that health and illness get defined, in part, by one's ability to be a productive member of the workforce.³² This is especially true of mental illness. Our culture historically has been quite tolerant of the "eccentric" so long as her behavior has not disrupted her own or others' productivity. Hence what Parsons and Ackerman refer to as the "sick role," with its already mentioned constraints upon autonomy, is very much a result of the working conditions and emphasis on productivity which are in turn a result of the motivational force of profit. Thus we see a self-perpetuating and contradictory cycle. Illness gets defined, in part, by one's (lack of) ability to be productive and one's (lack of) ability to be productive is diminished when

³¹Some of these problems are countered by regulations and fines which enlist the profit motive in order to promote safety. However, especially given the current climate of "deregulation" (OSHA is one of the most beleaguered of the federal agencies), those fines and regulations can only make a dent in the overall problem. Further, many would consider such governmental interference to be based on a socialist philosophy. (I am indebted to Betsy Postow for her suggestions here.)

³²See Sander Kelman, "The Social Nature of the Definition of Health" and Ronald Frankenberg, "Functionalism and After? Theory and Developments in Social Science Applied to the Health Field," both in Health and Medical Care in the U.S.

too much emphasis is placed on productivity, with its resulting increase in occupational and environmental hazards.

These considerations act as constraints on persons' autonomy in the following way. Decisions concerning desired work and lifestyles often must be made without knowledge of occupational and environmental hazards. The lack of knowledge here is comparable to such a deficiency in any situation involving voluntary informed consent. Waitzken's valuable contribution to the discussion is to show how the kinds of information necessary for making autonomous decisions often extend beyond immediate situational variables.

The second contradiction Waitzken discusses is between profit and an equitable distribution of health care services.³³ While some maldistribution results from health care workers desiring to be in favored geographic regions, Waitzken argues that economics is the most powerful determinant in the location and quality of health services.

On the patient level, maldistribution occurs from the patient's inability to afford more expensive private physician services. Hence,

poor people often have to use emergency rooms and outpatient departments of public hospitals for their care. Here they frequently face bureaucracy, impersonality, and lack of continuity

³³I do not mean to suggest that all inequities represent violations of autonomy. Rather, in what follows I hope to show that such inequities often lead to constraints.

because of rotating interns and residents who can follow their patients only for brief periods of time (Waitzken, 1983, p. 20).

When I discuss these kinds of issues with residents and interns, their predominant response is that lower income persons receive complete care at a cost considerably reduced from that which higher income groups pay. While this is sometimes undeniably true,³⁴ it ignores the more subtle problems with acquiring that complete care. As Waitzken points out, the care comes only after considerable effort (getting to the usually centralized location, waiting, hassling with overworked, often surly non-medical personnel, etc.). Further, the care is of an undeniably reduced quality. Patients are treated by relatively inexperienced, overworked, residents and interns who, in my experience, have little or no supervision from their educators. Each of these factors represents not only impairments of quality medical care, but of autonomy. First, as noted above in the section on micro-level constraints, these patients often are not treated with the same level of respect as higher income, Standard American English speaking patients. If they are allowed to be involved in the decision-making process at all, it is with reduced levels of communication and less appreciation for the time needed for careful deliberation.

³⁴It is true only in some geographic locations, primarily the inner city. Persons in isolated rural areas, such as the Appalachians, are realistically cut off from modern medical care for all but the most serious of ailments.

Second, even with health care workers sensitive to issues of discrimination, the working environment is such that they especially lack the time necessary to convey information and help patients deliberate over the issues.

On a broader level, economic factors determine the location of and type of care available. Health care workers, sometimes motivated by a desire for increased profit, are led to those economic centers where such profits are attainable. Furthermore, such workers are trained in educational institutions that are located, on the whole, in areas of relative economic prosperity. When their training is completed they often desire either to stay in the area in which they have been working or to move to communities with a similar economic and educational make-up.

Waitzken goes on to list a wide range of factors which determine the distribution of health care services. They extend from the concentration of finance capital (Waitzken, 1983, pp. 23, 50-51), to the discrepancies in care delivered in private insurance-supported vs. publicly-supported institutions (Waitzken, 1983, pp. 52-54), to increasing corporate involvement in health care (Waitzken, 1983, pp. 106-112, 232-234). The result of all these factors is that health care services in general are focused in urban locations with relatively strong economic bases. Again, this produces a medical environment in which autonomy is constrained in the ways described above. Lower income-patients are forced to

deal with reduced quality services. And, as noted above, poorer services frequently result in reduced patient involvement in the decision-making process as well as increased health problems with their corresponding constraints on autonomy. Higher income patients find their options restricted by care dependent on technology, in geographic locations determined by economic forces, from workers trained to work with profit producing technologies.

Summary and Conclusion

The main task of this part of the work has been to show that the range of constraints on autonomy is exceedingly broad and complex, far more so than generally acknowledged in the literature. In the process I hope to have shown first, that health care worker/patient interactions are far more complex than one free agent seeking services from another free agent, as Veatch's contractual model suggests, and second, that what constitutes a constraint against autonomy is much more inclusive than constraints against freedom. Through the latter goal we can understand more clearly what is involved in being a voluntary, self-governing, autonomous individual.

Taking all of this in perspective, however, seems to result in quite a gloomy picture. We have health care workers constrained by economics, educational training, socially

induced/approved prejudices, etc.; we have patients constrained by illness, economics, prejudices, the "sick role," etc. Given all of these constraints, is it possible to have a mutually satisfying interaction between an autonomous patient and an autonomous health care worker? Might we not be better off to shift our emphasis away from respecting or promoting patient autonomy and to appeal instead to a model of beneficence? By making such a shift we can strive for whatever is in the patient's best interest, regardless of whether the choice is consistent with her own chosen principles of self-governance.

Three points tell strongly against such a switch. The first and most obvious is the extremely difficult task of determining what in fact is in a patient's best interest. The pluralistic nature of our culture makes such a determination difficult enough to be impractical. Further, defenders of an autonomy model, myself included, believe that part of what is in a person's best interest is allowing that person to autonomously choose her own course of action.

Second, as Onora O'Neill points out,³⁵ on a beneficence-based model "it would then be irrelevant to medical

³⁵Onora O'Neill, "Paternalism and Partial Autonomy," Journal of Medical Ethics, Vol. 10, 1984, pp. 173-178. I will also be relying heavily on this excellent article in my section on autonomy as admitting of degrees in the next chapter.

treatment whether patients [were autonomous]. . . . Medical practice would be through and through paternalistic, and would treat patients as persons only if beneficence so required" (O'Neill, 1984, p. 173). That is, if part of our respect for persons is both for their ability to be self-governing and for their exercising of this capacity, then that basis of respect potentially would be lost on such a beneficence model.

Third, the beneficence model faces the same kinds of problems as does the autonomy model and thus does not represent a more attractive alternative. That is, the beneficence model relies on the assumption that those in power, the medical practitioners, should have the patient's best interest in mind. But one of the implicit points of this chapter has been that some of the same factors which can constrain autonomy also constrain one's ability to recognize correctly what is in the patient's best interest. To take just a few examples: when the staff at the newborn center denied the inevitable demise of the herpes-infected infant, it is extremely questionable whether they in fact had his or his mother's best interests in mind by continuing their aggressive treatment. We have already seen that when practitioners (unknowingly or otherwise) react with prejudice to speakers of a dialect, those speakers do not receive the same standard of care as do SAE speakers; i.e. dialect speakers' "best interests" are not responded to in the same

way as are those of SAE speakers. Finally, when practitioners are trained to use certain types of technology, as we have seen, diagnosis and treatment decisions tend to correspond to the use of that technology; the practitioner really has no other choice, using the technology is the only way she's been trained. More and more evidence is surfacing, however, which suggests that relying on technology is by no means always in the patient's best interest.

These examples could easily be expanded to include nearly all the factors discussed above as constraints on autonomy as well as other constraints which I have not included. The point is that determinations of what is in the best interest are constrained in the same sorts of ways as are persons' ability to be autonomous. Thus, appealing to a beneficence model so as to avoid the quagmires of an autonomy model obviously will not be fruitful.

What is needed, instead, is to gain an understanding of autonomy which does not include the requirement that the autonomous person be ultimately independent from her life-world. When we recognize the social nature of our belief and value structures we see that being autonomous is a process of deliberating over relevant information (as per Brandt) and identifying with the resulting decisions/actions, both processes to be done with the help of concerned parties who are sensitive to the kinds of factors that can constrain autonomy and how they may be influencing

a particular decision. However, a recognition that we are social creatures does not result in an acceptance of the status quo; if we recognize factors which impede persons' ability to be self-responsible we can and should do what is possible to change the social, economic, and/or institutional structures which support or promote those factors.

Furthermore, recognizing that we are social creatures does not mean we should lose sight of the individual in the midst of these constraints, which is exactly the mistake Waitzken makes in his normative recommendations:

Uneven development also rests on certain ideologic contradictions in capitalist society. One such contradiction is that between freedom and equality. This contradiction mystifies the problem of medical maldistribution. . . . Major reorganizational changes in the health system must occur, however, if equality is to become more than a rhetorical goal. One such change necessarily would limit the freedom that health professionals historically have enjoyed. . . . Compulsory assignment of health workers to needy areas has been the only technique that consistently has relieved maldistributional problems. The implementation of such policies always depends on basic social changes that include a strong emphasis on collective goals--even if these goals imply, for periods of time, the subordination of individual preferences (Waitzken, 1983, pp. 25, 26, 27).

Forced relocation clearly represents a most extreme sort of constraint on autonomy. This could be justified only if: first, it could be shown that patient autonomy would be enhanced in a degree sufficient to counter the constraint on health care workers' autonomy; and second, our value system

is based on teleological, as opposed to deontological, principles. I think a more fruitful approach is to appeal to the type of characterization of autonomy I have provided which I hope accounts for the wide range of social influences, while retaining our respect for responsible persons.

Finally, it must also be kept in mind that the sense of autonomy I have been defending admits of degrees, so that even in situations where we are partially constrained, we will often be autonomous enough that our decisions should nonetheless be honored. The subsequent, and final, chapter will provide an explicit defense of this view as well as arguments for my claims that persons have an obligation to promote autonomy in others and that persons have an obligation to attempt to be more fully autonomous.

CHAPTER IV

AUTONOMY AND CONTEXT

We now have a characterization of autonomy that seems to capture the normative concerns present in clinical practice. We also have a broad understanding of the range of factors which can constrain our ability to be responsible, self-governing, autonomous persons. But how does this sense of autonomy work? That is, how will the autonomous person behave in various contexts and what are the appropriate responses to that behavior?

As I have been suggesting throughout, that behavior will vary among contexts; i.e., what we will count as sufficiently autonomous behavior will depend on the situation in which the agent is engaged. Acceptance of this claim, however, is dependent upon acceptance of my claim that being autonomous admits of degrees. So we first need a more detailed look at that latter view.

Autonomy as Admitting of Degrees

What is the argument which supports my claim that autonomy admits of degrees? In essence it has already been provided in my characterizing autonomy as negatively free decisions/actions over which the agent has adequately deliberated and with which she identifies. Persons clearly can be more or less negatively free; they can have greater and

lesser degrees of constraint against their freedom and from a variety of sources. Similarly, the degree to which persons deliberate over decisions/actions will vary among persons and among situations.¹ And one can feel greater and lesser degrees of identification with one's decisions/actions as they are more or less consistent with one's sense of self and one's chosen principles of self-governance. Thus, given my characterization of autonomy it clearly follows that levels of autonomous behavior will vary among persons, through situations, and even among one's moods in a given day.²

If an acknowledgement that being autonomous admits of degrees follows so clearly, why is it that this view is not widely accepted? There are, I think, two predominant reasons. The first is that many characterizations of autonomy, even some of those which stress self-governance, do not clearly recognize that autonomy is both an exercise concept as well as a capacity concept. There is a great temptation

¹Further, as Onora O'Neill points out, such deliberation generally is "opaque". That is, when we deliberate "we do not necessarily 'see through' to the implications that we consent to and consent to these also" (O'Neill, 1984, p. 175). The more "transparent" the decision, the more we can know how the decision will affect who we are and want to be, the more autonomous it is.

²For this last view see, William Ernest Hocking, The Self: Its Body and Freedom (New Haven: Yale University Press, 1956) especially Chapter III.

to focus only on the capacities one needs to be a responsible, autonomous agent (e.g., Benn's conditions for being autarchic) and determine whether the agent in question satisfies those conditions which are minimally necessary for being such an agent. If she satisfies the conditions she is autonomous and if she does not she is not. Determinations of levels of autonomy are not applicable; either she satisfies the minimal conditions or she does not.³ But I have already stressed that those capacities are not sufficient for the kind of autonomous behavior which demands our respect in the clinical environment. While we would have the kind of respect for this agent that we have for persons qua moral agents, we would not honor her decisions unless we were also satisfied that she engaged in the type of activities which are necessary for being autonomous (namely, adequate deliberation and identification), i.e., unless she exercised those capacities she has as a moral agent.

The second reason autonomy is often regarded as an either/or concept is more practically grounded. Such a

³In an otherwise excellent article ("The Inalienability of Autonomy," Philosophy and Public Affairs, Vol. 13, #4, Fall 1984), Arthur Kuflik makes exactly this error: "To summarize, either the individual remains capable of functioning as a critically reflective moral agent or he does not" (Kuflik, 1984, p. 295). In addition to the problems discussed above, this view also leads to the kinds of "speciesism" that many animal rights proponents so detest. My own view is that the kind of respect we afford moral agents also falls on a continuum; the more conditions an entity is capable of satisfying, the more respect we accord.

regard allows us to create idealized versions of what the autonomous decision should look like. And, as O'Neill puts it,

This line of thought curiously allows us to combine ostensible concern for human autonomy with paternalistic medical practice. Having reasoned that some procedure would be consented to by ideally autonomous patients we may then feel its imposition on actual patients of imperfect autonomy is warranted (O'Neill, 1984, p. 175).

If autonomy admits of degrees, if different persons display different levels of autonomous behavior in different situations, then our formulation of what is to count as valid informed consent will be messy indeed. For example, we will not be able to rely on standardized consent forms. A signed consent form simply reveals that the patient and/or her proxy signed that consent form; they provide no evidence that the information on that form (assuming that there is important information on the form--many such forms appeal to communication that was supposed to have taken place between the patient and her physician) was understood and carefully deliberated or even that it was read. It is not unusual to see patients simply sign whatever forms are placed in front of them. What is needed instead is assurance that the real person, with whatever level of autonomy she is at the time expressing, understands the range of factors which are significant to the decision at hand.

But this context-laden understanding of autonomy and of valid consent clearly requires that the achievement of informed consent will be a time-consuming, difficult process. It means, minimally, that valid informed consent requires "doctors and others to avoid haste and pressure and to counteract the intimidation of unfamiliar, technically bewildering and socially alien medical environments" (O'Neill, 1984, p. 175). It also means taking into account the kinds of factors described in Chapter III, attempting to determine the kind of impact they are having on a particular decision-maker. And, ultimately, it means altering the kinds of social, economic and institutional factors which lead to constraints on autonomy.

Even if we required only some of these changes, two results would occur. First, the health care practitioner's job would be made more difficult. Instead of patients simply signing a consent form upon admission, thorough, careful communication will have to take place, at least for significant decisions. (I will return in a moment to the issues connected with this "significant decisions" qualifier). Second, there will be a distinct power shift. As much of medical practice now stands, the power advantage physicians hold (due to knowledge, social status, etc.) allows them to

engage in manipulation and control of patient decisions.⁴ But if that power advantage itself becomes an issue for deliberation, if the patient realizes that part of the reason a particular option seems more attractive is because the authority figure is recommending it, that advantage loses much of its punch.⁵ For both of these reasons the medical practitioner is happy to view autonomy as an either/or concept. She wishes neither to make more difficult an already excessively demanding profession nor to lose her status as a person of authority.⁶

⁴Madison Ave. evidently has recognized physician's power to manipulate patient decisions. In an ad attempting to sell advertising space in a magazine to be read by patients waiting to see their doctor, the following pitch was made:

'Your advertising message is surrounded by physician-written, physician-endorsed health editorial. . . . Reaches your customers in the physician's waiting room, when their health interest is at its peak. . . . Implied Physician endorsement. When doctors recommend, consumers buy!' (Quoted in Consumer Reports, Vol. 50, #1, November, 1985, p. 703).

⁵Bringing about this kind of patient awareness may require that someone other than or in addition to the physician be the information-giver and consent receiver. While there are many logistical problems associated with this suggestion, it may be the best way to achieve valid informed consent.

⁶Despite this common view on the part of many medical practitioners, I hope to show in the final section of this chapter that shifting the emphasis to patient's being more responsible for their own lives will be to the practitioner's advantage, as well as the patient's.

Both of these points--the confusion of autonomy regarding its status as an exercise concept and the practical ramifications of recognizing it as admitting of degrees--are speculative. That is, I cannot provide solid concrete evidence that they are the reasons why autonomy is not widely recognized as admitting of degrees. However, regardless of whether they confirm this claim, both reasons hold true independently. That is, there is the described confusion in the literature and the practical ramifications noted above would in fact result. My claim is that they provide plausible explanations for the prevalence of the view whose mistakenness I hope to have shown.

The obvious question now is, if we recognize that autonomy admits of degrees, how much autonomy is enough? What kinds of behavior in what situations demand our respect as autonomous?

Respect for Autonomy and Contextual Variables

In Chapter II, I said "the self-governing, autonomous person must engage in deliberation in as full a way as the situation allows and warrants." It is now time to explain what I meant by this caveat.

When we recognize that being autonomous admits of degrees we also are at least implicitly recognizing the kinds of constraints that prevent persons from being fully autonomous. That is, we are recognizing that certain contexts

have factors inherent in them which constrain autonomy. Given these constraints is it then legitimate to demand the kind of idealized sense of autonomy criticized by O'Neill above? The following is her perceptive answer.

[B]y shifting focus from what has (actually) been consented to, to what would (ideally) be consented to, we replace concern for others' autonomy with concern for the autonomy of hypothetical, idealized agents (O'Neill, 1984, p. 175).

The force of this point lies in recognizing that such hypothetical idealized agents do not exist. One cannot have complete deliberation over all potentially significant information, if for no other reason than the already noted "opaque" characteristic of deliberation. Further, total, complete identification with all aspects of one's life does not exist. The most we can hope for is full identification with an immediate decision/action and considerable identification with the ramifications and corollaries of that decision/action.

But what of the "reasonable person" standard I appealed to in discussing what kinds of information are relevant to decisions?⁷ Is a similar standard possible for determining what levels of autonomous behavior are sufficient to demand our respect?

⁷I appealed to this standard only as a starting point. My emphasis was on orienting information to the particular values, goals, etc. of the individual patient. However, the reasonable person standard is often still appealed to as a valid criterion in and of itself.

Remember why we appeal to the "reasonable person" standard in determining adequate information: we appeal to this standard exactly because persons are so different, because they seek, need to have and understand such different degrees of information, and because different persons regard different things as relevant. One patient may have the intelligence which allows her to grasp quickly the connections and consequences associated with a minimal amount of information. Another may need to be told much more in a more simplified way so as to gain that same degree of understanding. But since the health practitioner often will not know going in which type of patient she is working with, we ask her to provide that amount of information, at the degree of complexity, that the "reasonable" (often this should be read "average") person needs. With the more intelligent patient this may be too much, too simplified, information. With the other patient it may not be quite enough. Or with a patient who has had her capacity for deliberation significantly impaired by some of the described ramifications of illness, it may not be possible to inform her fully.

Does this mean we should not honor the latter two persons' decisions as autonomous since they do not meet what we might call the "reasonable" level of autonomous behavior? Once again the answer depends on the context, on the decision being considered and on how that decision will affect the patient concerned. We have already noted the obvious

point that different persons have different goals, values, etc. It seems just as obvious that because of these differences, different persons will be affected differently by the same decision. The issue, I think, is how much a particular decision will affect a particular patient's fundamental project. The greater the impact, the higher should be the required level of autonomous behavior.

Let us take an example. Two patients are diagnosed as having chondromalacia patella (an arthritic-like condition which attacks the knee joint, causing reduced mobility, pain and swelling). The first, Sam, is a 26 year old graduate student in philosophy. He has never been athletic; he spends the great majority of his time reading and writing. The second, Samantha, is a 22 year old exercise instructor and engages in a wide variety of athletic activities. Both are given the option of a relatively experimental form of surgery in which the tibia is extended so as to reduce some of the pressure on the joint. If the surgery works, both should be able to have nearly normal use of the joint for the remainder of their lives. If the surgery fails, both will suffer an immediate and permanent reduction in mobility. If the surgery is not performed there will be a gradual worsening of their condition, a worsening which is exacerbated and hastened by athletic activity.

Clearly the extent of deliberation "warranted" by this situation is different for Sam than it is for Samantha. Because mobility is not as important a part of his life, we should be satisfied if it is clear that he merely understands his options with their associated risks and benefits. However, with Samantha we should not only make sure that she understands the options, but that she has given them very careful deliberation. We must be satisfied that she is aware of how significantly her life will be altered if she opts for surgery and it fails. Further, she must also understand that if she does not have the surgery she will either have to change her current life-style or be faced with a more drastic alternative in the not-too-distant future. In short, the amount of deliberation the situation "warrants" is immediately tied with the goals, values, beliefs, etc. of the patient. Thus what is warranted, even with respect to the same basic decision, will vary from patient to patient and even over different periods in the same patient's life. (The decision for Samantha would be quite different if she were 52 years old, had spent the last 30 years as an exercise instructor, and were now independently considering other career alternatives).

By linking what is warranted to fundamental projects I am also suggesting that more trivial aspects of a particular decision do not require extensive, or sometimes even any, deliberation. O'Neill makes the same point as follows:

In human contexts, whether medical or political,⁸ the most that we can ask for is consent to the more fundamental proposed policies, practices and actions. . . . Respect for autonomy requires that consent be possible to fundamental aspects of actions and proposals, but allows that consent to trivial and ancillary aspects of actions and proposals may be absent or impossible (O'Neill, 1984, p. 176, her emphasis).

This also suggests two further points about the consent process. First, since what counts as valid consent depends on the particular patient, information giving should be tailored as much as possible to the goals, values, beliefs, etc. of that patient. This means that health practitioners must attempt to learn as much as possible about their patients. Thus the type of communication will, at times, have to switch from an attempt to gain (and/or provide) clinical information, to an attempt to gain (and/or provide) personal information.

But, and this is the second point about the consent process, it clearly cannot be expected of health practitioners to learn each of their patient's chosen principles of self-governance. Even if this were practically possible it would place the burden of responsibility solely on the shoulders of the practitioner. But, as I will be arguing more strongly in a moment, being a responsible, autonomous

⁸One of O'Neill's insightful points is that "Medical cases may . . . be not so much anomalies, with which consent theory cannot adequately deal, as revealing cases which highlight typical limits of human autonomy and consent" (O'Neill, 1984, p. 175).

person means taking on much of this "burden" ourselves. Thus the autonomous person will carry her chosen principles of self-governance into the consent situation and will attempt to determine for herself how given options coincide with those principles. And when she is in need of additional information so as to be able to make that determination, she will seek it herself, either from the practitioner with whom she is working or, if necessary, elsewhere.

But what of the first part of the caveat: the amount of deliberation the situation allows. Obviously different situations allow for greater and lesser levels of deliberation. And, unfortunately, those options which have the greatest impact on one's fundamental project are often those which take place in situations which are not conducive to extensive deliberation, e.g., emergencies and situations which carry with them greater amounts of, e.g., psychological constraints.

The answer to how much autonomous behavior must be present in these situations in order to demand our respect is once again neither clean nor neat. The factors which must be considered include, how serious the decision is (i.e., how much of an impact it is likely to have on the patient's fundamental project), how extensive the factors are which impede the patient's ability to engage in autonomous behavior, whether there is someone else present who knows the

patient well and can make an educated guess as to how the patient herself would decide, etc.

My response is admittedly not very informative. In essence all I am saying is that each situation should be approached individually and where it is possible to promote higher levels of autonomous behavior, such an avenue should be taken, other moral considerations being equal. As to which decisions must be honored as autonomous, again the answer will vary, based on the above factors. Some persons will be less affected by particular constraints than will others and thus will be more able to engage in higher levels of autonomous behavior. Or a particular patient may not obviously have engaged in thorough deliberation but a family member may be present who confirms that her decision coincides with her chosen principles of self-governance. And, as we have already seen, the same option will be more or less important to different patients and thus will demand a corresponding level of autonomous behavior.

This view would seem to place too much prerogative in the hands of the physician. In our current system it is the physician (often in consultation with the family) who makes at least the initial determination whether the patient meets the requirements of self-governance--whether, in legal terminology, the patient is competent. If the physician deems the patient incompetent a court hearing is held to determine if the patient needs a guardian assigned or if she needs to

be institutionalized, etc. On my characterization of autonomy it would seem that such actions could be taken not only when the patient is generally incompetent, but when she does not meet the high level of self-governance a particularly important decision demands. Thus, either the courtrooms would be additionally burdened with attempts to determine degrees of self-governance, or, more likely, physicians will simply exert their authority in more or less direct ways and take over the decision-making powers when they deem it necessary because a patient is not expressing a high enough level of autonomy.

But there is no reason why physician authority need be increased in this way. First, an acknowledgement that a patient is not autonomous enough to make an important decision implies that she may be autonomous enough to control most all other aspects of her life--including who the decision-maker should be in this case. The main force of this view of autonomy is that since persons generally express some level of autonomous behavior we cannot take over their complete decision-making authority simply because they are not autonomous enough to make a particular decision. The extent of infringement on patient decision-making must not exceed the degree of incompetence.

Second, I will be arguing in the last sections of this paper that it is consistent with the concept of autonomy that persons attempt to enhance another's level of autonomy.

Thus, in some cases, instead of abrogating the patient's authority, the best alternative will be to attempt to make the patient more autonomous.

Finally, I have been suggesting throughout that this sense of autonomy demands a more effective level of communication. When there is suspicion whether a patient is autonomous enough the first step (in at least important decisions) should be to talk, to talk with the patient, her family, allied health personnel (psychologists, social workers), etc. Furthermore, the physician often will not be the most qualified to determine how competent a patient is (especially since the physician, as an authority figure, often is one source of constraints on autonomy). Thus, as I suggested earlier, acquiring valid informed consent may require having someone other than the physician involved in this process. This person would need to be skilled at communication and would need to understand the issues involved in what it means to be autonomous.⁹

A final point should be made about this contextualist view of autonomy. Let us assume that two patients with relevantly similar principles of self-governance are faced with substantially the same choice. However, one of the patients is faced with that choice in an emergency; she does not have

⁹One of the areas clinical medical ethicists can be helpful is in teaching, for example, social workers those issues.

the time to deliberate extensively and she is constrained by such factors as fear and physical pain. The other patient makes this choice in, let us say, a family practice setting. There is no immediate crisis; she has ample time to deliberate and to deal with some of her fears or other psychological constraints. Further, because she has additional time, she also has access to a greater range of resources to help her make a decision. She can consult another physician, she can read about the ailment, etc.

What kinds of decisions do we respect as autonomous in these two situations? While we might honor decisions based on comparable levels of deliberation and identification, we would not have as much respect for the second patient if she did not take advantage of her opportunity to be a responsible chooser. Our level of respect for persons as responsible choosers, I think, corresponds to how much the patient is willing to take advantage of such opportunities to be autonomous. In family practice settings, the opportunity is often great and we expect patients to be as much responsible for their lives as the situation allows. In emergencies, however, we also respect those persons whose decisions we honor. We respect them because we recognize at least implicitly that the wide range of constraints inherent to these types of decisions make it much more difficult for patients to achieve high degrees of deliberation and identification.

This issue will come up again in my argument that persons have an obligation to be autonomous.

Hence, the phrase, "the self-governing, autonomous person must engage in deliberation in as full a way as the situation allows and warrants," implies that such contextual variables as who the person is (what her goals, values, beliefs, etc. are), how significant the decision is, what constraints exist, etc. must be taken into account in determining whether the decision is autonomous enough to demand our respect. Too often autonomy is presented as an either/or proposition: either a patient is autonomous and her decisions deserve our respect or she is not and they do not. I think, instead, that we should recognize that what counts as being autonomous (or autonomous enough) varies by context. Further, and at least as important, we need to start focusing on those factors which exist in greater and lesser degrees in different settings that constrain persons' ability to be autonomous.

The focus of this work has been on "respecting" and "honoring" autonomous decisions. It is now time to consider whether it is consistent with the concept of autonomy to claim that it is legitimate to attempt to promote autonomy in others as well as the related question whether persons have an obligation to be autonomous.

Promotion of Autonomy and the Obligation To Be Autonomous

It is sometimes suggested that since to be autonomous means to be a self-governing and negatively free person that, even given the value of autonomy, it is illegitimate for others to attempt to promote it in us. But such a promotion can only be conceived of as illegitimate in two senses. The first is if by "self-governance" we mean that the agent must choose her principles in complete independence, without any external influence. But I have already shown that this sense of self-governance relies on an unrealistic notion of our social existence as persons. Our chosen principles of self-governance clearly are and should be influenced by those around us.

However, promotion of autonomy is also thought to be illegitimate when the agent openly objects to the attempts to make her more autonomous; for example she refuses to accept information which is relevant to her decision. In this situation the promoter would be doing more than simply influencing; she would be actively interfering with the agent's wishes. Can such an interference ever be legitimate?

David Ost and Arthur Kuflik argue that this sort of interference is justified because persons do not have the right to refuse relevant information, to be nonautonomous. Their claim is that the concept of autonomy logically

entails that persons cannot have the right to be nonautonomous. I am sympathetic to their claim, but I think that their arguments do not hold up. In what follows I will show why they fail.¹⁰ I will also, though, take a different approach to the same claim. Rather than showing that persons do not have a right to be nonautonomous, I will argue that persons have an overriding obligation to be autonomous.

However, the claim that persons have an obligation to be autonomous does not necessarily justify, for example, a physician forcing information on an unwilling patient. I will conclude this section with a highly qualified argument that, depending on the information at stake, on how that information will affect the patient's fundamental project, etc., it is legitimate to impose information on unwilling patients.

The right to refuse information. Two recent articles--David Ost's "The 'Right' Not to Know" (Ost, 1984) and Arthur Kuflik's "The Inalienability of Autonomy" (Kuflik, 1984)--provide interesting arguments, based on the same basic

¹⁰Of course, no reason for claiming that persons do have such a right is provided by the failure of the arguments against them having such a right.

premises, that persons cannot have the right to refuse information which is relevant to an important decision.¹¹

Their arguments are enough similar that I will rely on Ost's, as his is explicitly concerned with issues in medical ethics.¹² Further, since his argument is complete and well-stated, I will simply summarize his primary points.

The crux of his argument is that, on any definition of rationality, it would be irrational not to accept (relevant) information for use in making (important) decisions. And

If we can show that refusal of information is irrational, we will have shown that there is no such right [to refuse information]. For if such refusal is irrational, and irrationality is an autonomy-defeating condition, and autonomy is the basis of rights, then to refuse information is

¹¹Actually, neither Ost nor Kuflik take the turn that O'Neill and I have taken--i.e., that only the most serious of decisions demand high levels of autonomous behavior. That is, they do not distinguish between (a) having the right not to know trivial information and (b) having the right not to know information which is relevant to an important decision. (Ost touches on the issue [Ost, 1984, p. 306], but claims it is not of importance for his purposes.) But clearly we need to distinguish information which is important for a decision from that which is not. Even if it could be shown that persons do not have the right to refuse information which is relevant to important decisions, no one would want to claim that persons do not have the right to ignore trivial information or that they must accept all possible information which is relevant for trivial decisions.

¹²The primary difference between their articles is that in addition to the Kantian argument presented by both, Kuflik also presents some utilitarian types of claims: e.g., "In an autonomy-abdicating arrangement the gain may be clear, but the potential costs are, in principle, unbounded" (Kuflik, 1984, p. 291). Also, Kuflik provides the historical background to the view that autonomy is inalienable in which he appeals to such diverse sources as Spinoza, Locke, Rousseau, and Kant (Kuflik, 1984, pp. 277-284).

ipso facto to claim that one is not autonomous, i.e., not a bearer of rights (Ost, 1984, p. 304, his emphasis).

This Kantian type of argument is oriented around one's status as a moral agent. Simply put, to be a moral agent, to be a bearer of rights, one must be rational. The foundation of all rights, on this view, is rationality. Hence it is contradictory to claim a right which is founded on an irrational basis, i.e., the refusal of relevant information.¹³ All that needs to be shown, therefore, is that such a refusal is in fact irrational.

Ost's arguments here are essentially the same as those provided in Chapter II of this work. He argues there could be only two grounds for refusing information and, for example, placing oneself completely in the hands of one's physician. "First, the individual's intentions may be so fixed and unalterable that no information would, in fact, be relevant to them" (Ost, 1984, p. 306). But, as Ost points out, this position represents a clear-cut example of an obsession; i.e. a compulsive, irrational preoccupation with a

¹³Both Ost and Kuflik attempt to make a stronger, and I think erroneous claim. When Ost says that irrationality is an "autonomy-defeating condition" he seems to mean that one loses all of one's status as an autonomous (moral) agent: "To recognize a right not to know is to assert that a right is borne by a non-right holder" (Ost, 1984, p. 305). But irrationality with respect to a particular action does not void one's general status as a moral agent. The (temporarily) irrational person is still a holder of rights. What we need to focus on instead is whether this particular 'right' is founded on an irrational basis and if, thus, it is in fact not a right.

fixed idea. Second, the individual may be claiming to know what he cannot know prior to your disclosure of the information; namely, his evaluation of its relevance to his decision" (Ost, 1984, p. 306). Again, such a belief clearly is irrational. These points coincide with the definition of rationality we borrowed from Brandt. Further, since Brandt's definition was the most minimalist of those we considered, they would be a part of the more inclusive definitions as well. Thus, if these are the only grounds for refusing the information, they are in fact irrational and therefore do not provide the basis of a right.

However, Ost does not acknowledge a third possible ground for refusing information. Kuflik, though, does: in giving up one's autonomy one's "goal is to achieve some [other] highly desirable state of affairs" such as improved health (Kuflik, 1984, p. 285, my example). It is at this point that Kuflik presents the utilitarian argument noted above (footnote 10). Although I do not have the space to provide the details of his position, he argues that the abdication of autonomy rarely if ever will result in a state of affairs more desirable than being autonomous. However, his conclusion is based on the situation in which one completely abdicates one's status, thereby "stripping the agent of the right to make any further choices while subordinating the whole future course of his life to the unconstrained will of another" (Kuflik, 1984, p. 291). But one can give

up the autonomy to make a particular decision without giving up the option for future autonomous behavior. If I give over the decision whether to have surgery to my physician I have abdicated my autonomy with respect to this particular decision (with the idea that she knows better and thus my health will be promoted), but I have not abdicated my autonomy in other areas of my life.¹⁴

In short the error both Ost and Kuflik make lies in their lack of acknowledgment that being autonomous is not an either/or proposition, that one can be irrational or non-self-governing with respect to particular decisions while maintaining one's status both as moral agent and as a more or less autonomous individual. Because of this they fail to provide good reasons for assuming that persons do not have a right to refuse (relevant) information for making (important) decisions. As I noted above, this does not mean that persons do in fact have such a right. Additional positive arguments would need to be provided to make such a claim and I have not seen any which are convincing. However, the issue can be side-stepped if we can provide an argument that persons have an undefeated obligation to be autonomous, for if they do then they cannot have an undefeated right to

¹⁴However, the effects of the initial abdication may constrain my future ability to be autonomous; e.g., through the side-effects of the surgery. Also, there is the danger that turning decision-making authority over to another will become habitual, as when we so adopt "the sick role" as to relinquish all medical authority to the physician.

refuse relevant information. The following section will be devoted to such an argument.

The obligation to be autonomous. The common objection to the view that persons have the obligation to be autonomous is that it is very unclear to whom the obligation is owed. The answer typically is as Ost writes: "There would seem to be only two possible candidates to whom such a duty could be owed: to humanity at large, or to the patient himself" (Ost, 1984, p. 307).

However, there are two ways of understanding the concept of obligation. There is the strong sense, wherein duties are owed to persons; where failure to meet one's duty will result in the violation of another person or persons' right(s). There is also a weaker sense, as in one "ought to act autonomously." This sense is weaker in that there need not be any harm to another which will result if the duty is unfulfilled.

With respect to the second sense, there does seem to be much to claim that persons should be as much self-responsible and autonomous as possible. We certainly hold greater respect for those persons who are; we think their lives have more dignity. As Veatch put it, "there is something dehumanizing about refusal to face important decisions affecting one's future. It is more noble, more responsible, to take an active part in making these decisions" (Veatch, 1981, p. 205). Kuflik, too, seems to think

that the view is inherent in our conception of responsible persons:

Perhaps it is not the sort of claim for which proof, in the usual sense, can be given (since any proof we might provide is likely to rest on considerations less plausible and less fundamental to our way of thinking than the thesis itself) (Kuflik, 1984, p. 285).

While I wholeheartedly agree with these points, I am hesitant to use "obligation" in this weaker sense. However, I have neither the time nor the space to go into all of my objections to such a usage. Put most simply, it strikes me in much the same way as does, "You have a right [sic] to have your chicken done right." More importantly, however, there is a firmly established tradition that views "obligation" in the stronger sense and in order to satisfy that perspective we must explain how not being autonomous will violate others' rights.

Within this perspective, it is generally assumed that, following Mill, achieving a state of dignified self-responsibility is purely self-regarding conduct and that since no one will be harmed if I do not achieve it, I do not have an obligation to do so. And if there is no obligation to be autonomous, we cannot justify such restrictions of liberty as imposing information on an unwilling recipient. But is this conduct purely self-regarding?

I think not. Consider what actually happens when persons do not act in a responsible manner, when they refuse to

make important decisions themselves. Additional burden will be placed on family, friends, or, frequently, on physicians; i.e., on those persons who will have to engage in the often difficult task of making the decision. We have already seen that making responsible decisions which have potentially serious consequences can be a burdensome task. The responsible agent must engage in considerable deliberation, must identify with the choice made and must thereby ultimately recognize that it was in fact her choice. This latter recognition easily can lead to evasion of that responsibility, to Sartre's "bad faith." What happens when one engages in evasion of this sort, when one fails to engage in those activities (deliberation and identification) which make the decision a responsible one? The burden is placed on someone else. We force another person, in our example the physician, to take responsibility for our own lives (or at least for the aspect of our lives to which the decision corresponds).

I wish to suggest that this evasion is immoral, that we have an obligation to the physician (or to whomever else will be forced into the role of decision-maker) to be responsible for our own lives, i.e. to be autonomous. We have an obligation not to impose this burden on the health care practitioner because of the emotional, physical, and social ills that have been shown to accompany such a position of

responsibility.¹⁵ Such a shifting of burden can be justified only if it can be shown that the health care practitioner is the only person qualified to make the decision. But much of this work has been devoted to showing that she is not; that the patient is the person best qualified to know how a given decision coincides with her chosen principles of self-governance.

Being a self-responsible, autonomous person means accepting the burdens which accompany such a position. Those burdens include engaging in the kind of deliberation over and identification with our decisions/actions described above. Being able to engage in that deliberation also means accepting and sometimes seeking the necessary information, especially if one's principles of self-governance are not the same as those of the physician or other information provider or if they do not coincide with the standards of the "reasonable person".

However, along with the burden comes respect, both self-respect and the respect others have for responsible persons. Ultimately, it seems that the kind of shift I am

¹⁵A number of studies have shown the harms which result from either taking or being forced to assume excessive responsibility. See, for example: G. Vaillant, "Some Psychological Vulnerabilities of Physicians," New England Journal of Medicine, Vol. 287(1972), pp. 272-275; Glen O. Gabbard, "The Role of Compulsiveness in the Normal Physician," Journal of the American Medical Association, Vol. 254, #20, Nov. 22, 1985, pp. 2926-2929; and David Hilfiker, "Facing Our Mistakes," New England Journal of Medicine, Vol. 310, #2 January 12, 1984, pp. 118-122.

suggesting can do nothing but create a more positive, healthy, and productive health care environment. Although I do not wish to resort to empty platitudes, it seems that in the end all parties would benefit from the creation of the mutually respecting, less adversarial relationship which would result from persons being self-responsible.¹⁶

Does such a relationship, though, allow for the active imposition of information on the part of the health care practitioner, even over the objection of the patient? That is, even if patients have an obligation to accept relevant information, do health care practitioners have the right to impose that information?

The imposition of unwanted information. Ost eloquently draws a distinction that is of help here.

The question of refusal of information is an important one in medical ethics because it brings into direct confrontation two value-orientations which are often conflated in ordinary experience: the humane and the humanistic. When we act humanely, we act in such a way as to minimize the pain, harm, or discomfort which inheres in a particular situation as a result of the human condition which we all share. . . . Humanistic values, by contrast, are demanding ones, for they project for us an ideal of what human actions and choices

¹⁶Further, it has been convincingly suggested that as corporate involvement in medical care becomes more pervasive, physicians and patients will have to reach a more cooperative stance so as to resist the economic pressures placed on them by bureaucratic organizations. One of the ways of reaching this cooperation is by giving patients more input in their health-care treatment. (See, Sue Carole Fisher, In the Patient's Best Interest, forthcoming.)

ought to be: free, self-determining, responsible.
. . . Humane acts have compassion as their underlying motive; humanistic ones, respect (Ost, 1984, p. 310).

Ost's point is not that these two value-orientations must be in conflict. Rather, his claim is that they are different and that both are highly prized. My emphasis in this work clearly has been on the humanistic, on persons being as autonomous as possible. However, Ost is correct in appealing to both values; promotion of autonomy should not be made at the complete expense of humane values. The information-provider's task, then, is to attempt to find a way to provide important information that the patient is resisting (and thereby treat the patient/person with respect) while showing compassion for the possible pain or trauma which will accompany that provision.

Obviously that task is difficult; it is the longstanding conflict between respect for the principle of beneficence vs respect for the principle of autonomy. My claim is that medical care in the last fifty years has taken a strong turn in support of beneficence. So much of a turn that respect for autonomy, in all aspects of illness, is frequently reduced to mechanical, meaningless gestures. It is time to turn the tide somewhat and attempt serious efforts at allowing and encouraging persons to be responsible as possible for their own lives.

In order to bring this about it will sometimes be necessary for information providers to impose information. However that right (to impose information) is greatly qualified. Such information should be pressed only if the provider has a reasonable certainty that its receipt will alter the patient's decision and if the question at hand has the potential of having a significant effect on the patient's fundamental project. Further, determinations of what information is relevant should be reached from as objective a stance as is possible. Given the kinds of social and institutional constraints described in Chapter III, it probably is the case that, at least with important decisions, someone other than or in addition to the primary care-giver should provide that information. Finally, whoever is the information provider, she must strive, in Ost's terms, to accomplish her task "tempered by the principle of humanness" (Ost, 1984, p. 311).

Closing Remarks

Although I hope that the work done here represents some significant advances on discussions of autonomy in medical ethics, there clearly is much more that needs to be done.

Much more research needs to be done on the range of factors that constrain persons' ability to be autonomous. We need to know better the impact of those constraints as well as ways to counter them. I fear that changing some of

them, e.g., the impact of the profit motive on health care delivery, would require such an extensive overhaul of the system that suggesting it is not plausible and might not be ultimately worthwhile. However, advances in how information is conveyed clearly are within our immediate grasp and would represent significant improvements. Philosophers should draw upon on the work of sociologists, psychologists and applied linguists in this area so as better to develop fruitful models of informed consent. Understanding how best to promote individually responsible, free, autonomous persons means not only understanding what is entailed by the concept, but how the system in which autonomy is being promoted works.

Finally, although the focus of this work has clearly been on autonomy as valuable, I have not meant to suggest that being autonomous is the final, most enlightened state a person could achieve. As Benn puts it:

Of course, autonomy is not an exhaustive characterization of a personality. Concentrating on process and modes of consciousness, I have necessarily left out of account the content of the autonomous man's principles and ideals. There is no reason why an autonomous man should not be deeply concerned about social justice and community--but I have said nothing to suggest he will be (Benn, 1975-76, pp. 129-130).

Benn explicitly recognizes that the autonomous person may not be the moral person. Being self-governing, I have stressed, does not mean being morally good. In fact,

Dworkin suggests that the truly autonomous person may necessarily be less compassionate and moral (Dworkin, 1981a, p. 277), much as Nietzsche's Übermensch is seen as an amoral entity. Yet clearly our respect for persons includes more than their status as self-governing, responsible persons. We also have great respect and admiration for persons, of compassion, generosity, moral steadfastness,¹⁷ and general concern for the well-being of others.

Ideally, persons are both autonomous and otherwise virtuous. Realistically, we are quite impressed if someone achieves a high degree of either. And if some of the more pessimistic authors are correct, if full autonomy is incompatible with full beneficence, it may well be that we would have greater respect for the person who manages the latter. But until that pessimism is confirmed, our premier moral goal should be the enhancement of compassionate, moral, freely responsible autonomy, both in ourselves and in others.

¹⁷I cannot help but have at least a grudging respect for the person who never tells a lie, or who because of believed moral disapprobation, never drinks alcohol, even if we feel that those decisions are not made with utmost deliberation or identification.

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VITA

Christopher Meyers was born June 11, 1957 in San Jose, California and was reared in Hermosa Beach, California. He received his Baccalaureate degree from the University of California, Santa Cruz, in 1980, his Master of Arts degree from the University of Tennessee, Knoxville, in June, 1985, and his Doctor of Philosophy degree from the University of Tennessee, Knoxville, in March, 1986. His areas of specialization include applied ethics (especially medical and business ethics) and phenomenology and existentialism.